

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application:

The following major changes are requested in this renewal:

- 1) the deletion of Psychological Services in favor of State Plan coverage;
- 2) changes/revisions to the quality improvement sections throughout the document;
- 3) the deletion of the current bundled service "Specialized Medical Supplies, Equipment, Assistive Technology and Appliances" in favor of State Plan coverage for Specialized Medical Supplies and Equipment;
- 4) the addition of Personal Emergency Response Systems (PERS) as a discrete waiver service;
- 5) the addition of Assistive Technology and Appliances as a discrete waiver service;
- 6) the availability of incontinence supplies for children up to age 21, based on medical necessity, under State Plan, as directed by CMS; and
- 7) the availability of incontinence supplies (diapers, under-pads, wipes, gloves and liners) for adults age 21 and over, based on medical criteria, provided as an extended state plan waiver service, as directed by CMS.

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

### 1. Request Information (1 of 3)

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- A. The **State of South Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**Community Supports Waiver**
- C. **Type of Request:**renewal

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

- 3 years  5 years

**Waiver Number:**SC.0676.R01.00

**Draft ID:** SC.12.01.00

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

Regular Waiver

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

07/01/12

Approved Effective Date: 07/01/12

**1. Request Information (2 of 3)**

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

 **Hospital**

Select applicable level of care

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

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

 **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160** **Nursing Facility**

Select applicable level of care

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

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

 **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140** **Intermediate Care Facility for 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 level of care:

Not Applicable

**1. Request Information (3 of 3)**

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

 **Not applicable** **Applicable**

Check the applicable authority or authorities:

 **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I** **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*): **§1915(b)(1) (mandated enrollment to managed care)** **§1915(b)(2) (central broker)** **§1915(b)(3) (employ cost savings to furnish additional services)** **§1915(b)(4) (selective contracting/limit number of providers)** **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

**A program authorized under §1915(i) of the Act.**  
 **A program authorized under §1915(j) of the Act.**  
 **A program authorized under §1115 of the Act.**  
 Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

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**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.

In keeping with the State's commitment to offer viable community options to institutional placement, the purpose of this waiver is to offer services that will prevent and/or delay institutionalization to people with intellectual disability or related disabilities whose waiver service needs will not exceed \$10,986 per year. The yearly amount may be adjusted in future years. All participants will meet ICF/MR Level of Care criteria.

Administrative authority for this waiver is retained by the South Carolina Department of Health and Human Services (DHHS). The South Carolina Department of Disabilities and Special Needs (DDSN) will perform waiver operations under a Memorandum of Agreement (MOA) and service contract with DHHS. DDSN has operational responsibility for ensuring that participants are aware of their options under this waiver. DDSN utilizes an organized health care delivery system that includes both county Disabilities and Special Needs (DSN) Boards and private providers as waiver service providers.

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

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

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

## 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E

specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

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

- F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

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

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

#### 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are inpatients 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 §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the

Quality Improvement Strategy specified in **Appendix H**.

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

DECEMBER 2011:

\*DHHS announced upcoming public meeting via agency web-site.

\*DHHS emailed information to agency "listserve".

\*DDSN presented CS Renewal information item at monthly Commission meeting.

\*DDSN emailed stakeholders public meeting information.

\*DDSN listed public meeting logistics on their agency website.

JANUARY 2012:

\*DHHS notified Catawba Indian Nation of intent to renew.

\*DHHS posted proposed changes on agency web-site and invited comment.

\*DHHS conducted public meeting 1/17/12 and video-conferenced to 3 previously announced locations across South Carolina.

\*DDSN presented proposed changes to Commission at monthly meeting.

FEBRUARY 2012:

\*CS Renewal proposed changes presented at DHHS Medical Care Advisory Committee.

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

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

## 7. Contact Person(s)

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **South Carolina**

**Zip:**

**Phone:**  **Ext:**   **TTY**

**Fax:**

**E-mail:**

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

<b>Last Name:</b>	<input type="text" value="Priest"/>
<b>First Name:</b>	<input type="text" value="Janet"/>
<b>Title:</b>	<input type="text" value="Director, Mental Retardation Division"/>
<b>Agency:</b>	<input type="text" value="South Carolina Department of Disabilities and Special Needs"/>
<b>Address:</b>	<input type="text" value="PO Box 4706"/>
<b>Address 2:</b>	<input type="text"/>
<b>City:</b>	<input type="text" value="Columbia"/>
<b>State:</b>	<b>South Carolina</b>
<b>Zip:</b>	<input type="text" value="29240"/>
<b>Phone:</b>	<input type="text" value="(803) 898-9620"/> <b>Ext:</b> <input type="text"/> <input type="checkbox"/> <b>TTY</b>
<b>Fax:</b>	<input type="text" value="(803) 898-9660"/>
<b>E-mail:</b>	<input type="text" value="jpriest@ddsn.sc.gov"/>

## 8. Authorizing Signature

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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.

<b>Signature:</b>	<input type="text" value="Anthony Keck"/> State Medicaid Director or Designee
<b>Submission Date:</b>	<input type="text" value="Dec 19, 2012"/>

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

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<b>Last Name:</b>	<input type="text" value="Keck"/>
<b>First Name:</b>	<input type="text" value="Anthony"/>
<b>Title:</b>	<input type="text" value="Director"/>
<b>Agency:</b>	<input type="text" value="South Carolina Department of Health and Human Services"/>
<b>Address:</b>	<input type="text" value="P.O. Box 8206"/>

<b>Address 2:</b>	<input type="text"/>		
<b>City:</b>	<input type="text" value="Columbia"/>		
<b>State:</b>	<b>South Carolina</b>		
<b>Zip:</b>	<input type="text" value="29202"/>		
<b>Phone:</b>	<input type="text" value="(803) 898-2504"/>	<b>Ext:</b> <input type="text"/>	<input type="checkbox"/> <b>TTY</b>
<b>Fax:</b>	<input type="text" value="(803) 898-4515"/>		
<b>E-mail:</b>	<input type="text" value="keck@scdhhs.gov"/>		

## Attachment #1: Transition Plan

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Specify the transition plan for the waiver:

The State expects that all current waiver participants will continue to be appropriate for the waiver. In the event that a participant's health and safety cannot be assured within the specified waiver cap limit and services, the participant will be assisted to identify alternative services, pursue another HCB waiver, or, if necessary or preferred, transferred to an ICF/MR.

Psychological services is being removed from the waiver in favor of Rehabilitative Behavioral Health Services which became available through the State Plan July 1, 2010. The core rehabilitative services offered under the State Plan are duplicative of those covered by the waiver. An analysis of waiver expenditures reflects extremely low utilization for this service. Those individuals currently receiving Psychological services through the waiver will be assisted to transition to the State Plan service, if needed, subsequent to the approved waiver renewal.

The bundled service "Specialized Medical Supplies, Equipment, Assistive Technology and Appliances" is being removed from the waiver in favor of other more narrowly defined services. The Medicaid State Plan covers medically necessary supplies and equipment. Personal Emergency Response Systems (PERS) is being removed from the bundled service noted above but added as a discrete waiver service.

"Assistive Technology/Appliances" is being removed from the bundled service but added to the waiver as a discrete service. Service Coordinators will discuss changes with participants/families prior to the anticipated waiver renewal date and document preferences in the participant record.

## Additional Needed Information (Optional)

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Provide additional needed information for the waiver (optional):

The Community Supports (CS) waiver has been under temporary extension since June 2012. At the suggestion of CMS, the State requests the original renewal date of July 1, 2012, for this 5 year renewal.

## Appendix A: Waiver Administration and Operation

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

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

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

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

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

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

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

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

DHHS and DDSN also have a service contract outlining the requirements and responsibilities for the provision

of waiver services by the operating agency. This contract clarifies the following:

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

The service contract is reviewed and updated at least every five years and amended as needed.

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

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

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

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

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

## Appendix A: Waiver Administration and Operation

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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 operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

DHHS contracts with a CMS-certified QIO to review a representative sample of ICF/MR levels of care determined by DDSN.

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

DDSN contracts with the Jasper DSN Board which is responsible for verifying the qualifications of and payment for all In-Home Support service providers.

DHHS contracts with Winthrop University to perform validation reviews, focus reviews and trend analysis.

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

## Appendix A: Waiver Administration and Operation

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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 (*Select One*):

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

DDSN contracts with local Disabilities and Special Needs (DSN) Board providers. Service Coordination and Early Intervention staff at the DSN Boards prepare the Plans of Service and complete Level of Care re-evaluations for the ICF/MR level of care.

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

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

DDSN contracts with approved/qualified private providers for service coordination/early intervention who prepare the Plans of Service and complete the Level of Care re-evaluations for ICF/MR level of care.

## Appendix A: Waiver Administration and Operation

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

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

## Appendix A: Waiver Administration and Operation

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

DDSN will assess the performance of its contracted and local/regional non-state entities responsible for conducting waiver operational functions. DDSN will contract with a Quality Improvement Organization (QIO) to assess the local DSN Boards and other qualified providers on a twelve to eighteen month cycle depending on the provider's past performance. The QIO will also conduct follow-up reviews as needed and will share the Report of Findings with DHHS in a timely manner. DDSN will provide technical assistance to the local DSN Boards, and provide DHHS reports of such reviews within 30 days of completion of the report.

Additionally, DDSN Internal Audit Division will conduct internal audit reviews of the local network of DSN Boards

and other approved providers. The local DSN Boards are required to have a financial audit conducted annually by a CPA firm that is chosen by the Boards, and all results related to waiver participants will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will also conduct special request audits, investigate fraud cases, provide training and technical assistance, and review the audited financial statements of the local DSN Boards. All findings will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will conduct a review of the contracted fiscal agent, and likewise, all findings related to waiver participants will be shared with DHHS within 30 days of completion.

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

State's methods for discovery and remediation.

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DHHS Desk/Focus Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted	

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> Other Specify: Winthrop University	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> Other Specify: as warranted	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Winthrop University	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As warranted

**Performance Measure:**

Quarterly meetings between DHHS and DDSN waiver administrative staff are held to discuss significant waiver issues.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS/DDS Agendas/Meeting Summaries**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted

**Performance Measure:**

All policy changes related to the CS waiver are approved by DHHS prior to implementation by DDSN.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Policy/Memo/Change Logs, etc.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: As warranted	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As warranted

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

**b. Methods for Remediation/Fixing Individual Problems**

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

DHHS produces reports of findings based on reviews. For non-recoupable findings, the State advises that DDSN include the findings in district staff trainings. For recoupable issues, the State refers the report of findings to DHHS – Program Integrity, who conducts an independent audit of program records and submits a separate report of findings to DDSN. DDSN must make the necessary financial adjustments to recover Federal Financial Participation (FFP). The State requires DDSN to include training on the recoupable issues in district staff trainings. DDSN must develop and implement remedial actions to prevent future occurrences of the issues. These remediation actions must be approved by DHHS.

- ii. **Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Winthrop University	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>

**c. Timelines**

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

- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

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

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

subgroup:

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<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 checked="" type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	0		<input checked="" type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

The State of South Carolina is transitioning from the use of text which includes "mentally retarded" to "intellectually disabled".

Persons with related disabilities defined as:

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

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

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

## Appendix B: Participant Access and Eligibility

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

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
  - Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

- Other**

*Specify:*

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

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

\$10,986 per year. The State analyzed the service plans of current and potential waiver participants to determine the kinds and amounts of services utilized and likely to be needed. The individual cost cap of \$10,986/year is considered appropriate to meet assessed need.

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

- The following dollar amount:**

Specify dollar amount:

**The dollar amount** (*select one*)

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

The needs of the applicant will be assessed by the service coordinator, and services to address those needs will be determined in a plan of care. A centralized approval process will ensure that entrance will be granted only when anticipated costs do not exceed the specified cost limit and health and welfare can be reasonably assured. Applicants denied waiver entry for this reason will be notified of the opportunity to request a fair hearing.

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

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

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

- Other safeguard(s)**

Specify:

--

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3300
Year 2	3630
Year 3	4000
Year 4	4400
Year 5	4840

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

- The State does not limit the number of participants that it serves at any point in time during a waiver year.
- The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2970
Year 2	3260
Year 3	3600
Year 4	3960
Year 5	4350

## Appendix B: Participant Access and Eligibility

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

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

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes
----------

Individuals receiving State-Funded Day services.
Participants enrolled in the ID/RD Waiver who choose to enroll in the CS waiver.

## Appendix B: Participant Access and Eligibility

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

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

Individuals receiving State-Funded Day services.

**Purpose** (describe):

Those individuals already receiving State-funded Day services.

**Describe how the amount of reserved capacity was determined:**

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

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

Waiver Year	Capacity Reserved
Year 1	350
Year 2	50
Year 3	50
Year 4 (renewal only)	50
Year 5 (renewal only)	50

## Appendix B: Participant Access and Eligibility

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

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

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

**Purpose** (describe):

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

**Describe how the amount of reserved capacity was determined:**

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

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

Waiver Year	Capacity Reserved
Year 1	100
Year 2	

	100
Year 3	100
Year 4 (renewal only)	100
Year 5 (renewal only)	100

## Appendix B: Participant Access and Eligibility

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.**
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. **Allocation of Waiver Capacity.**

*Select one:*

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

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

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

The Community Supports Waiver includes reserved capacity for two (2) groups of people: 1) those individuals with Intellectual Disabilities/Related Disabilities who are participants in the State's ID/RD Waiver; and 2) those individuals with ID/RD who currently receive DDSN-Funded Day Services. Upon disenrollment from the ID/RD Waiver, or as appropriate, for those currently receiving DDSN-funded Day Services, applicants may enroll directly into the Community Supports Waiver without being subjected to any existing waiting list.

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

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

- a.

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

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

2. **Miller Trust State.**

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

- No  
 Yes

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

---

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

---

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

*Select one:*

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

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)  
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)  
 Medically needy in 209(b) States (42 CFR §435.330)  
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)  
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

*Specify:*

All other mandatory or optional groups under the State Plan.

---

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

---

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

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

- a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine

eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

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

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

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

- The following standard included under the State plan**

*Select one:*

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

- The following formula is used to determine the needs allowance:**

Specify:

- Other**

Specify:

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

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

Specify:

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

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

Specify:

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

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**

**The following dollar amount:**

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

**The amount is determined using the following formula:**

Specify:

**Other**

Specify:

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

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

Select one:

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

Specify:

State Plan: Supplement 3 to attachment 2.6-A

## Appendix B: Participant Access and Eligibility

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it

determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(select one):

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

Specify percentage:

- The following dollar amount:

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

- The following formula is used to determine the needs allowance:

Specify formula:

- Other

Specify:

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

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:

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

## Appendix B: Participant Access and Eligibility

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

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

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

**i. Minimum number of services.**

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

**ii. Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly**
- Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

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

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

*Specify the entity:*

- Other**  
*Specify:*

The initial ICF/MR level of care (LOC) evaluation is performed by DDSN's Consumer Assessment Team (CAT). Reevaluations are done by service coordinators and early interventionists employed by contracted providers of DDSN, or the CAT as needed.

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

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

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

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

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

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

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

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

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

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

AND

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

AND

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

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

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

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

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

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

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

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

*Specify the other schedule:*

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

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

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

*Specify the qualifications:*

Service coordinators/early interventionists must hold at least a Bachelor's degree in Social Work or a related field from an accredited college or university, or hold at least a Bachelor's degree in an unrelated field from an accredited college or university and have at least one (1) year of experience in programs for people with disabilities or at least one (1) year of experience in a case management program and demonstrate knowledge of disabilities.

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

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

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

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

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the*

State's methods for discovery and remediation.

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Proportion of new enrollees whose Level of Care completion date is not 30 days prior to waiver enrollment.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN Waiver Enrollment Reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Waiver Enrollment Reviews**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100px;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 150px;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100px;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 150px;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 200px;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Proportion of participants whose Level of Care reevaluation does not occur prior to the 365th day of the previous Level of Care evaluation.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN Waiver Tracking System**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Other**  
Specify:

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Reports**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN CAT Log**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<b>Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted
--

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>

**Other**  
 Specify:  
 DDSN QIO Reviews are conducted every 12-18 months based on past provider performance. Reports are available within 45 days post review.

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

**Performance Measures**

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

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

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

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS QIO Reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = (+/-) 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>
---

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

When DDSN's QIO identifies problems, the provider agency being reviewed is required to submit a plan of correction to address the issues discovered. The QIO conducts a follow-up review to determine if corrections have been made. Additionally, QIO reports are reviewed by DDSN Operations staff. As needed, technical assistance is provided to providers by the Operations staff. Documentation of all technical assistance is available to DHHS. DHHS conducts focus reviews and also has an independent contractor to conduct reviews of DDSN/the DDSN QIO. DHHS issues a report of findings requesting a Plan of Correction from DDSN. Any recoupable items are referred to DHHS Program Integrity.

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

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

## Appendix B: Participant Access and Eligibility

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### B-7: Freedom of Choice

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

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

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

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination

Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

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

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health Care Services		
Statutory Service	Personal Care Services		
Statutory Service	Respite Care Services		
Extended State Plan Service	Incontinence Supplies		
Other Service	Adult Day Health Care - Nursing services		
Other Service	Adult Day Health Care - Transportation services		
Other Service	Assistive Technology and Appliances		
Other Service	BEHAVIOR SUPPORT SERVICES		
Other Service	CAREER PREPARATION SERVICES		
Other Service	COMMUNITY SERVICES		
Other Service	DAY ACTIVITY		
Other Service	EMPLOYMENT SERVICES		
Other Service	Environmental Modifications		
Other Service	In-Home Support services		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	PRIVATE VEHICLE MODIFICATIONS		
Other Service	SUPPORT CENTER SERVICES		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

Adult Day Health Care Services

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

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

**Service Definition** (*Scope*):

Services furnished 5 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Authorization of services will be based on the recipient's need for the service as identified and documented in the individual's plan of care. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care are not furnished as component parts of this service.

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Health Care Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Adult Day Health Care Services**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care Provider

**Provider Qualifications**

**License** (*specify*):

SC Code Annotated §44-7-260 (Supp. 2007); 25 SC Code Annual Regulations 61-75 (1976)

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Health and Environmental Control; DHHS

**Frequency of Verification:**

Upon contract; at least every 18 months

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request

through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Personal Care Services

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

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

**Service Definition (Scope):**

Assistance, either hands-on (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself, in the performance of IADLs or ADLs. ADLs include eating,, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life-like activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, to include informing a client that it is time to take medication as prescribed by his/her physician or handing a client a medication container, and money management to consist on delivering payments to a designated recipient of behalf of the client. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services, to the extent allowed under state law. Authorization of this service will be made to providers at two different payment levels. The higher level will be called Personal Care 2 and will be used when the majority of care is related to activities of daily living. The lower level, Personal Care 1, will be authorized when most of the needed care is for instrumental activities of daily living.

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Personal Care Providers

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Personal Care Services**

**Provider Category:**

Agency

**Provider Type:**

Personal Care Providers

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

**Certificate (specify):**

**Other Standard (specify):**

Contracted with DHHS as a Personal Care provider; Contract scope of service.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DHHS

**Frequency of Verification:**

Upon contract; at least every 18 months.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

**Service:**

**Alternate Service Title (if any):**

Respite Care Services

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

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

**Service Definition (Scope):**

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

Respite may be provided in the following locations:

Individual's home or other private residence selected by the participant/representative;

Group home;

Foster home;

Medicaid certified nursing facility;

Medicaid certified ICF/MR; and/or,

Licensed Community Residential Care facility.

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

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

- Participant-directed as specified in Appendix E**

**Provider managed**

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	DDSN
Agency	Licensed Community Residential Care Facility
Agency	Medicaid certified ICF/MR
Agency	Medicaid certified nursing facility

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Respite Care Services**

**Provider Category:**

Agency

**Provider Type:**

DDSN

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

DDSN Respite Standards

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDSN; DHEC

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Respite Care Services**

**Provider Category:**

Agency

**Provider Type:**

Licensed Community Residential Care Facility

**Provider Qualifications**

**License (specify):**

SC Code, Sec. 44-7-260 Reg. #61-84, Equivalent for NC & GA

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHEC; DHHS

**Frequency of Verification:**

Upon Contract; Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite Care Services**

**Provider Category:**

Agency

**Provider Type:**

Medicaid certified ICF/MR

**Provider Qualifications**

**License (specify):**

SC Code Ann 44-7-250 thru 44-7-260 Reg 61-103

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHEC

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite Care Services**

**Provider Category:**

Agency

**Provider Type:**

Medicaid certified nursing facility

**Provider Qualifications**

**License (specify):**

SC Code, Sec. 44-7-250 thru 44-7-260; Reg. #61-17, Equivalent for NC & GA

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHEC; DHHS

**Frequency of Verification:**

Upon contract; Annually

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Incontinence Supplies

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

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

**Service Definition (Scope):**

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

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

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

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

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Incontinence Supply Provider

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Incontinence Supplies**

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**Provider Category:**

Agency

**Provider Type:**

Incontinence Supply Provider

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

South Carolina business license

**Certificate** (*specify*):
**Other Standard** (*specify*):

Enrolled with DHHS to provide Incontinence Supplies

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DHHS

**Frequency of Verification:**

Upon enrollment

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**


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

**Service Title:**

Adult Day Health Care - Nursing services

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

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

**Service Definition** (*Scope*):

Nursing services provide in and by the Adult Day Health Care Center and limited to the following skilled procedures as ordered by a physician: Ostomy Care, Urinary Catheter Care; Decubitus/Wound Care; Tracheotomy Care; Nebulizer; and Tube Feedings.

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

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

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

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

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

**Provider Specifications:**


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Provider Category	Provider Type Title
Agency	Adult Day Health Care Agency

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Adult Day Health Care - Nursing services

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care Agency

**Provider Qualifications**

**License** (*specify*):

SC Code Ann. §44-77-260, (Supp 2007); 25 SC Code Ann. Regs. 61-75 (1976)

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHEC; DHHS

**Frequency of Verification:**

Upon contract; at least every 18 months.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Adult Day Health Care - Transportation services

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

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

**Service Definition** (*Scope*):

This service is prior-authorized for participants receiving the Adult Day Health Care (ADHC) service, who reside within fifteen (15) miles of the ADHC Center. Transportation will be provided using the most direct route, door to door, from the Center to the participant's place of residence or other location, as agreed to by the provider and as indicated on the service authorization.

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Health Care Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Adult Day Health Care - Transportation services**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care Agency

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

SC Code Ann. §44-7-260, (Supp 2007); 25 SC Code Ann. Regs. 61-75 (1976)

**Certificate** (specify):
**Other Standard** (specify):

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Health and Environmental Control; DHHS

**Frequency of Verification:**

Upon Enrollment;

At least every 18 months

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

## Assistive Technology and Appliances

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

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

**Service Definition (Scope):**

Assistive Technology and/or Appliances means a device, an item, piece of equipment, or product system, that is used to increase or improve functional capabilities of participants thereby resulting in a decrease or avoidance of need for other waiver services (e.g., personal care, respite, etc.). This service may include the evaluation of the assistive technology/appliance needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; and training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant. Appliances intended for general household utility that do not result in a decrease in need for other waiver services are not covered. This service is not intended to replace traditional household appliances for the convenience of family/household members or caregivers. Additionally, devices, items, equipment and/or product systems not proven effective, or deemed trial or experimental are not covered. Repairs not covered by warranty are covered, and replacement of parts/equipment are covered, if these repairs or parts/equipment are not related to abuse, mistreatment or carelessness. The lifetime limit on repairs (not covered under warranty) and/or replacement of parts/equipment is \$1,000.

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

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

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Provider
Agency	DDSN

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Assistive Technology and Appliances**

**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment Provider

**Provider Qualifications**

**License (specify):**

SC Code Annotated 33-1-200 thru 33-1-420 (Supp 2007)

**Certificate (specify):**

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS

**Frequency of Verification:**

Upon enrollment

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Assistive Technology and Appliances**

**Provider Category:**

Agency

**Provider Type:**

DDSN

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

DDSN Contract

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

BEHAVIOR SUPPORT SERVICES

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

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.

- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Services which use current empirically validated practices to identify causes of, intervene to prevent, and appropriately react to problematic behavior. These services include initial assessment for determining need for and appropriateness of behavior support services; behavioral assessment (i.e., functional assessment and/or analysis) that includes direct observation, interview of key persons, collection of objective data; analysis of behavioral/functional assessment data to determine the function of the behaviors (and later to assess success of intervention and any needed modifications) and behavioral intervention based on the functional assessment that is primarily focused on prevention of the problem behavior(s) based on their function.

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Behavior Support Provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: BEHAVIOR SUPPORT SERVICES**

**Provider Category:**

Individual

**Provider Type:**

Behavior Support Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DDSN Standards and Qualifications

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Verified/approved by DDSN and enrolled by DHHS.

**Frequency of Verification:**

Upon enrollment; verification of continuing education every two years.

## Appendix C: Participant Services

**C-1/C-3: Service Specification**

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

**Service Type:**


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

**Service Title:**

CAREER PREPARATION SERVICES

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

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

**Service Definition (Scope):**

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

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

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

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

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

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

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

**Provider Specifications:**

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

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: CAREER PREPARATION SERVICES**

**Provider Category:**

Agency

**Provider Type:**

DDSN (Day Services Provider)

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

SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs 88-105 thru 88-020 (1976)

**Certificate (specify):**

**Other Standard (specify):**

DDSN Career Preparation standards

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

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

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

COMMUNITY SERVICES

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

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

**Service Definition (Scope):**

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

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

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


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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

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

## Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** COMMUNITY SERVICES

**Provider Category:**

Agency

**Provider Type:**

DDSN (Day Services Provider)

**Provider Qualifications**

**License** (specify):

SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs. 88-105 thru 88-920 (1976)

**Certificate** (specify):

**Other Standard** (specify):

DDSN Community Services Standards

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

DAY ACTIVITY

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

- Service is included in approved waiver. There is no change in service specifications.  
 Service is included in approved waiver. The service specifications have been modified.

- Service is not included in the approved waiver.**

**Service Definition (Scope):**

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

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

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

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

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

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

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

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: DAY ACTIVITY**

**Provider Category:**

Agency

**Provider Type:**

DDSN (Day Services Provider)

**Provider Qualifications**

**License (specify):**

SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs. 88-105 thru 88-920 (1976)

**Certificate (specify):**

**Other Standard (specify):**

DDSN Standards for Day Activity Services

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

EMPLOYMENT SERVICES

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

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

**Service Definition (Scope):**

Employment services consist of intensive, on-going supports that enable participants for whom competitive employment at or above minimum wage is unlikely absent the provision of supports and who, because of their disabilities, need supports to perform in a regular work setting. Employment services may include services to assist the participant to locate a job or develop a job on behalf of the participant. Employment services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed and include activities such as supervision and training needed to sustain paid work. Employment services may be provided in group settings, such as mobile work crews or enclaves, or in community-based individual job placements.

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

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** EMPLOYMENT SERVICES

**Provider Category:**

Agency

**Provider Type:**

DDSN (Day Services Provider)

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

**Certificate (specify):**

**Other Standard (specify):**

DDSN Employment Services Standards

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

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

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental Modifications

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

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

**Service Definition (Scope):**

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence, and without which, the individual would require institutionalization. Home is defined as non-government subsidized living quarters, and modifications to any government-subsidized housing (i.e., group homes or community residential care facilities) are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add square footage to the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. Approval of a request for environmental modification is a multi-step process. The modification is initially determined by the service coordinator/early interventionist based on the recipient's need as documented in the plan of care. Three bids for the modification are obtained by the service coordinator/early interventionist and submitted with documentation of the need. The consultation/assessment

does not require the submission of bids. This information is reviewed by South Carolina Department of Disabilities and Special Needs (SCDDSN) staff for programmatic integrity and cost effectiveness.

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Environmental Modification Providers
Agency	DDSN

## Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Environmental Modifications

**Provider Category:**

Agency

**Provider Type:**

Environmental Modification Providers

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

**Other Standard** (*specify*):

Enrolled with DHHS

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS

**Frequency of Verification:**

Upon enrollment and at least every 18 months.

## Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Environmental Modifications

**Provider Category:**

Agency

**Provider Type:**

DDSN

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

**Certificate (specify):**

**Other Standard (specify):**

DDSN Standards

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

Prior to service provision

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**


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

**Service Title:**

In-Home Support services

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

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

**Service Definition (Scope):**

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

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

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

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

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

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: In-Home Support services****Provider Category:**

Individual

**Provider Type:**

Independent In-Home Support providers

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

**Certificate (specify):**

**Other Standard (specify):**

DDSN In-Home Support Standards

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDSN Waiver Participant/Representative and DDSN Contracted Entity

**Frequency of Verification:**

Prior to service provision

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response Systems (PERS)

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

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

**Service Definition (Scope):**

PERS is an electronic device which enables a participant who is at high risk of institutionalization to secure help

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

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

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Personal Emergency Response Systems (PERS)

**Provider Category:**

Agency

**Provider Type:**

Personal Emergency Response Provider (PERS)

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS

**Frequency of Verification:**

Upon contract with DHHS

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

PRIVATE VEHICLE MODIFICATIONS

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

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

**Service Definition (Scope):**

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

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

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	DDSN
Agency	Durable Medical Equipment Provider

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: PRIVATE VEHICLE MODIFICATIONS**

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**Provider Category:**

Agency

**Provider Type:**

DDSN

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

**Certificate (specify):**

**Other Standard (specify):**

DDSN Standard

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

Prior to service provision

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: PRIVATE VEHICLE MODIFICATIONS**

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**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment Provider

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

**Certificate (specify):**

**Other Standard (specify):**

Enrolled with DHHS

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DHHS

**Frequency of Verification:**

upon enrollment

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

SUPPORT CENTER SERVICES

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

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

**Service Definition (Scope):**

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

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

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

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

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

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

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

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: SUPPORT CENTER SERVICES**

**Provider Category:**

Agency

**Provider Type:**

DDSN (Day Services Provider)

**Provider Qualifications**

**License (specify):**

SC Code Annotated § 44-20-710 (Supp 2007); 26 C Code Ann. Regs 88-105 thru 88-920 (1976)

**Certificate (specify):**

**Other Standard** (*specify*):

DDSN Standards for Support Center Services

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDSN

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):
- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.
- Check each that applies:*
- As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
- As an administrative activity.** Complete item C-1-c.
- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Service coordination functions are conducted by entities that are established by the SC Code of Laws as county DSN Boards, entities qualified by DDSN as a service coordination provider, or entities directly enrolled with the Medicaid Agency. If the participant/family declines the service coordination services, required waiver functions will be performed by an entity chosen by DDSN/DHHS.

## Appendix C: Participant Services

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### C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):
- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Community Residential Care Facilities, Home Health Agencies, Personal Care Agencies, Adult Day Health Care Agencies, Nursing Homes providing respite and DDSN direct care staff are all required to have background checks completed in accordance with state law. Compliance reviews are conducted by DDSN's QIO and DHHS Provider Compliance to ensure mandatory investigations are conducted.

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

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Nursing and Personal Care 2 Providers are required to check the Certified Nursing Assistant (CNA) registry and the Office of Inspector General (OIG) exclusions list for all staff. Anyone appearing on either of these lists is not allowed to provide services to waiver participants or participate in any Medicaid funded programs. The website addresses are:

CNA Registry - [www.pearsonvue.com](http://www.pearsonvue.com)

OIG Exclusions List - <http://www.oig.hhs.gov/fraud/exclusions.asp>

SCDHHS Provider Compliance monitors contract compliance for Nursing providers, personal care providers, Adult Day Health Care providers, Adult Day Health Care Nursing providers and Adult Day Health Care Transportation providers. This occurs at least every eighteen months.

Additionally, abuse registry screenings must be completed for all staff of SCDDSN contracted service providers. The SC Department of Social Services maintains a Central Registry of person's convicted of abusing a child under the age of 18. All provider agency personnel must have a Central Registry Check. DDSN's policy, as indicated in Department Directive 406-04-DD, outlines the specific timelines that must be met. DDSN uses its QIO to monitor provider compliance with this policy.

## Appendix C: Participant Services

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### C-2: General Service Specifications (2 of 3)

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

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

## Appendix C: Participant Services

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### C-2: General Service Specifications (3 of 3)

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

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar**

**services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

Reimbursement for services may be made to certain family members who meet SC Medicaid provider qualifications. The following family members may NOT be reimbursed:

1. A parent of a minor Medicaid participant;
2. A step-parent of a minor Medicaid participant;
3. A foster parent of a minor Medicaid participant; and,
4. Any other legally responsible guardian of a minor Medicaid participant or court appointed guardian of an adult Medicaid participant.
5. The spouse of a Medicaid participant.

Additionally, the following family members may not be reimbursed for providing Respite:

1. Parent or step-parent of an adult Medicaid participant who resides in the same household as the respite recipient.

All other qualified family members may be reimbursed for their provision of the services listed above. Should there be any question as to whether a paid caregiver falls in any of the categories listed above, DHHS legal counsel will make a determination.

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

Potential providers are given the opportunity to enroll/contract with South Carolina Medicaid and/or

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

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

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**Proportion of the NEW providers the meet the required licensing, certification, and other state standards prior to the provision of waiver services.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DHEC Licensing Reports/Data**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: SC Department of Health and Environmental Control	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Provider Compliance Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: 100% prior to contract/ enrollment	

**Other**

If 'Other' is selected, specify:

**DDSN Behavior Support Provider Reports/Records**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SC Department of Health and Environmental Control	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHEC Licensing Reports/Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: SC Department of Health and Environmental Control	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Provider Compliance Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100%</b>

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<b>Review</b> <input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: 100% within 18 months	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN Behavior Support Provider Reviews/Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: DDSN Contractor	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b>	

	Specify: Periodic reviews to include all providers within a 4 year timeframe.	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: 1. SC Department of Health and Environmental Control; 2. DDSN Contractor	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

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

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

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

**Performance Measure:**

**Proportion of non-licensed/non-certified providers that continue to meet waiver requirements.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DDSN QIO Review Reports**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<b>Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: QIO Reviews are conducted every 12-18 months depending on past provider performance. Reports are available within 45 days post review.	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Provider Compliance Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: 100% within 18 months.	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Proportion of NEW non-licensed/non-certified providers that meet waiver requirements.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DHHS Provider Compliance Review Reports**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample Confidence</b>

		Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: 100% prior to enrollment/ contract.	

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: QIO Reviews are conducted every 12-18 months	

	depending on past provider performance. Reports are available within 45 days post review.	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

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

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

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

**Performance Measure:**

**Proportion of providers that meet training requirements by provider type as specified by the State's scope of service of other operational directive.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DDSN QIO Review Reports**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<b>Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: DDSN QIO Reviews are conducted every 12-18 months depending on past provider performance. Reports are available within 45 days post review.	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Provider Compliance Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: 100% within 18 months	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

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

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted.	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
Information about agencies that were reviewed, compliance issues uncovered, and corrections made will be maintained along with timeframes of correction.

DDSN will share this information with DHHS on an on-going basis as reports are received from the QIO and/or the contracting agency.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

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

- No**
- Yes**

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

**Appendix C: Participant Services**

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**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

**Appendix C: Participant Services**

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

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in

## Appendix C-3.

- Applicable** - The State imposes additional limits on the amount of waiver services.

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

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Support Plan

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

- Registered nurse, licensed to practice in the State**  
 **Licensed practical or vocational nurse, acting within the scope of practice under State law**  
 **Licensed physician (M.D. or D.O)**  
 **Case Manager** (qualifications specified in Appendix C-1/C-3)  
 **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker.**

*Specify qualifications:*

 **Other**

*Specify the individuals and their qualifications:*

Service Coordinators/Early Interventionists; must hold at least a Bachelor's degree in social work or a related field from an accredited college or university or hold a Bachelor's degree in an unrelated field from an accredited college or university and have at least one year of experience in a case management program and demonstrate knowledge of disabilities.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (2 of 8)

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

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The state utilizes a standardized tool for assessing the needs of all waiver participants. Once needs are identified and prioritized, service coordinators explain the service options that are available to meet those needs. Participants are given the names of available, qualified providers of needed services from which they may choose. Their choice is documented.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (3 of 8)

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

During the planning process the participant, family, his/her legal guardian and/or representative, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The information obtained is used by the service coordinator in order to develop the Service Plan. Upon completion a copy of the service plan will be provided to either the participant, family, legal guardian and/or representative.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (4 of 8)

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

The Service Plan is developed by the service coordinator and is based on the comprehensive assessment of the waiver participants strengths, needs, and personal priorities (goals) and preferences. The participant, family, his/her legal guardian and/or representative, caregivers, professional service providers (including physician) and others of the participants choosing may provide input. Service plans are developed/updated for all newly enrolled waiver participants and will include the need for all waiver services prior to service authorization. A new plan will be developed at least within 365 days of the previous service plan or more often as the participants needs change.

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

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

The plan will include the roles and responsibilities of the service coordinator and the participant, family, and his/her legal guardian and/or representative for each service included in the plan. The service coordinator will have primary responsibility for coordination of services but must rely on the participant, family, legal guardian and/or representative 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 least every 6 months the Service Coordinator will review the entire support plan to determine if updates are needed. This review is conducted by the service coordinator in consultation with the participant, family, legal guardian and/or representative during which the effectiveness, usefulness, and benefits of the plan will be discussed in addition to the overall satisfaction with the services/providers.

Changes to the plan will be made as needed by the Service Coordinator when the results of monitoring or when information obtained from the participant, family, legal guardian and/or representative, or service providers indicates the need for a change to the plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (5 of 8)

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

Waiver participants' needs, including potential risks associated with their situations, are assessed and considered during the annual planning process. The plan of service document includes a section for a description of a back-up plan to be implemented during an emergency/natural disaster and a description of how care will be provided in the unexpected absence of a caregiver/supporter. A standardized assessment tool is used for all waiver participants. This tool assesses the person's current situation, risks, and his/her personal preferences. The plan of service document includes sections that outline the responsibilities of the waiver participant, family, legal guardian and/or representative, and the responsibilities of the service coordinator. When back-up plans are needed, those details are included with responsibilities for all parties delineated.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (6 of 8)

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

Upon request or as service needs change, participants, families, legal guardians and/or representatives are given a list

of providers of specified waiver services for which a change is requested or needed in order to select a provider. This list includes phone numbers. They are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider. Lists are also available on the DDSN website.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (7 of 8)

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

The format and content of the questions for the service plan document, as well as the intended planning process must be reviewed and approved by DHHS prior to implementation. Participant plans are available upon request. A sample of participant plans are reviewed by DDSN and results shared with the service coordinator and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS in an annual report.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

*Specify the other schedule:*

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

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

*Specify:*

Service Coordinator

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-2: Service Plan Implementation and Monitoring

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

At a minimum Service Coordinators will provide contact with the participant, family, legal guardian and/or representative every 60 calendar days.

Every 180 calendar days, the Service Coordinator will provide a face-to-face contact with the participant, family, legal guardian and/or representative.

At least every 6 months, Service Coordinators will complete a plan review in consultation with the participant, family, legal guardian and/or representative to determine if the current services should be continued, modified or discontinued.

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

The frequency of monitoring/contacts is subject to changes in Medicaid Policy.

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

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **Quality Improvement: Service Plan**

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Proportion of plans that include services and supports consistent with needs identified in the assessment.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DDSN QIO Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>

<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contract Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**  
**Proportion of plans that include services/supports to address personal goals.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN Report**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Proportion of newly enrolled participants whose plans were updated to include the need for waiver services prior to authorization.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Reports**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative

		<b>Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence

		warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: sampling determined by evidence warranting a special review
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>

<input type="checkbox"/> <b>Continuously and Ongoing</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Proportion of participants whose new support plans were developed at least annually and when warranted by a change in participants needs.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

	<input checked="" type="checkbox"/> <b>Other</b> Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	
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**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<b>Agency</b>		
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: sampling determined by evidence warranting a special review
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Proportion of participants receiving services and supports in the type, amount, frequency, and duration as specified in their plans.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Reports**

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

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

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

<b>collection/generation</b> (check each that applies):	<i>(check each that applies):</i>	
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and</b>	<input checked="" type="checkbox"/> <b>Other</b>

	<b>Ongoing</b>	Specify: sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**Proportion of newly enrolled waiver participant records which contain an appropriately signed Freedom of Choice Form that specifies choice was offered between home and community-based services or institutional care.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Review Reports**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

	Specify: <input type="text"/>
--	----------------------------------

**Performance Measure:**

**Proportion of waiver participant records that indicate participant was offered choice of qualified providers.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Review Reports**

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

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

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

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:

		sampling determined by evidence warranting a special review.
<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted		

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
 When DDSN's QIO identifies problems, the provider agency being reviewed is required to submit a plan of correction to address the issues discovered. The QIO conducts a follow-up review to determine if corrections have been made. Additionally, QIO reports are reviewed by DDSN Operations staff. As needed, technical assistance is provided to providers by the Operations staff. Documentation of all technical assistance is available. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are available to DHHS.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> <b>Other</b> Specify:  <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

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

- No**  
 **Yes**

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

## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

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

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

**Indicate whether Independence Plus designation is requested** (select one):

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

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

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

This Waiver offers In-Home Support as a participant directed service with employer authority. The participant or his/her representative can choose to direct the participant's service. The participant or representative must have no

communication or cognitive deficits that would interfere with participant/representative directions.

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

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

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

The Service Coordinator will determine if participants/representatives are interested and in need of In-Home Support. If so, their likely ability to direct those services will be assessed using a standardized assessment. The assessment will determine the participant's communication ability, cognitive patterns, mood/behavior and understanding of the service and role. When direction by a representative is desired, the tool assesses the representative's relationship and proximity/availability to the participant, ability to communicate and understanding of the service and role. Adverse recommendations are reviewed by a Human Rights Committee and disagreements regarding the results may be reconsidered/appealed.

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

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

At the time of the initial assessment, the Service Coordinator will introduce participant direction of In-Home Support and provide information about this option. The Service Coordinator will provide this information initially or at the request of the participant/representative. If the participant/representative is interested the Service Coordinator will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The Service Coordinator will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant/representative direction.

## Appendix E: Participant Direction of Services

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### E-1: Overview (5 of 13)

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

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

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

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

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

A participant may choose to have waiver services directed by a representative and he/she may choose anyone (subject to DDSN or Medicaid Policy) willing to understand and assume the risks, rights, and responsibilities of directing the participant's care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant's preferences, and must agree to a predetermined frequency of contact with the participant. A representative may not be paid to be a representative, and may not be paid to provide waiver services to the participant.

## Appendix E: Participant Direction of Services

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### E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each

waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
In-Home Support services	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

**Governmental entities**

**Private entities**

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

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

#### Provide the following information

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Vendors, government fiscal agents or agencies approved through a request for proposal (RFP) process.

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

Contractual monthly fee

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

**Other**

*Specify:*

Verify participant's/representative's verification of minimum qualifications.

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Supports furnished when the participant exercises budget authority:

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- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

*Specify:*



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Additional functions/activities:

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

*Specify:*

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

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

## Appendix E: Participant Direction of Services

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### E-1: Overview (9 of 13)

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

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

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

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
<b>DAY ACTIVITY</b>	<input type="checkbox"/>
<b>PRIVATE VEHICLE MODIFICATIONS</b>	<input type="checkbox"/>
Assistive Technology and Appliances	<input type="checkbox"/>
Personal Emergency Response Systems (PERS)	<input type="checkbox"/>
Adult Day Health Care - Transportation services	<input type="checkbox"/>
Personal Care Services	<input type="checkbox"/>
Respite Care Services	<input type="checkbox"/>
Adult Day Health Care Services	<input type="checkbox"/>
<b>BEHAVIOR SUPPORT SERVICES</b>	<input type="checkbox"/>
Adult Day Health Care - Nursing services	<input type="checkbox"/>
Incontinence Supplies	<input type="checkbox"/>
<b>SUPPORT CENTER SERVICES</b>	<input type="checkbox"/>
In-Home Support services	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
<b>COMMUNITY SERVICES</b>	<input type="checkbox"/>
<b>CAREER PREPARATION SERVICES</b>	<input type="checkbox"/>
<b>EMPLOYMENT SERVICES</b>	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

The FMS supports are provided by a contractor, vendor or governmental entity. The operating agency will have a contract with the FMS to provide these supports. The supports include providing each participant with a checklist of responsibilities they have in hiring their workers, and verification of qualifications and requirements. The operating agency will assess the performance of the FMS on a quarterly basis. The FMS is also required to have an independent financial audit every year.

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

#### k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.**

- Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

The Center for Disability Resources at the University of South Carolina. This advocacy is accessed through the Service Coordinator.

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	50	
Year 2	100	
Year 3	150	
Year 4	150	
Year 5	150	

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

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

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

- Recruit staff**  
 **Refer staff to agency for hiring (co-employer)**  
 **Select staff from worker registry**  
 **Hire staff common law employer**  
 **Verify staff qualifications**  
 **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost for background checks will be handled by DDSN.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**  
 **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**  
 **Determine staff wages and benefits subject to State limits**  
 **Schedule staff**  
 **Orient and instruct staff in duties**  
 **Supervise staff**  
 **Evaluate staff performance**  
 **Verify time worked by staff and approve time sheets**  
 **Discharge staff (common law employer)**  
 **Discharge staff from providing services (co-employer)**  
 **Other**

Specify:

## Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

## Appendix E: Participant Direction of Services

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

- b. **Participant - Budget Authority**

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

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

## Appendix E: Participant Direction of Services

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

- b. **Participant - Budget Authority**

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

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

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

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

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

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

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

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

## Appendix F: Participant Rights

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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.

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

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

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

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

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

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

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

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

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

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

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

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

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

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

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

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

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

DDSN operates the Complaint/Grievance system

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

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

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

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

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

- No. This Appendix does not apply** (*do not complete Items b through e*)

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

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

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

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

In addition, DDSN Directive 534-02-DD specifically addresses the procedures for preventing and responding to ANE. This directive sets the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers.

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

Waiver participants and/or their family members and legal representatives are provided written information about what constitutes abuse, how to report, and to whom to report. They are informed of their rights annually; this information is explained by their Service Coordinators. The State requires documentation in the participant's record to verify this was completed. The QIO monitors for compliance.

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

The reporting of Critical Incidents should follow the procedures outlined in DDSN Directive 100-09-DD. DDSN Directive 534-02-DD, specifically addresses the procedures for preventing and responding to Abuse, Neglect and Exploitation (ANE). This directive sets forth the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers. Reporting requirements specify that all incidents must be reported to DDSN within 24 hours or the next business day, per Directives 100-09-DD and 534-02-DD.

When there is reason to believe that a child has been abused, neglected or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. DSS is the mandated agency to investigate suspected ANE in these settings. DDSN and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN to assist contract provider agencies in resolving issues with DSS regarding intake referrals and investigations. DSS will conduct a complete investigation and contact law enforcement if criminal violations are

suspected. If the investigation is substantiated, notification is sent to appropriate agencies for personnel and other required actions to be taken. If the alleged perpetrator is also employed by DDSN, a contract provider agency, or the family and ANE substantiated, the employee will be terminated.

When there is reason to believe that an adult has been abused, neglected or exploited, mandated reporters have a duty to make a report to DSS or local law enforcement. All alleged abuse and other critical events are also reported to the operating agency within 24 hours. DDSN works closely with DSS and local law enforcement regarding applicable critical incidents and/or ANE allegations.

Incidents that do not meet the threshold for reporting under Directives 100-09-DD or 534-02-DD are captured under DDSN Directive 535-08-DD, Concerns of People Who Receive Services: Reporting and Resolution. All providers have a procedure for people who receive services and supports or representatives acting in their behalf that assures their right to voice concerns without actions being taken against them for doing so. The procedure delineates all steps in the process. Support may be provided, if needed, to people who wish to express a concern but need assistance in understanding or following the process. All efforts are made to resolve concerns at the most immediate staff level that can properly address the concern. Concerns involving health and safety of people receiving services receive immediate review and necessary action is taken if the person's health or safety is at risk.

On a regular basis, DDSN Quality Management staff review critical incidents and ANE reports, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. Statewide trend data is provided to DSN Boards and contracted service providers to enhance awareness activities as a prevention strategy, as addressed in Directive 100-28-DD. Each regional center, DDSN Board or contracted service provider will also utilize their respective risk managers and committees to regularly review all critical incidents for trends and to determine if the recommendations made in the final written reports were actually implemented and are in effect. Statewide trend data and training curriculum will be provided to DHHS on an annual basis.

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

The DDSN Critical Incident and ANE directives set forth the reporting requirements of state law and also identify DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive, 100-09-DD, also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers.

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

#### SLED/Child Fatalities Review Office

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

#### Protection and Advocacy for People with Disabilities, Inc.

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

#### Vulnerable Adult Fatalities Review

The Vulnerable Adult Fatalities (VAF) Review Office of the State Law Enforcement Division (SLED) will investigate all deaths involving abuse, physical and sexual trauma, as well as, suspicious and questionable deaths of vulnerable adults. The State Vulnerable Adult Investigations Unit (VAIU) will also review the involvement that various agencies may have had with the person prior to death.

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

trending analysis will be shared with DHHS on an annual basis.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

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

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

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

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

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

In accordance with DDSN policy, restraints may be employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the person's needs. The following types of restraints may be used:

- (1.) Planned restraint (mechanical or manual) when approved by the person his/her legal guardian, the program director/supervisor, an approved provider of behavior support services, the Human Rights Committee (HRC) of the Executive Director.
- (2.) Mechanical restraints to allow healing of injury produced by an inappropriate behavior when approved by the person or his/her legal guardian, the program director/supervisor, an approved provider of behavior support services, the HRC, and the Executive Director.
- (3.) Psychotropic medication when approved by the person or legal guardian, the program director/supervisor, an approved provider of behavior support services, the HRC, and the Executive Director.

The use of the following are prohibited by DDSN policy:

- (1.) Procedures, devices, or medication used for disciplinary purposes, for the convenience of the staff or as a substitute for necessary supports for the person;
- (2.) Seclusion (defined as the placement of an individual alone in a locked room);
- (3.) Enclosed cribs;
- (4.) Programs that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
- (5.) Having a service recipient discipline other people with disabilities;
- (6.) Prone (i.e., face down on the floor with arms folded under the chest) basket-hold restraint;
- (7.) Timeout rooms; and,
- (8.) Aversive consequence (defined as the application of startling, unpleasant, or painful consequences) unless specifically approved by the State Director of DDSN or his/her designee.

The unauthorized or inappropriate use of restraints would be considered abuse by the State; therefore, the same methods used to detect abuse (e.g., staff supervision, identification of situations that may increase risk, etc.) are employed to detect inappropriate use of restraints/seclusion.

The State's policy requires that only curricula or systems for teaching and certifying staff to prevent and respond to disruptive and crisis situations that are validated and competency-based be employed. Any system employed must emphasize prevention and de-escalation techniques and be designed to utilize physical confrontation only as a last resort. Each system dictates its own specific certification and re-certification procedures. Examples of systems approved by the State are MANDT, Crisis Prevention Institute (CPI), and Professional Crisis Management (PCM).

Any individual program that involves restrictive procedures may only be implemented when less restrictive procedures are proven ineffective. Restrictions may only be implemented with the informed consent of the individual/representative and with the approval of the Human Rights Committee. Restrictions must be monitored by staff, and the behavior supports provider, and the HRC. Additionally, when planned restraints are employed, State policy requires that restraints may not be applied for more than one continuous hour and release must occur when the person is calm. Mechanical restraints must be applied under continuous observations.

DDSN utilizes a QIO to conduct contract compliance reviews which include direct observation of service provision and record reviews. The QIO reviews include, but are not limited to, determining if staff are appropriately trained, that risk management and quality assurance systems are implemented consistent with policy, and that abuse and critical incidents are reported and responded to in accordance with policy. Additionally, the QIO determines if individuals are provided the degree and type of supervision needed but not inappropriately restricted. Information collected by the QIO is shared with DHHS.

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

DDSN is responsible for oversight of the use of restraints. DDSN policies dictate the responsibilities of service providers and the HRC regarding monitoring programs that include restraint. DDSN monitors compliance with policies through its contract compliance reviews conducted by the QIO and through its licensing reviews.

Contract compliance review and licensing review reports are provided to SCDHHS per the requirements of the MOA. Traditional survey methods including record reviews, staff interviews, and observation are implemented to detect unauthorized use, over use, or inappropriate/ineffective use of restraint procedures. Deficiencies noted must be addressed in a written plan of correction that provides individual and systemic remediation. DDSN provides technical assistance as needed based on findings. Follow-up reviews are conducted, as needed.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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

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

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

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

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

DDSN policy allows the use of:

- (1.) Restrictive procedures (procedures that limit freedom or cause loss of personal property or rights excluding restraint) when approved by the person or his/her legal guardian, the program director/supervisor, an approved behavior support provider, and the Human Rights Committee (HRC).
- (2.) Adverse consequences which are defined as startling, unpleasant or painful consequences, consequences that have a potentially noxious effect, when approved by the person or his/her legal guardian, the physician, an approved provider of behavior support services, HRC, the Executive Director,

and the State Director of DDSN. Such procedures may only be employed to protect the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the needs of the person.

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

DDSN is responsible for oversight of the use of the restrictive procedures. DDSN policies dictate the responsibilities of service providers and the HRC regarding monitoring programs that include restrictive procedures. DDSN monitors compliance with policies through its contract compliance reviews conducted by the QIO and through its licensing reviews. When adverse consequences are approved, in addition to monitoring through contractual compliance and licensing reviews, the procedures are monitored by a DDSN state office staff person.

DDSN Standards and Directives referenced include the following:  
Behavior Support Plans 600-05-DD  
Human Rights Committee 535-02-DD

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

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

- a. **Applicability.** Select one:

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

- b. **Medication Management and Follow-Up**

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

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

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

DDSN has established a procedural directive, "Medication Error Reporting," to standardize the definition and reporting system for medication errors/events in order to improve the health and safety of DDSN consumers. DDSN recognizes that medication errors represent one of the largest categories of treatment-caused risks to consumers. As a result, every agency that provides services and supports to people must have a medication error/event reporting, analyzing, and follow-up capability, as part of their overall risk management program. Safe medication requires training, experience, and concentration on the part of the person dispensing the medication. The provider's system of tracking, trending, and analyzing their Medication Error data is reviewed by the QIO.

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) has urged agencies, institutions, and researchers to utilize this standard definition of medication errors. DDSN has adopted this definition. (For more information on NCC MERP, please see [www.nccmerp.org](http://www.nccmerp.org).) "A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order

communication; product labeling, packaging, and nomenclature; compounding; dispensing; administration; education; monitoring; and use." DDSN has followed the general guidelines of the NCC MERP "Taxonomy of Medication Errors" in developing a Medication Error/Event Report Form. DDSN Service Providers are required to develop their own data collection system to track, monitor and analyze medication errors/events. At the provider level, reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including Medication Technician Training), changes in procedure, securing additional technical assistance from a consulting pharmacist, and improving levels of supervision. DDSN is the state agency responsible for follow-up and monitoring and, as such, may request all data related to medication error/event reporting at any time or during any of the Service Provider's reviews.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

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

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

##### ii. State Policy.

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

DDSN was granted the statutory authority for selected unlicensed persons to administer medications to DDSN service recipients in community settings. DDSN policy requires that staff receive training on medication assistance/administration prior to service.

DDSN sets forth the minimum requirements for medication administration or assistance, which includes: checking physician's orders, knowing common medications prescribed for the individuals supported and indentifying their interactions/side effects, administering medications/treatments accurately and in accordance with agency policy, and recording medication administration on the appropriate forms. Staff must demonstrate knowledge/understanding of these minimum competencies on an annual basis.

DDSN requires that errors in administration of medications to service recipients must be reported, recorded, and that trends be analyzed. Additionally, both reactive and proactive follow-up activities following reports must be completed and documented.

DDSN monitors the administration of medication through annual licensing/certification reviews and monitors compliance with medication error reporting through the agency's contract compliance reviews.

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

The Standards or Directives referenced include:  
 Employee Orientation, Pre-Service and Annual Training (567-01-DD)  
 Residential Certification Standards  
 Day Facilities Licensing Standards  
 Medication Error/ Vent Reporting (100-29-DD)  
 Medication Technician Certification (603-13-DD)

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

- Providers that are responsible for medication administration are required to both record and report**

**medication errors to a State agency (or agencies).**

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Significant Medication Errors are reported to SCDDSN as a Critical Incident. All Medication Error/Event reports are subject to periodic review by SCDDSN or its QIO, Delmarva Foundation, or its Licensing inspection contractor, SCDHEC.

SCDDSN has adopted the NCC MERP definition of Medication Errors: “A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer.” SC DDSN has followed the general guidelines of the NCC MERP “Taxonomy of Medication Errors” in developing a Medication Error/Event Report Form. SCDDSN Service Providers are required to develop their own data collection system to track, monitor and analyze medication errors/events. At the provider level reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including medication technician certification), changes in procedure, securing additional technical assistance from a consulting pharmacist, and improving levels of supervision. SCDDSN may request all data related to medication error/event reporting at any time or during any of the Service Provider’s annual reviews.

#### Types of Medication Errors/Events

According to the above definition, there are some kinds of medication errors that are outside the control of SCDDSN and its network of service providers (e.g., naming; compounding; packaging etc.). If provider agency staff discovers errors of this type, the pharmacist should be notified immediately in order for corrective action to occur. The types of medication errors/events that are within the direct control of SCDDNS and its network of service providers, and therefore of most interest, can be divided into three categories: 1) bona fide or “true” medication errors; 2) transcription and documentation errors; and 3) “red flag” events.

#### 1) MEDICATION ERRORS

- Wrong person given a medication
- Wrong medication given
- Wrong dosage given
- Wrong route of administration
- Wrong time
- Medication not given by staff (i.e., omission)
- Medication given without a prescriber’s order

#### 2) TRANSCRIPTION & DOCUMENTATION ERRORS

- Transcription error (i.e., from prescriber’s order to label, or from label to MAR)

- Medication not documented (i.e., not signed off)

### 3) RED FLAG EVENTS

- Person refuses medication (this event should prompt the organization to make every effort to determine why the person refused the medication. Specific action taken should be documented. Each organization must develop a reporting system for these events).

#### Reporting Procedure

The first person finding the medication error is responsible to report the error or event to supervisory/administrative staff, such as the employee's supervisor, program director, nurse in charge or Executive Director/Facility Administrator. A medication error resulting in serious adverse reactions must be considered a critical incident and reported according to policy. The person finding the error or identifying the event completes the Medication Error/Event Report form and submits it to the supervisor/administrator. The Provider Administration will assure this data is available to the quality assurance and risk management staff/team for analysis, trend identification, and follow-up activity as needed. In addition, the Medication Error/Event records are reviewed during the provider's annual licensing review. The QIO also reviews Medication Error/Event data and the provider's analysis and risk management activities during their scheduled reviews.

Each provider must adopt a method for documenting follow-up activities such as utilizing memoranda or the minutes of risk management/quality assurance meetings. This information must be included as part of the data collection system related to medication error/event reporting.

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

DDSN is responsible for monitoring the performance of Waiver providers in the administration of medication. DDSN requires all providers to follow the policy/procedures outlined in the previous responses. DDSN may request all data related to medication error/event reporting at any time or during any of the Service Provider's reviews. In addition, DHHS may review the Provider documentation at any time.

## Appendix G: Participant Safeguards

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### Quality Improvement: Health and Welfare

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

#### a. **Methods for Discovery: Health and Welfare**

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

##### i. **Performance Measures**

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

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

#### **Performance Measure:**

**Number of incidents of abuse, neglect, or exploitation that are reported within required timeframe.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number of incidents of abuse, neglect, or exploitation in which the internal review was completed within required timeframe.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input checked="" type="checkbox"/> Annually

<input type="checkbox"/> <b>Continuously and Ongoing</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and proportion of participants who receive information yearly about how to report abuse, neglect and exploitation.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN QIO Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: QIO Reviews are conducted every 12-18 months depending on past performance of the provider organization.	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Proportion of Day Service providers who report medication errors/events in accordance with policy.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DDSN Reports**

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Proportion of Day Services Providers reviewed by the Human Rights Committee to assure participant rights are protected.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DDSN Reports**

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<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

DDSN contracts with an independent QIO to conduct provider compliance reviews. Administrative Key Indicators are included with each compliance review. The Administrative Review determines if the organization has systems in place that identify whether employees are reporting according to State Law and DDSN policy, and responding appropriately. There are separate indicators to address abuse, neglect, exploitation (ANE), reporting procedures, risk management, and prevention.

DDSN collects, responds and reports data related to other critical incidents that do not rise to the level of ANE. DDSN employs a full-time Incident Management Coordinator who tracks reports throughout the system to ensure compliance with State Law and DDSN policy. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider’s management action taken to remediate identified issues such as staff training, staff suspension or termination, updates to risk management and quality assurance procedures and policies and other measures to provide safeguards for the consumers. This data is also reviewed by the SCDDSN Director of Quality Management for trending analysis at both the provider and statewide levels along with corresponding QIO and Licensing data.

- ii. Remediation Data Aggregation

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid #ccc; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid #ccc; height: 20px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

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

- No
- Yes

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

**Appendix H: Quality Improvement Strategy (1 of 2)**

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

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

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

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

### **Quality Improvement Strategy: Minimum Components**

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

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

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

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

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

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

## **Appendix H: Quality Improvement Strategy (2 of 2)**

### **H-1: Systems Improvement**

#### **a. System Improvements**

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The objective of DDSN's Quality Management Systems is to identify positive and negative trends allowing for

necessary adjustments to enhance the overall performance of the system.

DDSN's system improvement activities are designed to ensure that they address all six (6) CMS assurances based on performance measures. Statewide problems can be addressed through any of the following: 1) revisions to the training program; 2) revisions of policy and/or procedures; or 3) modifications to improve the data reporting system.

Timely discovery and remediation of aggregated data allows the state to take the necessary action to improve the system's performance, thereby learning how to improve meaningful outcomes for waiver participants. DDSN contracts with an independent QIO to assess service providers by making on-site visits. Records are reviewed, consumers and staff are interviewed, and observations made to evaluate that services are implemented as planned, and that needs are identified in the plan of care. In addition, the service providers are reviewed to ensure compliance with DDSN standards, contracts, policies and procedures.

DDSN monitors the QIO reports approximately 30 days after the review date to ensure overall compliance with QA measures and to determine appropriate remediation. For each finding, the provider must submit a plan of correction (POC) within 30 days to the QIO and the QIO conducts a follow-up review approximately 6 months later to ensure successful implementation of the POC. The POC will address remediation at the individual level. DDSN District Office staff are also available to provide training and technical assistance as needed.

DDSN also monitors the QIO reports of findings to identify larger system-wide issues that require training and/or technical assistance. Issues noted are communicated through the provider network. This information is addressed through quarterly counterpart meetings with DDSN personnel and representatives of the SC Human Services Provider Association. Minutes from these meetings are shared with DHHS QA Staff.

DDSN is able to stratify information related to each approved waiver program and is also able to stratify by provider and waiver type. DDSN's Quality Management System has formal processes and activities in place for trending, prioritizing, and implementing system improvements. DDSN is continuously reviewing and updating its Quality Management System processes to ensure it is responsive to the quality assurances.

DDSN provides DHHS with the results of all quality assurance review activities throughout the year. This includes, but is not limited to, critical incident data, results of all QIO provider reviews, and DHEC licensing data.

The State maintains a MOA and a waiver service contract to outline the responsibilities for the operating agency and the administrating agency as they participate in joint quality improvement and trend analysis efforts.

## ii. System Improvement Activities

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: DHEC	<input checked="" type="checkbox"/> <b>Other</b> Specify: DDSN QIO Reviews are conducted every 12-18 months per past provider performance.

## b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DDSN has a comprehensive incident management system which allows the State Office and individual provider agencies to track, trend and analyze reporting information. This information may include: the number and proportion of reports of abuse, neglect and exploitation; the number and proportion of reported incidents of substantiated abuse, neglect and exploitation; and the number and proportion and critical incidents (including mortality, injuries and client-to-client altercations).

The State schedules quarterly meetings to review policy and any pertinent waiver issues. Quality Assurance/Quality Improvement is generally a standing agenda item.

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

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

## Appendix I: Financial Accountability

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### I-1: Financial Integrity and Accountability

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

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

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

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

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 any service provider. Issues that involve fraudulent billing by providers are referred 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. The Internal Audit Division at SCDDSN has planned audits of State Agency Medicaid Contracts in its audit plan.

## Appendix I: Financial Accountability

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### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*

**i. Performance Measures**

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

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

**Performance Measure:**

**Proportion of paid claims for waiver participants that are coded and paid in accordance with the approved waiver document and corresponding waiver policy.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN/QIO Adjustment Logs**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Focus/Desk Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<b>Agency</b>		
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted.	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Paid Claims in Medicaid Management Information System**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b>	

	Specify: <input type="text"/>	
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**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> Other Specify: Winthrop University	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> Other Specify: as warranted	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Winthrop University	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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**Performance Measure:**  
**Proportion of paid claims for waiver services identified on an approved service plan.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Desk/Focus Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> Other Specify: As warranted.	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		+/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN/QIO Adjustment Logs**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**  
**Proportion of paid claims for waiver services rendered during a current and valid Level of Care determination.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Desk/Focus Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHHS Contractor Review Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: sampling determined by evidence warranting a special review.
	<input checked="" type="checkbox"/> <b>Other</b> Specify: as warranted	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDSN/QIO Adjustment Logs**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Winthrop University	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

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

DDSN's Internal Audit division conducts periodic reviews of billing systems and contracted providers to ensure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS in a timely manner.

**b. Methods for Remediation/Fixing Individual Problems**

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

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

- ii. **Remediation Data Aggregation**

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: As warranted

**c. Timelines**

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

**No**

**Yes**

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

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (1 of 3)

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

The DHHS Bureau of Reimbursement Methodology and Policy is responsible for the development of waiver service payment rates. DDSN also provides some assistance with establishing new rates and the maintenance of existing rates. DHHS has retained the services of an actuarial firm to assist in such efforts as needed. Significant rate changes or changes in rate setting methodology are presented to the DHHS Medical Care Advisory Committee.

For waiver services provided by DDSN, rates are established based upon the costs of the service to be provided. Costs used in the determination of the waiver rates include salaries, fringe benefits, travel, training, and indirect costs. Billable units were determined in order to adjust for time spent on leave, training, travel, and administration. DDSN will perform financial reviews as needed to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

For services provided by private providers, rates were established to coincide with those paid for similar services rendered in other waiver programs (ex. adult day care, personal care services).

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

Providers maintain the option of billing directly to DHHS or they may voluntarily reassign their right to direct payments to DDSN. Providers billing DHHS directly may bill either by use of a CMS 1500 form or by the State's electronic billing system.

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (2 of 3)

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

- No. State or local government agencies do not certify expenditures for waiver services.
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

*Select at least one:*

**Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

(a) The South Carolina Department of Disabilities and Special Needs (SCDDSN). (b) SCDDSN files annual cost reports that report the total costs incurred for both their institutional services (ie ICF/MRs) and all waiver services providers. (c) The SCDDSN receives annual state appropriations for these services. The contract between SCDHHS and SCDDSN applicable to these services will require the following contract language:

“SCDDSN agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable, and necessary cost for the provision of services to be provided to Medicaid recipients under the contract prior to submitting claims under the contract. Documentation of the non-federal expenditures necessary to support the claims for reimbursement must be maintained by SCDDSN and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures are not adequately documented. As required by 42 CFR Part 201.5, all funds expended for the non-federal share of this contract must be in compliance with 42 CFR Part 433 Subpart B. Such non-federal funds must be actually expended for the provision of services under this contract”. Additionally, the Internal Audit Division within the SCDHHS has included in its’ audit plan planned audits of State Agency Medicaid contracts.

**Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

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

Claims for waiver services are submitted to MMIS through either the use of a CMS 1500 form or through the State's electronic billing system. For almost all waiver services, providers are given a service authorization which reflects the service identified on the service plan. This authorization is produced by the service coordinator and contains the amount, frequency, effective date and type of service authorized along with a unique authorization number. Once the claim is properly submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is an indication in MMIS that the participant is enrolled in the waiver program. Other waiver services, such as extra prescription drugs, are authorized simply by the presentation of the waiver participant's Medicaid card. When the Medicaid number is entered into the proper electronic system, it will identify the waiver

benefit available to the individual. This is all linked to the recipient special program (RSP) in MMIS identifying an individual as a waiver participant.

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 §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

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

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

DDSN contracts with a financial management services entity to make payments for in-home support services delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed periodically.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

SCDDSN will receive payment and provide the waiver services except for Adult Day Health Care services, Personal Care services, Adult Day Health Care Nursing, Adult Day Health Care Transportation, Personal Emergency Response Systems, and Behavior Supports. These services will be provided by private Medicaid providers directly enrolled/contracted in the Medicaid program.

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

#### e. Amount of Payment to State or Local Government Providers.

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

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

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

#### f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

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

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

The Department of Disabilities and Special Needs

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

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

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

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid**

**ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

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

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

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

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

DDSN receives state appropriations to provide services under this waiver. A portion of these funds will be transferred to DHHS via an IGT for payments that will be made directly to private providers enrolled with DHHS. For services provided by DDSN, these funds will be directly expended by DDSN as CPE.

- Other State Level Source(s) of Funds.**

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

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

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

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.  
 **Applicable**

*Check each that applies:*

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the

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

## Appendix I: Financial Accountability

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

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

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

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

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

**Do not complete this item.**

## Appendix I: Financial Accountability

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

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

**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can**

be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
- i. **Co-Pay Arrangement.**

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

***Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):***

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. **Co-Payment Requirements.**
- ii. **Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: ICF/MR**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8152.93	1772.00	9924.93	111700.00	2255.00	113955.00	104030.07
2	8845.76	1825.00	10670.76	115051.00	2323.00	117374.00	106703.24
3	9831.00	1880.00	11711.00	118503.00	2393.00	120896.00	109185.00
4	10628.06	1936.00	12564.06	122058.00	2465.00	124523.00	111958.94
5	10723.65		12717.65			128259.00	115541.35

		1994.00	125720.00	2539.00	
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## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	3300	3300
Year 2	3630	3630
Year 3	4000	4000
Year 4	4400	4400
Year 5	4840	4840

## Appendix J: Cost Neutrality Demonstration

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

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

Year 1 - 282 days  
 Year 2 - 307 days  
 Year 3 - 331 days  
 Year 4 - 349 days  
 Year 5 - 351 days

These calculated lengths of stay are based on current enrollment with an additional anticipated growth level of participants for each year. There will be a gradual entry of participants, averaging a 10% increase of participants for each year. The average length of stay factor progressively increases as the numbers of participants grow within the waiver. The projected average length of stay increases by 8% for Year 2 and 3. Year 4 increases at a 5% growth with Year 5 leveling off.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.
- 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 for users and units are based on current and projected utilization. Year 1 rates are current with no expected change reflected for year 2 and only modest rate increases projected for years 3 and 4. Year 5 rate increases not projected at this time.
  - 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 originates with the CMS 372 Report for Waiver #0676 for year ending 6/30/2010. An inflation factor of 3% for SFY 10-11 and SFY 11-12 was used to arrive at the starting average per capita for the Renewal. This waiver serves participants with the same level of care.

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

The derivation originates with the CMS 372 Report for Waiver #0676 for year ending 6/30/2010. An inflation factor of 3% for SFY 10-11 and SFY 11-12 was used to arrive at the starting average per capita for the Renewal. This waiver serves participants with the same level of care.

- 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 originates with the CMS 372 Report for Waiver #0676 for year ending 6/30/2010. An inflation factor of 3% for SFY 10-11 and SFY 11-12 was used to arrive at the starting average per capita for the Renewal. This waiver serves participants with the same level of care.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Adult Day Health Care Services
Personal Care Services
Respite Care Services
Incontinence Supplies
Adult Day Health Care - Nursing services
Adult Day Health Care - Transportation services
Assistive Technology and Appliances
BEHAVIOR SUPPORT SERVICES
CAREER PREPARATION SERVICES
COMMUNITY SERVICES
DAY ACTIVITY
EMPLOYMENT SERVICES
Environmental Modifications
In-Home Support services
Personal Emergency Response Systems (PERS)
PRIVATE VEHICLE MODIFICATIONS
SUPPORT CENTER SERVICES

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Care Services Total:</b>						208791.00
Adult Day Health Care Services	Day	33	148.00	42.75	208791.00	
<b>Personal Care Services Total:</b>						366795.00
Personal Care I	Hour	33	195.00	11.40	73359.00	
Personal Care II	Hour	99	195.00	15.20	293436.00	
<b>Respite Care Services Total:</b>						828954.00
Non-Institutional Hourly	Hour	198	306.00	10.50	636174.00	
Institutional Nursing Facility	Day	17	28.00	120.00	57120.00	
Institutional ICF/MR	Day	17	28.00	285.00	135660.00	
<b>Incontinence Supplies Total:</b>						237600.00
Incontinence Supplies	month	330	9.00	80.00	237600.00	
<b>Adult Day Health Care - Nursing services Total:</b>						8963.25
Adult Day Health Care - Nursing services	Day	17	37.00	14.25	8963.25	
<b>Adult Day Health Care - Transportation services Total:</b>						69597.00
Adult Day Health Care - Transportation services	Day	33	148.00	14.25	69597.00	
<b>Assistive Technology and Appliances Total:</b>						288090.00
Assistive Technology and Appliances	item	165	1.00	1746.00	288090.00	
<b>BEHAVIOR SUPPORT SERVICES Total:</b>						65934.00
BEHAVIOR SUPPORT SERVICES	half hour	33	74.00	27.00	65934.00	
<b>CAREER PREPARATION SERVICES Total:</b>						7108101.00
CAREER PREPARATION SERVICES	Unit	1386	195.00	26.30	7108101.00	
<b>COMMUNITY SERVICES Total:</b>						4272741.00
Community Services - Group	Per Unit	726	195.00	26.30	3723291.00	
Community Services - Individual	Per Unit	165	74.00	45.00	549450.00	
<b>DAY ACTIVITY Total:</b>						4231012.50
DAY ACTIVITY	Unit	825	195.00	26.30	4231012.50	
<b>EMPLOYMENT SERVICES Total:</b>						7571292.00
Employment Services-Individual	Hour	403	195.00	80.00	6286800.00	
Employment Services-Group	Unit	1320	37.00	26.30	1284492.00	
<b>Environmental Modifications Total:</b>						247500.00
Environmental						

Modifications	Item	33	1.00	7500.00	247500.00	
<b>In-Home Support services Total:</b>						158301.00
In-Home Support services	Hour	66	195.00	12.30	158301.00	
<b>Personal Emergency Response Systems (PERS) Total:</b>						267300.00
Personal Emergency Response Systems (PERS)	month	990	9.00	30.00	267300.00	
<b>PRIVATE VEHICLE MODIFICATIONS Total:</b>						127500.00
PRIVATE VEHICLE MODIFICATIONS	Item	17	1.00	7500.00	127500.00	
<b>SUPPORT CENTER SERVICES Total:</b>						846202.50
SUPPORT CENTER SERVICES	Unit	165	195.00	26.30	846202.50	
<b>GRAND TOTAL:</b>						26904674.25
Total Estimated Unduplicated Participants:						3300
Factor D (Divide total by number of participants):						8152.93
Average Length of Stay on the Waiver:						282

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

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

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Care Services Total:</b>						249318.00
Adult Day Health Care Services	Day	36	162.00	42.75	249318.00	
<b>Personal Care Services Total:</b>						438246.40
Personal Care I	Hour	36	212.00	11.40	87004.80	
Personal Care II	Hour	109	212.00	15.20	351241.60	
<b>Respite Care Services Total:</b>						980937.00
Non-Institutional Hourly	Hour	218	333.00	10.50	762237.00	
Institutional Nursing Facility	Day	18	30.00	120.00	64800.00	
Institutional ICF/MR	Day	18	30.00	285.00	153900.00	
<b>Incontinence Supplies Total:</b>						290400.00
Incontinence Supplies	month	363	10.00	80.00	290400.00	
Adult Day Health Care -						

<b>Nursing services Total:</b>						10260.00
Adult Day Health Care - Nursing services	Day	18	40.00	14.25	10260.00	
<b>Adult Day Health Care - Transportation services Total:</b>						83106.00
Adult Day Health Care - Transportation services	Day	36	162.00	14.25	83106.00	
<b>Assistive Technology and Appliances Total:</b>						317772.00
Assistive Technology and Appliances	item	182	1.00	1746.00	317772.00	
<b>BEHAVIOR SUPPORT SERVICES Total:</b>						78732.00
BEHAVIOR SUPPORT SERVICES	half hour	36	81.00	27.00	78732.00	
<b>CAREER PREPARATION SERVICES Total:</b>						8502790.00
CAREER PREPARATION SERVICES	Unit	1525	212.00	26.30	8502790.00	
<b>COMMUNITY SERVICES Total:</b>						5118294.40
Community Services - Group	Unit	799	212.00	26.30	4454904.40	
Community Services - Individual	Unit	182	81.00	45.00	663390.00	
<b>DAY ACTIVITY Total:</b>						5062644.80
DAY ACTIVITY	Unit	908	212.00	26.30	5062644.80	
<b>EMPLOYMENT SERVICES Total:</b>						9040784.00
Employment Services- Individual	Hour	443	212.00	80.00	7513280.00	
Employment Services- Group	Unit	1452	40.00	26.30	1527504.00	
<b>Environmental Modifications Total:</b>						270000.00
Environmental Modifications	Item	36	1.00	7500.00	270000.00	
<b>In-Home Support services Total:</b>						190354.80
In-Home Support services	Hour	73	212.00	12.30	190354.80	
<b>Personal Emergency Response Systems (PERS) Total:</b>						326700.00
Personal Emergency Response Systems (PERS)	month	1089	10.00	30.00	326700.00	
<b>PRIVATE VEHICLE MODIFICATIONS Total:</b>						135000.00
PRIVATE VEHICLE MODIFICATIONS	Item	18	1.00	7500.00	135000.00	
<b>SUPPORT CENTER SERVICES Total:</b>						1014759.20
SUPPORT CENTER SERVICES	Unit	182	212.00	26.30	1014759.20	
<b>GRAND TOTAL:</b>						32110098.60
Total Estimated Unduplicated Participants:						3630
Factor D (Divide total by number of participants):						8845.76
Average Length of Stay on the Waiver:						307

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (7 of 9)****d. Estimate of Factor D.**

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

**Waiver Year: Year 3**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Care Services Total:</b>						<b>306448.80</b>
Adult Day Health Care Services	Day	40	174.00	44.03	306448.80	
<b>Personal Care Services Total:</b>						<b>537875.20</b>
Personal Care I	Hour	40	229.00	11.74	107538.40	
Personal Care II	Hour	120	229.00	15.66	430336.80	
<b>Respite Care Services Total:</b>						<b>1207570.20</b>
Non-Institutional Hourly	Hour	240	359.00	10.82	932251.20	
Institutional Nursing Facility	Day	20	33.00	123.60	81576.00	
Institutional ICF/MR	Day	20	33.00	293.55	193743.00	
<b>Incontinence Supplies Total:</b>						<b>362560.00</b>
Incontinence Supplies	month	400	11.00	82.40	362560.00	
<b>Adult Day Health Care - Nursing services Total:</b>						<b>12918.40</b>
Adult Day Health Care - Nursing services	Day	20	44.00	14.68	12918.40	
<b>Adult Day Health Care - Transportation services Total:</b>						<b>102172.80</b>
Adult Day Health Care - Transportation services	Day	40	174.00	14.68	102172.80	
<b>Assistive Technology and Appliances Total:</b>						<b>359676.00</b>
Assistive Technology and Appliances	item	200	1.00	1798.38	359676.00	
<b>BEHAVIOR SUPPORT SERVICES Total:</b>						<b>96778.80</b>
BEHAVIOR SUPPORT SERVICES	Hour	40	87.00	27.81	96778.80	
<b>CAREER PREPARATION SERVICES Total:</b>						<b>10422064.80</b>
CAREER PREPARATION SERVICES	Unit	1680	229.00	27.09	10422064.80	
<b>COMMUNITY SERVICES Total:</b>						<b>6265666.80</b>
Community Services - Group	Unit	880	229.00	27.09	5459176.80	
Community Services -					806490.00	

Individual	Unit	200	87.00	46.35		
<b>DAY ACTIVITY Total:</b>						6203610.00
DAY ACTIVITY	Unit	1000	229.00	27.09	6203610.00	
<b>EMPLOYMENT SERVICES Total:</b>						11115500.80
Employment Services-Individual	Hour	488	229.00	82.40	9208364.80	
Employment Services-Group	Unit	1600	44.00	27.09	1907136.00	
<b>Environmental Modifications Total:</b>						300000.00
Environmental Modifications	Item	40	1.00	7500.00	300000.00	
<b>In-Home Support services Total:</b>						232114.40
In-Home Support services	Hour	80	229.00	12.67	232114.40	
<b>Personal Emergency Response Systems (PERS) Total:</b>						407880.00
Personal Emergency Response Systems (PERS)	month	1200	11.00	30.90	407880.00	
<b>PRIVATE VEHICLE MODIFICATIONS Total:</b>						150000.00
PRIVATE VEHICLE MODIFICATIONS	Item	20	1.00	7500.00	150000.00	
<b>SUPPORT CENTER SERVICES Total:</b>						1240722.00
SUPPORT CENTER SERVICES	Unit	200	229.00	27.09	1240722.00	
<b>GRAND TOTAL:</b>						39323559.00
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						9831.00
Average Length of Stay on the Waiver:						331

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

#### Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Care Services Total:</b>						365158.20
Adult Day Health Care Services	Day	44	183.00	45.35	365158.20	
<b>Personal Care Services Total:</b>						641329.92
Personal Care I	Hour	44	241.00	12.09	128202.36	

Personal Care II	Hour	132	241.00	16.13	513127.56	
<b>Respite Care Services Total:</b>						1433076.04
Non-Institutional Hourly	Hour	264	378.00	11.14	1111682.88	
Institutional Nursing Facility	Day	22	34.00	127.31	95227.88	
Institutional ICF/MR	Day	22	34.00	302.36	226165.28	
<b>Incontinence Supplies Total:</b>						410770.80
Incontinence Supplies	month	440	11.00	84.87	410770.80	
<b>Adult Day Health Care - Nursing services Total:</b>						15301.44
Adult Day Health Care - Nursing services	Day	22	46.00	15.12	15301.44	
<b>Adult Day Health Care - Transportation services Total:</b>						121746.24
Adult Day Health Care - Transportation services	Day	44	183.00	15.12	121746.24	
<b>Assistive Technology and Appliances Total:</b>						407512.60
Assistive Technology and Appliances	item	220	1.00	1852.33	407512.60	
<b>BEHAVIOR SUPPORT SERVICES Total:</b>						115934.72
BEHAVIOR SUPPORT SERVICES	half hour	44	92.00	28.64	115934.72	
<b>CAREER PREPARATION SERVICES Total:</b>						12425767.20
CAREER PREPARATION SERVICES	Unit	1848	241.00	27.90	12425767.20	
<b>COMMUNITY SERVICES Total:</b>						7474992.80
Community Services - Group	Per Unit	968	241.00	27.90	6508735.20	
Community Services - Individual	Per Unit	220	92.00	47.74	966257.60	
<b>DAY ACTIVITY Total:</b>						7396290.00
DAY ACTIVITY	Unit	1100	241.00	27.90	7396290.00	
<b>EMPLOYMENT SERVICES Total:</b>						13242404.79
Employment Services-Individual	Hour	537	241.00	84.87	10983620.79	
Employment Services-Group	Unit	1760	46.00	27.90	2258784.00	
<b>Environmental Modifications Total:</b>						330000.00
Environmental Modifications	Item	44	1.00	7500.00	330000.00	
<b>In-Home Support services Total:</b>						276764.40
In-Home Support services	Hour	88	241.00	13.05	276764.40	
<b>Personal Emergency Response Systems (PERS) Total:</b>						462171.60
Personal Emergency Response Systems (PERS)	month	1320	11.00	31.83	462171.60	

<b>PRIVATE VEHICLE MODIFICATIONS Total:</b>						<b>165000.00</b>
PRIVATE VEHICLE MODIFICATIONS	Item	22	1.00	7500.00	165000.00	
<b>SUPPORT CENTER SERVICES Total:</b>						<b>1479258.00</b>
SUPPORT CENTER SERVICES	Unit	220	241.00	27.90	1479258.00	
<b>GRAND TOTAL:</b>						<b>46763478.75</b>
Total Estimated Unduplicated Participants:						<b>4400</b>
Factor D (Divide total by number of participants):						<b>10628.06</b>
Average Length of Stay on the Waiver:						<b>349</b>

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

#### Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Care Services Total:</b>						<b>402708.00</b>
Adult Day Health Care Services	Day	48	185.00	45.35	402708.00	
<b>Personal Care Services Total:</b>						<b>709358.31</b>
Personal Care I	Hour	48	243.00	12.09	141017.76	
Personal Care II	Hour	145	243.00	16.13	568340.55	
<b>Respite Care Services Total:</b>						<b>1591781.40</b>
Non-Institutional Hourly	Hour	290	381.00	11.14	1230858.60	
Institutional Nursing Facility	Day	24	35.00	127.31	106940.40	
Institutional ICF/MR	Day	24	35.00	302.36	253982.40	
<b>Incontinence Supplies Total:</b>						<b>507735.36</b>
Incontinence Supplies	month	484	12.00	87.42	507735.36	
<b>Adult Day Health Care - Nursing services Total:</b>						<b>16692.48</b>
Adult Day Health Care - Nursing services	Day	24	46.00	15.12	16692.48	
<b>Adult Day Health Care - Transportation services Total:</b>						<b>134265.60</b>
Adult Day Health Care - Transportation services	Day	48	185.00	15.12	134265.60	
<b>Assistive Technology and Appliances Total:</b>						<b>448263.86</b>

Assistive Technology and Appliances	item	242	1.00	1852.33	448263.86	
<b>BEHAVIOR SUPPORT SERVICES Total:</b>						126474.24
BEHAVIOR SUPPORT SERVICES	half hour	48	92.00	28.64	126474.24	
<b>CAREER PREPARATION SERVICES Total:</b>						13783130.10
CAREER PREPARATION SERVICES	Unit	2033	243.00	27.90	13783130.10	
<b>COMMUNITY SERVICES Total:</b>						8283263.86
Community Services - Group	Per Unit	1065	243.00	27.90	7220380.50	
Community Services - Individual	Per Unit	242	92.00	47.74	1062883.36	
<b>DAY ACTIVITY Total:</b>						8203437.00
DAY ACTIVITY	Unit	1210	243.00	27.90	8203437.00	
<b>EMPLOYMENT SERVICES Total:</b>						14652474.30
Employment Services-Individual	Hour	590	243.00	84.87	12167811.90	
Employment Services-Group	Unit	1936	46.00	27.90	2484662.40	
<b>Environmental Modifications Total:</b>						360000.00
Environmental Modifications	Item	48	1.00	7500.00	360000.00	
<b>In-Home Support services Total:</b>						307601.55
In-Home Support services	Hour	97	243.00	13.05	307601.55	
<b>Personal Emergency Response Systems (PERS) Total:</b>						554605.92
Personal Emergency Response Systems (PERS)	month	1452	12.00	31.83	554605.92	
<b>PRIVATE VEHICLE MODIFICATIONS Total:</b>						180000.00
PRIVATE VEHICLE MODIFICATIONS	Item	24	1.00	7500.00	180000.00	
<b>SUPPORT CENTER SERVICES Total:</b>						1640687.40
SUPPORT CENTER SERVICES	Unit	242	243.00	27.90	1640687.40	
<b>GRAND TOTAL:</b>					51902479.38	
Total Estimated Unduplicated Participants:					4840	
Factor D (Divide total by number of participants):					10723.65	
Average Length of Stay on the Waiver:						351