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

1. Request Information

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

B. Program Title:
Head and Spinal Cord Injury (HASCI) Waiver

C. Waiver Number:SC.0284
Original Base Waiver Number: SC.0284.

D. Amendment Number:SC.0284.R04.01

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

03/01/14

Approved Effective Date: 03/01/14
Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The State is seeking to amend this waiver for the following reasons:
1) Add Waiver Case Management(WCM) as a service using a multi-year phase-in rate;
2) Change the minimum number of required waiver services that an individual must receive each month from one to two;
3) Revise Quality Improvement sections as needed;
4) Update Appendices as needed; and
5) Enhance clarity of language as needed.

The requested effective date for this amendment is March 1, 2014 or the first day of the month after approval from CMS.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	
☑ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	
☑ Appendix C – Participant Services	
☑ Appendix D – Participant Centered Service Planning and Delivery	
☑ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	
☑ Appendix H	
☑ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	

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

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

  Specify:
  Quality Improvement 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:amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: SC.0284
Waiver Number:SC.0284.R04.01
Draft ID: SC.09.04.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/13
Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

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:

☑ **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.
South Carolina is seeking to renew the South Carolina Head and Spinal Cord Injury Waiver. This Waiver will serve 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 the aging. All persons must meet either the Nursing Facility level of care or the ICF-ID level of care criteria.

Administrative authority for this Waiver is retained by the South Carolina Department of Health and Human Services (DHHS). The South Carolina Department of Disabilities and Special Needs (DDSN) perform Waiver operations under a memorandum of agreement and service contract with DHHS. DDSN has the operational responsibility for ensuring that participants are aware of their options under this Waiver. DDSN utilizes an organized health care delivery system that includes county Disability and Special Need Boards, private providers,and enrolled DHHS Medicaid providers as Waiver service providers. Services in this Waiver are provided at the local level mainly through a traditional service delivery system. This Waiver does have a participant-directed service that allows individuals or responsible party to direct their own attendant care services if they chose this option.

The services offered in this Waiver are meant to prevent and/or delay institutionalization in a nursing home or ICF-ID. This Waiver reflects the State's commitment to offer viable community options to institutional placement.

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:
SCDHHS secures public input into the development of the HASCI waiver amendment that involves the following actions:

-Presentation(s) were conducted at the SCDHHS Medical Care Advisory Committee (MCAC) on March 19, 2013 and September 17, 2013;
-Notices to the Tribal Governments was conducted by SCDHHS on August 21, 2013 and September 11, 2013;
-Information to the public on the amendment was submitted on the SCDHHS email listserv on September 19, 2013 and comments were solicited for two weeks;
-SCDDSN announced information about the waiver amendment to their Commission at the September 19, 2013 meeting.

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:	Atwood
First Name:	Anita
Title:	Program Coordinator II
Agency:	Department of Health and Human Services
Address:	PO Box 8206
Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29202
Phone:	(803) 898-4641 **Ext:** ☐ **TTY**
Fax:	(803) 255-8209
E-mail:	Atwood@scdhhs.gov

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

Last Name:	Veldheer
First Name:	Linda
Title:	Director, Head and Spinal Cord Injury Division
Agency:	Department of Disabilities and Special Needs
Address:	PO Box 4706
Address 2:	Harden St. Ext.
City:	Columbia
State:	**South Carolina**
Zip:	29240
Phone:	(803) 898-9789 **Ext:** ☐ **TTY**
Fax:	(803) 898-9653
E-mail:	LVeldheer@ddsn.sc.gov

8. Authorizing Signature

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

Signature:	Anthony Keck
	State Medicaid Director or Designee
Submission Date:	Jan 14, 2014

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

Last Name:	Keck
First Name:	Anthony
Title:	State Director
Agency:	South Carolina Department of Social 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: keck@scdhhs.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

March 1, 2014 : The State expects that all current waiver participants receiving service coordination as a state plan service will continue to receive waiver case management once it becomes a formal waiver service. The State does not anticipate any impact on access to care but does expect to implement improved quality measures.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

Specify the division/unit name:
The South Carolina Department of Disabilities and Special Needs (DDSN)

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
DHHS and DDSN have a Memorandum of Agreement (MOA) to ensure an understanding between agencies regarding the operation and administration of the waiver. The MOA delineates the waiver will be operated by DDSN under the oversight of DHHS. The MOA specifies the following:
- Agreement Period
- Purpose
- Scope of Services
- Fiscal Administration
- Terms and Conditions
- Appendices

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

DHHS and DDSN also have a service contract outlining the requirements and responsibilities for the provision of waiver services by the operating agency. The service contract includes the following:
- Definition of Terms
- Scope of Services
- SCDDSN Responsibilities
- Conditions of Reimbursement
- Audits and Records
- Termination of Contract
- Appeals Procedures
- Covenants and Conditions
- Appendices

The service contract is reviewed and updated every three to five years and amended as needed.

DHHS utilizes various quality assurance methods to evaluate the DDSN's compliance with the terms and conditions established in the MOA and service contract, with special focus on DDSN''s performance of assigned waiver operational functions in accordance with waiver requirements. DHHS uses a Quality

Improvement Organization (QIO), quality assurance staff, and other agency staff to continuously evaluate the operating agency''s quality management processes to ensure compliance. The following describes the roles of each entity:

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

DHHS QA Staff: Conducts periodic quality assurance reviews. These reviews focus on the CMS quality assurance indicators and performance measures. A report of findings is provided to DDSN, who is required to develop and implement a remediation plan, if applicable.

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

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

The frequency of the Medicaid agency's assessment of the waiver operation by DDSN is on an annual basis.

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.:*
  1. DDSN contracts with the USC School of Medicine, Center for Disability Resources (CDR): This contract provides quality assurance of the operational function of the University Affiliated Program (UAP) Self-Directed Attendant Care Program.

  2. DDSN contracts with the USC School of Medicine, CDR: This contract provides for the single point of preliminary intake and eligibility screening for all individuals seeking services through the Head and Spinal Cord Injury Division and HASCI Waiver.

  3. DDSN contracts with the USC School of Medicine, CDR: This contract provides for quality assurance reviews of Level of Care (LOC) reevalations.

  4. DDSN contracts with a CMS certified QIO contractor for oversight and review of waiver services and providers participating in DDSN operated waivers.

  5. DDSN contracts with the Jasper DSN Board which is responsible for verifying the qualifications of and payment for all providers of self-directed attendant care.

  6. DHHS contracts with a CMS certified QIO contractor. This entity reviews a representative sample of initial ICF/ID levels of care determinations performed by DDSN.

  7. DHHS periodically contracts with Winthrop University to perform validation reviews, focus reviews, and trend analysis.
- ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   ○ **Not applicable**

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

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

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

   DDSN contracts with its local Disabilities and Special Needs (DSN) Board providers. Service coordination and early intervention staff at the local Disabilities and Special Needs Board prepares the Plans of Service and complete reevaluations of NF and ICF-ID levels of care.

   DDSN contracts with the Jasper Disabilities and Special Needs (DSN) Board which operates as the fiscal agent of the UAP Self-Directed Attendant Care Program.

   ☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

   DDSN contracts with approved/qualified private providers for Waiver Case Managers (WCM) /Early Intervention (EI) staff members, who prepare the Plans of Service and complete reevaluations for NF and ICF-ID levels of care.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   DDSN will assess the performance of its contracted local/regional non-state entities responsible for conducting waiver operational functions on a 12-18 month cycle.

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   The DHHS/DDSN MOA sets forth the operational agency responsibility for QA and the administering agency oversight of the QA process.

DDSN will assess the performance of its contracted and local/regional non-state entities responsible for conducting waiver operational functions. DDSN will contract with a Quality Improvement Organization (QIO) to assess the local DSN Boards and other qualified providers on a twelve to eighteen month cycle depending on the provider's past performance. The QIO will also conduct follow-up reviews of the local DSN Boards and other approved providers. A comprehensive Report of Findings will be issued by the QIO to the local DSN Board provider/other approved providers and to DDSN. DDSN will provide technical assistance to the local Boards/other approved providers. Copies of all reviews and the Report of Findings are shared with DHHS within 45 days of completion. DDSN Central Office will also conduct reviews and provide technical assistance to the local DSN Boards, and provide DHHS reports of such reviews and technical assistance in a timely manner.

Additionally, DDSN Internal Audit Division will conduct internal audit reviews of the local network of DSN Boards and other approved providers. The local DSN Boards are required to have a financial audit conducted annually by a CPA firm that is chosen by the Boards, and all results related to waiver participants will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will also conduct special request audits, investigate fraud cases, provide training and technical assistance, and review the audited financial statements of the local DSN Boards. All findings will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will conduct a review of the contracted fiscal agent, and likewise, all findings related to waiver participants will be shared with DHHS within 30 days of completion. DHHS will review DDSN Internal Audit Division annual reports, special request audits, and fraudulent case investigations and request remedial action(s) as determined necessary.

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

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

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

Performance Measure:
All policy changes related to the HASCI waiver are approved by DHHS prior to implementation by DDSN. 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:
Policy/Memo/Change Logs, etc.

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 warranted	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of desk/focus reviews, utilization reviews, and/or suspected fraud investigations whose results are specific to delegated operational waiver functions as outlined in the MOA.

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling is determined by evidence warranting a special review.
	☑ **Other** Specify: as warranted	

Data Aggregation and Analysis:

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

Performance Measure:
Quarterly meetings between DHHS and DDSN waiver administrative staff are held to discuss significant waiver issues. N= Number of meetings held/D= Number of meetings indicated in the MOA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS/DDSN Agendas/Meeting Summaries

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 warranted	

Data Aggregation and Analysis:

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

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

ii. Remediation Data Aggregation

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

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

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 a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

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			

	☐				☐
	☐	**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 on the HASCI Waiver before age 65 remain eligible for Waiver services after their 65th birthday if all other eligibility factors continue to be met.

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	1220
Year 2	1320
Year 3	1345
Year 4	1370
Year 5	1395

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	1190
Year 2	1290
Year 3	1315
Year 4	1340
Year 5	1365

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).**

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:

DDSN maintains a waiting list of applicants for the HASCI Waiver. Applicants are placed on the waiting list in Urgent or Regular status, based on severity of condition and level of need.
Criteria for the Urgent status on the waiting list are:

1. Very severe injury resulting in functional limitations requiring extensive or total care (i.e. spinal cord injury at a quadriplegic level or a very serious traumatic brain injury);

2. Emergency need for assistance with personal care and safety;

3. Recent loss of a primary caregiver (permanently gone within the past 90 days) or imminent risk of losing a primary caregiver (permanently gone within the next 90 days), and no other paid or unpaid supports to replace the primary caregiver;

4. Recently discharged (within the past 90 days) or pending discharge (within the next 90 days) from acute care or rehabilitation hospital with complex unmet service needs;

5. Lack of an active support network of family, friends, and community resources;

6. Specific extenuating circumstances affecting urgency(e.g. more than one person with disabilities or special needs in the household, primary caregiver is elderly or has a serious medical condition, primary caregiver is also responsible for minor children or elderly family members, etc.)

An applicant must meet at least two of the above criteria to qualify for Urgent status. If criteria for Urgent status are not met, the applicant will be placed on the waiting list in Regular status.

An applicant in Urgent status on the waiting in list who no longer meets criteria will be moved to Regular status based on original date of slot request. An applicant in Regular status on the waiting list who later meets Urgent criteria will be moved to Urgent status based on date it is determined Urgent criteria are met.

An applicant who meets Urgent criteria and is ready for enrollment will be allocated the first available HASCI Waiver slot. If more than one individual on the waiting list in Urgent status is ready for enrollment, they will be allocated an available HASCI Waiver slot based on the earliest documented date of request.

If there are no applicants on the waiting list in Urgent status ready for enrollment, applicants on the Regular waiting list ready for enrollment will be allocated the first available HASCI Waiver slot based on the earliest documented date of request.

An individual in a nursing facility, hospital swing bed, or hospital administrative day bed for at least 90 consecutive days who is ready for discharge and requests to receive community based services will be allocated the next available HASCI Waiver slot if it can be assured he or she will meet medical, financial, level of care, and all other HASCI Waiver eligibility requirements. The individual must have an available community residence and sufficient natural supports so that his or her health and safety can be assured with the types and amount of services available through the HASCI Waiver. Transition must be arranged through a HASCI Service Coordinator and will require approximately 1-3 months to complete after a HASCI Waiver slot has been allocated.

An individual terminated from the HASCI Waiver due to interruption of Medicaid eligibility will have his or her Waiver slot held up to 90 consecutive days after the date of termination if it is anticipated that Medicaid eligibility will be reinstated during that time.

An individual terminated from the HASCI Waiver because of hospitalization or temporary admission to a nursing facility exceeding a full calendar month will have his or her Waiver slot held up to 90 consecutive days after the date of termination if it is anticipated the person will be discharged from the hospital or nursing facility during that time.

An individual terminated from the HASCI Waiver because a service was not received during a full calendar month

due to non-availability of a provider or other circumstances will have his or her Waiver slot held up to 90 consecutive days after the date of termination if it is expected services can be resumed within that time.

Re-enrollment in the HASCI Waiver following termination is contingent upon the person continuing to meet medical, financial, level of care, and all other eligibility requirements.

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 4)

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

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

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete 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 4)

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:

1. Prescription drugs above the four (4) prescriptions-per-month limit, not to exceed $54.00 per additional prescription per month.

2. 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.

3. Dentures. 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 State DHHS.

4. Denture repair. Justified as necessary by a licensed dental practitioner. Not to exceed $69 per visit.

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

6. Hearing Aids. A one-time expense. 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 State DHHS.

7. 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.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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 4)

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-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:

This Waiver employs both the Nursing Facility and ICF-ID levels of care in assessing potential Waiver eligibility. The majority of the participants currently enrolled in this Waiver are assessed using the Nursing Facility level of care. The initial Nursing Facility level of care evaluation is performed directly by DHHS. All reevaluations of the Nursing Facility level of care are done by waiver case managers employed by contracted providers of DDSN. All initial ICF-ID level of care evaluations are performed directly by DDSN's Consumer Assessment Team (CAT). Reevaluations of the ICF-ID level of care are performed by waiver case managers employed by contracted providers of DDSN.

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

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

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

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an

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

The South Carolina level of care criteria for Intermediate Care Facitlity/Intellectual Disability (ICF-ID) issued by DHHS states:

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

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

“Intellectual Disability” means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

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

• It is attributable to cerebral palsy, epilepsy, autism or any other condition other than mental illness found to be closely related to 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-one years of age.
• It is likely to continue indefinitely.
• It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

AND

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

AND

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

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

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

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

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The same process and level of care determination form are used.

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

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

Specify the other schedule:

Conducted at least annually (within 365 days from the date of the previous level of care (LOC) determination.

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

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

Specify the qualifications:

Waiver case managers(WCM) and Early Interventionists (EI)must hold a 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; must successfully pass a criminal background check with South Carolina Law Enforcement (SLED); and at a minimum must be screened against the following: 1) Child Abuse and Neglect Central Registry and 2) Sexual Offender Registry.

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

An automated system produced by the DDSN tracks LOC due dates for reevaluations and alerts the WCM/EI and/or his/her supervisor to its impending date. Additionally, if any LOC determination is found to be out of date, FFP is recouped from DDSN for all waiver services that were billed when the LOC was not timely.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the 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

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

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

Performance Measure:
Proportion of new enrollees whose Level of Care (LOC) is not dated more than 30 days prior to waiver enrollment. N= The number of LOC evaluations within the defined time period that are dated more 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:
DDSN Waiver Enrollment Reviews

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Proportion of participants whose LOC reevaluation does not occur prior to the 365th day of the previous LOC evaluation.

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 = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Waiver Tracking System

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

Data Source (Select one):

Other
If 'Other' is selected, specify:
DDSN Consumer Assessment Team (CAT) Log

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:

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

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

Performance Measure:
Proportion of LOC determinations that were conducted using the appropriate criteria and instrument.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☑ **Other** Specify: DHHS QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 DDSN's QIO identifies problems, the provider agency being reviewed is required to submit a plan of correction to address the issues discovered. The QIO conducts a follow-up review to determine if corrections have been made. Additionally, QIO reports are reviewed by DDSN Operations Staff. As needed, technical assistance is provided to providers by the Operations staff. Documentation of all technical assistance is available. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are available to DHHS.

ii. Remediation Data Aggregation

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

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

☐ **Continuously and Ongoing**

☐ **Other**

Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Long-term care options are discussed with potentially eligible individuals (or their legal representatives) during the assessment and subsequent visits. A written Freedom of Choice (FOC) Form is secured from each waiver participant to ensure that the participant is involved in planning his/her long-term care. This choice will remain in effect until the participant changes his/her mind. If the participant lacks the physical or mental ability required to make a written choice regarding his/her care, a responsible party may sign the Freedom of Choice Form. If the FOC is signed prior to the waiver participant reaching the age of eighteen, the current form or a new form is signed within 90 days after the waiver recipient reaches the age of eighteen.

The Freedom of Choice (FOC) form does not include language about the services available under the waiver. That information is on the Waiver Information Sheet which is given to every waiver applicant, and contains language about all services available under the waiver. The FOC form is used to offer individuals or his/her guardian the choice between institutional services and home and community-based waiver services. This form, which documents the preferred choice of location for service delivery, is provided by the waiver case manager/early interventionist and is maintained in the waiver record.

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):
DDSN's policy entitled "Compliance with Title VI of the Civil Rights Act of 1964, American Disabilities Act of 1990, Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 and Establishment of the Complaint Process" (700-02-DD) describes the methods DDSN utilizes. As specified in DDSN policy, when required, service coordination providers can access funds to pay for an interpreter to provide meaningful access to the waiver. Additionally, the State contracts with the University of South Carolina (USC) for a telephone interpreter service line called the "Language Line", and for written materials translation services.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Attendant Care/Personal Assistance
Statutory Service	Residential Habilitation
Statutory Service	Respite Care
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	Prescribed Drugs
Extended State Plan Service	Speech and Hearing Services
Other Service	Behavior Support
Other Service	Career Preparation
Other Service	Day Activity
Other Service	Employment Services
Other Service	Environmental Modifications
Other Service	Health Education for Consumer-Directed Care
Other Service	Medicaid Waiver Nursing
Other Service	Peer Guidance for Consumer-Directed Care
Other Service	Personal Emergency Response System
Other Service	Private Vehicle Modifications
Other Service	Psychological Services
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

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 and safety 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 designated 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.

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	Attendant care provider agencies
Agency	DSN Board/contracted providers

Appendix C: Participant Services

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

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

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:
Medicaid agency
Frequency of Verification:
Annually/biannually

Appendix C: Participant Services

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

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

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

Certificate *(specify):*
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.

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:

Department of Disabilities and Special Needs/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:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Service Definition *(Scope):*

Residential Habilitation means personal care, assistance with activities of daily living, 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 may also include social and leisure activities and community inclusion opportunities.

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)

There are no HASCI participants that are receiving this service in an unlicensed setting; therefore, no individuals will lose this service.

No current HASCI participants are receiving residential habilitation in a certified CRCF or in a CARF-certified rehabilitation facility; therefore, there will be no impact to HASCI participants.

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 sites 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):*
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 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 and 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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

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**
- ☑ **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 providers
Agency	Residential Care Facility
Agency	Medicaid certified ICF-ID
Agency	Foster Home
Agency	Medicaid Certified Nursing Facility
Agency	Respite Provider Agencies
Agency	Hospital

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

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/DHEC

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

Provider Category:

Agency

Provider Type:
Residential Care Facility
Provider Qualifications
License *(specify):*
Yes 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:
Department of Health and Environmental Control (DHEC); Medicaid Agency
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

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

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:
Department of Social Services

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

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

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

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;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)

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**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Case Management Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Waiver Case Management (WCM)

Provider Category:
Agency

Provider Type:
Waiver Case Management Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Service Definition *(Scope):*

Incontinence Supplies are standard diapers, briefs (protective underwear), under pads, liners,wipes,and gloves needed by a HASCI Waiver participant age 21 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.

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 does not intend to decrease the allowable number of pads or under pads; therefore, no HASCI participants will be impacted. The State is proposing to be consistent with other programs that offer 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

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 DHHS to provide Incontinence Supplies

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

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.

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

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.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	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:
Prescribed Drugs
Service Definition *(Scope):*
Prescribed Drugs funded by the HASCI Waiver are an Extended State Plan Service, but may not include any drugs available to a participant under Medicare Part D.

Services that are provided when the limits of prescribed drugs under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from prescribed drug services furnished under the State plan. The provider qualifications specified in the State plan apply.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Three additional prescription drugs above the state plan limit.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Pharmacists
Agency	Pharmacy Providers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Prescribed Drugs

Provider Category:
Individual
Provider Type:
Pharmacists
Provider Qualifications
License *(specify):*
Pharmacy permit chapter 43 section 40-43-10 et.seq. SC code of laws. Equivalent in 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: Prescribed Drugs

Provider Category:
Agency

Provider Type:
Pharmacy Providers

Provider Qualifications

License *(specify):*
Pharmacy permit chapter 43 section 40-43-10 et.seq. SC code of laws. Equivalent in 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

Service Definition *(Scope):*
Services that are provided when speech, and hearing 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.

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
Agency	Speech Pathology Groups
Individual	Speech Therapists
Agency	Speech Therapy Group
Agency	Audiology Groups
Individual	Audiologists
Individual	Speech Pathologists

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: 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 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:
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:
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:
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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support

Service Definition *(Scope):*

Behavior Support addresses problem behaviors of a HASCI Waiver participant by using 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 controlling/modifying inappropriate behaviors.

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. For documentation and monitoring purposes, however, Behavior Support is separately authorized to the residential provider.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support

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:
Career Preparation

Service Definition *(Scope):*
Career Preparation replaces Prevocational Services. Prevocational Services are provided in day program facilities. Career Preparation frequently uses community settings to prepare the participant for employment by exposure to various careers and real jobs. It includes volunteer placements to learn job skills. Career Preparation provides more flexibility and community focus than Prevocational Services.

Career Preparation assists a HASCI waiver participant for paid or unpaid employment by exposure to various careers and teaching such concepts as compliance, 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.

-Participants can choose from among these three services (Career Preparation, Day Activity, and Employment Services)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.

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: Other Service
Service Name: Career Preparation

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 State has selected provider types DSN Board or other contracted provider for Career Preparation Services to allow the HASCI waiver participants to have free choice of provider options and access to the waiver service. 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.

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 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:

Day Activity

Service Definition *(Scope):*

Day Activity is replacing Day Habilitation because it provides more flexibility and community focus. "Habilitation" is not a term/concept typically used with traumatic brain/spinal cord injury and similar disabilities. Coordination with therapy services is a responsibility of Day Activity providers and this is monitored by the Service Coordinator.

Day Activity assists a HASCI Waiver participant to acquire, retain, or improve in self-help, adaptive, and socialization skills. 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. It is normally provided four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week.

-Participants can choose from among these three services (Day Activity, Career Preparation, and Employment Services) 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.

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**
- ☑ **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: Other Service
Service Name: Day Activity

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):*

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 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 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:

Employment Services

Service Definition *(Scope):*

Employment Services is replacing Supported Employment Services because the service will allow individual supported employment or supports in a group setting, such as an enclave or a mobile work crew. Employment Services are provided in regular competitive employment settings such as factories, offices, stores, restaurants, etc. where people without disabilities are employed. This allows for more options than under the current service and may attract more participants. 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 (Day Services Provider)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Services

Provider Category:
Agency
Provider Type:
DDSN (Day Services 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, 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

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 and automatic door systems, 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. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. 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 for Home and Vehicle Modifications) 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**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DHHS Enrolled Providers
Individual	Licensed Contractors
Agency	DDSN/DSN Boards/contracted providers
Individual	Licensed Occupational and Physical Therapists
Individual	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).
Individual	Technicians or professionals certified in the installation and repair of manufacturers equipment
Individual	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
Individual	Vendors with a retail or wholesale business license contracted to provide services

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:
DHHS Enrolled Providers
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Enrolled with DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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)

• 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: 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:

Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by Professional Resources in Management (PRIME)

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: Environmental Modifications

Provider Category:

Individual

Provider Type:

Technicians or professionals certified in the installation and repair of manufacturers 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

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:

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; 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:

Vendors with a retail or wholesale business license contracted to provide services

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: 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 Consumer-Directed Care

Service Definition *(Scope):*

Health Education for Consumer-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 Consumer-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:

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 Consumer-Directed Care

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):*

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

Note: The State deleted the CARF-certified rehabilitation facility due to this not being a core service function they provide. Currently, there are no individuals utilizing this service;therefore, a transition plan is not necessary.

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: 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

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.

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 Consumer-Directed Care

Service Definition *(Scope):*
Peer Guidance for Consumer-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 spinal cord injury/severe physical disability in recruiting, training, and supervising primary and back-up attendant care/personal assistance providers.
The Peer Mentor is a person with a spinal cord injury/severe physical disability who successfully lives in the community with a high degree of independence and who directs his or her own personal care. The Peer Mentor serves as a role model and shares information and advice from his or her experiences.

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:

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: Other Service
Service Name: Peer Guidance for Consumer-Directed Care

Provider Category:

Agency

Provider Type:

DSN Board/Contracted Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DDSN and Peer Mentors must be registered with and trained by the SC Spinal Cord Injury Association.

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:

• Have a spinal cord injury or other severe physical disability and live 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 read, write, and speak English, as well as communicate effectively
• Free from communicable diseases
• Provide a statement that he or she has never been convicted of a felony
• Be trained/approved by South Carolina Spinal Cord Injury Association
• 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 persons with spinal cord injury or severe physical disability who desire to manage their own care

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Upon enrollment and 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 System

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**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response Providers

Appendix C: Participant Services

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

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

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

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

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. Private vehicle modifications include consultation and assessment to determine the specific modifications/equipment needed, follow-up inspection after modifications are completed, 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 for Home and Vehicle Modifications) 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**
- ☑ **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 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)
• 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: 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

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.

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	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:

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:
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

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 consultation and assessment to determine the specific needs, 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**

☑ **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	o Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
Agency	DDSN/DSN Board/contracted providers
Individual	Licensed Contractors
Individual	Technicians or professionals certified in the installation and repair of manufacturer's equipment.

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:

o 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/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:
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: 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: 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:

Waiver case management functions are conducted by entities that are governmental or non-governmental. If the participant/family declines the waiver case management service, required waiver functions will be performed by an entity chosen by DDSN/DHHS.

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, Adult Day Health Care Agencies, Nursing Homes providing respite and SCDDSN direct care staff and Waiver Case Managers are all required to have background checks completed by South Carolina Law Enforcement (SLED). Compliance reviews are conducted by DDSN''s QIO and DHHS Provider Compliance to ensure mandatory investigations are conducted.

A request for a Criminal Background Checks from South Carolina is completed by entering the person's name and date of birth through the South Carolina State Law Enforcement Division's (SLED) web site @ http://www.sled.sc.gov/default.aspx?MenuID=Home or SLED also accepts limited requests for criminal records checks by mail. This option should only be used for special services (e.g. notarization, certification) not available through the online access. Due to limited staffing, there is no expedited processing of mailed requests. Requests for special services may be mailed to SLED Records Department, P.O. Box 21398, Columbia, S.C. 29221-1398. Results of the criminal background checks will be sent directly to the requesting employer.

When a provider is unable to verify South Carolina residency as described above or residency in another state for the 12 months preceding the date of the employment application or that is expecting a direct caregiver to work directly with children from birth to age 18, shall conduct a Federal Criminal Record Check conducted by the Federal Bureau of Investigation (FBI) prior to employment. The results will include both the applicable state law enforcement agency and FBI database check. The Federal Criminal Record Check shall be done by an electronic fingerprint scan. No other type of criminal background check can be substituted for an FBI database check when a Federal background check is required.

Nursing Homes, Community Residential Care Facilities, Home Health Agencies and Adult Day Health Care agencies are all required by law to have background checks completed on direct care staff. These are state level investigations performed by South Carolina Law Enforcement (SLED checks) for each of the agencies above that hire and recruit direct care staff. The State Health Department performs licensure inspections incorporating the requirement that all direct care staff of these agencies have the required background check.

Personal Care Agencies and Attendants are required by the SCDHHS to have a background check completed for anyone providing direct care to a waiver participant. The State Health Department is currently promulgating rules for licensure of Personal Care Agencies. Those regulations will include background checks of all direct care aides and workers.

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

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Nursing and Personal Care 2 Providers are required to check the Certified Nursing Assistant (CNA) registry and the Office of Inspector General (OIG) exclusions list for all staff. Anyone appearing on either of these lists is not

allowed to provide services to waiver participants or participate in any Medicaid funded programs. The website addresses are:

CNA Registry - www.pearsonvue.com
OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

SCDHHS Provider Compliance monitors contract compliance for nursing and personal care providers. This occurs at least every eighteen months.

Additionally, abuse registry screenings must be completed for all staff of SCDDSN contracted service providers. The SC Department of Social Services maintains the abuse registry list and screens those names submitted by contracted providers against the registry. SCDDSN, through Contract Compliance 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).**

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

Facility Type
Community Training Home II (CTH II)
Community Residential Care Facility -DDSN Contracted (CRCF)
Community Training Home I (CTH I)
Supervised Living Placement I (SLP I)
Supervised Living Placement II (SLP II)

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

The individual is able to access community services on an on-going basis to increase his/her independence. The Waiver can provide supplemental services for persons that require more care and assistance than what is provided in that setting. Waiver services must comply with any licensing requirements of that setting.

Residential Habilitation funded by the HASCI Waiver is not offered in licensed facilities larger than 8 residents; the majority is served in licensed residences of 4 or less, such as, Community Training Homes (CTH), or Supervised Living Programs (SLP), and smaller Community Residential Care Facilities (CRCF). All of the conditions below are addressed through licensure by the DDSN-contracted QIO or by South Carolina Department of Health and Environmental Control (DHEC) through licensure of CRCFs.

Community Residential Care Facilities (CRCFs) are licensed by the State and are defined by regulation as those facilities which maximize each resident's dignity, autonomy, privacy, independence, and safety, and encourage family and community involvement. Regulations require that the facility provide an attractive, homelike and comfortable environment with homelike characteristics throughout the facility. CRCF's must have methods to ensure privacy between residents and visitors and must offer a variety of recreational programs suitable to the interests and abilities of the residents.

For each individual there is privacy in their sleeping or living unit; units have lockable entrance doors with appropriate staff having keys to doors; individuals have the freedom to furnish and decorate their sleeping or living units; individuals share units only at the individual's choice; individuals have the freedom and support to control their own schedules and activities, and have access to food at any time; individuals are able to have visitors of their choosing at any time; and the setting is physically accessible to the individual.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Training Home II (CTH II)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech and Hearing Services	☐
Occupational Therapy	☐
Health Education for Consumer-Directed Care	☐
Employment Services	☐
Behavior Support	☑
Prescribed Drugs	☐
Physical Therapy	☐
Day Activity	☐
Psychological Services	☐
Attendant Care/Personal Assistance	☐
Waiver Case Management (WCM)	☐
Medicaid Waiver Nursing	☐
Respite Care	☑
Supplies, Equipment and Assistive Technology	☐
Personal Emergency Response System	☐
Private Vehicle Modifications	☐
Environmental Modifications	☐
Residential Habilitation	☑
Career Preparation	☐
Incontinence Supplies	☐
Peer Guidance for Consumer-Directed Care	☐

Facility Capacity Limit:

4

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residential Care Facility -DDSN Contracted (CRCF)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech and Hearing Services	☐
Occupational Therapy	☐
Health Education for Consumer-Directed Care	☐
Employment Services	☐
Behavior Support	☑
Prescribed Drugs	☐
Physical Therapy	☐
Day Activity	☐

Psychological Services	☐
Attendant Care/Personal Assistance	☐
Waiver Case Management (WCM)	☐
Medicaid Waiver Nursing	☐
Respite Care	☑
Supplies, Equipment and Assistive Technology	☐
Personal Emergency Response System	☐
Private Vehicle Modifications	☐
Environmental Modifications	☐
Residential Habilitation	☑
Career Preparation	☐
Incontinence Supplies	☐
Peer Guidance for Consumer-Directed Care	☐

Facility Capacity Limit:

N/A

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Training Home I (CTH I)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech and Hearing Services	☐
Occupational Therapy	☐
Health Education for Consumer-Directed Care	☐
Employment Services	☐
Behavior Support	☑
Prescribed Drugs	☐
Physical Therapy	☐
Day Activity	☐
Psychological Services	☐
Attendant Care/Personal Assistance	☐
Waiver Case Management (WCM)	☐
Medicaid Waiver Nursing	☐
Respite Care	☑
Supplies, Equipment and Assistive Technology	☐
Personal Emergency Response System	☐
Private Vehicle Modifications	☐
Environmental Modifications	☐
Residential Habilitation	☑
Career Preparation	☐
Incontinence Supplies	☐
Peer Guidance for Consumer-Directed Care	☐

Facility Capacity Limit:

2

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supervised Living Placement I (SLP I)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech and Hearing Services	☐
Occupational Therapy	☐
Health Education for Consumer-Directed Care	☐
Employment Services	☐
Behavior Support	☑
Prescribed Drugs	☐
Physical Therapy	☐
Day Activity	☐
Psychological Services	☐
Attendant Care/Personal Assistance	☐
Waiver Case Management (WCM)	☐
Medicaid Waiver Nursing	☐

Respite Care	☑
Supplies, Equipment and Assistive Technology	☐
Personal Emergency Response System	☐
Private Vehicle Modifications	☐
Environmental Modifications	☐
Residential Habilitation	☑
Career Preparation	☐
Incontinence Supplies	☐
Peer Guidance for Consumer-Directed Care	☐

Facility Capacity Limit:

3

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supervised Living Placement II (SLP II)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech and Hearing Services	☐
Occupational Therapy	☐
Health Education for Consumer-Directed Care	☐
Employment Services	☐
Behavior Support	☑
Prescribed Drugs	☐
Physical Therapy	☐
Day Activity	☐
Psychological Services	☐
Attendant Care/Personal Assistance	☐
Waiver Case Management (WCM)	☐
Medicaid Waiver Nursing	☐
Respite Care	☑
Supplies, Equipment and Assistive Technology	☐
Personal Emergency Response System	☐
Private Vehicle Modifications	☐
Environmental Modifications	☐
Residential Habilitation	☑
Career Preparation	☐
Incontinence Supplies	☐
Peer Guidance for Consumer-Directed Care	☐

Facility Capacity Limit:

3

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑

Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

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.*

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; any other person legally responsible (sole, joint or otherwise) for the Medicaid participant; and a court appointed guardian of a 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 their provision of the services listed above. Should there be any question as to whether a paid caregiver falls in any of the categories listed above, 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 are made aware of the requirements for enrollment through either the operating or administrating agency by contacting them directly. All potential providers are given a packet of information upon contacting the agencies that describe the requirements for enrollment, the procedures used to qualify and the timeframes established for qualifying and enrolling providers. Additionally, potential providers can find information regarding enrollment requirements and timeframes for enrollment at the state's (2) websites at:

DHHS:
http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/BureauofLongTermCareServices/
DDSN:
http://www.state.sc.us/ddsn/qpl/HowToBecomeQualified.htm.

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

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

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

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

Performance Measure:
Proportion of new waiver providers that meet required licensing, certification and other state standards prior to the provision of waiver services.

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

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: 100% within 18 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Behavior Support Provider Reports/Records

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

DDSN QIO Contractor		Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Periodic reviews to include all providers within a 4 year timeframe.	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of waiver providers that continue to meet required licensing, certification, and other state standards.

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: 100% within 18 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Behavior Support Provider Reviews/Data

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

	Specify: Periodic reviews to include all providers within a four year time frame.	

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measure:
Proportion of non-licensed/non-certified providers that continue to meet waiver requirements.

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

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

	☑ **Other** Specify: 100% within 18 months	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post review.	

Data Aggregation and Analysis:

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

☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DDSN QIO CONTRACTOR	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of new non-licensed, non-certified providers that meet waiver requirements.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **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. Reports are available within 45 days post review.	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 100% within 18 months	

Data Aggregation and Analysis:

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

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

Performance Measure:
Waiver Case Manager meets required education and experience for employment. N = the number of waiver case managers who meet the required education and experience /D = the # of waiver case managers reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted on a 12-18 month cycle depending on past performance of the	

	provider organization. Reports are available 45 days post-review.	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Proportion of qualified providers that meet training requirements in the waiver.

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: 100% within 18 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO QA 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 = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **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. Reports are available within 45 days post review.	

Data Aggregation and Analysis:

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

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.
The Provider's QIO Quality Assurance reports will outline the provider's overall compliance with key indicators, any citations, corresponding appeals (if applicable), plans of correction, and follow-up with documentation of remediation.

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 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 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:*

-Service Plan is developed by the waiver case manager (WCM) /Early Interventionist (EI) provider. Each participant is offered the choice of WCM/EI providers initially and annually thereafter, and may freely change providers upon request throughout the year.

-Once a waiver case manager/EI provider is chosen, he/she is required to utilize a standardized tool for assessing the needs of all waiver participants. These tools must be supported by current professional reports. Once needs are identified, waiver case managers/EIs explain the service options available to meet the assessed needs. Each need identified in the assessment is discussed with the participant, family, his/her legal guardian and/or representative, caregivers, professional service providers, and others of the participant's choosing to provide input. The information obtained is used by the WCM/ EI provider in order to develop the Service Plan. Upon completion, a copy of the Service Plan is provided to the participant, family, legal guardian and/or representative.

-At the time of waiver enrollment and annually, participants are given a copy of the "Acknowledgement of Rights and Responsibilities" form. This form outlines the participant's right to be told about services, participate in the completion of an assessment and plan, and choose services from all qualified providers, contact available providers, change providers, and request reconsideration of decisions.

-DDSN's Quality Improvement Organization (QIO)reviews each entity providing waiver case management to assure waiver participants are offered choice, have been given "Acknowledgment of Rights" annually and assure that the services in the plan correspond to a documented assessed need. QIO review results are made available to DHHS through a secure, Web-based reporting portal within 30 days of the review. The QIO measures compliance approves all required plan of corrections and conducts a follow-up review to ensure successful remediation.

-In addition to the QIO reviews, SCDDSN also ensures that the service plans and Annual Assessments are reviewed through an internal random selection review process. Random review samples are selected by SCDDSN 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 waiver case managers/ EIs providers complete indicated corrections. SCDDSN tracks this quality assurance activity in detail and uses findings to direct its training and technical assistance efforts.

SCDDSN maintains an automated Consumer Data Support System (CDSS) in which the Annual Assessments and Support Plans are completed by WCM/EI. The system will not allow the user to complete the assessment until a response has been given for each question/ item. Once complete, a decision is required whether or not to formally address each need identified by the assessment. To "formally address" means that the need is included in the Support Plan and services/interventions in response to the need are authorized. The decision is made by the participant and those chosen by the participant to assist with planning.

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.

During the planning process input from the participant, legal guardian, and/or representative, caregivers, professional service providers and others of the participant's choosing may be invited to this meeting if this is of the participant's choosing. The information obtained is used by the waiver case manager/EI in order to develop the service plan. Upon

completion of the plan, a copy of the plan is provided to the participant, family, legal guardian and/or representative. Person-centered planning cannot be performed in the absence of the individual receiving services.

Additionally, the waiver case manager / EI will review the entire support plan to determine if updates are needed. This review is conducted by the waiver case manager/EI in consultation with the participant, family, legal guardian, and/or representative during which the effectiveness, usefulness, and benefits of the plan will be discussed in addition to the overall satisfaction with the services/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):

Support Plan meetings are scheduled by the waiver case manager (WCM)or Early Interventionist(EI)to be at a date, time, and location chosen or agreed to by the participant/parent/guardian.

The Service Plan is developed by the WCM or EI and is based on the comprehensive assessment of the waiver participant's strengths, needs, and personal priorities (goals) and preferences. The participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing may provide input. Service plans are developed prior to the delivery of a waiver-funded service and at least within 365 days of the previous service plan or more often as the participant's needs change.

Participants are informed in writing at the time of enrollment of the names and definitions of waiver services that can be funded through the waiver when the need for the service has been identified by the WCM/EI.

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

Health status is identified in the participant's Initial/Annual Assessment. Healthcare needs are addressed in the participant's Initial/Annual Support Plan and updated as necessary by the WCM or EI.

The plan also includes the roles and responsibilities of the WCM or EI and the participant and his/her guardian for each service included in the plan. The WCM or EI will have primary responsibility for coordination of services but must rely on the participant/guardian to choose a service provider from among those available, and honor appointments scheduled with providers when needed for initial service implementation, and cooperate with coordination efforts. The degree of coordination may vary based on the needs of the participant and his/her support network and their preferences for self-coordination.

-Every calendar month the waiver case manager/early interventionist 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 (2) of four quarterly visits each plan year the WCM/EI 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/EI based on the results of plan monitoring or when information obtained from the participant, his/her legal guardian, and/or service providers indicates the need for a change to the plan.

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

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. The WCM/EI provider agency also conducts training with staff annually to review proper reporting procedures for abuse or neglect.

DDSN utilizes a standardized 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 waiver 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.

WCM/EI's share information about available providers of needed services to help participants make an informed choice. Annually, uUpon 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.

Additonally, 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, and the Brain Injury Alliance of South Carolina. 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. Participants can contact their WCM/EI with questions about available providers and/or check the DDSN's website for the most current listing.

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 WCM/EI 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 periodically reviews service plans on an annual basis. The information included in the person-center 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:

Updated at least annually (within every 365 days from the date of the previous Plan).

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

Early Interventionist (EI)

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.

WCMs/EIs are required to monitor the service plan with the participant/family by making monthly contacts. This monitoring is completed for all waiver and non-waiver services or interventions included in the service plan. The form used for monitoring specifically requires the WCM/EI to indicate if the service/intervention was furnished, if the service was effective, and if the participant was satisfied with the service and/or provider. The form also requires the WCM/EI to document the actions taken to follow-up and remediate identified problems. WCMs/EIs routinely monitor the participant's' emergency plan and health/welfare status. This monitoring is documented in the participant's' waiver record. Monthly contacts to service providers, review of progress notes/records, or visits to school professionals is also acceptable as long as the required monthly contact to the participant/family has been conducted to monitor the service plan and health and welfare.

On a quarterly basis the WCM/EI monitors the service plan with a face-to-face contact with the participant/family. This may be conducted more frequently as needed. Two (2) of the four (4) face-to-face visits each calendar year must be conducted in the participant's home/natural environment in order to more carefully assess and obtain information about the participant's health, safety and welfare in that location. Additionally, changes to the family dynamic should be assessed to determine any impact they may have on the needs of the participant.

At least every 365 days from the date of the previous plan, or more often if the participant's needs change, a new Plan will be developed by the Waiver Case Manager in consultation with the participant, family legal guardian and/or representative.

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:*

Policy dictates the minimum frequency with which monitoring must occur and the elements (service effectiveness/usefulness, service providers, service delivery and participant/family satisfaction with services) that must be included. Annually or more often as concerns are noted, information about available providers of needed services including Waiver Case Management/Early Intervention, is shared with participants/families. Waiver service monitoring is reviewed by the QIO.

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

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

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

Performance Measure:
Proportion of participants whose plans that include services and supports that are consistent with needs identified in the assessment in accordance with waiver policy.

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

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of participants whose plans include services/supports to address personal goals in accordance with waiver policy.

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

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

Performance Measure:
Proportion of participants whose plans were completed/revised prior to the provision of waiver services and monitored in accordance with waiver policy.

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 = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **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. Reports are available 45 days post review.	

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 Aggregation and Analysis:

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

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

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

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

Performance Measure:
Proportion of participants whose plans were updated/revised at least annually and when warranted in accordance with waiver policy.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **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. Reports are available 45 days post review.	

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 Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Proportion of participants who are receiving the services and supports in the type, amount, frequency, and duration as specified in their plans in accordance with waiver policy.

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 = +/- 5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **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= # of required non face to face contacts / D = # of all completed 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 = +/- 5%

☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post-review.	

Data Aggregation and Analysis:

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

Performance Measure:
Waiver Case Manager must complete four (4) quarterly face to face visits with the participant/family during each plan year. N= # of completed quarterly face to face visits/D = # of all face to face visits.

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post-review.	

Data Aggregation and Analysis:

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

Performance Measure:
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 = # of completed quarterly face to face visits in the home/natural environment / D = # of completed quarterly face to face visits.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post-review.	

Data Aggregation and Analysis:

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

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 waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Proportion of newly enrolled 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.

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 = +/-5%

☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **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. Reports are available 45 days post review.	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of waiver participants who were offered choice among services and qualified providers in accordance with waiver policy.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO 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 = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **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. Reports are available 45 days post review.	

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

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

		Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.
SCDDSN contracts with a CMS recognized Quality Improvement Organization (QIO) to conduct Quality Assurance reviews. As part of this process, DDSN has incorporated Key Indicators that measure compliance with program standards and Waiver requirements. When the 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.

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. To be eligible for Self-Directed Attendant Care (UAP option), a participant is assessed with a "DDSN Prescreening for Participant-Directed Care", which is based upon the participant's current NF or ICF-ID Level of Care evaluation. It is administered by the participant's Waiver Case Manager (WCM). If a participant lacks appropriate behavior, sufficient cognitive ability, and/or communication skills to safely self-direct his or her own care, then a Responsible Party 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 Service Coordinator will assist in finding resources for behavior supports/instruction/training.

The participant or his/her Responsible Party (RP) can choose to direct the participant's care. The participant or RP must have no communication or cognitive deficits that would interfere with participant or RP direction.

Waiver Case Managers (WCM) will provide detailed information to the Waiver participant and/or RP about participant direction as an option, including the benefits and responsibilities of the option. If the participant or RP want to pursue participant direction, additional information about the risks, responsibilities, and liabilities of the option will be shared by the WCM. Information about the role of the FMS is also provided and information concerning the hiring, management and firing of workers. Independent advocacy is available to recipients who feel the need for additional support.

Once the participant has chosen to direct his/her services, the waiver case manager (s) will continue 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
2) Private Residence
3) Temporary living arrangement such as a hotel/motel, shelter, or camp.

-To specify the size of the specified living arrangements where participant direction is supported (e.g., the number of persons unrelated to the proprietor who are served in the living arrangement); there could be up to 16 individuals in a licensed CRCF.

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 participants 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

-DDSN contracts with the University Of South Carolina School Of Medicine, Center for Disability Resources for a licensed RN to interview each participant who will self-direct or a Responsible Party who will direct the service. The RN also observes the participant or Responsible Party directing caregivers. The RN confirms that the participant or responsible Party is able to direct the participant's care.

-Only those individuals who can safely and effectively direct their own care, or who have a Responsible Party to direct the care, can be approved for Self- Directed Attendant Care (UAP option).

-The participant or RP must have no communication or cognitive deficits that would interfere with participant or RP direction. The waiver case manager (WCM) will assess and determine if these criteria are met. Participants interested in self-directed care are prescreened to assure capability utilizing a standardized pre-screen form. If he/she is not capable a responsible party may direct care if he/she passes the pre-screen. The prescreening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare of the participant.

-The three principal areas screened during the assessment are communication, cognitive patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/responsible party to make them understood and the ability of others to understand the participant/responsible party. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the participant/responsible party.

-Finally the assessment tool reviews the mood and behavior patterns of the participant/responsible party to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the participant/responsible party. If the participant/responsible party disagrees with the results they may appeal the decision. The RN match visit is completed prior to service authorization.

-Waiver case managers assess the cognitive and communication abilities of participants/family members who wish to direct some of their waiver services. This process is consistent for all participants meeting the ICF/ID Level of Care in the Head and Spinal Cord Injury waiver (HASCI), the Pervasive Developmental Disorder (PDD), and the ID/RD waiver.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

At the time of the initial assessment, the Waiver Case Manager (WCM) will introduce participant direction of Attendant Care/Personal Assistance services as an option and provide a brochure giving information about this option. The WCM will provide this information initially or at the request of the participant. If the participant is interested, the WCM will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The WCM will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant direction. The WCM will continue to assess the participant''s interest on an annual basis or more frequently if requested by the participant.

-A Responsible Party may direct care for a participant unable or unwilling to self-direct. This may be a relative or any other person who is not also a paid provider of HASCI Waiver services received by the participant. The Responsible Party must have a strong personal commitment to the participant as well as knowledge of the participant’s condition/functioning. The Responsible Party must understand and assume the risks, and responsibility of directing the participant’s care.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant may choose to have waiver services directed by a representative and he/she may choose anyone (subject to DDSN or Medicaid Policy) willing to understand and assume the risks, rights and responsibilities of directing the participant''s care if the participant is unable or unwilling to self-direct.

A Responsible Party may be a relative or any other person who is not also a paid provider of HASCI Waiver services received by the participant. The Responsible Party must have a strong personal commitment to the participant, as well as, knowledge of the participant’s condition/functioning, and knowledge of the participant''s preferences, and must agree to a predetermined frequency of contact with 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.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Attendant Care/Personal Assistance	☑	☐

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 C1/C3**

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] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes 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:

- [ ] **Maintains a separate account for each participant's participant-directed budget**
- [ ] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [ ] **Processes and pays 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:

- [ ] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the**

status of the participant-directed budget

☐ **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

An annual independent audit is required to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

For the adult 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/RP has chosen to direct their services, waiver case managers continue to monitor service delivery 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
Speech and Hearing Services	☐
Occupational Therapy	☐
Health Education for Consumer-Directed Care	☐
Employment Services	☐
Behavior Support	☐
Prescribed Drugs	☐
Physical Therapy	☐
Day Activity	☐
Psychological Services	☐

Attendant Care/Personal Assistance	☐
Waiver Case Management (WCM)	☐
Medicaid Waiver Nursing	☐
Respite Care	☐
Supplies, Equipment and Assistive Technology	☐
Personal Emergency Response System	☐
Private Vehicle Modifications	☐
Environmental Modifications	☐
Residential Habilitation	☐
Career Preparation	☐
Incontinence Supplies	☐
Peer Guidance for Consumer-Directed Care	☐

☑ **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 Waiver Case Manager (WCM) will provide their phone number and contact names to participants.-The advocacy organization does not provide direct services.

-Independent advocacy is not a function of DHHS or DDSN.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The Waiver Case Manager (WCM) will accommodate the participant by providing a list of qualified providers they can select from to maintain service delivery. The WCM 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 provide-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 waiver case manager (WCM) will transition services from participant direction to agency directed services.

The WCM 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 WCM.

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 WCM 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.

- [x] **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.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

-The Waiver Case Manager (WCM) 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 Service Coordinator 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 by their WCM. The waiver 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 Service Coordination 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 WCM 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 WCM 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:

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 rise to the level of critical incidents, ANE or waiver matters that would normally follow the reconsideration/appeal process. People are encouraged to first seek remediation through their local service provider where all efforts will be made to resolve concerns at the most immediate staff level. If the concern cannot be resolved at the provider level, the matters is referred to the DDSN Office of Consumer Affairs or the appropriate District Director. Follow-up to a concern reported to the DDSN Office of Consumer Affairs or District Director will include contact with the person or representative expressing the concern, review and research of the concern, efforts to mediate resolution, and documentation of all actions taken. The nature of the concern and the needs of the individual factor into the time period required for response but generally all responses with feedback to the complainant are provided within 10 business days. Concerns involving health and safety of people receiving services will receive immediate, same day review and necessary action will be taken if the person's health or safety is at risk.

The participant shall be informed in all circumstances that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing.

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 rise to the level of critical incidents, ANE or waiver matters that would normally follow the reconsideration/appeal process. People are encouraged to first seek remediation through their local service provider where all efforts will be made to resolve concerns at the most immediate staff level. If the concern cannot be resolved at the provider level, the matters is referred to the DDSN Office of Consumer Affairs or the appropriate District Director. Follow-up to a concern reported to the DDSN Office of Consumer Affairs or District Director will include contact with the person or representative expressing the concern, review and research of the concern, efforts to mediate resolution, and documentation of all actions taken. The nature of the concern and the needs of the individual factor into the time period required for response but generally all responses with feedback to the complainant are provided within 10 business days. Concerns involving health and safety of people receiving services will receive immediate, same day review and necessary action will be taken if the person's health or safety is at risk.

The participant shall be informed in all circumstances that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events

occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The South Carolina Child Protection Reform Act requires the reporting and investigating of suspected abuse, neglect and exploitation (ANE) of a vulnerable child (under the age of eighteen) to the Department of Social Services (DSS)/Child Protective Services (CPS) and local and state law enforcement. The South Carolina Omnibus Adult Protection Act requires the reporting and investigating of suspected ANE of a vulnerable adult (age 18 and above) to DSS/Adult Protective Services (APS) and local and state law enforcement. The appropriate reporting agency is determined by the age of the victim, suspected perpetrator, and the location of the alleged incident. These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing. These incidents are defined as physical abuse, or psychological abuse, threatened or sexual abuse, neglect, and exploitation. Mandatory reporters have a duty to report if they have information, facts or evidence that would lead a reasonable person to believe that a child or vulnerable adult has been or is at risk for ANE. Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected ANE to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the ANE. All DDSN staff are required to have annual training on mandated reporting responsibilities and reporting channels. This is outlined in DDSN Directive 543-02-DD. It is part of the agency's preservice 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 waiver case management services sustains a serious injury while the service coordinator is in the child's home, then it should be reported as a critical incident; however, if the waiver 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.

-In order to coordinate the process of reviewing all reports, DDSN has implemented a secure, Web-based Incident Management System (IMS) which contains three different modules: ANE reporting, Critical Incident reporting, and Death reporting. The applicable DDSN Directives govern the reporting process, but the IMS provides a mechanism for processing the reports. In some cases, a provider may make a verbal notification to the District Director, but a report on the IMS is required within 24 hours, or the next business day.

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

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

-DDSN Directives 100-09-DD and 534-02-DD require the service provider to make an initial report of the incident within 24 hours or the next business day. The providers must then complete an internal review of the incident within 10 working days. The internal review is submitted to DDSN for acceptance by the Statewide Incident Management Coordinator. DDSN policies require the provider, upon completion of the internal review, to notify the participant and/or responsible party of the outcome of the review. The Case Management Provider is also informed in order to ensure that any health and safety concerns are addressed.

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, 100-09-DD, also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers.

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 2)

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

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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

-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 or seclusion 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 2)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services
Complete Items G-2-b-i and G-2-b-ii.

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

DDSN policy allows the use of:

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

2. Adverse consequences which are defined as startling, unpleasant or painful consequences, consequences that have a potentially noxious effect, when approved by the person or his/her legal guardian, the physician, an approved provider of behavior support services, HRC, the Executive Director, and the State Director of DDSN. Such procedures may only be employed to protect the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the needs of the person.

-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 Service Coordinator, 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; and the use of aversive consequences. 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 Service Coordinator, 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-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 or bi-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.

-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 recommends that all providers utilize an established Medication Technician Certification Program, which includes sixteen hours of classroom instruction and practicum experience taught by a Registered Nurse and supervised medication passes.

The Standards or Directives referenced include:
Employee Orientation/Pre-Service/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.

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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

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

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

Performance Measure:
Number and proportion of incidents of reported abuse, neglect, or exploitation that are

reported within required timeframes.

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:
Proportion of HASCI waiver participants that report concerns of abuse, neglect, or exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Consumer Complaint Database

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 warranted	

Data Aggregation and Analysis:

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

	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As warranted.

Performance Measure:
Number of incidents of abuse, neglect, or exploitation in which the internal review was completed within the required timeframes.

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:
Number and proportion of critical incidents reported (including mortality, injuries, and client to client altercations)within the required timeframes.

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

Performance Measure:
Number and proportion of substantiated incidents of abuse, neglect, and exploitation.

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:
Proportion of waiver participants who receive information yearly about how to report abuse, neglect, and exploitation through their Waiver Case Manager Provider.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other**	

	Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

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

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

Performance Measure:
Proportion of participants whom report that they know their rights.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN CDSS 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:
Proportion of participants that have access to their case manager provider outside of traditional business hours.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider	

	organization. Reports are available within 45 days post review.	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of consumers that have an emergency plan.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Consumer Complaint Database

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:

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.

For DDSN operated services, individual citations are addressed through the provider's POC and/or through individualized technical assistance. As abuse, neglect, or exploitation are identified, DDSN is collecting data and analyzing for trends, and strategies are developed and implemented to prevent future occurrences. For every allegation of abuse, neglect, or exploitation or other critical incident report, the provider is required to complete a review to determine policy or procedure violations or improper conduct. This review is in addition to the investigations that may be conducted by local law enforcement, the Department of Social Services, or the State Long Term Care Ombudsman Program.

DDSN / DDSN QIO reviews all incident management reports to ensure continuity of care, appropriate provider response, and to determine the need for additional technical assistance and training. Additional recommendations may include a review of provider policies, evaluation of assistive technology, crisis

management plans, or other staffing ratios.

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

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

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

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

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

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.

DDSN employs a Quality Management system that includes the cycle of design, discovery, remediation and improvement. SC DDSN contracts with a Quality Improvement Organization, Alliant ASO, to conduct assessments of Targeted Case Management (known as Service Coordination) and service providers by making on-site visits as a part of its quality assurance process. During these visits, records are reviewed, consumers and staff are interviewed, and observations made to ensure that services are being implemented as planned and based on the consumer's need, that the consumer/family still wants and needs them, and that they comply with contract and/or funding requirements and best practices. In addition, the provider's administrative capabilities are reviewed to ensure compliance with DDSN standards, contracts, policies, and procedures. Any deficiencies found with the provider's compliance will require a written Plan of Correction that addresses the deficiency both individually and systemically. A follow-up review will be conducted approximately 6 months after the original review to ensure successful remediation and implementation of the plan of correction. If the findings indicate repeat citations, another Plan of Correction must be submitted and the QIO will determine if additional follow-up is needed.

All newly qualified providers are reviewed between three to six months of accepting their first consumer (i.e., during their 12 month probation period). Providers, who are beyond their first year, will be reviewed at least annually to every 18 months, depending on prior compliance. Follow-up reviews will be conducted approximately 6 months following annual – 18 month review.
The QA process utilizes "Key Indicators" which are measures to determine compliance with policies and

standards. These indicators are grouped by type (administrative, general agency, early intervention). Each type is further grouped by a domain (e.g. service coordination, HASCI Waiver, support plan, residential).
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 will address remediation at the individual level, and when warranted, include 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 DDSN 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 at www.ddsn.sc.gov/aboutddsn.
In addition to the Quality Assurance Reviews, State law requires licensing of certain programs and residential facilities. This licensing relates to the health and safety aspects of facilities and services. The law authorizes the establishment of standards for the qualifications of staff, staff ratios, fire safety, medication management, facility size and construction, storage of hazardous liquids and health maintenance. All Residential and Facility-Based Respite and Career Preparation, Support Center, Day Activity, Employment, Community Services Programs (Day Programs) must be licensed according to state law and licensing standards. The licensing inspections are conducted by a CMS approved QIO, Alliant ASO.
The primary focus of the Licensing review is to assure basic health, safety and welfare standards. Key indicators measure the following:
• The facility's environment promotes the consumers' health and safety.
• The physical plant of each facility, to include fire marshal inspections, HVAC, Water Quality, and Health and Sanitation.
• There must be evidence of Fire Safety training and evacuation, Disaster Preparedness, First Aid supplies and other emergency items.
• Facilities must provide documentation of continuous, coordinated health care, appropriate medical follow-up, and assistance with medications (as indicated in each consumer's residential Plan).

For Residential Habilitation, Facility-based Respite, and Day Services, a license is issued only after an application is submitted to DDSN. A completed application must include pre-licensing inspections (State Fire Marshal Inspection, HVAC, and electrical inspection). Only when all pre-licensing requirements have been met, is an on-site inspection conducted. Only when licensed are providers added to the Qualified Provider List. Due to the pre-licensing requirements and follow-up, 100% of providers meet the required licensing, certification or other state standard prior to the provision of waiver services.

DDSN strives to ensure the health and welfare of its consumers is the first priority. The agency has a comprehensive system for reporting, collecting & responding to data related to abuse, neglect exploitation or other critical incidents that do not meet the established definitions of abuse, neglect or exploitation. The agency employs a full-time Incident Management Coordinator who tracks reports throughout the system to ensure compliance with State Law and DDSN policy. DDSN has a web-based reporting system on its secure provider portal that provides a real-time analysis function and allows the user to pull a variety of reports to assist in tracking and trending information. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider's management action taken to remediate identified issues such as staff training, staff suspension or termination, updates to risk management and quality assurance procedures and policies and other measures to provide safeguards for the consumers. This data is available to SCDHHS for their monitoring. The data is also reviewed for trending analysis at both the provider and statewide levels along with corresponding QIO and Licensing data. This review occurs on an annual basis unless there is an indication the provider's performance deviates significantly from the statewide averages in any area of quality management (quality assurance, licensing, or incident management). At that time, a review of all systems would be conducted. As an additional measure, the Incident Management Coordinator provides on-site training and technical assistance to providers that fall significantly above or below the statewide average for reporting and the types of incidents. This training is also available to providers upon request.

-1) QIO Quality Assurance Reports- completed within approximately 30 days of the completion of a review, these reports include compliance rates for key indicators within individual service areas; 2) QIO Licensing

reports- completed within approximately 30 days of the completion of a review, these reports address compliance with basic physical plant issues, as well as medication and health-related indicators; 3) Incident Management Reports- completed in real-time as reports are submitted for provider specific data, or quarterly for trend analysis and the identification of training and/or technical assistance needs.

Trend reports, based on data described above, are routinely shared with provider agencies during quarterly statewide QA/ Risk Management meetings. The data is also shared on a semi-annual basis during the DDSN Commission meetings. These are public meetings and frequently attended by parent/ family organizations, self-advocates, and other advocacy and support groups. DDSN is currently evaluating methods for public reporting of provider data via its website. Quality/ compliance performance data will be available for participants and/or family members to review when selecting a service provider.
-The frequency for evaluating and updating the QIS for DDSN QIS it is a continuous, evolving process. At a minimum, the process is re-evaluated at the time of the Waiver Evidence reporting and at the time of the Waiver renewal.

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	☑ **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 the need for any system design changes. Any changes recommended to the overall system's design or to any sub-systems are brought to the DHHS/DDSN Policy Committee.
-DDSN employs a Quality Management system that includes the cycle of design, discovery, remediation and improvement. SC DDSN contracts with a Quality Improvement Organization (QIO) to conduct assessments of Waiver Case Management and service providers by making on-site visits as a part of its quality assurance process.

-During these visits, records are reviewed, consumers and staff are interviewed, and observations made to ensure that services are being implemented as planned and based on the consumer's need, that the consumer/family still wants and needs them, and that they comply with contract and/or funding requirements and best practices.

-In addition, the provider's administrative capabilities are reviewed to ensure compliance with DDSN standards, contracts, policies, and procedures. Any deficiencies found with the provider's compliance will require a written Plan of Correction that addresses the deficiency both individually and systemically. A follow-up review will be conducted approximately 6 months after the original review to ensure successful remediation and implementation of the plan of correction.

-All newly qualified providers are reviewed between three to six months of accepting their first consumer (i.e., during their 12 month probation period). Providers who are beyond their first year, will be reviewed at least annually to every 18 months, depending on prior compliance. Follow-up reviews will be conducted

approximately 6 months following annual – 18 month review.

-The QA process utilizes “Key Indicators” which are measures to determine compliance with policies and standards. These indicators are grouped by type (administrative, general agency, early intervention). Each type is further grouped by a domain (e.g. waiver case management, HASCI Waiver, support plan, residential).

-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 will address remediation at the individual level, and when warranted, include 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 at www.ddsn.sc.gov/aboutddsn.

-In addition to the Quality Assurance Reviews, State law requires licensing of certain programs and residential facilities. This licensing relates to the health and safety aspects of facilities and services. The law authorizes the establishment of standards for the qualifications of staff, staff ratios, fire safety, medication management, facility size and construction, storage of hazardous liquids and health maintenance.

-All Residential and Facility-Based Respite and Career Preparation, Support Center, Day Activity, Employment, Community Services Programs (Day Programs) must be licensed according to state law and licensing standards. The licensing inspections are conducted by a CMS approved QIO.

-The primary focus of the Licensing review is to assure basic health, safety and welfare standards. Key indicators measure the following:
• The facility’s environment promotes the consumers’ health and safety.
• The physical plant of each facility, to include fire marshal inspections, HVAC, Water Quality, and Health and Sanitation.
• There must be evidence of Fire Safety training and evacuation, Disaster Preparedness, First Aid supplies and other emergency items.
• Facilities must provide documentation of continuous, coordinated health care, appropriate medical follow-up, and assistance with medications (as indicated in each consumer’s residential Plan).

-For Residential Habilitation, Facility-based Respite, and Day Services, a license is issued only after an application is submitted to DDSN. A completed application must include pre-licensing inspections (State Fire Marshal Inspection, HVAC, and electrical inspection). Only when all pre-licensing requirements have been met, is an on-site inspection conducted. Only when licensed are providers added to the Qualified Provider List. Due to the pre-licensing requirements and follow-up, 100% of providers meet the required licensing, certification or other state standard prior to the provision of waiver services.

-DDSN has a comprehensive system for reporting, collecting & responding to data related to abuse, neglect exploitation or other critical incidents that do not rise to the threshold of abuse, neglect or exploitation. The agency employs a full-time Incident Management Coordinator who tracks reports throughout the system to ensure compliance with State Law and DDSN policy. DDSN has a web-based reporting system on its secure provider portal that provides a real-time analysis function and allows the user to pull a variety of reports to assist in tracking and trending information. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider’s management action taken to remediate identified issues such as staff training, staff suspension or termination, updates to risk management and quality assurance procedures and policies and other measures to provide safeguards for the consumers. This data is also reviewed for trending analysis at both the provider and statewide levels along with corresponding QIO

and Licensing data. This review occurs on an annual basis unless there is an indication the provider's performance deviates significantly from the statewide averages in any area of quality management (quality assurance, licensing, or incident management). At that time, a review of all systems would be conducted. As an additional measure, the Incident Management Coordinator provides on-site training and technical assistance to providers that fall significantly above or below the statewide average for reporting and the types of incidents. This training is also available to providers upon request.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DHHS and DDSN meet periodically to discuss the effectiveness of Quality Improvement initiatives implemented by both state agencies. Changes are brought to the DHHS/DDSN Policy Committee for review.

-The Quality Improvement Strategy is a continuous evolving process that at a minimum, the process is re-evaluated at the time of the Waiver Evidence reporting and at the time of the Waiver renewal.

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 waiver services in different departments within DHHS and DDSN.

Methods employed include the following:
-The State employs a licensed Registered Nurse to conduct on-site reviews of all providers of personal care services and Adult Day Health Care (including ADHC Nursing and Transportation services), at least once every eighteen months, and usually much more frequently. These reviews consists of three components: staffing reviews, administrative reviews and participant reviews. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other requirements as outlined in the contract. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

-DDSN maintains a quality review process utilizing their QIO and other independent contractors to ensure local Board/other qualified provider qualifications are valid and appropriate.

- 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.

-Each DSN Board is required to perform a yearly audit of their financial position. These yearly audits are performed by independent CPA firms to determine if provider agencies are upholding general accepted accounting practices and are maintaining a sound financial position.

-The Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity any audit payments to service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office.

-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. The Internal Audit Division within SCDDSN has planned audits of State Agency Medicaid contracts in its audit plan.

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
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. Performance Measures

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

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

Performance Measure:
Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver.

Data Source (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**	☑ **Other**

	Ongoing	Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN web-based adjustments

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

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 = +/-15%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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.

DDSN reviews and amends its' financial policies and procedures with approval by DHHS. DHHS Financial policy requires DDSN to void/replace incorrect claims using the web-based system whenever possible. Some corrections require submission of manual adjustments. QA reviews that identify inappropriate payments due to invalid Level of Care Determinations or incomplete Plan of Service Documents, for example, generate an automatic referral to DHHS-Program Integrity for an independent record review and, if warranted, recoupment of Federal Financial Participation (FFP). DHHS requires DDSN to include recoupable review findings in field staff training.

-Additional information on remediation on what warrants a special review and how claims are being paid in accordance with the approved waiver if no special review is triggered. - DDSN has a system in place, through the QIO review process, to identify and report any programmatic findings that could result in inappropriate Medicaid claims. The sampling strategy to identify participant records has been established to maintain a 95% confidence interval. These claims are marked as "recoupable" indicators and isolated in their own section of the Provider's QIO Review report. Reports are available on the Portal 30 days after completion of the review. Special circumstance reviews may be conducted when DDSN has identified a pattern of billing that would negatively impact service delivery.

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 Bureau of Reimbursement Methodology and Policy is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public meetings, or through meetings with association representatives.

-Effective October 1, 2012, waiver service fixed rates were established based upon the projected costs of the service to be provided. Projected costs used in the determination of the waiver rates effective October 1, 2012 were based on FY 2010 Medicaid waiver cost reports adjusted for a trend factor to closely approximate allowable Medicaid reimbursable costs for the services provided at October 1, 2012. Both SCDDSN and SCDHHS, Bureau of Reimbursement Methodology perform financial reviews to ensure that funding provided by the SC General Assembly was appropriately expended by providers of these services.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers maintain the option of billing directly to 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.)*

- [ ] **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

J-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.

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.**

☑ **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: *Complete item I-3-e.*

SCDDSN will receive payment for waiver services and will provide the following waiver services: UAP Attendant Care services to include any DSN Board billed waiver services and Service Coordination.

SCDDSN will not receive payment or provide the following services: Adult Day Health Care Services, Personal Care Services, Adult Day Health Care Nursing, Adult Day Health Care Transportation, Personal Emergency Response System and Behavior Support. These services will be provided by private Medicaid providers directly enrolled and contracted in the Medicaid Program.

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:

SCDDSN will submit annual cost reports that reflect the total costs incurred by SCDDSN and/or its local Boards of the services provided under this waiver. The SCDHHS will desk review the cost report and determine the average unit cost of the services provided under this waiver based upon costs and units of the total population served (i.e. both Medicaid and non-Medicaid recipients). The actual cost rate will then be compared against the fixed rate paid to determine if an overpayment has been made. If an overpayment occurs, the SCDHHS will recoup the federal portion of the overpayment from the SCDDSN and return it to CMS via the quarterly expenditure report.

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 the local DSN County Boards and together they form an OHCDS. The OHCDS establishes contracts with other qualified providers to furnish home and community based services to people served in this waiver. (b) Providers of waiver services may direct bill their services to DHHS. (c) At a minimum, waiver participants are given a choice of providers, regardless of their affiliate with the OHCDS, annually or more frequent if requested or warranted (d) DDSN will assure that providers that furnish waiver services under contract with the OHCDS meet applicable provider qualifications through the state's procurement process. (e) DDSN assures that contracts with providers meet applicable requirements via QIO reviews of the provider, as well as, periodic record reviews. (f) DDSN requires its local DSN County Boards to perform annual financial audits.

Providers are not required to contract with an OHCDS in order to furnish services to waiver participants.-

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.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State

entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

SCDDSN receives state appropriations to provide services under this waiver. A portion of these funds will be transferred to 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d 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	37025.48	11075.00	48100.48	48932.00	8308.00	57240.00	9139.52
2	39799.39	11297.00	51096.39	49911.00	8474.00	58385.00	7288.61
3	40434.04	11523.00	51957.04	50909.00	8643.00	59552.00	7594.96
4	40878.18	11753.00	52631.18	51927.00	8816.00	60743.00	8111.82
5	41820.70	11988.00	53808.70	52966.00	8992.00	61958.00	8149.30

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 Number 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	1220	1192	28
Year 2	1320	1289	31
Year 3	1345	1313	32
Year 4	1370	1336	34
Year 5	1395	1360	35

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 - 11.47 months; 349 days
Year 2 - 11.49 months; 349 days
Year 3 - 11.50 months; 350 days
Year 4 - 11.52 months; 350 days
Year 5 - 11.53 months; 351 days

This basis originates with the CMS 372 Report for Waiver #0284 for the year ending 6/30/2010 reporting an Average Length of Stay at 349 days. A slight increase in days would be attributable to the small projected increases in enrollments over the remaining five year renewal.

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:

The estimates are based on projected utilization of services. The projected utilizations are based on current industry practices for each service level included in the waiver. The costs per services were determined by surveying current provider of services.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The derivation of the figures originate with the CMS 372 Report for Waiver #0284 for the year ending 6/30/2010 with an inflation factor of 1.5% built in to account for increases in expenditures over the last three years of the preceding waiver. Average per capita expenditures are projected to increase by 2% annually for each of the remaining renewal years.

-Factor D' was based on 372 reports that exclude dual eligible clients pharmacy expenditures; therefore, Factor D' did not require additional adjustment.

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 derivation of the figures originate with the CMS 372 Report for Waiver #0284 for the year ending 6/30/2010 with an annual inflation factor of 1.5% built in to account for increases in expenditures over the last three years of the preceding waiver. Average per capita expenditures are projected to increase by 2% annually for each of the remaining renewal years.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The derivation of the figures originate with the CMS 372 Report for Waiver #0284 for the year ending 6/30/2010 with an annual inflation factor of 1.5% built in to account for increases in expenditures over the last three years of the preceding waiver. Average per capita expenditures are projected to increase by 2% annually for each of the remaining renewal years.

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
Residential Habilitation
Respite Care
Waiver Case Management (WCM)
Incontinence Supplies
Occupational Therapy
Physical Therapy
Prescribed Drugs
Speech and Hearing Services
Behavior Support
Career Preparation
Day Activity
Employment Services
Environmental Modifications
Health Education for Consumer-Directed Care
Medicaid Waiver Nursing
Peer Guidance for Consumer-Directed Care
Personal Emergency Response System
Private Vehicle Modifications
Psychological Services
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 Total:						**25584405.28**
UAP Independent Attendant Care	Per Hour	366	1754.00	14.13	**9070951.32**	
Agency Attendant Care	Per Hour	488	1754.00	16.00	**13695232.00**	
SCDDSN Board Attendant Care	Per Hour	122	1754.00	13.17	**2818221.96**	
Residential Habilitation Total:						**5788316.00**
Residential Habilitation	Per Day	73	344.00	230.50	**5788316.00**	
Respite Care Total:						**1764356.88**
Institutional ICF/MR Based	Per Day	24	34.00	286.00	**233376.00**	
Institutional NF/Hospital Based	Per Day	24	34.00	130.00	**106080.00**	
Non Institutional Based	Per Hour	244	378.00	15.09	**1391780.88**	
CRCF Respite	Per Day	24	23.00	60.00	**33120.00**	
Waiver Case Management (WCM) Total:						**1699289.20**
Face to Face	15 Minutes	1220	7.00	41.74	**356459.60**	
Non-Face to Face	15 Minutes	1220	28.00	39.31	**1342829.60**	
Incontinence Supplies Total:						**1073600.00**
Incontinence Supplies	Month	976	11.00	100.00	**1073600.00**	
Occupational Therapy Total:						**32175.00**
Occupational Therapy	15 minutes	13	275.00	9.00	**32175.00**	
Physical Therapy Total:						**39528.00**
Physical Therapy	15 minutes	24	183.00	9.00	**39528.00**	
Prescribed Drugs Total:						**364140.00**
Prescribed Drugs	Per Item	306	34.00	35.00	**364140.00**	
Speech and Hearing Services Total:						**118287.00**
Speech, Hearing and Language Therapy	15 minutes	13	183.00	9.00	**21411.00**	
Licensed Speech Therapist	Assessment	13	46.00	54.00	**32292.00**	
Licensed Audiologist	Assessment	13	46.00	54.00	**32292.00**	
Licensed SLP	Assessment	13	46.00	54.00	**32292.00**	
Behavior Support Total:						**66240.00**
Behavior Support	1/2 hour	24	92.00	30.00	**66240.00**	

Career Preparation Total:						**502901.84**
Career Preparation	1/2 Day	62	413.00	19.64	**502901.84**	
Day Activity Total:						**502901.84**
Day Activity	1/2 Day	62	413.00	19.64	**502901.84**	
Employment Services Total:						**22554.72**
Employment Services	Per Hour	24	46.00	20.43	**22554.72**	
Environmental Modifications Total:						**2208000.00**
Environmental Modifications	Per Item	184	1.00	12000.00	**2208000.00**	
Health Education for Consumer-Directed Care Total:						**9680.00**
Health Education for Consumer-Directed Care	Hour	44	11.00	20.00	**9680.00**	
Medicaid Waiver Nursing Total:						**2778092.60**
Licensed Practical Nurse	Per Hour	122	734.00	23.75	**2126765.00**	
Registered Nurse	Per Hour	49	424.00	31.35	**651327.60**	
Peer Guidance for Consumer-Directed Care Total:						**13230.80**
Peer Guidance for Consumer-Directed Care	Hour	62	11.00	19.40	**13230.80**	
Personal Emergency Response System Total:						**143100.00**
Recurring Maintenance	Per Month	428	11.00	30.00	**141240.00**	
Initial Installation	Per Item	62	1.00	30.00	**1860.00**	
Private Vehicle Modifications Total:						**1548000.00**
Private Vehicle Modifications	Per Item	86	1.00	18000.00	**1548000.00**	
Psychological Services Total:						**173085.12**
Drug/Alcohol Counseling	Per Hour	36	46.00	40.00	**66240.00**	
Mental Health Services	1/2 Hour	36	92.00	32.26	**106845.12**	
Supplies, Equipment and Assistive Technology Total:						**739200.00**
Supplies, Equipment and Assistive Technology	Per Item	672	11.00	100.00	**739200.00**	

GRAND TOTAL:	**45171084.28**
Total Estimated Unduplicated Participants:	**1220**
Factor D (Divide total by number of participants):	**37025.48**
Average Length of Stay on the Waiver:	349

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 Total:						**28329727.44**
UAP Independent Attendant Care	Per Hour	397	1757.00	14.41	**10051392.89**	
Agency Attendant Care	Per Hour	528	1757.00	16.32	**15139998.72**	
SCDDSN Board Attendant Care	Per Hour	133	1757.00	13.43	**3138335.83**	
Residential Habilitation Total:						**6489036.00**
Residential Habilitation	Per Day	80	345.00	235.11	**6489036.00**	
Respite Care Total:						**1983227.28**
Institutional ICF/MR Based	Per Day	28	34.00	291.72	**277717.44**	
Institutional NF/Hospital Based	Per Day	28	34.00	132.60	**126235.20**	
Non Institutional Based	Per Hour	264	379.00	15.39	**1539861.84**	
CRCF Respite	Per Day	28	23.00	61.20	**39412.80**	
Waiver Case Management (WCM) Total:						**4260788.40**
Face to Face	15 Minutes	1320	25.00	36.23	**1195590.00**	
Non-Face to Face	15 Minutes	1320	74.00	31.38	**3065198.40**	
Incontinence Supplies Total:						**1184832.00**
Incontinence Supplies	Month	1056	11.00	102.00	**1184832.00**	
Occupational Therapy Total:						**32937.84**
Occupational Therapy	15 Minutes	13	276.00	9.18	**32937.84**	
Physical Therapy Total:						**47295.36**
Physical Therapy	15 Minutes	28	184.00	9.18	**47295.36**	
Prescribed Drugs Total:						**399340.20**
Prescribed Drugs	Per Item	329	34.00	35.70	**399340.20**	
Speech and Hearing Services Total:						**120772.08**
Speech, Hearing and Language Therapy	15 minutes	13	184.00	9.18	**21958.56**	
Licensed Speech Therapist	Assessment	13	46.00	55.08	**32937.84**	

Licensed Audiologist	Assessment	13	46.00	55.08	**32937.84**	
Licensed SLP	Assessment	13	46.00	55.08	**32937.84**	
Behavior Support Total:						**126684.00**
Behavior Support	1/2 Hour	45	92.00	30.60	**126684.00**	
Career Preparation Total:						**537705.35**
Career Preparation	1/2 Day	65	413.00	20.03	**537705.35**	
Day Activity Total:						**537705.35**
Day Activity	1/2 Day	65	413.00	20.03	**537705.35**	
Employment Services Total:						**26841.92**
Employment Services	Per Hour	28	46.00	20.84	**26841.92**	
Environmental Modifications Total:						**2435760.00**
Environmental Modifications	Per Item	199	1.00	12240.00	**2435760.00**	
Health Education for Consumer-Directed Care Total:						**18849.60**
Health Education for Consumer-Directed Care	Hour	84	11.00	20.40	**18849.60**	
Medicaid Waiver Nursing Total:						**3088953.15**
Licensed Practical Nurse	Per Hour	133	735.00	24.23	**2368603.65**	
Registered Nurse	Per Hour	53	425.00	31.98	**720349.50**	
Peer Guidance for Consumer-Directed Care Total:						**18849.60**
Peer Guidance for Consumer-Directed Care	Hour	84	11.00	20.40	**18849.60**	
Personal Emergency Response System Total:						**157834.80**
Recurring Maintenance	Month	463	11.00	30.60	**155845.80**	
Initial Installation	Per Item	65	1.00	30.60	**1989.00**	
Private Vehicle Modifications Total:						**1707480.00**
Private Vehicle Modifications	Per Item	93	1.00	18360.00	**1707480.00**	
Psychological Services Total:						**198572.80**
Drug/Alcohol Counseling	Per Hour	40	46.00	40.80	**75072.00**	
Mental Health Services	1/2 Hour	40	92.00	33.56	**123500.80**	
Supplies, Equipment and Assistive Technology Total:						**832007.88**
Supplies, Equipment and Assistive Technology	Per Item	727	11.00	104.04	**832007.88**	
				GRAND TOTAL:		**52535201.05**
				Total Estimated Unduplicated Participants:		**1320**

Factor D (Divide total by number of participants):	**39799.39**
Average Length of Stay on the Waiver:	349

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 Total:						**29472960.00**
UAP Independent Attendant Care	Per Hour	404	1760.00	14.70	**10452288.00**	
Agency Attendant Care	Per Hour	538	1760.00	16.65	**15765552.00**	
SCDDSN Board Attendant Care	Per Hour	135	1760.00	13.70	**3255120.00**	
Residential Habilitation Total:						**6618756.00**
Residential Habilitation	Per Day	80	345.00	239.81	**6618756.00**	
Respite Care Total:						**2036029.16**
Institutional ICF/MR Based	Per Day	26	35.00	297.55	**270770.50**	
Institutional NF/Hospital Based	Per Day	26	35.00	135.25	**123077.50**	
Non Institutional Based	Per Hour	269	380.00	15.70	**1604854.00**	
CRCF Respite	Per Day	26	23.00	62.42	**37327.16**	
Waiver Case Management (WCM) Total:						**3365606.95**
Face to Face	15 Minutes	1345	25.00	30.71	**1032623.75**	
Non-Face to Face	15 Minutes	1345	74.00	23.44	**2332983.20**	
Incontinence Supplies Total:						**1388309.76**
Incontinence Supplies	Month	1112	12.00	104.04	**1388309.76**	
Occupational Therapy Total:						**38750.40**
Occupational Therapy	15 Minutes	15	276.00	9.36	**38750.40**	
Physical Therapy Total:						**44778.24**
Physical Therapy	15 Minutes	26	184.00	9.36	**44778.24**	
Prescribed Drugs Total:						

						430730.30
Prescribed Drugs	Per Item	338	35.00	36.41	**430730.30**	
Speech and Hearing Services Total:						**142126.20**
Speech, Hearing and Language Therapy	15 minutes	15	184.00	9.36	**25833.60**	
Licensed Speech Therapist	Assessment	15	46.00	56.18	**38764.20**	
Licensed Audiologist	Assessment	15	46.00	56.18	**38764.20**	
Licensed SLP	Assessment	15	46.00	56.18	**38764.20**	
Behavior Support Total:						**180893.16**
Behavior Support	1/2 Hour	63	92.00	31.21	**180893.16**	
Career Preparation Total:						**879634.08**
Career Preparation	1/2 Day	104	414.00	20.43	**879634.08**	
Day Activity Total:						**879634.08**
Day Activity	1/2 Day	104	414.00	20.43	**879634.08**	
Employment Services Total:						**25426.96**
Employment Services	Per Hour	26	46.00	21.26	**25426.96**	
Environmental Modifications Total:						**2534414.40**
Environmental Modifications	Per Item	203	1.00	12484.80	**2534414.40**	
Health Education for Consumer-Directed Care Total:						**25970.88**
Health Education for Consumer-Directed Care	Per Hour	104	12.00	20.81	**25970.88**	
Medicaid Waiver Nursing Total:						**3205576.08**
Licensed Practical Nurse	Per Hour	135	736.00	24.71	**2455185.60**	
Registered Nurse	Per Hour	54	426.00	32.62	**750390.48**	
Peer Guidance for Consumer-Directed Care Total:						**25970.88**
Peer Guidance for Consumer-Directed Care	Hour	104	12.00	20.81	**25970.88**	
Personal Emergency Response System Total:						**178926.93**
Recurring Maintenance	Per Month	472	12.00	31.21	**176773.44**	
Initial Installation	Per Item	69	1.00	31.21	**2153.49**	
Private Vehicle Modifications Total:						**1779084.00**
Private Vehicle Modifications	Per Item	95	1.00	18727.20	**1779084.00**	
Psychological Services Total:						**205083.64**

Drug/Alcohol Counseling	Per Hour	41	46.00	41.62	**78495.32**	
Mental Health Services	1/2 Hour	41	92.00	33.56	**126588.32**	
Supplies, Equipment and Assistive Technology Total:						**925123.68**
Supplies, Equipment and Assistive Technology	Per Item	741	12.00	104.04	**925123.68**	

GRAND TOTAL:	**54383785.78**
Total Estimated Unduplicated Participants:	**1345**
Factor D (Divide total by number of participants):	**40434.04**
Average Length of Stay on the Waiver:	350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Total:						**30676701.92**
UAP Independent Attendant Care	Per Hour	412	1762.00	14.99	**10881900.56**	
Agency Attendant Care	Per Hour	548	1762.00	16.98	**16395480.48**	
SCDDSN Board Attendant Care	Per Hour	138	1762.00	13.98	**3399320.88**	
Residential Habilitation Total:						**7024709.98**
Residential Habilitation	Per Day	83	346.00	244.61	**7024709.98**	
Respite Care Total:						**2157521.14**
Institutional ICF/MR Based	Per Day	29	35.00	303.51	**308062.65**	
Institutional NF/Hospital Based	Per Day	29	35.00	137.96	**140029.40**	
Non Institutional Based	Per Hour	274	380.00	16.01	**1666961.20**	
CRCF Respite	Per Day	29	23.00	63.67	**42467.89**	
Waiver Case Management (WCM) Total:						**2434490.00**
Face to Face	15 Minutes	1370	25.00	25.20	**863100.00**	
Non-Face to Face	15 Minutes	1370	74.00	15.50	**1571390.00**	
Incontinence Supplies Total:						**1461909.12**
Incontinence Supplies	Month	1148	12.00	106.12	**1461909.12**	

Occupational Therapy Total:						**36901.20**
Occupational Therapy	15 Minutes	14	276.00	9.55	**36901.20**	
Physical Therapy Total:						**50958.80**
Physical Therapy	15 Minutes	29	184.00	9.55	**50958.80**	
Prescribed Drugs Total:						**445865.70**
Prescribed Drugs	Per Item	343	35.00	37.14	**445865.70**	
Speech and Hearing Services Total:						**135323.72**
Speech, Hearing and Language Therapy	15 minutes	14	184.00	9.55	**24600.80**	
Licensed Speech Therapist	Assessment	14	46.00	57.31	**36907.64**	
Licensed Audiologist	Assessment	14	46.00	57.31	**36907.64**	
Licensed SLP	Assessment	14	46.00	57.31	**36907.64**	
Behavior Support Total:						**237271.68**
Behavior Support	1/2 Hour	81	92.00	31.84	**237271.68**	
Career Preparation Total:						**1055129.20**
Career Preparation	1/2 Day	122	415.00	20.84	**1055129.20**	
Day Activity Total:						**1055129.20**
Day Activity	1/2 Day	122	415.00	20.84	**1055129.20**	
Employment Services Total:						**28921.12**
Employment Services	Per Hour	29	46.00	21.68	**28921.12**	
Environmental Modifications Total:						**2610572.50**
Environmental Modifications	Per Item	205	1.00	12734.50	**2610572.50**	
Health Education for Consumer-Directed Care Total:						**31066.08**
Health Education for Consumer-Directed Care	Hour	122	12.00	21.22	**31066.08**	
Medicaid Waiver Nursing Total:						**3342507.30**
Licensed Practical Nurse	Per Hour	138	737.00	25.20	**2562991.20**	
Registered Nurse	Per Hour	55	426.00	33.27	**779516.10**	
Peer Guidance for Consumer-Directed Care Total:						**31066.08**
Peer Guidance for Consumer-Directed Care	Hour	122	12.00	21.22	**31066.08**	
Personal Emergency Response System Total:						**185213.28**
Recurring Maintenance	Per Month	479	12.00	31.84	**183016.32**	

Initial Installation	Per Item	69	1.00	31.84	**2196.96**	
Private Vehicle Modifications Total:						**1833767.04**
Private Vehicle Modifications	Per Item	96	1.00	19101.74	**1833767.04**	
Psychological Services Total:						**209176.26**
Drug/Alcohol Counseling	Per Hour	41	46.00	42.45	**80060.70**	
Mental Health Services	1/2 Hour	41	92.00	34.23	**129115.56**	
Supplies, Equipment and Assistive Technology Total:						**958900.32**
Supplies, Equipment and Assistive Technology	Per Item	753	12.00	106.12	**958900.32**	

GRAND TOTAL:	**56003101.64**
Total Estimated Unduplicated Participants:	**1370**
Factor D (Divide total by number of participants):	**40878.18**
Average Length of Stay on the Waiver:	350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Total:						**31889084.55**
UAP Independent Attendant Care	Per Hour	419	1765.00	15.29	**11307490.15**	
Agency Attendant Care	Per Hour	558	1765.00	17.32	**17057948.40**	
SCDDSN Board Attendant Care	Per Hour	140	1765.00	14.26	**3523646.00**	
Residential Habilitation Total:						**7165141.00**
Residential Habilitation	Per Day	83	346.00	249.50	**7165141.00**	
Respite Care Total:						**2201730.12**
Institutional ICF/MR Based	Per Day	27	35.00	309.58	**292553.10**	
Institutional NF/Hospital Based	Per Day	27	35.00	140.72	**132980.40**	
Non Institutional Based	Per Hour	279	381.00	16.33	**1735862.67**	
CRCF Respite	Per Day	27	23.00	64.95	**40333.95**	
Waiver Case Management (WCM) Total:						**2478915.00**

Face to Face	15 Minutes	1395	25.00	25.20	**878850.00**	
Non-Face to Face	15 Minutes	1395	74.00	15.50	**1600065.00**	
Incontinence Supplies Total:						**1540471.68**
Incontinence Supplies	Month	1186	12.00	108.24	**1540471.68**	
Occupational Therapy Total:						**37771.72**
Occupational Therapy	15 Minutes	14	277.00	9.74	**37771.72**	
Physical Therapy Total:						**48651.30**
Physical Therapy	15 Minutes	27	185.00	9.74	**48651.30**	
Prescribed Drugs Total:						**462826.35**
Prescribed Drugs	Per Item	349	35.00	37.89	**462826.35**	
Speech and Hearing Services Total:						**138152.00**
Speech, Hearing and Language Therapy	15 minutes	14	185.00	9.74	**25226.60**	
Licensed Speech Therapist	Assessment	14	46.00	58.45	**37641.80**	
Licensed Audiologist	Assessment	14	46.00	58.45	**37641.80**	
Licensed SLP	Assessment	14	46.00	58.45	**37641.80**	
Behavior Support Total:						**292749.52**
Behavior Support	1/2 Hour	98	92.00	32.47	**292749.52**	
Career Preparation Total:						**1235206.00**
Career Preparation	1/2 Day	140	415.00	21.26	**1235206.00**	
Day Activity Total:						**1235206.00**
Day Activity	1/2 Day	140	415.00	21.26	**1235206.00**	
Employment Services Total:						**27460.62**
Employment Services	Per Hour	27	46.00	22.11	**27460.62**	
Environmental Modifications Total:						**2727729.90**
Environmental Modifications	Per Item	210	1.00	12989.19	**2727729.90**	
Health Education for Consumer-Directed Care Total:						**36372.00**
Health Education for Consumer-Directed Care	Hour	140	12.00	21.65	**36372.00**	
Medicaid Waiver Nursing Total:						**3467691.36**
Licensed Practical Nurse	Per Hour	140	738.00	25.71	**2656357.20**	
Registered Nurse	Per Hour	56	427.00	33.93	**811334.16**	
Peer Guidance for						

Consumer-Directed Care Total:						**36372.00**
Peer Guidance for Consumer-Directed Care	Hour	140	12.00	21.65	**36372.00**	
Personal Emergency Response System Total:						**192806.86**
Recurring Maintenance	Per Month	489	12.00	32.47	**190533.96**	
Initial Installation	Per Item	70	1.00	32.47	**2272.90**	
Private Vehicle Modifications Total:						**1909410.44**
Private Vehicle Modifications	Per Item	98	1.00	19483.78	**1909410.44**	
Psychological Services Total:						**218586.48**
Drug/Alcohol Counseling	Per Hour	42	46.00	43.30	**83655.60**	
Mental Health Services	1/2 Hour	42	92.00	34.92	**134930.88**	
Supplies, Equipment and Assistive Technology Total:						**997539.84**
Supplies, Equipment and Assistive Technology	Per Item	768	12.00	108.24	**997539.84**	

GRAND TOTAL:	**58339874.74**
Total Estimated Unduplicated Participants:	**1395**
Factor D (Divide total by number of participants):	**41820.70**
Average Length of Stay on the Waiver:	351