

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

South Carolina Department of Health and Human Services (SCDHHS)

Submission Date: October 1, 2006

CMS Receipt Date (CMS Use)

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

This request is for a new waiver to provide early intensive behavioral intervention services (EIBI) to children who have been diagnosed with a pervasive developmental disorder, including autism and Asperger's Syndrome and who meet the ICF-MR level of care criteria. The Department of Disabilities and Special Needs will operate the waiver with administrative oversight from DHHS. The waiver will be for children ages three through ten. Under no circumstances will these services be provided in a setting where educational services are being provided. This waiver will seek to develop skills of children in the areas of cognition, behavior, communication and social interaction.

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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.

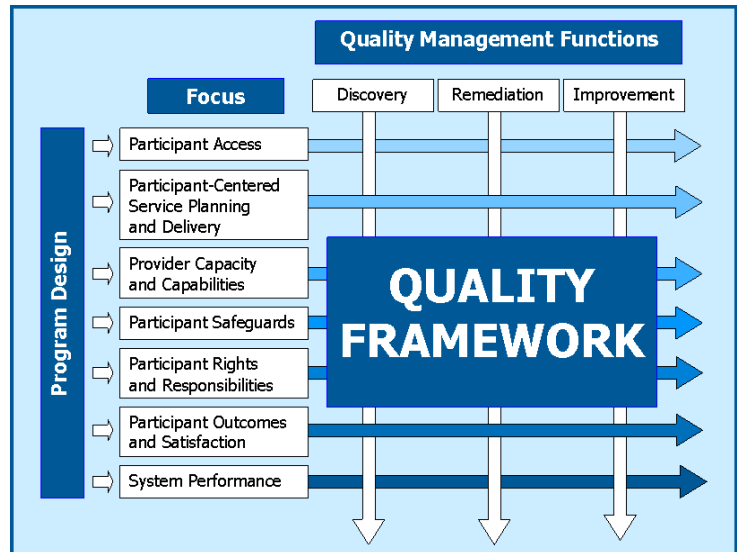
The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other 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.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- ◆ **Participant Access:** *Individuals have access to home and community-based services and supports in their communities.*
- ◆ **Participant-Centered Service Planning and Delivery:** *Services and supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.*
- ◆ **Provider Capacity and Capabilities:** *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- ◆ **Participant Safeguards:** *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- ◆ **Participant Rights and Responsibilities:** *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- ◆ **Participant Outcomes and Satisfaction:** *Participants are satisfied with their services and achieve desired outcomes.*
- ◆ **System Performance:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.



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1. Request Information

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

B. **Waiver Title** (optional): **Pervasive Developmental Disorder Waiver**

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

<input checked="" type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (<i>CMS Use</i>):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (<i>CMS Use</i>):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input type="radio"/>	Renewal (5 Years) of Waiver #		
<input type="radio"/>	Amendment to Waiver #		

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

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver , as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** **January 1, 2007**

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

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

<input type="checkbox"/>	Hospital (<i>select applicable level of care</i>)
<input type="radio"/>	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:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	Nursing Facility (<i>select applicable level of care</i>)
<input type="radio"/>	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:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input checked="" type="checkbox"/>	Not applicable		

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2. Brief Waiver Description

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

The purpose of this waiver is to support Medicaid eligible children ages three through ten. The services in this waiver are case management and early intensive behavioral intervention. The latter service is habilitative in nature and is not available to children through the Medicaid State plan. Operations for this waiver will be conducted by the Department of Disabilities and Special Needs.

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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*):

<input checked="" type="radio"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="radio"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- 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 Management Strategy.** Appendix H contains the Quality Management 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*):

<input type="radio"/>	Yes
<input checked="" type="radio"/>	No
<input type="radio"/>	Not applicable

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

<input type="radio"/>	Yes (<i>complete remainder of item</i>)
<input checked="" type="radio"/>	No

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

<input type="checkbox"/>	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. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
<input type="checkbox"/>	Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make <i>participant direction of services</i> 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. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

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**.

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- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.
- Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State’s procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** 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 Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

A public meeting was held on September 13, 2006 to discuss the design of the waiver and to receive comments. Notice of this meeting was publicized on the DHHS website, was posted at each DHHS County and Regional Eligibility Office, and letters were sent to interested parties announcing the public meeting. Over fifty persons representing consumers/families, providers, advocates and other stakeholders attended the session. Participants were also given the opportunity to provide written input to DHHS; a number of those were received and many were incorporated in the final document. In addition, a presentation was made to the State Developmental Disabilities Council on September 12, 2006. The waiver was also presented to DHHS’s Medical Care Advisory Committee on

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September 19, 2006.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State’s intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

First Name:	Kara
Last Name	Lewis
Title:	Waiver Administrator
Agency:	SC Department of Health and Human Services
Address 1:	PO Box 8206
Address 2:	
City	Columbia
State	South Carolina
Zip Code	29202
Telephone:	(803) 898-2702
E-mail	
Fax Number	(803) 255-8209

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

First Name:	Daniel
Last Name	Davis
Title:	Director, Division of Autism
Agency:	SC Department of Disabilities and Special Needs
Address 1:	3440 Harden Street Extension
Address 2	
City	Columbia
State	South Carolina
Zip Code	29203

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Telephone:	(803) 898-9609
E-mail	Ddavis@ddsn.sc.gov
Fax Number	(803) 898-9653

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8. Authorizing Signature

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

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

Signature: _____ **Date:** _____
 State Medicaid Director or Designee

First Name:	Robert
Last Name	Kerr
Title:	Director
Agency:	South Carolina Department of Health and Human Services
Address 1:	P.O. Box 8206
Address 2:	
City	Columbia
State	South Carolina
Zip Code	29202-8206
Telephone:	803-898-2504
E-mail	kerr@scdhhs.gov
Fax Number	803-255-8235

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not Applicable

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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*):

<input type="radio"/>	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 (<i>select one; do not complete Item A-2</i>):	
<input type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>):	
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (<i>name of division/unit</i>)	
<input checked="" type="radio"/>	The waiver is operated by The Department of Disabilities and Special Needs a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. <i>Complete item A-2.</i>	

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, 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:

A Memorandum of Agreement between DHHS and DDSN is completed and reviewed every three (3) years. A service contract between DHHS and DDSN is completed and reviewed every three (3) years. The memorandum of agreement and service contract ensure that the waiver is operated by DDSN under the supervision of DHHS. DHHS exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The contract and memorandum of agreement also set forth the formal communication schedule between the agencies. Bi-monthly operational level meetings are held between DHHS and DDSN. Quarterly policy meetings are held between DHHS and DDSN with Deputy Directors and other Waiver administrative staff. Weekly/multiple contacts by telephone and email are conducted between DDSN and DHHS when necessary.

The memorandum of agreement and service contract specify the entities performing the assurances of freedom of choice, level of care, quality assurance and issues of financial liability. DDSN reviews contracts and conducts waiver program reviews with the Disabilities and Special Needs (DSN) Boards and other service providers annually. Subject to DHHS review and approval, DDSN also amends contracts with DSN Boards and other service providers as necessary. DHHS will periodically conduct program reviews and review contracts to ensure full oversight of the DDSN quality assurance process.

Services provided in this waiver will be done in coordination with the child’s family, waiver service provider, case manager and the Local Education Agency (LEA). The purpose of this coordination is to avoid duplication and ensure that identified needs are met.

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

<input checked="" type="radio"/>	<p>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i></p>
	<ol style="list-style-type: none"> 1. DHHS contracts with the quality assurance contractor to perform functions related to independent quality assurance of all waiver functions for this waiver. 2. DDSN contracts with an independent quality assurance contractor. This contract is for oversight and review of all waiver services and providers participating in the Waiver. 3. DHHS contracts with a separate quality assurance contractor. This entity reviews ICF/MR level of care determinations preformed by DDSN. This entity provides monthly reports and quarterly summaries of the outcome of their review process.
<input type="radio"/>	<p>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</p>

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

<input type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input checked="" type="checkbox"/>	<p>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). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p> <p>DHHS and DDSN contract with private for-profit and non-profit entities to provide case management (service coordination) services.</p>
<input type="checkbox"/>	<p>Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.</p>

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:

<p>The Department of Health and Human Services and the Department of Disabilities and Special Needs jointly share the responsibility of assessing the performance of contracted local/regional non-state entities in conducting waiver operational and administrative functions.</p>
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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:

<p>The Department of Health and Human Service (DHHS) and the Department of Disabilities and Special Needs (DDSN) jointly share responsibility in assessing the performance of contracted and local/regional non-state entities in conducting waiver operational and administrative functions. DHHS utilizes both a quality assurance contractor and its Medicaid Program Integrity Unit (MPI) to oversee and review the operational functions of DDSN. The memorandum of agreement sets forth both the operational agencies responsibility for quality assurance and the administering agencies oversight of the quality assurance process.</p> <p>DDSN contracts with an independent provider of quality assurance and quality performance to annually assess the qualified providers of the services offered in this waiver. DDSN also conducts reviews and provides technical assistance to the providers of autism services. DHHS completes quality assurance reviews of providers and submits findings to DDSN and DDSN reviews the findings with</p>
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Appendix A: Waiver Administration and Operation

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providers and provides technical assistance and follows up as necessary. DDSN Internal Audit Division may conduct special request audits, investigates fraud cases, provides training and technical assistance.

DDSN's quality contractor assesses the qualified/approved providers through DDSN at least annually. The quality contractor also conducts follow-up reviews of the local DSN Boards and other approved providers. The quality contractor issues a comprehensive Report of Findings to DDSN and the approved provider. DDSN shares the Report of Findings with the administrative agency. The administrative agency reviews these reports and will conduct independent reviews to validate the findings of the DDSN quality contractor. Upon request, DHHS Medicaid Program Integrity (MPI) Division conducts reviews. Follow-up to the MPI reviews are conducted as necessary based on a Report of Findings. The quality contractor also completes annual mail-out surveys (family surveys) to supplement the quality review process. DDSN has been awarded a Choice Grant to evaluate the Quality Assurance process, specifically the Quality Framework.

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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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assist individuals in waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Manage waiver enrollment against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor waiver expenditures against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Perform prior authorization of waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct utilization management functions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Recruit providers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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Appendix B: Participant Access and Eligibility

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

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

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	Aged or Disabled, or Both			
<input type="checkbox"/>	Aged (age 65 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Disabled (Physical) (under age 65)			
<input type="checkbox"/>	Disabled (Other) (under age 65)			
Specific Aged/Disabled Subgroup				
<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/>	Mental Retardation or Developmental Disability, or Both			
<input checked="" type="checkbox"/>	Autism	3 years	10 years	<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/>	Mental Illness			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)			

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

1. Waiver participants will be terminated from the waiver after either a total of three years of service or upon reaching the eleventh birthday.
2. Children who have been diagnosed with a pervasive developmental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and who meet the ICF-MR level of care criteria.

- 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

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- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Upon reaching age eleven, waiver participants may be transitioned into the State's 1915c waiver for persons with mental retardation and related disabilities or other state services as appropriate. Six months before the participant phases out of the waiver, the parent or legal guardian will be provided an explanation of the transition process and offered choices of other services and supports as appropriate. The case manager will coordinate the disenrollment and transition to other services.

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Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

<input type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>	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. <i>Complete Items B-2-b and B-2-c.</i>		
<input checked="" type="radio"/>	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. <i>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.</i>		
The cost limit specified by the State is (<i>select one</i>):			
<input checked="" type="radio"/>	The following dollar amount: \$	50,000	
The dollar amount (<i>select one</i>):			
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input checked="" type="radio"/>	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.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="radio"/>	Other – <i>Specify</i> :		

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- 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:

EIBI services can be provided for up to 40 hours per week. Even if the participant requires this maximum amount of service, along with case management, the cost of waiver services will remain below the State cap.

- 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*):

<input checked="" type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual’s needs.
<input type="checkbox"/>	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:
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	120
Year 2	120
Year 3	120
Year 4 (renewal only)	
Year 5 (renewal only)	

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

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	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	100
Year 2	100
Year 3	100
Year 4 (renewal only)	
Year 5 (renewal only)	

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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*):

<input checked="" type="radio"/>	Not applicable. The state does not reserve capacity.	
<input type="radio"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Waiver Year		
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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

<input type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input checked="" type="radio"/>	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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.

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

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	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:

Waiver applicants will be admitted to the waiver after they meet all criteria for enrollment. If there are not sufficient slots for all applicants, applicants will be admitted based upon date of
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Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

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

<input checked="" type="radio"/>	Phased-in
<input type="radio"/>	Phased-out

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

Year One	Year Two	Year Three	Year Four	Your Five
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Month	Waiver Year
Waiver Year: First Calendar Month	January	
Phase-in	January	One
Phase-out	June	One

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

Phase-In or Phase-Out Schedule			
Waiver Year:		One	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit
January	0	30	100
February	30	15	100
March	45	15	100
April	60	15	100
May	75	15	100
June	90	10	100
July	100	0	100

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

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

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

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:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input checked="" type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input type="checkbox"/>	Optional State supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input checked="" type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	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)
<input checked="" type="checkbox"/>	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)
<input type="checkbox"/>	Medically needy
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
<i>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</i>	
<input type="radio"/>	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.
<input checked="" type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217

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	<input checked="" type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):	
	<input checked="" type="checkbox"/>	A special income level equal to (select one):	
	<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>	%	of FBR, which is lower than 300% (42 CFR §435.236)
	<input type="radio"/>	\$	which is lower than 300%
	<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
	<input type="checkbox"/>	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
	<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
	<input checked="" type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)	
	<input checked="" type="radio"/>	100% of FPL	
	<input type="radio"/>	%	of FPL, which is lower than 100%
	<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :	

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Appendix B-5: Post-Eligibility Treatment of Income

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

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

<input type="radio"/>	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 (<i>select one</i>):
<input type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input checked="" type="radio"/>	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. <i>Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

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

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

i. Allowance for the needs of the waiver participant (<i>select one</i>):	
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>):
<input type="radio"/>	SSI standard
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):
C	300% of the SSI Federal Benefit Rate (FBR)
C	% of the FBR, which is less than 300%
C	\$ which is less than 300%.
<input type="radio"/>	% of the Federal poverty level
<input checked="" type="radio"/>	Other (specify):
	The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust.

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input checked="" type="radio"/>	Not applicable (see instructions)		
iii. Allowance for the family (select one):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input checked="" type="radio"/>	Not applicable (see instructions)		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:			
a. Health insurance premiums, deductibles and co-insurance charges			
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>			
<input checked="" type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (specify):		

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

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

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<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State’s approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <div style="border: 1px solid black; height: 20px; width: 100%; background-color: #e0e0e0;"></div>
<input type="radio"/>	Other (specify): <div style="border: 1px solid black; height: 20px; width: 100%; background-color: #e0e0e0;"></div>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State’s Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <div style="border: 1px solid black; height: 60px; width: 100%; background-color: #e0e0e0;"></div>

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State. 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 <i>(select one)</i> :		
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i> :	
<input type="radio"/>	C	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	C	% of the FBR, which is less than 300%
<input type="radio"/>	C	\$ which is less than 300%.
<input type="radio"/>	C	% of the Federal poverty level
<input type="radio"/>	Other (specify):	
<input type="radio"/>		
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>		
ii. Allowance for the spouse only <i>(select one)</i> :		
<input type="radio"/>	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:	
<input type="radio"/>		
<input type="radio"/>	Specify the amount of the allowance:	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>		
<input type="radio"/>	Not applicable	

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iii. Allowance for the family (<i>select one</i>):	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input style="width: 50px;" type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <input style="width: 100%; height: 20px;" type="text"/>
<input type="radio"/>	Other (specify): <input style="width: 100%; height: 20px;" type="text"/>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <input style="width: 100%; height: 20px;" type="text"/>

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

i. Allowance for the needs of the waiver participant (<i>select one</i>):	
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)
<input type="radio"/>	The following standard under 42 CFR §435.121: <input style="width: 100%; height: 20px;" type="text"/>
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of the FBR, which is less than 300%
<input type="radio"/>	\$ which is less than 300% of the FBR
<input type="radio"/>	% of the Federal poverty level
<input type="radio"/>	Other (specify): <input style="width: 100%; height: 20px;" type="text"/>

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<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	The following standard under 42 CFR §435.121:	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable	
iii. Allowance for the family (select one)		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (see instructions)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third		

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party, specified in 42 CFR 435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

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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, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant (select one):	
<input type="radio"/>	SSI Standard
<input type="radio"/>	Optional State Supplement standard
<input type="radio"/>	Medically Needy Income Standard
<input type="radio"/>	The special income level for institutionalized persons
<input type="radio"/>	300% of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:
<input type="radio"/>	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:	
<input type="radio"/>	Allowance is the same
<input type="radio"/>	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges.	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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

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

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

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is <i>(insert number)</i> :
	1
ii.	Frequency of services. The State requires <i>(select one)</i> :
<input checked="" type="radio"/>	The provision of waiver services at least monthly
<input type="radio"/>	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)*:

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By the operating agency specified in Appendix A
<input type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity</i> :
<input type="radio"/>	Other <i>(specify)</i> :

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:

1) Physician (M.D. or D.O.) or a certified nurse practitioner; 2) the Director of Consumer Assessment. Director of Consumer Assessments: Minimum qualifications are a Master's degree in Social Work or a related field from an accredited college or university; or a Bachelor's degree in Social Work from an accredited college or university; or a Bachelor's degree from an accredited college or university in an unrelated field of study, and at least one year of experience in programs for persons with mental retardation or a service coordination program, and; 3) Psychologist: Minimum qualifications are a Master's degree in psychology plus two years of experience working with persons with lifelong disabilities, or a Master's degree in a health or human

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service field plus four years experience working with person with lifelong disabilities.

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- 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.

A standardized instrument is utilized to gather assessment information necessary for ICF-MR level of care determinations. There are three components to the criteria:

- 1) Diagnosed with mental retardation or a related disability;
- 2) Behaviors requiring supervision; and,
- 3) Services are needed for acquisitions of behaviors necessary to function with as much self-determination and independence as possible and/or to prevent the deceleration or regression or loss of current optimal functional status.

The MR/RD Form 9 is used for this determination.

- 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*):

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	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 is used. The same instrument and level of care 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
----------------------------------	--

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The qualifications are different. The qualifications of individuals who perform reevaluations are (*specify*):

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

An automated tickler system tracks due dates and timing of reevaluations. Additionally, if any level of care is found out of date FFP is taken back from the operating agency for any services that were billed when the level of care was not timely.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The original evaluations and all subsequent reevaluations are in the participant's official case management file.

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Appendix B-7: Freedom of Choice

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

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

A written Freedom of Choice Form is secured from each waiver participant's parent or guardian to ensure that the participant is involved in planning his/her services. This choice will remain in effect until such time as the participant changes his/her mind.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, 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.

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

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

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

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Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

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

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input checked="" type="checkbox"/>	Service Coordination
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input checked="" type="checkbox"/>	Early Intensive Behavioral Intervention (EIBI)
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (select one)		
<input checked="" type="radio"/>	Not applicable	
<input type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (list each service by title):	
Extended State Plan Services (select one)		
<input checked="" type="radio"/>	Not applicable	

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The following extended State plan services are provided (*list each extended State plan service by service title*):

Supports for Participant Direction (*select one*)

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	<input type="checkbox"/>	
Financial Management Services	<input checked="" type="checkbox"/>	

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

a.	
b.	
c.	

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b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*check each that applies*):

<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input checked="" type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

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

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Appendix C-2: General Service Specifications

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

<input checked="" type="radio"/>	<p>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):</p> <p style="margin-left: 20px;">All service providers in this waiver are required to have background checks done on direct care staff. These are state level investigations performed by South Carolina Law Enforcement (SLED checks) for each of the providers.</p>
<input type="radio"/>	<p>No. Criminal history and/or background investigations are not required.</p>

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*):

<input checked="" type="radio"/>	<p>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):</p> <p style="margin-left: 20px;">The Registry captures persons who have been convicted of abusing children under the age of 18. It is maintained by the South Carolina Department of Social Services.</p>
<input type="radio"/>	<p>No. The State does not conduct abuse registry screening.</p>

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

<input checked="" type="radio"/>	<p>No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input type="radio"/>	<p>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>Complete Items C-2-c.i –c.iii.</i></p>

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

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

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

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

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

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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:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	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 <i>extraordinary care</i> 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. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

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:*

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

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- 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 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. Potential providers are given a packet of information that is used in the enrollment and/or subcontracting process. DDSN will validate the provider meets all standards and qualifications and then the Medicaid agency may enroll the provider should they choose to enroll with the Medicaid agency.

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Appendix C-3: Waiver Services Specifications

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

Service Specification			
Service Title:	Case Management		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.</p> <p>The following minimum standards will apply for the provision of case management.</p> <p>Case managers will provide a monthly contact with the EIBI service provider and/or family. On a quarterly basis, there will be a review of the entire waiver plan of care which includes the most recent EIBI service provider quarterly progress report and a contact with the participant’s family. If progress toward established goals does not meet expectations, then consultation with DDSN will occur. On an annual basis, there will be a face-to-face contact with the family.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Case management is an ongoing service that is billed in monthly increments. In order for billing to occur, the minimum standards outlined above must be met. Regardless of the number of contacts and intensity, only a single billing will be made each month.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Independent Case Managers	Agency. List the types of agencies: Case Management Providers
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Independent Case Manager			Bachelor’s degree in humanities, social science or a related field plus, two years of experience in social or community work, and experience or training pertaining to children with PDD.

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Case Management Providers			Bachelor's degree in humanities, social science or a related field plus, two years of experience in social or community work, and experience or training pertaining to children with PDD.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Independent Case Manager	Department of Disabilities and Special Needs/Department of Health and Human Services	Upon Enrollment; Annually	
Case Management Providers	Department of Disabilities and Special Needs /Department of Health and Human Services	Upon Enrollment; Annually	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification	
Service Title:	Early Intensive Behavioral Intervention (EIBI)
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the current waiver.
Service Definition (Scope):	
<p>This service has four distinct components: Assessment, Program Development and Training; Plan Implementation; Lead Therapy Intervention; and Line Therapy.</p> <p>Service Level Components</p> <p>1) Assessment, Program Development and Training provided by the EIBI consultant</p> <ul style="list-style-type: none"> • Completion of an adaptive assessment; • Completion of a functional behavior assessment; • Development of a treatment and behavioral support plan; and • Training key personnel to implement interventions. <p>The service coordinator conducts a global assessment which is different from the assessments identified above. The global assessment will indicate the need for this service component.</p> <p>2) Plan Implementation provided by the EIBI consultant</p> <ul style="list-style-type: none"> • Implementation of the behavior support plan; • Educating family, caregivers and/or service providers concerning strategies and techniques to assist the participant in behavior reduction and skill acquisition; • Monthly monitorship of the effectiveness of the behavior support plan; • Modifying the behavior support plan as necessary; and • Updating initial assessments and modifying the plan as necessary. <p>3) Lead Therapy Interventions provided by the lead therapist</p> <ul style="list-style-type: none"> • Assuring the behavior support plan is implemented as written; • Weekly monitorship of the effectiveness of the behavior support plan; • Reviewing all recorded data; • Providing guidance to and supervision of the Line Therapist; • Receiving family/caregiver feedback; and • Assuring the coordination and continuity with other programs and services. • <p>4) Line Therapy provided by the line therapist</p> <ul style="list-style-type: none"> • Implement interventions designed in the behavior support plan; • Records data and reports concerns and progress to the Lead Therapist. 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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8 hours of service per day; the average amount will be below this maximum and based upon the identified needs and other services of the participant.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Medicaid enrolled EIBI providers		Medicaid enrolled EIBI providers
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Medicaid enrolled EIBI providers			Standards and qualifications verified by DDSN and approved by DHHS	
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:		Frequency of Verification
	Medicaid enrolled EIBI providers	Medicaid agency		Upon enrollment
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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

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

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

<input type="checkbox"/>	<p>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. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>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. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p>
<input checked="" type="checkbox"/>	<p>Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.</p>

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

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

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input checked="" type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

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

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> 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. <i>Specify:</i>

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant’s authority to determine who is included in the process.

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

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be provided to other service providers of the participant's/legal guardian's choosing.

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

The Service Plan is developed by the case manager 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 provide input. Service plans are developed prior to the delivery of a waiver funded service and at least annually thereafter.

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 case manager. When amendments to the waiver affect the information provided, the information is again provided in writing.

Participation in the planning process (assessment, plan development, implementation) 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. All needs identified during the assessment process must be addressed. The case manager must utilize information about the participant's strengths, priorities and preferences to determine how those needs will be addressed. The Plan will include a statement of the participant's need, indication of whether or not the need relates to a personal goal, the specific service to meet the need, the amount, frequency, duration of the service, and the type of provider who will furnish the service.

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

At a minimum, case managers will provide a monthly contact with the EIBI service provider and/or family. On a quarterly basis, there will be a review of the entire waiver plan of care which includes the most recent EIBI service provider quarterly progress report and a contact with the participant's family. If progress toward established goals does not meet expectations, then consultation with

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DDSN will occur. On an annual basis, there will be a face-to-face contact with the family.

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

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

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

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

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

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

The Service Plan document and description of the planning process are approved by the Medicaid agency prior to implementation. Participant plans are available upon request. A sample of participant plans are reviewed by the operating agency and results shared with the case manager and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS. DHHS will also review a sample of plans on an annual basis.

- 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:*

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule (<i>specify</i>):

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- 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 §74.53. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

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Appendix D-2: Service Plan Implementation and Monitoring

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

Case managers will provide a monthly contact with the EIBI service provider and/or family. On a quarterly basis, there will be a review of the entire waiver plan of care which includes the most recent EIBI service provider quarterly progress report and a contact with the participant's family. If progress toward established goals does not meet expectations, then consultation with DDSN will occur. On an annual basis, there will be a face-to-face contact with the family.

- b. Monitoring Safeguards.** *Select one:*

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> 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. <i>Specify:</i>

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Appendix E: Participant Direction of Services

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

Applicability (select one):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	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):

<input type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input checked="" type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

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

This waiver offers participants the opportunity to direct their waivers services with employer authority. Since all participants in this waiver will be children ages 3 through age 10, their parent or a legally responsible adult can choose to direct the participant’s care. Representatives must have no communication or cognitive deficit that would interfere with their representation of the participant and must agree to act in this capacity.

Case managers will provide detailed information to the participant and representative about participant direction as an option including the benefits and responsibilities of the option. If the participant and representative want to pursue participant direction, additional information about the risks, responsibilities and liabilities of the option will be shared by the case manager. 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 participants who feel the need for additional support. Once the participant has chosen to direct their services, case managers continue to monitor service delivery and the status of the participant’s health and safety.

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

<input checked="" type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , 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
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	authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , 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.
<input type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . 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:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	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.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

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

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input checked="" type="radio"/>	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. <i>Specify the criteria:</i>
	Participants or their representatives may direct their own services if they have no communication or cognitive deficits. The case manager will assess and determine if these criteria are met.

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 case manager will introduce participant direction as an option and provide a brochure giving participants basic information about this option. Case managers will provide this information at least annually or at the request of the participant. If the participant is interested, the case manager will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The case manager will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant

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direction. The case manager will continue to assess the participant’s interest on an annual basis or more frequently if requested by the participant.

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

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input type="checkbox"/>	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:

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Early Intensive Behavioral Intervention	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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*:

<input checked="" type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. (<i>Complete item E-1-i</i>). Specify whether governmental and/or private entities furnish these services. <i>Check each that applies</i> :
<input checked="" type="checkbox"/>	Governmental entities
<input type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i</i> .

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

<input type="radio"/>	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3.
<input checked="" type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information</i> :
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: The operating agency currently uses an FMS to provide these services to participants. This is a sole source procurement with a governmental entity.
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

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	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 (<i>check each that applies</i>):
	<i>Supports furnished when the participant is the employer of direct support workers:</i>
<input type="checkbox"/>	Assist participant in verifying support worker citizenship status
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
<input checked="" type="checkbox"/>	Other (<i>specify</i>):
	The FMS will verify the participant's verification of the worker's minimum qualifications to include all required background checks.
	<i>Supports furnished when the participant exercises budget authority:</i>
<input type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
<input type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other services and supports (<i>specify</i>):
	<i>Additional functions/activities:</i>
<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
<input checked="" type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other (<i>specify</i>):
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.

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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*):

<input type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p>
<input type="checkbox"/>	<p>Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: _____</p>
<input checked="" type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>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:</i></p> <p>The FMS supports are provided by a sole source contractor, which is one of the operation agency's disabilities and special needs boards. The operating agency will have a contract with the FMS to provide these supports. The supports include providing each participant with a checklist of responsibilities they have in hiring their workers, and verification of qualifications and requirements. The operating agency will assess the performance of the FMS on a quarterly basis. The FMS is also required to have an independent financial audit every year.</p>

k. Independent Advocacy (*select one*).

<input checked="" type="radio"/>	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p> <p>The Developmental Disabilities Council has agreed to provide this advocacy when requested. The case manager will provide their phone number and contact names to participants.</p>
<input type="radio"/>	<p>No. Arrangements have not been made for independent advocacy.</p>

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:

<p>The case manager will accommodate the participant by providing a list of qualified providers they can select from to maintain service delivery. The case manager and the operating agency will work together to ensure the participant's health and safety in this transition and will work to avoid any break in service delivery.</p>
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m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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If the participant or his representative are no longer able to communicate or if they experience cognitive deficits which keep them from acting in their or the participant's best interest, the case manager will transition services from participant direction to agency directed services. The authorization of agency directed services will be coordinated by the case manager. The operating agency will use written criteria in making this determination. The participant and/or representative will be informed of the opportunity and means of requesting a fair hearing, choosing an alternate provider and the service plan will be revised to accommodate changes.

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- 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	0*	
Year 2	10	
Year 3	10	
Year 4 (renewal only)		
Year 5 (renewal only)		

* It is the intent to offer participant direction at the beginning of Year 2. This will allow the State time to create an infrastructure to support financial management services.

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Appendix E-2: Opportunities for Participant-Direction

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

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

<input type="checkbox"/>	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. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</i>
<input checked="" type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

<input checked="" type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input checked="" type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	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 the FMS.
<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input checked="" type="checkbox"/>	Schedule staff
<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

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

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

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

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

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

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

<input type="radio"/>	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:
<input type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential

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service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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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.

An appeal may be made on behalf of a waiver participant by a parent or legal guardian whenever any decision adversely affects his/her eligibility status and/or receipt of services. Parents/legal guardians are informed of this decision verbally and in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et. seq.

A parent/legal guardian who is dissatisfied with a level of care decision by DDSN has the right to request an appeal of the action, as well as the right to request an appeal of DDSN's decision to reduce, suspend, or terminate a waiver service.

A request for reconsideration of an adverse decision by DDSN must be sent in writing to the State Director at SCDDSN. 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. In order for waiver benefits/services to continue during the reconsideration/appeal process, the parent/legal guardian's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. 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).

If the parent/legal guardian continues to be dissatisfied with decision a request for appeal can be made to SC DHHS. The parent/legal guardian must write a letter requesting an appeal within 30 days of the date of the official written notification issued by DDSN. If the appeal is filed within ten (10) days, services may continue pending the outcome of the hearing.

Information regarding the right to appeal and instructions for initiating an appeal are printed on the Notice of Denial Forms and the formal letter of denial from DDSN. Also included on these forms is the information on continuation of services and possible liability if the participant elects to continue receiving services.

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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:*

<input type="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input checked="" type="radio"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- 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.

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Appendix F-3: State Grievance/Complaint System

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

<input checked="" type="radio"/>	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 (<i>complete the remaining items</i>).
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>).

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

The Department of Disabilities and Special Needs operates the Complaint/Grievance System.

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

<p>Complaints are taken at the Department of Disabilities and Special Needs. Parent/legal guardians are notified of their right to complain/grieve through a Participant’s Rights and Responsibilities statement reviewed and signed at the initial visit during waiver entry. When a parent/legal guardian elects to file a grievance or make a complaint, the parent/legal guardian is informed that doing so is not a prerequisite or substitute for a Fair Hearing.</p> <p>Each applicant for services or participant has the right to make complaints regarding services or treatment. Every effort will be made to resolve concerns as quickly as possible and at the most immediate staff level that can properly address the concern.</p> <p>A three-step process is established to ensure a fair and impartial review of complaints. The written grievance/appeal will be made to the Autism Division Director. The Autism Division Director or designee shall investigate the concern. The Autism Division Director shall issue a written decision within ten (10) working days of receipt of the written grievance/appeal. If the grievance/appeal is resolved, it shall be acknowledged in writing and documented in the consumer's record.</p> <p>If the participant/representative is not satisfied, he/she may appeal in writing to the Associate State Director for Policy. The Associate State Director for Policy shall review the facts of the case and all supporting documents, consult with the Autism Division, and render a written decision within ten (10) working days. If the grievance/appeal is resolved, it shall be acknowledged in writing and documented in the participant's record.</p> <p>If the participant/representative is not satisfied with this decision, he/she may appeal in writing. All information regarding reconsiderations and appeals for the Autism Waiver is in Appendix F-1 of this application.</p>
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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

The South Carolina Child Protection Reform Act as specified in Section 20-7-480, et seq, requires reporting of abuse, neglect and exploitation to those state agencies having statutory authority to receive reports and investigate allegations of suspected abuse, neglect or exploitation. These agencies include Child Protective Services - South Carolina Department of Social Services (DSS) and local and state law enforcement agencies. 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, emotional, mental or psychological abuse, verbal, threatened or sexual abuse, neglect, and physical and financial 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 has been or is at risk for abuse, neglect or exploitation. Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected abuse, neglect, or exploitation to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the abuse, neglect or exploitation.

- b. **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.

Upon waiver enrollment, participants and parents/legal guardians are provided written information about reporting abuse, neglect and exploitation of children. The material provided explains what is considered abuse, neglect and exploitation. In addition, participants and parents/legal guardians are given phone numbers of where to report suspected abuse cases. Case managers explain this information to participants during the initial visit. This information will also be discussed during the periodic survey process all families participate in.

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

When there is reason to believe that a child has been abused, neglected, or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. DSS is the mandated agency to investigate

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suspected abuse, neglect, or exploitation in these settings. DDSN/DHHS and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN/DHHS to assist contract provider agencies in resolving issues with DSS regarding intake referrals and investigations. DSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification is sent to appropriate agencies for personnel and other required actions to be taken. If the alleged perpetrator is also employed by DDSN or DHHS, a contract provider agency, or the family and abuse, neglect, or exploitation is substantiated, the employee will be terminated.

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

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

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

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

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

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. Select one:

<input checked="" type="radio"/>	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions (<i>complete only Item G-2-c-ii</i>)
C	This Appendix applies. Check each that applies:
<input type="checkbox"/>	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. <i>Complete item G-2-b.</i>
<input type="checkbox"/>	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. <i>Complete item G-2-c.</i>

b. Safeguards Concerning Use of Restraints or Seclusion

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

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

c. Safeguards Concerning the Use of Restrictive Interventions

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.

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- 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:

The operating agency (DDSN) is responsible for oversight. DDSN contracts with the case management provider to monitor the service plan which includes asking the participant and their representative their satisfaction with service delivery on an ongoing basis. In addition, the early intensive behavioral intervention service standards specifically preclude the use of any type of restraint. The person completing the assessment will not include any seclusion or restraints in the development of the EIBI. This plan will be reviewed by the case manager and the operating agency prior to implementation to ensure it does not contain any restraint or seclusion interventions. In addition, the line therapy provider, whether participant directed or otherwise will be supervised weekly by the behavioral lead therapist.

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Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

<input type="radio"/>	Yes. This Appendix applies (<i>complete the remaining items</i>).
<input checked="" type="radio"/>	No. This Appendix is not applicable (<i>do not complete the remaining items</i>).

b. Medication Management and Follow-Up

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

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

c. Medication Administration by Waiver Providers

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

<input type="radio"/>	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. (<i>complete the remaining items</i>)
<input type="radio"/>	Not applicable (<i>do not complete the remaining items</i>)

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).

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

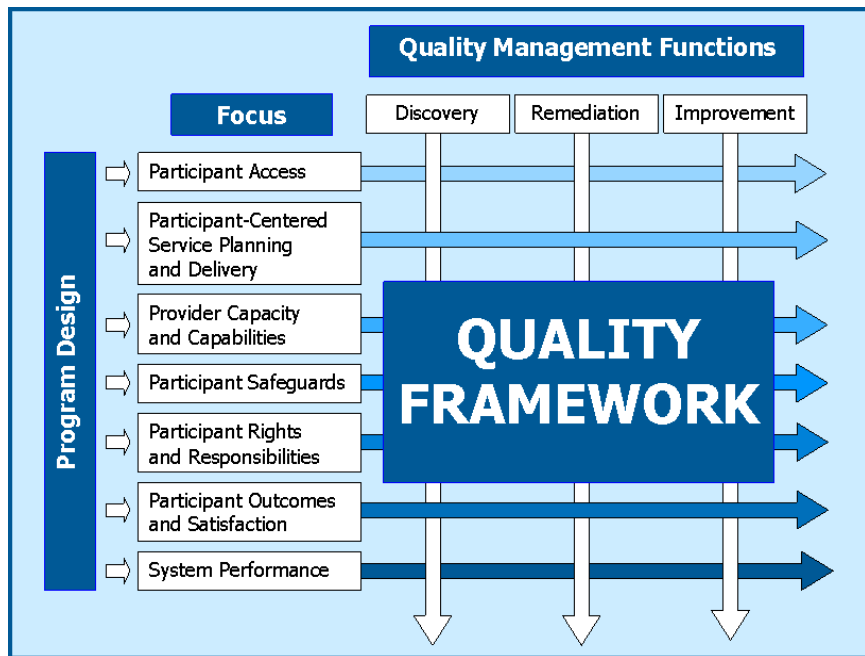
<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify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

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

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Appendix H: Quality Management Strategy

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 Management 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. A Quality Management Strategy explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state’s waiver Quality Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

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Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:

- Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
- The entities or individuals responsible for conducting the discovery/monitoring processes;
- The types of information used to measure performance; and,
- The frequency with which performance is measured.

2. The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.

Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.

3. Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement. *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*

4. The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public. *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*

5. The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.

If the State's Quality Management 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Management 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 identify the other long-term services that are addressed in the Quality Management Strategy.

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Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

DDSN has a multi-tiered quality management system that was designed using the CMS quality framework. This system is grounded in the uniform collection and analysis of reliable and valid data. The design of this system sets the stage for achieving person-centered desired outcomes along seven dimensions: level of care determination, plan of care, qualified providers, health and welfare, administrative authority, financial accountability and systems improvement. The quality management functions gauge the effectiveness and functionality of our design and pinpoint where attention should be devoted to secure improved outcomes. It encompasses 3 functions: discovery (collecting data and participant's experiences), remediation (taking action to remedy specific problems or trends that occur), and continuous improvement (using data and quality information to engage in actions that lead to continuous improvement in service delivery). Data is trended and analyzed monthly and where possible compared with national data. In areas that require strengthening, the agency develops an action plan with all stakeholders and re-evaluates the effectiveness of the interventions on an annual basis.

DHHS has a comprehensive Quality Management process that has been developed and refined over the last several years based upon State initiatives and ongoing consultation and technical assistance from Thomson Medstat, the national quality improvement organization contracted by CMS. Quality assurance practices have been developed to ensure the standards defined for the program are maintained and quality services are provided to our participants.

Assurances and Requirements

Initial Level of Care Evaluations:

DDSN ensures ICF/MR level of care (LOC) determinations are accurate and appropriate. An initial evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future. All waiver referrals go through a centralized intake process using a toll-free number. The intake workers apply the intake criteria to determine if sufficient evidence is present to proceed, including age and diagnostic criteria. If these criteria are met, the child and his/her family are given the choice of a case management provider and are assigned a case manager in the child's local area. The case manager submits a waiver application to DDSN. The case manager collects the required information from the child and his/her family to proceed with the level of care determination done by the DDSN assessment team. If the child meets the LOC criteria, the case manager is notified and enrollment is requested. A centralized team who verifies Medicaid eligibility and forwards such to the waiver's administrative authority, SCDHHS, handles the waiver enrollment.

Level of Care Re-evaluations:

Enrolled participants are re-evaluated at least annually or more frequently if warranted. The same DDSN assessment team who conducts the initial level of care determinations also conducts the re-evaluations. The DDSN participant data system generates reports that indicate participants that are due for re-evaluations to ensure they are completed timely. Each case manager receives on-line feedback about the status of the re-evaluations due in the next 3 months. They are reminded monthly until completed. The case manager's supervisor is notified on-line when the re-evaluation is due within one month. This system permits early identification of problems and potential problems so action can be taken quickly. Trend data is evaluated quarterly to determine statewide issues that may require a change in policy or procedure. Technical assistance is provided to those providers who need help with the timeliness and completeness of their referrals for LOC determination. The level of care process is monitored by both the state operating agency and the Medicaid agency. Action is taken to address inappropriate level of care determinations.

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LOC Oversight:

Monitoring of initial, re-evaluation, and adverse ICF/MR level of care determinations are performed by a DHHS contracted independent quality improvement organization (QIO). A representative sample of records is selected and the case record documentation is reviewed by the QIO for level of care validation. The QIO verifies supporting documentation and monitors compliance with Medicaid criteria. The QIO produces detailed, summary reports on a monthly and quarterly basis to DHHS reporting their findings and any recommendations for policy clarification. Upon receipt of this information, DHHS presents the findings to DDSN for discussion and necessary action.

Service Plan/Plan of Care:

DDSN ensures that the Plan of Care (POC) address all participants' needs and personal goals, whether by waiver services or other means. The POC is updated as changes in the waiver participant's situation occur. Services are delivered in accordance with the POC. DDSN monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of the POC.

DDSN's participant data support system, which includes the POC also contains the assessment data, therefore the assessment and POC documents are linked. This means that needs identified through the assessment process must be addressed through the POC document or the system will not allow the case manager to proceed.

DDSN contracts with a QIO designated by CMS to conduct face-to-face interviews and mail surveys to participants. These surveys were developed by the Human Services Research Institute (HSRI) and are used across the nation allowing for national comparison. Data are analyzed and shared within the organization, service providers and the Medicaid agency to improve services and satisfaction of participants.

DDSN uses the QIO to conduct annual and follow-up quality assurance reviews of participants using the POC as the main source of information. The review indicators are lined up with the CMS POC quality framework to ensure its comprehensiveness. This includes ensuring the provider type, amount, frequency, and duration criteria are met.

DDSN, through contract with local case management providers, requires that the case management supervisor review 2 case management files per case manager per month. They review whether sufficient activity occurs to meet the needs, verification that the plan includes all needs, and that the case manager has reassessed participants and updated their service plans as appropriate. Surveys are sent to a random sample of case management caseloads to ask about the assistance the case manager is providing. In addition, the HSRI surveys mentioned above have very specific information about the quality of care the case manager is providing. Case managers are notified of problems or areas needing improvement and receive training and technical assistance if needed by the supervisor or DDSN staff.

Service Plan/Plan of Care Oversight:

DHHS contracts with an independent quality assurance (QA) organization to monitor POC, through focus reviews of assessed needs of the participant, LOC assessment, health and welfare, and freedom of choice issues.

Qualified Providers:

DDSN verifies, on a periodic basis, that providers meet required certification standards and adhere to other state standards. All providers are reviewed annually, and a sample of their employees' personnel files is reviewed to ensure minimum qualifications are met.

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Qualified Providers Oversight:

DHHS monitors provider records to ensure proper service authorizations are on file, services are billed to Medicaid as authorized, and personnel continue to meet waiver standards and qualifications. The findings are summarized and discussed with DDSN and appropriate action is taken.

Health and Welfare:

DDSN assures participants' health, safety and welfare on a regular basis. It identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation. By South Carolina Code, the state investigative agency for children under 18 is the Department of Social Services. They receive and investigate reports of abuse and neglect. DDSN simultaneously receives reports of alleged abuse to ensure the first response is protecting the child, and then to determine if trends are noted. In all cases, the alleged perpetrator is not allowed to provide services until the investigation is complete. If abuse is substantiated, the employee is terminated.

Health and Welfare Oversight:

Health and welfare concerns are monitored by the DHHS QA contractor through case record reviews. The QA process includes receiving incident, abuse, neglect, and mortality reports that are used to trend data and perform follow-up focus reviews. Health and welfare issues are also investigated by The SC Department of Social Services' Adult & Child Protective Services, The SC Department of Mental Health, and the Long Term Care Division of the Ombudsman's Office. In addition, participants may utilize The SC Department of Health and Environmental Control's hotline to report incidents of abuse, neglect, and unsafe living conditions.

Administrative Authority:

DHHS engages in routine ongoing oversight of the waiver program. Responsibilities include but are not limited to: enforcing the terms and conditions of the Memorandum of Agreement, improving and clarifying policies and procedures to ensure system performance, and waiver operations.

DHHS' QA process also includes verifying claims and records for consistency with dates and services billed, and also monitoring and investigating reports of abuse, neglect, and mortality as necessary. Case reviews are conducted at least quarterly to ensure waiver compliance. DHHS shares findings with the operating agency in order for them to be aware of their performance, as well as to present any corrective action(s) that need to be taken.

Financial Accountability:

DDSN conducts financial oversight through a review of claims to ensure that they are coded and paid for in accordance with the reimbursement methodology specified in the waiver. Claims must meet all applicable criteria to be submitted to Medicaid Management Information System (MMIS) for payment at which time the billing code determines the rate of reimbursement.

Financial Accountability Oversight:

Ongoing monitoring of finances is conducted by DHHS Fiscal, Audits, and Program Integrity staff. DHHS also utilizes the QA process to monitor the paid claims data and participant utilization reports. Cost reports are developed to ensure that funds are being applied and used properly by analyzing financial records maintained by the state, sub-state entities and providers. All findings are used to determine needed improvements as well as corrective actions.

Roles and Responsibilities/Review of Findings/Report of Findings:

DDSN and DHHS continue to develop and improve the quality management (QM) systems. DDSN is evaluating the validity and reliability of its QM system through a systems change grant from CMS. Preliminary results indicate a strong statistically significant relationship between DDSN's QA processes and participant outcomes. DDSN and DHHS meet regularly to discuss the results of all data collected and

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analyzed related to waiver participants' outcomes and experiences with the waiver. Areas requiring improvement are discussed and an action plan is implemented. This leads to continuous quality improvement.

Quality Management Strategy:

Evaluating the six assurances through a QA process allows DHHS to utilize the findings in various ways to identify and address areas of major concern, to identify issues for policy change, corrective action, training needs, and provider compliance. The combined information allows the QA entity to perform focus reviews and develop trending reports to assure waiver eligible participants are served fairly and equitably based on Medicaid policy and procedure.

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APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State employs several methods to ensure the integrity of payments made for waiver services in different departments within the agency. Following are descriptions of the methods employed:

The State has a memorandum of agreement with the operating agency, DDSN, to assure provider qualifications for the provision of Early Intensive Behavior Intervention, assessments, and case management. DDSN maintains a quality review process utilizing their quality assurance contractor to ensure provider qualifications are valid and appropriate. The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and all other specified requirements. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

The Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office. In addition, the Division of Audits reviews DHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged.

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APPENDIX I-2: Rates, Billing and Claims

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Bureau of Reimbursement Methodology and Policy, with assistance from DDSN, is responsible for the development of waiver service payment rates. The Bureau of Reimbursement Methodology operates under the direction of the South Carolina Department of Health and Human Services. The Medicaid agency allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives.

Waiver service rates were established based upon the projected costs of the service to be provided. Projected costs used in the determination of the waiver rates would include salaries, fringe benefits, travel, training, and the application of a ten percent indirect cost rate. Billable hours were determined in order to adjust for time spent on leave, training, travel, and administration. Both DDSN and the Bureau of Reimbursement Methodology perform financial reviews on an as needed basis to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

The case management service rates provided to waiver participants were based upon the projected costs of the service to be provided and adjusted for patient caseload. Projected costs used in the determination of the waiver rates would include salaries, fringe benefits, travel, training, and the application of a ten percent indirect cost rate. Billable hours were determined in order to adjust for time spent on leave, training, travel, and administration. The reasonableness of the case management rate developed was determined by comparing the rate against private provider case management rates for children similar to those enrolling in the waiver.

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

Providers maintain the option of billing directly to the Medicaid agency or they may voluntarily reassign their right to direct payments to the Department of Disabilities and Special Needs. Providers billing Medicaid directly may bill either by use of a CMS 1500 form or by the State’s electronic billing system.

- c. Certifying Public Expenditures (select one):**

Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):

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<input checked="" type="checkbox"/>	<p>Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)</p> <p>(a) – The South Carolina Department of Disabilities and Special Needs (SCDDSN). (b) – SCDDSN files annual cost reports that report the total costs incurred for both their institutional services (ie ICF/MRs) and all waiver services providers. (c) – The SCDDSN received \$3 million in state appropriations for these services in SFY 2006/2007. The contract between SCDHHS and SCDDSN applicable to these services will require the following contract language: “SCDDSN agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable, and necessary cost for the provision of services to be provided to Medicaid recipients under the contract prior to submitting claims under the contract.” Additionally, the Internal Audit Division within the SCDHHS has included in its’ audit plan planned audits of State Agency Medicaid contracts.</p>
<input type="checkbox"/>	<p>Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)</p>
<input type="radio"/>	<p>No. Public agencies do not certify expenditures for waiver services.</p>

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- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) the services were provided:

Claims for waiver services are submitted to MMIS through either the use of a CMS 1500 form or through the State’s electronic billing system. Providers of waiver services are given a service authorization, which reflects the service identified on the service plan. This authorization is produced by the case manager and contains the 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. This is the case for all claims.

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

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

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (*select one*):

<input checked="" type="radio"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="radio"/>	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
<input type="radio"/>	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:
<input type="radio"/>	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

<input checked="" type="checkbox"/>	The Medicaid agency makes payments directly to providers of waiver services.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input checked="" type="checkbox"/>	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent: A financial management services entity is used to make payments for in-home services delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed periodically.
<input type="checkbox"/>	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.

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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:*

<input type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input checked="" type="radio"/>	<p>Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.</p> <p>SCDDSN will be reimbursed retrospectively for its total allowable Medicaid costs incurred of providing services under this waiver. Therefore, the supplemental payment will equate to a cost settlement that will be determined upon the completion of the SCDHHS review of the annual cost report submitted by the SCDDSN. The waiver services that SCDDSN will provide as part of its OHCDs are EIBI Line Therapy and case management</p>

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

<input checked="" type="radio"/>	<p>Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i></p> <p>SCDDSN will receive payment for waiver services and will provide the following waiver services: EIBI Line Therapy and case management.</p>
<input type="radio"/>	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

e. Amount of Payment to Public Providers. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="radio"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
<input checked="" type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

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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 (ie both Medicaid and non-Medicaid recipients). The actual cost rate will then be compared against the interim rate paid to determine an overpayment or underpayment. If an overpayment occurs, the SCDHHS will recoup the federal portion of the overpayment from the SCDDSN and return it to CMS via the quarterly expenditure report.

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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:*

<input checked="" type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="radio"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input type="radio"/>	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

<input checked="" type="radio"/>	Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
The Department of Disabilities and Special Needs	
<input type="radio"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

<input checked="" type="radio"/>	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:
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	<p>(a) DDSN operates as an organized health care delivery system (OHCDS). This system of care is comprised of DDSN and the local DSN County Boards and together they form an OHCDS. The OHCDS establishes contracts with other qualified providers to furnish home and community based services to people served in this waiver. (b) Providers of waiver services may direct bill their services to DHHS. (c) At a minimum, waiver participants are given a choice of providers, regardless of their affiliate with the OHCDS, annually or more frequent if requested or warranted (d) DDSN will assure that providers that furnish waiver services under contract with the OHCDS meet applicable provider qualifications through the state’s procurement process. (e) DDSN assures that contracts with providers meet applicable requirements via an annual quality assurance review of the provider, as well as periodic record reviews. (f) DDSN requires its local DSN County Boards to perform annual financial audits.</p>
○	<p>No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.</p>

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

<input type="radio"/>	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 <i>voluntarily</i> elect to receive <i>waiver</i> 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.
<input type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> 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.
<input checked="" type="radio"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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APPENDIX I-4: Non-Federal Matching Funds

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

<input type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input checked="" type="checkbox"/>	<p>Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:</p> <p>The South Carolina Department of Disabilities and Special Needs (SCDDSN) received state appropriations to provide services under this waiver. A portion of these funds will be transferred to the South Carolina Department of Health and Human Services (SCDHHS) via an IGT for payments that will be made directly to private providers enrolled with the SCDHHS. For services provided by SCDDSN, these funds will be directly expended by SCDDSN as CPE.</p>
<input type="checkbox"/>	<p>Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:</p>

- b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

<input type="checkbox"/>	<p>Appropriation of Local Revenues. Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:</p>
<input type="checkbox"/>	<p>Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:</p>
<input checked="" type="checkbox"/>	<p>Not Applicable. There are no non-State level sources of funds for the non-federal share.</p>

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c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

<input type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
<input checked="" type="checkbox"/>	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

<input checked="" type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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:

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

<input type="radio"/>	<p>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. <i>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:</i></p> <div style="border: 1px solid black; height: 50px; width: 100%; background-color: #e0e0e0;"></div>
<input checked="" type="radio"/>	<p>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.</p>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

- ii Participants Subject to Co-pay Charges for Waiver Services.** Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

- iii. Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

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iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care (<i>specify</i>):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	\$26,860	\$8,004	\$34,864	\$98,550	\$2,003	\$100,553	\$65,689
2	\$32,923	\$8,244	\$41,167	\$101,507	\$2,063	\$103,570	\$62,403
3	\$33,900	\$8,491	\$42,391	\$104,552	\$2,125	\$106,677	\$64,286
4							
5							

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Appendix J-2 - Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	120	ICF/MR	
Year 2	120	ICF/MR	
Year 3	120	ICF/MR	
Year 4 (renewal only)			
Year 5 (renewal only)			

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Year 1 – 9 months
 Year 2 – 11 months
 Year 3 – 11 months

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates are based on projected utilization of services. The projected utilizations are based on current industry practices for each service level included in the waiver. The cost 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 #0237.90.R1 for the year ending 9/30/2004 with an inflation factor of 3% per year. This waiver serves participants with the same level of care (ICF/MR).

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AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

1ST YEAR OF RENEWAL	$\$8,004 * 1.00 =$	\$8,004
2ND YEAR OF RENEWAL	$\$8,004 * 1.03 =$	\$8,244
3RD YEAR OF RENEWAL	$\$8,244 * 1.03 =$	\$8,491

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

2005 ICF/MR Cost Reports and the 2006 Preliminary Cost Reports.
 The 2005 Cost Report is on file at Department of Health and Human Service.
 .

AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

1ST YEAR OF RENEWAL	$\$98,550 * 1.00 =$	\$98,550
2ND YEAR OF RENEWAL	$\$98,550 * 1.03 =$	\$101,507
3RD YEAR OF RENEWAL	$\$101,507 * 1.03 =$	\$104,552

- 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 #0237.90.R1 for the year ending 9/30/2004 with an inflation factor of 3% per year. This waiver serves participants with the same level of care (ICF/MR).

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AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

1ST YEAR OF RENEWAL	\$2,003 * 1.00 =	\$2,003
2ND YEAR OF RENEWAL	\$2,003 * 1.03 =	\$2,063
3RD YEAR OF RENEWAL	\$2,063 * 1.03 =	\$2,125

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

<input type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
EIBI Assessment	Annual assessment	110	1	\$2,100	\$231,000
EIBI Plan Implementation	Hour	120	54	\$60	\$388,800
EIBI Lead Therapy	Hour	120	216	\$30	\$777,600
EIBI Line Therapy	Hour	120	1,008	\$14	\$1,693,440
Case Management	Monthly	120	9	\$122.50	\$132,300
GRAND TOTAL:					\$3,223,140
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					120
FACTOR D (Divide grand total by number of participants)					\$26,860
AVERAGE LENGTH OF STAY ON THE WAIVER					9 months

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Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
EIBI Assessment	Annual assessment	20	1	\$2,100	\$42,000
EIBI Plan Implementation	Hour	120	66	\$60	\$475,200
EIBI Lead Therapy	Hour	120	288	\$30	\$1,036,800
EIBI Line Therapy	Hour	110	1,344	\$14	\$2,069,760
EIBI Self-Directed Line Therapy	Hour	10	1,344	\$12.30	\$165,312
Case Management	Monthly	120	11	\$122.50	\$161,700
GRAND TOTAL:					\$3,950,772
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					120
FACTOR D (Divide grand total by number of participants)					\$32,923
AVERAGE LENGTH OF STAY ON THE WAIVER					11 months

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Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
EIBI Assessment	Annual assessment	20	1	\$2,100	\$42,000
EIBI Plan Implementation	Hour	120	66	\$61.80	\$489,456
EIBI Lead Therapy	Hour	120	288	\$30.90	\$1,067,904
EIBI Line Therapy	Hour	110	1,344	\$14.42	\$2,131,853
EIBI Self-Directed Line Therapy	Hour	10	1,344	\$12.67	\$170,285
Case Management	Monthly	120	11	\$126.18	\$166,558
GRAND TOTAL:					\$4,068,056
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					120
FACTOR D (Divide grand total by number of participants)					\$33,900
AVERAGE LENGTH OF STAY ON THE WAIVER					11 months

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