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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The State is proposing to renew the Intellectually Disabled and Related Disabilities (ID/RD) home and community-based waiver program for an additional five-year period with the following changes:

-Revise the Medicaid ICF/IID level of care criteria to clarify the developmental period for intellectual disability is prior to age 22;
-Address the CMS Final Rule requirements;
-Revise performance measures for quality improvement as needed;
-Clarified the entrance requirements;
-Increased provider options for respite service;
-Implement a 2 waiver service minimum related to the addition of the waiver case management service;
-Add Pest Control as a new service;
-Remove Psychological services due to the service's availability through the State Plan;
-Update Appendices as needed; and
-Enhance clarity of text as needed.

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

1. Request Information (1 of 3)

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

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Intellectually Disabled and Related Disabilities Waiver (ID/RD)

C. **Type of Request: renewal**

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: SC.0237
Waiver Number:SC.0237.R05.00
Draft ID: SC.014.05.00

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

Regular Waiver

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

01/01/15

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Not applicable

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

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

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
South Carolina is seeking to renew the Intellectually Disabled and Related Disabilities Waiver(ID/RD). This waiver will serve people with intellectual disabilities and related disabilities who meet the ICF-IID level of care criteria. The services offered in this waiver are meant to prevent and/or delay institutionalization. This waiver reflects the State's commitment to offer viable community options to institutional placement.

Administrative authority for this waiver is retained by the South Carolina Department of Health and Human Services (SCDHHS). The South Carolina Department of Disabilities and Special Needs (SCDDSN) will perform waiver operations under a Memorandum of Agreement (MOA)and an administrative contract with SCDHHS. SCDDSN has the operational responsibility for ensuring that participants are aware of their options under this waiver. SCDDSN utilizes both county Disability and Special Need Boards and private providers as waiver service providers. Services in this waiver are provided at the local level mainly through a traditional service delivery system.

3. Components of the Waiver Request

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

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

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

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

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the

State uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of

waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

required in 42 CFR §431.210.

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Notice to Tribal Governments was sent by SCDHHS on June 5 and June 23, 2014 and discussed with the tribe at a standing monthly meeting on June 25, 2014. Public notice was conducted by SCDHHS at the SCDHHS Medical Care Advisory Committee Meeting (MCAC) on May 13, 2014 and July 8, 2014. Information was also submitted August 6, 2014 to the SCDHHS email list-serve and the SCDHHS website, and comments were solicited through September 5, 2014. SCDHHS conducted four regional meetings to discuss the proposed waiver renewals for public input on August 12, 2014 (Columbia); August 14, 2014 (Charleston); August 19, 2014 (Florence); and August 21, 2014 (Greenville). Public comment was gathered from the public meetings listed above, from electronic communications sent to SCDHHS, and from any communications mailed to SCDHHS. Additionally, the South Carolina Department of Disabilities and Special Needs (SCDDSN) announced the information about the waiver renewal at their July 17, 2014 Commission Meeting.

-Public notice on the ID/RD waiver renewal and waiver transition plan, including the draft waiver application document and the waiver transition plan document, was posted on the following websites in August 2015:
o SCDHHS website (https://www.scdhhs.gov/public-notices)
o SCDDSN website (www.ddsn.sc.gov)
o Family Connections website (www.familyconnectionsc.org)
o South Carolina Developmental Disabilities Council website (www.scddc.state.sc.us)

-Public notice on the ID/RD waiver renewal and waiver transition plan was sent out via the SCDHHS listserv in August 2015.
-Printed public notice on the ID/RD waiver renewal and waiver transition plan was posted at SCDHHS Jefferson Square/Headquarters Lobby in August 2015.
-Printed copy of the ID/RD waiver renewal document and waiver transition plan document were made available for public view and comment at SCDHHS Jefferson Square/Headquarters Lobby in August 2015.
-Printed copies of public notice on the ID/RD waiver renewal and waiver transition plan, including a printed copy of the draft waiver application document and waiver transition plan document, were provided in all 46 Healthy Connections Medicaid County Offices in August 2015.
-Public comments were submitted to SCDHHS and were reviewed and taken into consideration for the waiver renewal and its transition plan.

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

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

7. Contact Person(s)

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

Last Name:

	Atwood
First Name:	Anita
Title:	Program Coordinator II
Agency:	SC Department of Health and Human Services
Address:	PO Box 8206
Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29202
Phone:	(803) 898-4641 **Ext:** ☐ **TTY**
Fax:	(803) 255-8204
E-mail:	Atwood@scdhhs.gov

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

Last Name:	Orner
First Name:	Ben
Title:	Program Coordinator
Agency:	SC Department of Disabilities and Special Needs
Address:	PO Box 4706
Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29240
Phone:	(803) 898-9729 **Ext:** ☐ **TTY**
Fax:	(803) 898-9660
E-mail:	borner@ddsn.sc.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Soura

First Name: Christian

Title: State Director

Agency: South Carolina Department of Health and Human Services

Address: 1801 Main Street

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202

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

Fax: (803) 898-4515

E-mail: Christian.Soura@scdhhs.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

-January 1, 2015 ID/RD Renewal contains updates to address operational issues and service delivery in addition to the HCBS Final Rule as required by the Centers for Medicaid and Medicare Services (CMS).

-Psychological services is being removed from the waiver in favor of State Plan services covered by Rehabilitative Behavioral Health Services. Those individuals currently receiving Psychological services through the waiver will be assisted to transition to other services, if needed, subsequent to the approved waiver renewal. In the future event that a participant's health and safety cannot be assured within specified service limits of the waiver, his/her WCM/EI provider will assist in identifying alternate services and supports available in the community. Placement in an ICF/IID may also be a preferred or necessary option.

-The State will be adding an anticipated number of participants for the first year of the waiver based on the approved legislature allocated funding for SFY 2015 and continues discussions with the legislature for an anticipated number of participants for the second year of the waiver, SFY 2016.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

South Carolina Department of Health and Human Services
Intellectually Disabled and Related Disabilities (ID/RD) Waiver
Transition Plan
July 2015

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

CMS requires that each state submit a "Transition Plan" for each waiver renewal or amendment. The Transition Plan outlines how the state will come into conformance and compliance with the HCBS Rule settings requirements. Once any waiver renewal or amendment is submitted to CMS with the waiver specific Transition Plan, the state must then submit, 120 days later, a "Statewide Transition Plan" that outlines how the state will come into conformance with the new requirements of the HCBS Rule. States must come into full compliance with HCBS Rule requirements by March 17, 2019.

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

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

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

Communications and Outreach – Public Notice Process

Initial Plan Development
SCDHHS formed a workgroup to address and solicit input on how the state could come into compliance with the HCBS rule, including the ID/RD waiver renewal. This group is composed of members from:
• SC Department of Health and Human Services
• SC Department of Mental Health
• SC Department of Disabilities and Special Needs
• SC Vocational Rehabilitation Department
• Advocacy groups:
o AARP
o Family Connections
o Protection & Advocacy
• Providers:
o Local Disabilities and Special Needs Boards
o Housing providers for the mentally ill population
o Adult Day Health Care Providers
o Private providers of Medicaid and HCBS services
• Beneficiaries and family members

The large workgroup broke into sub-groups to address different tasks of coming into compliance with the HCBS Rule, including a waiver renewal workgroup. The large group meets monthly to discuss the progress of the sub-groups and to examine issues, concerns and the overall vision of how the state can come into compliance with the new regulation.

Public Notice and Comment on Waiver Renewal
SCDHHS has developed policy to provide multiple methods of public notice and input on waiver renewals which also includes its accompanying transition plan.
• The Medical Care Advisory Committee (MCAC) was provided advisories on the HCBS Rule and the ID/RD waiver renewal and transition plan on May 13, 2014 and July 8, 2014.
• Per 42 CFR 441.304 (f) (4), Tribal Notification was provided on June 5 and June 23, 2014. A Tribal Notification conference call for the waiver renewal and transition plan was held June 25, 2014.
• Public notice for comment on the ID/RD waiver renewal and transition plan was posted on the SCDHHS website on Aug. 6, 2014.
• Public notice for comment on the ID/RD waiver renewal and transition plan was sent out via the SCDHHS listserv on Aug. 6, 2014.
• Four public meetings were held to discuss the ID/RD waiver renewal and its transition plan, as well as the HCBS Rule and what it means for South Carolina beneficiaries. These meetings were held in August 2014 on the ID/RD waiver renewal and the HCBS Rule in the following cities:
o Columbia, SC Aug. 12, 2014
o Charleston, SC Aug. 14, 2014
o Florence, SC Aug. 19, 2014
o Greenville, SC Aug. 21, 2014
• Public notice on the ID/RD waiver renewal and waiver transition plan, including the draft waiver application document and

the waiver transition plan document, was posted on the following websites in August 2015:
o SCDHHS website (https://www.scdhhs.gov/public-notices)
o SCDDSN website (www.ddsn.sc.gov)
o Family Connections website (www.familyconnectionsc.org)
o South Carolina Developmental Disabilities Council website (www.scddc.state.sc.us)
• Public notice on the ID/RD waiver renewal and waiver transition plan was sent out via the SCDHHS listserv in August 2015.
• Printed public notice on the ID/RD waiver renewal and waiver transition plan was posted at SCDHHS Jefferson Square/Headquarters Lobby in August 2015.
• Printed copy of the ID/RD waiver renewal document and waiver transition plan document were made available for public view and comment at SCDHHS Jefferson Square/Headquarters Lobby in August 2015.
• Printed copies of public notice on the ID/RD waiver renewal and waiver transition plan, including a printed copy of the draft waiver application document and waiver transition plan document, were provided in all 46 Healthy Connections Medicaid County Offices in August 2015.
• Public comments will be gathered from the public meetings listed above, from electronic communications sent to SCDHHS and from communications mailed to SCDHHS.
-SCDHHS will review the comments and incorporate any appropriate changes to the waiver renewal and its transition plan based on public comments.

Assessment of Regulations, Policies, Licensing Standards, and Other Provider Requirements

Process of System-Wide Review
As part of the larger scope of the Statewide Transition Plan, SCDHHS reviewed the regulations, policies, standards, and other provider requirements that directly impact home and community-based settings. The list of regulations, policies, etc., was separated according to HCB setting. They were read and reviewed to determine that the regulation, policy, etc. is not a barrier to the settings standards outlined in the HCBS Rule.
The list of laws, regulations, etc., was separated according to HCB setting. They were read and reviewed to determine that the law, regulation, etc. is not a barrier to the settings standards outlined in the HCBS Rule. The settings for South Carolina are divided as follows:
• Day Facilities
• Adult Day Health Care Centers
• Residential settings (serving individuals with intellectual disabilities or related disabilities that are served through the ID/RD Waiver):
o Community Training Home I
o Community Training Home II
o Supervised Living Program II
o Supported Living Program I
o Community Residential Care Facilities

A report was developed detailing the relevant laws, regulations, policies, standards, and directives that correspond with each HCBS settings requirement. A committee of external stakeholders (including providers, advocates, and other state agencies) reviewed the system-wide assessment and document. That group provided feedback to verify the findings of the SCDHHS review.

Outcomes of System-Wide Review
As part of the Statewide Transition Plan, the following standards, rules, requirements, law, regulations, and policies were assessed:
1. Adult Protection, S.C. Code Ann. §§ 43-35-5 et seq.
2. Department of Health and Human Services, S.C. Code Ann. §§ 44-6-10 et seq.
3. South Carolina Intellectual Disability, Related Disabilities, Head Injuries, and Spinal Cord Injuries Act, S.C. Code Ann. §§ 44-20-10 et seq.
4. Rights of Mental Health Patients, S.C. Code Ann. §§ 44-22-10 et seq.
5. Rights of Clients with Intellectual Disability, S.C. Code Ann. §§ 44-26-10 et seq.
6. Bill of Rights for Residents of Long-Term Care Facilities, S.C. Code Ann. §§ 44-81-10 et seq.
7. Community Residential Care Facilities, S.C. Regs. 61-84
8. Day Care Facilities for Adults, S.C. Regs. 61-75
9. Department of Disabilities and Special Needs, S.C. Regs. Chapter 88
10. Department of Health and Human Services S.C. Regs. Chapter 126
11. SC DDSN Standards

a. SCDDSN Day Standards (All services)
b. SCDDSN Residential Habilitation Standards
c. SCDDSN Residential Licensing Standards
d. Licensing Day Facilities Standards
e. CLOUD Licensing Standards
f. HASCI Division Rehabilitation Supports Standards
12. SCDDSN Directives
a. Behavior Support, Psychotropic Medications, and Prohibited Practices (600-05-DD)
b. SCDDSN Certification & Licensure of Residential & Day Facilities and New Requirements For DHEC Licensed CRCFs (104-01-DD)
c. Concerns of People Who Receive Services: Reporting and Resolution (535-08-DD)
d. Confidentiality of Personal Information (167-06-DD)
e. Consumer Elopement (100-10-DD)
f. Critical Incident Reporting (100-09-DD)
g. SCDDSN Quality Assurance Reviews for Non-ICF/ID Programs (104-03-DD)
h. SCDDSN Waiting List (502-02-DD)
i. Death or Impending Death of Persons Receiving Services from SCDDSN (505-05-DD)
j. Family Involvement (100-17-DD)
k. Human Rights Committee (535-02-DD)
l. Individual Clothing and Personal Property (604-01-DD)
m. Individual Service Delivery Records Management (368-01-DD)
n. Insuring (sic) Informed Choice in Living Preference for Those Residing in ICFs/ID (700-03-DD)
o. Management of Funds for People Participating in Community Residential Programs (200-12-DD)
p. Obtaining Consent for Minors and Adults (535-07-DD)
q. Personal Funds Maintained at the Residential Level (200-01-DD)
r. Preventing and Responding to Disruptive Behavior and Crisis Situations (567-04-DD)
s. Preventing and Responding to Suicidal Behavior (101-02-DD)
t. Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency (534-02-DD)
u. Review and Approval of Research Involving Persons Receiving Services from or Staff Employed by the SC Department of Disabilities and Special Needs (535-09-DD)
v. Sexual Assault Prevention, and Incident Procedure Follow-up (533-902-DD)
w. Social-Sexual Development (536-01-DD)
x. Supervision of People Receiving Services (510-01-DD)
y. Transition of Individuals from SCDDSN Regional Centers to Community (502-10-DD)
13. SCDDSN Policy Manuals
a. Day Services Manual
b. Head and Spinal Cord Injury (HASCI) Waiver Manual
c. Intellectual Disability and Related Disabilities (ID/RD) Waiver Manual
d. Pervasive Developmental Disorder Waiver Manual
e. Community Supports (CS) Waiver Manual
f. Human Rights Committee Training Resource Manual
14. SCDHHS Provider Manuals
a. CLTC Provider Manual
b. SC Medicaid Policy and Procedures Manual
After a review of these sources, SCDHHS has identified the following areas as not being fully compliant with the Federal settings regulations and will seek specific action to come into compliance:
1. SC Code Ann. § 44-20-420: “The director or his designee may designate the service or program in which a client is placed. The appropriate services and programs must be determined by the evaluation and assessment of the needs, interests, and goals of the client.”
a. This law is only partially compliant with 42 C.F.R. 441.301(c) (4) (iv). Having the director or his designee designate the services or program in which a client is placed does not optimize an individual’s initiative, autonomy, and independence in making life choices. However, this law only gives the director the authority to designate services or programs for an individual and does not mandate that they do so, and because of that, SCDHHS does not foresee having to ask the South Carolina General Assembly to make changes to this law. Additionally, the effect of this law is mitigated by the person-centered service process that places an individual in the center of the service planning process and empowers them to make their own choices as to which services they are provided and by whom.
2. SC Code Ann. § 44-20-490: “When the department determines that a client may benefit from being placed in an employment situation, the department shall regulate the terms and conditions of employment, shall supervise persons with intellectual disability, a related disability, head injury, or spinal cord injury so employed, and may assist the client in the

management of monies earned through employment to the end that the best interests of the client are served."
a. This law is not compliant with 42 C.F.R. 441.301(c) (4) (iv). Having the director or his designee determine that a client may benefit from being placed in an employment situation, and then regulating the term and conditions of that employment does not optimize an individual's initiative, autonomy, and independence in making life choices. The language of this statute reflects the role given to SCDDSN under current legislation. While it may not reflect policy or practice within the disabilities community, it may be mitigated through policy changes at the administrative level to better reflect current practices and to ensure an individual's autonomy is not curtailed. Administrative action will be explored prior to seeking any legislative action.
3. SCDDSN Day Services Standards & SCDDSN Waiver Policy Manuals: Day/Support/Community Services "will only be provided in or originate from facilities licensed by SCDDSN as Day Facilities. SCDDSN Day Services will only be provided by SCDDSN qualified Day Service providers."
a. This standard/policy is not fully compliant with 42 C.F.R. 441.301(c) (4) (ii). Having day services only provided or originating from facilities licensed by SCDDSN does not give an individual the option to select a non-disability specific setting in which to receive this service. It is recommended that this standard be updated to comply with federal regulations.
4. SCDDSN Waiver Policy Manuals: "Career Preparation Services will only be provided in or originate from facilities licensed by SCDDSN as Day Facilities."
a. This standard/policy is not fully compliant with 42 C.F.R. 441.301(c) (4) (ii). Having day services only provided or originating from facilities licensed by SCDDSN does not give an individual the option to select a non-disability specific setting in which to receive this service. It is recommended that this policy be updated to comply with federal regulations.
5. SCDDSN Directive 200-01-DD, Personal Funds Maintained at the Residential Level: "A locking cash box shall be maintained in a secure location at each residence for the sole purpose of securing cash for the people living there. Access to the cashbox shall be limited to a minimum level of staff."
a. This directive is not fully compliant with 42 C.F.R. 441.301(c) (4) (i) and is not fully compliant with 42 C.F.R. 441.301(c) (4) (iv). Storing an individual's personal cash in a cash box collectively with other residents' money, and that cash box is only accessible by a limited number of staff, does not optimize an individual's autonomy and does not allow an individual to control personal resources. This places a barrier on an individual's free use of their own money and may create a situation where an individual has to justify the use of their own money to a staff member to gain access to it. There may be situation where an individual may not be able to personally manage their own funds without causing harm to themselves, but this needs to be documented in their person centered service plan. Having a directive that applies to all individuals may unnecessarily restrict an individual's autonomy and control over their own resources. It is recommended that this directive be updated to comply with federal regulations.
6. SCDDSN Directive 200-120-DD, Management of Funds for People Participating in Community Residential Programs: "Personal funds should be managed under the direction of the provider except in the following situations: 1) A different representative payee has already been established for a person, or 2) An assessment of the person's abilities clearly demonstrates that he/she has the cognitive ability and financial skills to manage his/her funds."
a. This directive is not fully compliant with 42 C.F.R. 441.301(c) (4) (i) and is not fully compliant with 42 C.F.R. 441.301(c) (4) (iv). Having the default protocol put an individual's personal funds under the control of the provider does not optimize an individual's autonomy and does not allow an individual to control personal resources. There may be a situation where an individual, or their personal representative, consents to having the provider act as the representative payee for personal funds, but this should be the exception and not the rule as it is currently stated in this directive. It is recommended that this directive be updated to comply with federal regulations.
7. SCDDSN Directive 533-902-DD, Sexual Assault Prevention, and Incident Procedure Follow-up: "The family/guardians/family representative of both alleged perpetrator and victim should be notified of the incident as soon as possible by the Facility Administrator/Executive Director (or designee)."
a. This directive is not fully compliant with 42 C.F.R. 441.301(c) (4) (iii) and it is not fully compliant with 42 C.F.R. 441.301 (c) (4) (iv). It is recommended that this directive and any underlying statutes be reviewed to determine if revisions are necessary to comply with federal regulations.
8. SCDHHS Policy, Waiver Documents, and SCDDSN Medicaid Waiver Policy Manuals Medicaid HCB Waiver Policy Regarding Waiver Services Provided while Clients Travel Out-of-State: "[…] Waiver participants may travel out of state and retain a waiver slot under the following conditions: the trip is planned and will not exceed 90 consecutive days; the participant continues to receive a waiver service consistent with SCDDSN policy; the waiver service received is provided by a South Carolina Medicaid provider; South Carolina Medicaid eligibility is maintained. During travel, waiver services will be limited to the frequency of service currently approved in the participant's plan. Services must be monitored according to SCDDSN policy. The parameters of this policy are established by SCDHHS for all HCB Waiver participants."
a. This policy does not specifically touch on any of the home and community-based settings requirements, but it may be an unnecessary restriction on an individual with disabilities. This policy may need further review.
All other laws, regulations, standards, directives, and policies reviewed were either supporting of or not objecting to the home and community-based settings regulations and no further action needs to be taken.

Actions to Bring System into Compliance

For any relevant state laws that do not meet the HCBS settings requirements outlined in the Code of Federal Regulations (CFR), changes will be pursued as appropriate and noted above.

For any relevant regulations that do not meet the HCBS settings requirements outlined in the CFR, changes will be pursued as appropriate and noted above and in accordance with the "Regulatory Process in South Carolina."

For any relevant SCDHHS policies that do not meet the HCBS setting requirements outlined in the CFR, SCDHHS will utilize its internal process for initiating or revising policies.

For any relevant external policies, standards, or directives that do not meet the HCBS setting requirements outlined in the CFR, SCDHHS will work with the appropriate external agency to revise them to reflect the standards in the CFR.

Ongoing Compliance of System
Compliance will be monitored on an on-going basis per SCDHHS policies. This includes, but is not limited to, SCDHHS internal policy review process, provider enrollment and revalidation requirements as well as program area policies, quality assurance standards and indicators, and provider qualification requirements.

Assessment of Settings

Setting Types
There are three primary settings where home and community-based services are provided in the ID/RD waiver, excluding private residences.
Day Facilities. There are approximately 90 day program facilities across the state that provide various day services to ID/RD waiver participants. Most of these are licensed as an Adult Activity Center (AAC) and/or a Work Activity Center (WAC). This does not include Adult Day Health Care facilities. There are approximately 3000 waiver participants who use day program facilities to facilitate the use of various day services assessed in their service plan.
Adult Day Health Cares (ADHC). There are currently 83 Adult Day Health Care facilities that are available for ID/RD waiver participants to use across the state. There are approximately 200 waiver participants who use ADHC as part of their service plan.
Residential Homes. There are approximately 1200 residential settings. Participants in this waiver have options as to where they live, based on need and availability. Participants can live at home, or in a residential placement like a Community Training Home (CTH) or a Supervised Living Program (SLP). There are five types of residential facilities available through the ID/RD waiver.
Supervised Living Program II (SLP II). This model is for individuals who need intermittent supervision and supports who are able to achieve most daily activities independently but periodically may need advice, support and supervision. It is typically offered in an apartment setting that is integrated into a community. Staff is available on-site or in a location from which they may be on the site within 15 minutes of being called, 24 hours daily.
Supported Living Program I (SLP I). This model is similar to the Supervised Living Model II; however, individuals generally require only occasional support. It is offered in an apartment setting and staff are available 24 hours a day by phone.
Community Training Home I (CTH I). In the Community Training Home I Model, personalized care, supervision and individualized training are provided, in accordance with a person-centered service plan, to a maximum of two people living in a support provider's home where they essentially become one of the family. Support providers are qualified and trained private citizens.
Community Training Home II (CTH II). The Community Training Home II Model offers the opportunity to live in a homelike environment in the community under the supervision of qualified and trained staff. Care, supervision and skills training are provided according to individualized needs as reflected in the person-centered service plan. No more than four people live in each residence.
Community Residential Care Facility (CRCF). This model, like the Community Training Home II Model, offers the opportunity to live in the community in a homelike environment under the supervision of qualified, trained caregivers. Care, supervision and skills training are provided according to identified needs as reflected in the service plan.

The number of each type of facility and the number of waiver participants served is provided in the table below:

Table 1.1 Residential Type and Approximate Number of Participants served

Residential Type	Number of Residences	Approximate Number of Waiver Participants Served
SLP II	413	461
SLP I	219	200
CTH I	159	174
CTH II	666	2,511

CRCF 49 402
TOTAL 1506 3,748

Setting Assessment Process
The setting assessment process is part of the overall process detailed in the Statewide Transition Plan. The C4 Individual Facilities/Settings Assessment process and the Waiver Participant Surveys are detailed here.
C4 Individual Facilities/Settings Assessment. The C4 assessment is designed to evaluate individual facilities to determine compliance with the HCBS criteria outlined in 42 CFR Part 441.301(c) (4).
Development of the assessment tools and criteria. Two assessment tools were developed for individual facilities: one for residential facilities and another for day (non-residential) facilities. The criteria used to create these tools is outlined in the 42 CFR Part 441.301(c) (4). Additionally, SCDHHS used the exploratory questions issued by CMS for the settings requirements. The assessment tools will be used in two ways to measure individual facilities. First, they will be used by providers to complete the self-assessment of individual facilities. Second, SCDHHS or a contracted vendor will use the tools as an independent assessment during site visits. The setting-specific assessments are online tools. For providers who may not have internet access, SCDHHS will provide paper copies.
SCDHHS conducted a pilot test of the setting-specific assessment tools to determine reliability and decide if any revisions need to be made prior to distributing to providers. Testing the pilot was conducted with providers who own or operate home and community-based settings. The testing process also aided in the development of clear instructions on how to complete the assessment. Pilot testing began in January 2015 and was completed in March 2015.
Resources to conduct assessments and site visits. Resources to conduct the assessments will come from SCDHHS personnel and financial resources as well as individual provider personnel and financial resources.
SCDHHS sent electronic notification of the individual facility assessment process to providers in April 2015. Following the notification the agency sent individual letters to providers with instructions on how to conduct the setting-specific assessments in May 2015. For providers who may not have internet access, paper copies of the assessment tools were made available to them.
Individual letters were sent on May 15, 2015, to all ID/RD residential and non-residential providers with instructions on how to complete that assessment within a 45 calendar day time frame. The deadline, which was July 1, 2015, was established based on the letter's approximate day of delivery to providers. All day (non-residential) settings will be assessed. Due to the large number of residential settings and limited SCDHHS resources, each residential provider conducted a self-assessment of a representative sample of their residential settings, as determined by SCDHHS. It is expected that each ID/RD residential provider conduct a self-assessment on all of their residential settings to determine its level of compliance and establish any steps that may be needed to come into compliance if there are deficiencies.
Individual site visits will occur during after the provider self-assessments. These site visits will be on individual ID/RD settings and will be conducted by SCDHHS or a contracted vendor. All day (non-residential) settings will be subject to an independent site visit. Providers of ID/RD residential services only completed self-assessments on a representative sample of their settings as determined by SCDHHS. Any residential setting from a provider may be subject to a site visit. Any setting, residential or non-residential, that self-identified through the C5 assessment as potentially being subject to the heightened scrutiny process will be subject to an independent site visit.
Timeframe to conduct assessments and site visits. Each part of the assessment process has an estimated time for completion. These time frames are based on personnel and financial resources and may vary.
Providers had 45 calendar days to complete and return the self-assessment for the settings they own and/or operate to SCDHHS. The deadline was established based on the letter's approximated day of delivery to providers.
Independent site visits are anticipated to take approximately 12 months to complete. This timeframe will begin once either SCDHHS or a contracted vendor is confirmed as the entity who will conduct the site visits. The site visits will start later than the provider self-assessment time frame.
Assessment review. SCDHHS will individually review all setting-specific assessments to determine if each setting is or is not in compliance. To determine the level of compliance or non-compliance, SCDHHS will use the data collected during both the provider self-assessment and the independent site visit assessment. Providers will receive written feedback from SCDHHS on each setting after the assessments are reviewed. SCDHHS' goal is to complete the assessment review within 12 months from the start of the independent site visits.

Waiver Participant surveys. Waiver participant experience and satisfaction surveys are waiver specific and ask questions directly of the waiver participant/Primary Contact about their experiences with services in the waiver and their satisfaction level with those services. There is a survey for ID/RD waiver participants.
Development of the assessment tools and criteria. This survey is created and conducted by an external contracted entity. The survey will be reviewed and any supplemental questions may be added as they relate to the standards listed in 42 CFR Part 441.301(c) (4).
Resources to conduct assessments. Resources to conduct the surveys will come from SCDHHS personnel and financial resources as well as the contracted vendor's personnel and financial resources.
SCDHHS has contracted with an external entity and they are currently developing the ID/RD waiver participant experience

and satisfaction survey.
Timeframe to conduct assessments. Each part of the assessment process has an estimated time for completion. These time frames are based on personnel and financial resources and may vary.
The agency anticipates that the ID/RD waiver participant experience and satisfaction survey will be completed in 2015 per the contract requirements.
Assessment review. SCDHHS will review all relevant data gathered from the ID/RD waiver participant experience and satisfaction survey to aid in determining where settings may or may not be in compliance.

Outcomes
C4 Individual Facilities/Settings Assessment. As individual facilities are assessed and reviewed, SCDHHS will compile that data to submit to CMS. Upon completion, SCDHHS will be able to show what percentage of facilities, by type, meet the settings criteria and what percentage do not.

Waiver Participant surveys. When the ID/RD waiver participant experience and satisfaction survey is completed, SCDHHS will review the data and determine if any changes are needed in waiver policies or procedures. Additionally, the agency will use the data to assist providers as they develop their action plans for compliance.

Actions for facilities deemed not in compliance
SCDHHS will develop an individualized response for each facility to the self-assessment and site visit. The agency will leverage responses from the self-assessment and site visit to identify gaps in compliance. Providers create an action plan for their facility and indicate how they will bring it into compliance with the requirements. The action plan must include a timeframe for completion and be submitted to SCDHHS for approval within 30 days of receiving the written notice.

SCDHHS, or a contracted vendor, will conduct site visits to monitor the progress of those providers who must come into compliance. These will occur after a facility's action plan has been approved by SCDHHS, but before the March 2019 compliance deadline.

Ongoing compliance
Compliance will be monitored on an on-going basis per SCDHHS policies. This includes, but is not limited to, provider enrollment and revalidation requirements as well as program area policies, quality assurance standards and indicators, and provider qualification requirements.

The State also has a transition plan timeline table that will be submitted separately to our SCDHHS website link and the CMS website link Waiver Page:
Public Notice Page: https://www.scdhhs.gov/public-notices

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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

DHHS and DDSN are implementing an administrative contract regarding the operation and administration of the ID/RD, HASCI, PDD, and CS waivers to facilitate the delivery of Medicaid waiver services, and state plan

services. It is the intent of both parties to enhance interagency communication and coordination.

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

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

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

The following describes the roles of each entity:

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

-DHHS QA staff: Conducts periodic quality assurance reviews. These reviews focus on the CMS quality assurance indicators and performance measures. A report of findings is provided to DDSN, who is required to develop and implement a remediation plan, if applicable, within 45 days.

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

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

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

Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   DDSN contracts with a CMS-certified QIO for oversight and review of waiver services and providers participating in this waiver.

   DHHS contracts with a CMS-certified QIO to validate a representative sample of ICF/IID level of care determinations made by DDSN.

DDSN contracts with the Jasper County Board of Disabilities and Special Needs to operate as the fiscal agent for the self-directed Adult Attendant Care Program.

DHHS contracts with an independent entity to periodically perform consumer satisfaction surveys, focused evaluations, validation reviews and trend analysis.

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

DDSN contracts with local Disabilities and Special Needs (DSN) Board providers. Waiver case managers and early intervention staff at local Disabilities and Special Needs Boards prepare the Plans of Service and complete reevaluations of ICF/IID levels of care.

DDSN contracts with the Jasper County Board of Disabilities and Special Needs to operate as the fiscal agent for the self-directed Adult Attendant Care Program.

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

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

DDSN contracts with approved /qualified private providers for waiver case managers/early intervention staff members, who prepare the Plans of Service and complete level of care reevaluations.

Appendix A: Waiver Administration and Operation

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

DHHS QA staff will conduct quarterly reviews of the waiver operational functions performed by DDSN and any of its contracted local/regional non-state entities, in addition to assessing the performance of contracted entities in conducting waiver administrative functions.

DHHS Quality Assurance (QA) staff will conduct quarterly reviews of waiver operational functions performed by the DHHS contracted local/regional non-state entities, in addition to assessing the performance of contracted entities in conducting administrative functions.

Additionally, upon request, DHHS Medicaid Program Integrity also conducts provider reviews.

Appendix A: Waiver Administration and Operation

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

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

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

DHHS will utilize: 1) a Quality Improvement Organization (QIO) to conduct reviews of a representative sample of initial Level of Care Determinations performed by DDSN; 2) QA staff to conduct periodic quality assurance focus reviews on the CMS quality assurance indicators and performance measures; and 3) Other DHHS Staff to conduct utilization reviews of DDSN/DSN Boards/qualified providers as warranted. DDSN is to take remedial actions within 45 days upon receipt of the report of findings from DHHS.

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

Appendix A: Waiver Administration and Operation

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

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

Participant waiver enrollment	☑	☑	☐	☑
Waiver enrollment managed against approved limits	☑	☑	☐	☑
Waiver expenditures managed against approved levels	☑	☑	☐	☑
Level of care evaluation	☑	☑	☐	☑
Review of Participant service plans	☑	☑	☑	☑
Prior authorization of waiver services	☑	☑	☐	☑
Utilization management	☑	☑	☐	☑
Qualified provider enrollment	☑	☑	☐	☐
Execution of Medicaid provider agreements	☑	☑	☑	☑
Establishment of a statewide rate methodology	☑	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Policy changes related to the ID/RD waiver are approved by DHHS prior to implementation. N = the number of waiver policy changes approved by DHHS prior to implementation. / D = the total number of changes implemented.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Policy/Memo/Bulletin/etc.

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

Data Aggregation and Analysis:

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

Performance Measure:

Residential programs will complete self-assessments per the HCBS settings requirements as required by DHHS. N = The number of residential programs that complete the self-assessments as required by DHHS. D = The total number of Residential program providers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Day programs will complete self-assessments per the HCBS settings requirements as required by DHHS. N = the number of day programs that complete the self-assessments as required by DHHS. D = the total number of day programs providers.

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

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

Data Aggregation and Analysis:

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

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHHS produces reports of findings based on reviews. These reports are shared with DDSN to address identified issues, as warranted, through a remediation plan, which may include training, policy corrections, or financial adjustments for Federal Financial Participation. The report of findings identifies issues such as untimely level of care re-evaluations, incomplete service plans, and/or incorrect billings to Medicaid. DDSN is responsible for developing and implementing remedial actions to prevent future occurrences of the same issues.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - **Other**

    Specify:

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

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

  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:

At the time of waiver enrollment the individual/family is informed that the waiver, apart from Residential Habilitation, is not a source of 24 hour care, advised of any waiver service limits noted in Appendix C, and makes an informed decision as to whether the waiver is the appropriate form of long term care services. Any participant denied admission to the waiver due to expected high costs is given the opportunity to appeal this denial.

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:

To avoid an adverse impact on the participant, services in the excess of the individual cost limit may be authorized if approved by SCDHHS. The State will assure that, in the aggregate, the cost of this waiver will not exceed the cost of care in an ICF/IID. If the individual’s health remains unstable, and/or the waiver is unable to meet the newly assessed needs, the participant will receive assistance with transitioning to another form of long term care, and will receive appeal rights.

☐ **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	7830
Year 2	8630
Year 3	9230
Year 4	9630
Year 5	9830

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	7630
Year 2	8430
Year 3	9030
Year 4	9430
Year 5	9630

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
ICF/IID discharges;foster care child/youth;CS waiver transfers; indiv.at imminent risk/harm;DDSN sponsored,licensed, or certified community-based housing

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):*

ICF/IID discharges;foster care child/youth;CS waiver transfers; indiv.at imminent risk/harm;DDSN sponsored,licensed, or certified community-based housing

Purpose *(describe):*

Capacity will be reserved for the following individuals:

1-Discharged from an ICF/IID;

2-Children and youth served by the South Carolina Department of Social Services (DSS) Foster Care (FC) program;

3-Participants transferring from the Community Supports (CS) waiver program according to policy.

4-Individuals requiring a service through the waiver, which if not provided, will likely result in serious and imminent harm; AND has an immediate need for direct care or supervision, which directly relates to the person's disability; OR has recently lost a primary caregiver or is at imminent risk of losing a primary caregiver; OR is ready for or has recently been discharged from a hospital and needs services immediately to prevent readmission.

5-Individuals admitted to community-based housing sponsored, licensed, or certified by the South Carolina Department of Disabilities and Special Needs needing waiver supports and services.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on previous utilization for these purposes.

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

Waiver Year	Capacity Reserved
Year 1	400
Year 2	400
Year 3	400
Year 4	400
Year 5	400

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:

All applicants are required to be South Carolina Medicaid eligible, or have proof of Medical Assistance Only (MAO) and will be admitted to the waiver on a first-come, first-served basis by date of application.

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

In addition, applicants in the following situations will be enrolled on a priority basis (bypassing the waiting list):

1) Individuals discharged from an ICF/IID, if the enrollment process is begun within 30 days of discharge.

2) Children and youth served by the South Carolina Department of Social Services Foster Care Program.

3) Participants enrolled in the Community Supports (CS) Waiver Program with newly changed circumstances that will require long term/ongoing needs that will exceed the individual cost limit of the CS Waiver.

4) Individuals requiring a service through the waiver, which if not provided, will likely result in serious and imminent harm; AND has an immediate need for direct care or supervision, which directly relates to the person's disability; OR has recently lost a primary caregiver or is at imminent risk of losing a primary caregiver; OR is ready for or has recently been discharged from a hospital and needs services immediately to prevent readmission.

5) Individuals admitted to community-based housing sponsored, licensed, or certified by the South Carolina Department of Disabilities and Special Needs needing waiver supports and services.

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 7)

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box

should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the State plan**

Select one:

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

(*select one*):

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

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

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

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

Specify:

- **Other**

Specify:

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

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

Select one:

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

Specify:

State Plan: Supplement 3 to attachment 2.6-A

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:
- ○ **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate 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 (6 of 7)

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- (●) **Other**

Specify:

This waiver uses the ICF/IID level of care when assessing potential waiver eligibility. The initial level of care evaluation is performed by the DDSN Consumer Assessment Team (CAT). LOC reevaluations are completed by waiver case managers and early intervention (WCM/EI) providers. In some instances reevaluations are conducted by the CAT. Internal policy dictates when this is necessary.

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 and 3 years of experience in the practice of Applied Psych subsequent to 1 year graduate work of at least 30 hours in Psych; or Master's degree in Applied Psych and 5 years of 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.

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

1. The person has a confirmed diagnosis of mental retardation, OR a related disability as defined by 42 CFR § 435.1010 and S.C. Code Ann. § Section 44-20-30.
"
"Intellectual Disability" means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which is defined as prior to the age of 22.

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

• It is attributable to cerebral palsy, epilepsy, autism or any other condition other than mental illness found to be closely related to mental retardation because this condition results in impairment similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons.
• It is manifested before 22 years of age.
• It is likely to continue indefinitely.
• It results in substantial functional limitations in 3 or more of the following areas of major life activities: 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 effects/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/ID.

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

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

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under**

the State Plan.

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

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

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

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

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

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

  Conducted at least annually (within 365 days from the date of the previous level of care 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:

  WCM/EI providers must hold a Bachelor’s degree or higher in a Health or Human Services field plus one year of experience with services to people with disabilities and special needs and/or with case management services; OR a Bachelor's degree or higher in a field unrelated to the Health or Human Services field plus two years of experience with services to people with disabilities and special needs and/or case management services; OR be a Registered Nurse licensed in the State of South Carolina plus have one year of experience with services to people with disabilities and special needs and/or with case management services.

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

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

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

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

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

care are maintained:

Written and electronically retrievable documents are housed with qualified providers.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
ID/RD waiver enrollees have a LOC Determination completed within 30 days prior to waiver enrollment. N = the number of new ID/RD waiver enrollees whose LOC Determination was completed within 30 days prior to waiver enrollment. D = the total number of LOC Determinations for new enrollees in the ID/RD waiver.

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
LOC determinations are conducted using the appropriate criteria and instrument.
N = the number of ID/RD waiver LOC determinations that were conducted using appropriate criteria and instrument. D = the total number of ID/RD waiver LOC

determinations reviewed.

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

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

Data Aggregation and Analysis:

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

	Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When DDSN's QIO identifies problems, the provider agency being reviewed is required to submit a plan of correction to address the issues discovered. The QIO conducts a follow-up review to determine if corrections have been made. Additionally, QIO reports are reviewed by DDSN Operations staff. As needed, technical assistance is provided to providers by the Operations staff. Documentation of all technical assistance is provided to DHHS. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are provided to DHHS. On a monthly basis, the DHHS QIO randomly pulls a sample of all new LOC Determinations and Re-determinations for ID/RD participants to verify accuracy. In addition, 100% of all adverse LOC determinations are reviewed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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

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).

Prior to waiver enrollment, a written Freedom of Choice (FOC)form is secured from each waiver participant to ensure that the participant is involved in his/her long term care planning. This choice will remain in effect until the participant/guardian changes his/her mind. If the participant lacks the physical or mental ability required to make a written choice regarding care, a representative may sign the FOC form. If the FOC form is signed prior to the participants 18th birthday, the current form or a new form is signed again within 90 days following the participant's 18th birthday.

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

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

The FOC Form is maintained in the participant's record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Operating agency 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 1975 and Establishment of the Complaint Process" (700-02-DD) describes the methods DDSN utilizes to provide meaningful access to the waiver services by persons with limited English proficiency. As specified in DDSN policy, when required, WCM providers can access funds to pay for an interpreter to provide meaningful access to the waiver. Additionally, the State utilizes telephone interpreter services and written materials translation services.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Health Care, Adult Day Health Care Services
Statutory Service	Personal Care 2, Personal Care 1
Statutory Service	Residential Habilitation

Statutory Service	**Respite Care**
Statutory Service	**Waiver Case Management (WCM)**
Extended State Plan Service	**Adult Dental Services**
Extended State Plan Service	**Adult Vision**
Extended State Plan Service	**Audiology Services**
Extended State Plan Service	**Incontinence Supplies**
Extended State Plan Service	**Prescribed Drugs**
Other Service	**Adult Attendant Care Services**
Other Service	**Adult Companion Services**
Other Service	**Adult Day Health Care Nursing**
Other Service	**Adult Day Health Care Transportation**
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	**Nursing Services**
Other Service	**Personal Emergency Response System (PERS)**
Other Service	**Pest Control Bed Bugs**
Other Service	**Pest Control Treatment**
Other Service	**Private Vehicle Assessment/Consultation**
Other Service	**Private Vehicle Modifications**
Other Service	**Specialized Medical Equipment and Assistive Technology Assessment/Consultation**
Other Service	**Specialized Medical Equipment, Supplies and Assistive Technology**
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, Adult Day Health Care Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**

04 Day Services	04050 adult day health

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

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

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

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

Service Definition *(Scope):*
Services 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 functions of the individual. Authorization of services will be based on the participant's need for the service as identified and documented in his/her plan of care. Meals provided as part of this service shall not constitute a full nutritional regime (3 meals per day). Physical, occupational and speech therapies indicated in the participant'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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Providers contracted with SCDHHS

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Adult Day Health Care Providers contracted with SCDHHS

Provider Qualifications

License *(specify):*
SC Code of Laws 1976 as amended § 44-7-260

Certificate *(specify):*

Other Standard *(specify):*
SCDHHS Contract Scope of Service

Verification of Provider Qualifications

Entity Responsible for Verification:
SC Department of Health and Environmental Control (SCDHEC); SCDHHS

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:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Care 2, Personal Care 1

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Active, hands-on assistance in the performance of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to the waiver participant in his/her home; outside the home, and/or to assist an individual to function in the work place or as an adjunct to the provision of employment services, based on the determination of its need by the waiver case manager. The service location must be defined in the Plan of

Service. ADLs include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, and assistance with ambulation. If it is determined that a participant requires more than one personal care aide, this must be prior approved by SCDDSN/SCDHHS and documented on the Plan of Service. IADLs include light housework, laundry, meal preparation and shopping. These IADL activities are for the specific needs of the participant, not the general needs of the household. IADLs may also include home safety, assistance with communication, medication monitoring to include informing the participant that it is time to take medication prescribed by his/her physician or handing the participant a medication container, and limited assistance with financial matters such as delivering payments as directed by the participant on his/her behalf. Personal care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide except as allowed by the Nurse Practice Act and prior approved by a licensed physician. Authorizations to providers will be made at two different payment levels. Based on SCDDSN assessed need, the higher level service, Personal Care 2 (PC2), may be considered appropriate when the care needed is for assistance with ADLs alone or in conjunction with assistance with IADLs/home support.

Based on SCDDSN assessed need, the lower level service, Personal Care 1 (PC1), may be considered appropriate when the only needed care is for IADLs/home support activities. PC1 does not include hands-on care. Unless prior-approved, 2 aides may not be authorized for service delivery at the same time.

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

Personal Care 2 (PC2): Up to 112 units (28 hours) per week as determined by SCDDSN assessment. A unit is defined as 15 minutes of service provided by one aide. When PC2 is authorized in conjunction with Adult Attendant and/or Adult Companion, the combined total hours per week of all of these services may not exceed 28 hours per week.

Personal Care 1 (PC1): Up to 24 units (6 hours) per week as determined by SCDDSN assessment. A unit is defined as 15 minutes of service provided by one aide.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care 2, Personal Care 1

Provider Category:

Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
SCDHHS Contracted Scope of Services

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

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:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Residential habilitation services include the care, skills training and supervision provided to individuals in a non-institutional setting. The degree and type of care supervision, skills training and support of individuals will be based on the plan of care and the individual's needs. Services include assistance with acquisition, retention, or

improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act. Participants who receive Residential Habilitation paid at a daily rate are not allowed to receive the Adult Companion 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	Supported Living Providers
Agency	Residential Habilitation Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency

Provider Type:
Supported Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
SCDDSN Residential Program Habilitation Standards; Admission Criteria

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDDSN

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Residential Habilitation Providers
Provider Qualifications
License *(specify):*
Code of Laws of SC, 1976 as amended: 40-20-710 through 44-10-1000; 44-20-10 et seq.; and 44-21-10 et seq.; SC licensing regulations: mo. 61-103
Certificate *(specify):*

Other Standard *(specify):*
SCDDSN Residential Program Habilitation Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDDSN
Frequency of Verification:
Annually; DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Respite
Alternate Service Title (if any):
Respite Care

HCBS Taxonomy:

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

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

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 provided to individuals unable to care for themselves; furnished on a short –term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s):
Individual's home or place of residence, or other residence selected by the recipient/representative.
Foster home
Medicaid certified ICF/ID
Group home
Licensed respite care facility

Other community care residential facility approved by the State that is not a private residence (Specify type):
Community Residential Care Facility
Licensed Nursing Facility (NF)
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limit up to 68 hours of in-home respite/month as determined by SCDDSN assessment. In-home respite is provided outside of a Medicaid certified ICF/ID or Medicaid NF. An exception of up to 240 units per month of in-home respite may be authorized due to the following special need circumstances: 1) the caregiver's hospitalization or need for medical treatment; 2) the participant's need for constant hands-on/direct care and supervision due to a medically complex condition or severity/degree of disability; or 3) seasonal relief for those participants over age 12 who attend public school and whose parents work full time and care is needed during summer break from school. These exceptions must be approved by SCDDSN.

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	Medicaid certified nursing facility
Agency	Personal Care Provider/Respite
Agency	Medicaid certified ICF/ID
Individual	Certified Respite Caregiver
Agency	DSS licensed Foster Home

Agency	**DDSN/DSN Board/Contracted provider**
Agency	**Licensed Community Residential Care Facility**

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Medicaid certified nursing facility
Provider Qualifications
License *(specify):*
SC Code Ann. §44-7-250 thru 44-7-260 Reg. 61-17; Equivalent for NC and GA
Certificate *(specify):*

Other Standard *(specify):*
Contracted with DHHS for Institutional Respite
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

Provider Category:
Agency
Provider Type:
Personal Care Provider/Respite
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract and enroll with DHHS for respite services/personal care II services.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS
Frequency of Verification:
Upon enrollment, and at least every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Medicaid certified ICF/ID
Provider Qualifications
License *(specify):*
SC Code Ann. §44-7-250 thru 44-7-260 Reg. 61-13
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN; 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

Provider Category:
Individual
Provider Type:
Certified Respite Caregiver
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):*
SCDHHS Respite Standards 18 years of age; capable of following a care plan with minimal supervision, free from communicable diseases and able to demonstrate a competency in care for the waiver participant.

DDSN Respite Standards; DDSN Residential Habilitation Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS
DDSN
Frequency of Verification:
Upon enrollment; Annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
DSS licensed Foster Home
Provider Qualifications
License *(specify):*
SC Code Ann. §63-11-10 thru 63-11-790 (Supp 2008).
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
SC Department of Social Services
Frequency of Verification:
Prior to the provision of services; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
DDSN/DSN Board/Contracted provider
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/DDSN Residential Habilitation Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN
Frequency of Verification:
Upon enrollment and annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency

Provider Type:
Licensed Community Residential Care Facility
Provider Qualifications
License *(specify):*
S.C. Code Ann. § 44-7-260 and S.C. Code Ann. Regs. 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: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Case Management
Alternate Service Title (if any):
Waiver Case Management (WCM)

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, education and other services, regardless of the funding sources for the services to which access is gained. Waiver case managers are responsible for initiating and/or conducting the process to evaluate and/or re-evaluate the individual's level of care as specified in waiver policy. Waiver case managers are responsible for conducting assessments and service plans as specified in waiver policy. This includes the ongoing monitoring for the provision of services included in the participant's service plan. Waiver case managers are responsible for the ongoing monitoring of the participant's health and welfare, as specified in waiver policy. For waiver participants utilizing participant/representative directed-care waiver services, waiver case managers must provide supports to participants/representatives about any options and/or obligations. Case managers should ensure that all participants obtain a complete list of all qualified case manager Medicaid providers to avoid conflict of interest. Each participant is offered the choice of WCM/EI qualified providers initially and annually thereafter, and may freely change qualified providers upon request throughout the year.

Waiver case managers are responsible for documenting the choice between institutional care or home and community-based services using the approved Freedom of Choice document. Pre-enrollment activities that directly facilitate waiver enrollment for individuals leaving the facility can be conducted for 120 days prior to enrollment as part of waiver case management. Billing for these activities may not occur until after the participant is enrolled.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Case Management Provider

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Waiver Case Management Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Qualified waiver case managers must meet these standards prior to employment. The provider agency who employs the case manager is responsible for ensuring case manager qualifications. The waiver case management agency enrolls/contracts with SCDHHS.
Frequency of Verification:
Upon employment and annually per standards

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Adult Dental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*
The service is defined and described in the approved State Plan and will not duplicate any service available to adults age 21 and older in the State Plan. Items/services allowed under the waiver are the same as the standard items/services for children under age 21 covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)services mandate; items/services requiring a prior authorization are not allowed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Available to those individuals age 21 or over.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Dentists
Individual	Licensed Dental Hygienist
Agency	Licensed Dental Hygienists
Agency	Board Certified Oral Surgeons
Individual	Board Certified Oral Surgeon
Individual	Licensed Dentist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:
Agency
Provider Type:
Licensed Dentists

Provider Qualifications

License *(specify):*
Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Medicaid Enrolled Providers

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:
Individual

Provider Type:
Licensed Dental Hygienist

Provider Qualifications

License *(specify):*
Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Medicaid Enrolled Providers

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:
Agency

Provider Type:
Licensed Dental Hygienists

Provider Qualifications

License *(specify):*
Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Medicaid Enrolled Providers

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:
Agency

Provider Type:
Board Certified Oral Surgeons

Provider Qualifications

License *(specify):*
Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Medicaid Enrolled Providers

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:
Individual

Provider Type:
Board Certified Oral Surgeon

Provider Qualifications

License *(specify):*
Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Medicaid Enrolled Providers

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:
Individual

Provider Type:
Licensed Dentist

Provider Qualifications

License *(specify):*
Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Medicaid Enrolled Providers

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Adult Vision

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
This service is defined as described in the State Plan. This service will not duplicate any services available to adults in the State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Available to those participants age 21 and over.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians
Agency	Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Vision

Provider Category:
Individual
Provider Type:
Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians
Provider Qualifications
License *(specify):*
SC Code of Laws 1976 as amended; 40-37-5 thru 40-37-420 et seq.; 40-38-5 thru 40-38-390 et seq.; 40-47-5 thru 40-47-1620 et seq.
Certificate *(specify):*
Other Standard *(specify):*
Medicaid Enrolled Providers
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Vision

Provider Category:
Agency
Provider Type:
Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians
Provider Qualifications
License *(specify):*
SC Code of Laws 1976 as amended; 40-37-5 thru 40-37-420 et seq.; 40-38-5 thru 40-38-390 et seq.; 40-47-5 thru 40-47-1620 et seq.
Certificate *(specify):*
Other Standard *(specify):*
Medicaid Enrolled Providers
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Audiology Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
This service will be defined as described in the approved State Plan. This service will not duplicate any services available to adults in the State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Available to those participants age 21 or older.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Audiology Providers
Individual	Licensed Audiologists

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Audiology Services

Provider Category:
Agency
Provider Type:
Licensed Audiology Providers
Provider Qualifications
License *(specify):*
Code of Laws of SC, 1976 as amended; 40-67-10 et seq.
Certificate *(specify):*
Other Standard *(specify):*
Enrolled with SCDHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Audiology Services

Provider Category:
Individual

Provider Type:
Licensed Audiologists

Provider Qualifications

License *(specify):*
Code of Laws of SC, 1976 as amended; 40-67-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Enrolled with SCDHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Incontinence Supplies

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Diapers/briefs, 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/briefs monthly;
*up to two (2) cases of under-pads monthly;
*up to eight (8) boxes of wipes monthly;
*up to two (2) boxes of liners monthly.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Incontinence Supply Provider

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Incontinence Supply Provider
Provider Qualifications
License *(specify):*
South Carolina business license
Certificate *(specify):*
Other Standard *(specify):*
Enrolled with SCDHHS to provide incontinence supplies
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon enrollment

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Prescribed Drugs

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11060 prescription drugs
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

An extended state plan service which allows an additional two (2) prescribed drugs, per month, over the State Plan limit for those participants age 21 and over.

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

Limited to two additional drugs, per month, over the state plan limit for those participants age 21 and over. This waiver service is not allowed for participants who receive the Medicare Part D benefit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy Providers

Individual	Licensed Pharmacists

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Pharmacy Providers
Provider Qualifications
License *(specify):*
Code of Laws of SC, 1976 as amended; 40-43-30 et seq.
Certificate *(specify):*
Other Standard *(specify):*
Medicaid Enrolled Providers
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon Medicaid enrollment

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Licensed Pharmacists
Provider Qualifications
License *(specify):*
Code of Laws of SC, 1976 as amended; 40-43-30 et seq.
Certificate *(specify):*
Other Standard *(specify):*
Medicaid Enrolled Providers
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Attendant Care Services

HCBS Taxonomy:

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

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 related to the performance of activities of daily living and/or instrumental activities of daily living and personal care which may include hands-on care, of both a medical and non-medical supportive and health related nature, specific to the needs of a medically stable adult with physical and /or cognitive disabilities whom is able to self-direct their own care or has a representative who is able to direct their care. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities provided under attendant care are specified in the plan of care and are incidental to the care furnished, or are essential to the health and welfare of the adult. Any community access activities must be directly related to the adult's care and must be specified in the plan of care. Transportation is not a component of this service.

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

Up to 28 hours per week based on SCDDSN assessed need. When Adult Attendant care is authorized in conjunction with Adult Companion and/or Personal Care 2, the combined total hours per week of services may not exceed 28. The unit of service is one hour provided by one Attendant Care Aide.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Attendant Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Attendant Care Services

Provider Category:
Individual

Provider Type:
Independent Attendant Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Scope of Service as defined in the UAP/SCDDSN Contract

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDDSN/UAP

Frequency of Verification:
Upon enrollment/Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Adult Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*
Non-medical care, supervision and socialization, provided to a functionally impaired adult individual. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care but may entail hands-on assistance or training to the recipient in performing activities of daily living and independent living skills. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not diversional in nature. Reimbursement will not be made to any family members residing in the same residence as the individual.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Up to 28 hours per week based on SCDDSN assessed need. When Adult Companion is authorized in conjunction with Adult Attendant and /or Personal Care 2, the combined total hours per week of services cannot exceed 28. One unit of service equals one hour provided by one Companion worker.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSN Boards/contracted providers for Adult Companion providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:
Agency
Provider Type:
DSN Boards/contracted providers for Adult Companion providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
SCDDSN Adult Companion Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDDSN

Frequency of Verification:
Upon enrollment and 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:
Adult Day Health Care Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Adult Day Health Care Nursing Services are provided in and by the adult day health care center and are limited to the following skilled procedures: Ostomy Care, Urinary Catheter Care, decubitus/ wound care, Tracheotomy Care, Tube Feedings, Nebulizer Treatment.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult Day Health Care Nursing and Nursing Services, as defined in the ID/RD Waiver, cannot be received during the same day. Recipients must be 18 or older.

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 Providers

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Adult Day Health Care Providers
Provider Qualifications
License *(specify):*
Code of Laws of SC, 1976 as amended:44-7-260
Certificate *(specify):*
Other Standard *(specify):*
SCDHHS Contracted Providers
Verification of Provider Qualifications
Entity Responsible for Verification:
SC Department of Health and Environmental Control; SCDHHS
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:

Adult Day Health Care Transportation

HCBS Taxonomy:

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

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):*

The Adult Day Health Care Transportation service is prior-authorized for participants receiving the Adult Day Health Care (ADHC) service, who reside within 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:

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Center Providers

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Adult Day Health Care Center Providers
Provider Qualifications
License *(specify):*
Codes of Laws of SC, 1976 as amended: 44-7-260
Certificate *(specify):*

Other Standard *(specify):*
SCDHHS contracted providers
Verification of Provider Qualifications
Entity Responsible for Verification:
SC Department of Health and Environmental Control; SCDDSN
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:
Behavior Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Behavior Support are those services which use current, empirically validated practices to identify functions of target behaviors, prevent the occurrence of problem behavior, teach appropriate, functionally equivalent replacement behavior and react therapeutically to problematic behavior. These services include:
a) Initial behavioral assessment for determining the need for and appropriateness of Behavior Support Services and for determining the function of the behaviors. Behavioral assessment (i.e., functional assessment and/or analysis) includes direct observation and collection of antecedent-behavior-consequence data, an interview of key persons, a preference assessment, collection of objective data (including antecedent-behavior-consequence data) and analysis of behavioral/functional assessment data to determine the function of the behaviors
b) Behavioral intervention (including staff/caregiver training), based on the functional assessment, that is primarily focused on replacement and prevention of the problem behavior(s) based on their function; and
c) an assessment of the success of the intervention through progress monitoring that includes analysis of behavioral data, any changes (including medication) and any needed modifications.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	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 2 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
CAREER PREPARATION SERVICES

HCBS Taxonomy:

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

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

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

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

rather than explicit employment objectives. Services will be provided in facilities licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Career Preparation. On site attendance at the licensed facility is not required to receive services that originate from the facility.

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	Career Preparation 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:
Career Preparation 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; DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

COMMUNITY SERVICES

HCBS Taxonomy:

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

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 can not include the cost of 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	Community 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:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Day Activity

HCBS Taxonomy:

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

04 Day Services	04020 day habilitation

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

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

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

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

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

Service Definition *(Scope):*
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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Activity 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:

Day Activity 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; DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

EMPLOYMENT SERVICES

HCBS Taxonomy:

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

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

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

○ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*
Employment services 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. Reimbursement for employment services will be made at two rates: a group rate or an individual job placement rate. When provided as a group service, the 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. Transportation is not included as part of the service or the rate paid for individual job placement.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Services Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: EMPLOYMENT SERVICES

Provider Category:
Agency
Provider Type:
Employment Services Providers
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 and annually. DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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 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, awning additions, etc. The following adaptations are excluded from this waiver benefit: modifications that add square footage to the home, pools, decks, stairs, elevators, breezeways, carports and hot tubs/whirlpools. All services shall be provided in accordance with applicable State or local building codes. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. Approval of a request for environmental modification is a multi-step process. The modification is initially determined by the waiver case manager/early interventionist based on the recipient's need as documented in the plan of care. According to State procurement policy, bids for the modification are obtained by the waiver case manager/early interventionist and submitted with documentation of the need. This information is reviewed by SCDDSN staff for programmatic integrity and cost effectiveness. The environmental modification service must be within the lifetime monetary cap of $7,500 per recipient. The waiver case manager/early interventionist will assist in identifying all appropriate resources, both waiver and non-waiver. Should it become necessary, the WCM/EI will assist with transitioning the client into institutional placement.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
$7,500 life time monetary cap per waiver recipient.

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	Licensed contractors
Agency	DDSN/DSN Board/Contracted Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Licensed contractors

Provider Qualifications

License *(specify):*
SC Code Ann. 40-59-15 (Supp. 2007)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN

Frequency of Verification:
Upon service authorization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

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

Certificate *(specify):*

Other Standard *(specify):*
DDSN Contract
Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*
Nursing services are continuous or intermittent skilled care provided by a nurse, licensed in accordance with the State Nurse Practice Act, in accordance with the participant's plan of care as deemed medically necessary by a physician. This service will be provided in the home unless deemed medically necessary by the physician and authorized in the plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Up to 56 units per week when provided by an LPN. Up to 42 units per week when provided by an RN. When a combination of LPN and RN services are used, the cost of the combination of services cannot exceed the cost of either LPN or RN services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Services

Provider Category:
Agency
Provider Type:
Nursing agencies
Provider Qualifications
License *(specify):*
RN/LPN licensure covered under Code of Laws of SC, 1976 as amended; 40-33-10 et seq.
Certificate *(specify):*

Other Standard *(specify):*
Enrolled with SCDHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS; Nursing Agency

Frequency of Verification:
Upon contract with SCDHHS and at least every 18 months; Ongoing

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PE
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
PERS is an electronic device which enables individuals 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 individuals who live alone, or who are alone in their own home for significant parts of the day or night, and who would otherwise require extensive routine supervision.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response providers
Agency	DSN Boards/contracted providers

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Personal Emergency Response providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
DSN Boards/contracted providers
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
1. FCC Part 68
2. UL (Underwriters Laboratories) approved as a "health care signaling product."
3. The product is registered with the FDA as a medical device under the classification "powered environments control signaling product."
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDDSN
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Pest Control Bed Bugs

HCBS Taxonomy:

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

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

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

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

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

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

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

For bed bugs all providers must go into the participant's home/or residence to inspect and treat the participant's home/or residence. A responsible adult who is eighteen years of age or older must be at the participant's home/or residence at the time of the treatment or the provider will need to reschedule for a time when the responsible adult who is eighteen years of age or older will be present at the participant's home/or residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are limited to one time per year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control Bed Bugs

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

SC Business License
Certificate *(specify):*
Certification by Clemson University
Other Standard *(specify):*

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Pest Control Treatment

HCBS Taxonomy:

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

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

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

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

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

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

Pest Control treatments need to include both in-home and exterior treatment. All providers must go into the participant's home/or residence to inspect and treat the home environment. A responsible adult who is eighteen years of age or older must be at the participant's home/or residence at the time of the treatment or the provider will need to reschedule for a time when the responsible adult who is eighteen years of age or older will be present at the participant's home/or residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Pest control treatment is limited to every other month.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control Treatment

Provider Category:
Agency
Provider Type:
Licensed Business
Provider Qualifications
License *(specify):*
SC Business License
Certificate *(specify):*
Certification by Clemson University
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS
Frequency of Verification:
Upon enrollment/annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Vehicle Assessment/Consultation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Private vehicle assessment/consultation may be provided once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. The criterion used in assessing a participant's need for this service are: 1) The parent or family member cannot transport the individual because the individual cannot get in or out of the vehicle; or 2) the individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve this barrier.

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

The consultation/assessment does not require submission of bids.

Private Vehicle Assessments/Consultations can be completed by Licensed Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional

Resource in Management (PRIME) or by vendors who are contracted through the DSN Board to provide the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The reimbursement for the Consultation/Assessment may not exceed $600.00.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN/DSN Board/Contracted provider
Agency	OT, PT, Rehabilitation Engineering Technologists,Assistive Technology Practitioners,Assistive Technology Suppliers, Environmental Access/Consultants/contractors

Appendix C: Participant Services

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

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

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

Certificate *(specify):*

Other Standard *(specify):*
Environmental Assessments/Consultations can be completed by vendors who are contracted through the DSN Board to provide the service.

Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

OT, PT, Rehabilitation Engineering Technologists,Assistive Technology Practitioners,Assistive Technology Suppliers, Environmental Access/Consultants/contractors

Provider Qualifications

License *(specify):*

Licensed Medicaid enrolled Occupational (OT)or Physical Therapists (PT), Medicaid enrolled Rehabilitation Engineering Technologists (RET).

Certificate *(specify):*

Assistive Technology Practitioners (ATP)and Assistive Technology Suppliers (ATS)certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors (EACC)certified by Professional Resource in Management (PRIME).

Other Standard *(specify):*

DHHS Medicaid enrolled provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Vehicle Modifications

HCBS Taxonomy:

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

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

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

○ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*
This service offers 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, follow-up inspection after modifications are completed, training in the use of the equipment, repairs not covered by warranty, and replacement of parts or equipment. The private vehicle modification service may not be used for general repair of the vehicle or regularly scheduled upkeep or maintenance of the vehicle except for maintenance of the modifications and does not cover factory installed modifications prior to purchase. This service may not be used to purchase or lease a vehicle. Payment may not be made to adapt vehicles that are owned or leased by paid providers of waiver services. To ensure cost-neutrality, the private vehicle modification service must be within a monetary cap of $7,500 per vehicle and a lifetime cap of 2 vehicles. The approval process for vehicle modifications is initially determined by the Waiver Case Manager 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. According to State procurement policy, bids for the vehicle modification are obtained and submitted along with the documentation of the need to SCDDSN. The consultation/assessment does not require 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:
$7,500 per vehicle and a lifetime cap of 2 vehicles.

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/DSN Board/Contracted provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency
Provider Type:
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

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

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency

Provider Type:
DDSN/DSN Board/Contracted provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
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:
Specialized Medical Equipment and Assistive Technology Assessment/Consultation

HCBS Taxonomy:

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

17 Other Services | 17990 other

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

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

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

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

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

Service Definition *(Scope):*
Specialized Medical Equipment and Assistive Technology Assessment/Consultation may be provided (if not covered under the State Plan Medicaid)once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. Consultation and assessment may include specific needs related to the participant's disability for which specialized medical equipment and assistive technology will assist the participant to function more independently. Assessment and consultation cannot be used to determine the need for supplies.

Assistive technology and assessments/consultations must be provided by Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional Resource in Management (PRIME).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The reimbursement for the Consultation/Assessment may not exceed $300.00.

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	OT, PT, Rehabilitation Engineering Technologists,Assistive Technology Practitioners,Assistive Technology Suppliers, Environmental Access/Consultants/contractors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Assistive Technology Assessment/Consultation

Provider Category:

Agency

Provider Type:

OT, PT, Rehabilitation Engineering Technologists,Assistive Technology Practitioners,Assistive Technology Suppliers, Environmental Access/Consultants/contractors

Provider Qualifications

License *(specify):*

Licensed Medicaid enrolled Occupational (OT)or Physical Therapists (PT), and Rehabilitation Engineering Technologists (RET).

Certificate *(specify):*

Assistive Technology Practitioners (ATP)and Assistive Technology Suppliers (ATS)certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors (EACC)certified by Professional Resource in Management (PRIME).

Other Standard *(specify):*

DHHS Medicaid enrolled provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment, Supplies and Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Specialized medical equipment, supplies and assistive technology to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. This service may include consultation and assessment to determine the specific needs related to the individual's disability for which specialized medical equipment and assistive technology will assist the individual to function more independently. Consultation and assessment cannot be used to determine the need for supplies.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The limit is 2 cases per month of liquid nutrition for waiver participants without a feeding tube. Liquid nutrition for waiver participants on a feeding tube is provided by Medicaid State Plan and is not covered by the waiver.

Cost per wheelchair is limited to a maximum of $8000 per chair and a maximum of 1 chair every 5 years if medically justified.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN/DSN Board/contracted providers
Agency	Durable Medical Equipment Providers

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
DDSN/DSN Board/contracted providers
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: Provider Specifications for Service

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

Provider Category:
Agency

Provider Type:
Durable Medical Equipment Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled with SCDHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Support Center Services

HCBS Taxonomy:

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

04 Day Services | 04060 adult day services (social model)

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

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

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

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

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

Service Definition *(Scope):*
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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Center 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:
Support Center 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 Support Center Services

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN

Frequency of Verification:
Initially and annually; DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

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

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

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

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

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

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

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

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

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

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

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

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

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

Appendix C: Participant Services

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

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

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	

Certified Residential Care Facility	

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

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

CRCFs are licensed under SC Code of Regulations 61-84 and when Residential Habilitation is provided in a CRCF, the SCDDSN Residential Habilitation Standards also apply.

Regulation 61-84 includes requirements for licensure that ensure:
Residents have freedom of movement and are not prohibited access to common usage areas; Telephones are available and privacy allowed when placing or receiving phone calls; Methods to ensure visual and auditory privacy between resident and visitors is provided as necessary; Residents are allowed to engage in food preparation; and Residents have the choice to furnish their rooms and bathrooms.

Regulation 61-84 allows for doors of resident rooms to be locked; and also includes a Residents Bill of Rights that requires written and oral explanation of the contents at the time of admission. The Bill of Rights includes the following: Assurance of security in storing person possessions; Allowance for immediate access to the Resident by family members/relatives (subject to the resident's right to deny) without unreasonable restriction or delay; Allowance that the resident is free to associate and communicate privately with persons of the resident's choosing.

When Residential Habilitation is provided, SCDDSN Residential Habilitation Standards are additionally applied. SCDDSN Residential Habilitation Standards include requirements that:

People's preferences/wishes/desires for how, where and with whom they live are learned from the person prior to entry into a residential setting and continuously; People are supported to make decisions and exercise choices regarding their daily activities; Unless contraindicated by assessment, each resident must be provided with a key to his/her bedroom; People are supported and encouraged to participate and be involved in the life of the community; and People are supported to maintain and enhance links with families, friends or other support networks.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Certified Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Vehicle Modifications	☐
Personal Care 2, Personal Care 1	☐
Pest Control Treatment	☐
Adult Companion Services	☐

Nursing Services	☐
EMPLOYMENT SERVICES	☐
Incontinence Supplies	☐
Day Activity	☐
Prescribed Drugs	☐
Personal Emergency Response System (PERS)	☐
Behavior Support Services	☐
Respite Care	☑
Adult Dental Services	☐
Pest Control Bed Bugs	☐
COMMUNITY SERVICES	☐
Specialized Medical Equipment, Supplies and Assistive Technology	☐
Adult Day Health Care Nursing	☐
Adult Vision	☐
Adult Day Health Care Transportation	☐
CAREER PREPARATION SERVICES	☐
Specialized Medical Equipment and Assistive Technology Assessment/Consultation	☐
Residential Habilitation	☑
Private Vehicle Assessment/Consultation	☐
Environmental Modifications	☐
Adult Attendant Care Services	☐
Audiology Services	☐
Waiver Case Management (WCM)	☐
Support Center Services	☐
Adult Day Health Care, Adult Day Health Care Services	☐

Facility Capacity Limit:

8

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	

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

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

All standards are addressed

Appendix C: Participant Services

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

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

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

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

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

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

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

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

◉ **Other policy.**

Specify:

Reimbursement for services may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members can not be reimbursed:
1. a parent of a minor Medicaid participant;
2. a spouse of a Medicaid participant;
3. a step-parent of a minor Medicaid participant;
4. a legally responsible foster parent of a minor Medicaid participant;
5. a legally responsible guardian of a minor Medicaid participant;and
6. a court appointed guardian of an adult Medicaid recipient.

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, SCDHHS legal counsel will make a determination.

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

Potential providers are given the opportunity to enroll/contract with SCDHHS and/or sub-contract with SCDDSN. 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 at the following two websites:

http://www.scdhhs.gov
http://www.ddsn.sc.gov

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Waiver providers continue to meet required licensing, certification and other state standards. N = the number of existing providers that continue to meet required licensing, certification and other state standards. D = the number of existing providers reviewed.

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Periodic reviews to include all providers within a 4 year timeframe.	

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 100% within 18 months	

Data Aggregation and Analysis:

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

Performance Measure:
New providers meet required licensing, certification and other state standards prior to the provision of waiver services. N = the number of new providers who meet licensing, certification and other state standards. D = the number of individuals/entities who apply to become providers.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
New non-licensed/non-certified providers meet waiver requirements prior to the provision of waiver services. N = the number of new non-licensed/non-certified waiver providers that meet waiver requirements prior to the provision of waiver services. D = the total number of new non-licensed/non-certified individuals/entities who apply to become providers.

Data Source (Select one):
Other

If 'Other' is selected, specify:
DHHS Focus/Desk Reviews

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

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

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

☑ **Other** Specify: DDSN QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted every 12-18 months based on past performance of the provider organization. Reports are available 45 days post review.	

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Existing non-licensed/non-certified providers continue to meet waiver requirements. N = the number of existing non-licensed/non-certified waiver providers that meet waiver requirements. D = the total number of existing non-licensed/non-certified providers reviewed.

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

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

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

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

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted every 12-18 months based on past performance of the provider organization. Reports are available 45 days post-review.	

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

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

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

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

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

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

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

Performance Measure:
Providers meet training requirements as specified in the State's scope of service or other operational directive. N = the number of providers who meet training requirements. D = the total number of providers reviewed.

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 100% within 18 months	

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
DDSN QIO Reports

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

Data Aggregation and Analysis:

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

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

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, timeframes for corrections and corrections made will be maintained. DDSN will share this information with DHHS upon completion.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the

future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

SCDHHS is in the process of determining if our settings are in compliance by completing a policies and standards review for our settings, which will be followed up by conducting facility self-assessments and site visits all of which is detailed in the waiver transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Support Plan

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

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

  Specify qualifications:

- ☐ **Social Worker**

  Specify qualifications:

- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

-The person-centered service plan (PCSP) is developed through a person-centered planning process. The individual will lead the person centered planning process whenever possible. The individual's legal guardian/representative will have a participatory role as needed. The PCSP is developed by a qualified WCM/EI Medicaid provider. Each participant is offered the choice of WCM/EI qualified providers initially and annually thereafter, and may freely change qualified providers upon request throughout the year. Waiver case managers currently avoid case management conflict by ensuring participants receive a full complete list of all State Medicaid Providers.

-Once a WCM/EI provider is chosen, he/she is required to utilize a standardized tool for assessing the needs of all waiver participants. These tools must be supported by current professional reports. Once needs are identified, WCM/EI providers explain the full range of service options available to meet the assessed needs. Each need identified in the assessment is discussed with the participant and other individuals they invite to participate. This may include family, his/her legal guardian and/or legal representative, caregivers, professional service providers, and others of the participant's choosing. Interpreters or communication device should be provided if needed.

-The information obtained is used by the WCM/EI provider in order to develop the person-centered service plan. Upon completion, copies of the service plan are provided to the individual and by the individual's choice in selecting those entities who were instrumental in the development of the service plan. The participant may for example choose to share signed/dated copies of the PCP with family, legal guardians, providers, and advocates or whomever they decide to allow to have copies of their participant-centered service plan.

-At the time of waiver enrollment and annually, participants are given a copy of the "Acknowledgement of Rights and Responsibilities" form. This form outlines the participant's right to be told about services, participate in the completion of an assessment and plan, and choose services from all qualified providers, contact available qualified providers, change providers, and request reconsideration of decisions. Additionally, participants and/or family members may choose a Life Planner at no cost to the participant or family for the service. The Life Planner serves as an advocate for the participant and family and may also act as a mediator to get all the information from all members of the circle or help in resolving any problems or issues which may arise. They navigate the planning meeting keeping everyone focused on the person's expressed preferences, and to make informed choices in order to identify and achieve their goals and aspirations for his/her future.

-Quality Improvement Organization (QIO) reviews each entity providing waiver case management to assure waiver participants are offered choice, have been given "Acknowledgment of Rights" annually and assure that the services in the Plan correspond to a documented assessed need. QIO review results are made available to DHHS through a secure, Web-based reporting portal within 45 days of the review. The QIO measures compliance, approves all required plan of corrections, and conducts a follow-up review to ensure successful remediation.
In addition to the QIO reviews, SCDDSN also ensures that the Service Plans and Annual Assessments are reviewed through an internal random selection review process. Random review samples are selected by SCDDSN and the names of waiver participants selected are tracked in a database. Using this sample, DDSN staff review Plans of those participants selected. Once a Plan is reviewed, feedback is provided to the provider. It is the responsibility of the Supervisors to ensure that WCM/EIs providers complete indicated corrections. SCDDSN tracks this quality assurance activity in detail and uses findings to direct its training and technical assistance efforts.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Person-centered planning (PCP) is a framework that provides services, supports and interventions that is directed by the participant and meets the individuals/families/legal guardians with long term support needs. The person-centered service plan honors the participant's goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, education, employment, community participation, wellness and relationship opportunities. PCP creates community connections, encourages the use of natural and community supports to assist in ending isolation, disconnections, disenfranchisement by engaging the individual/family/legal guardians in the community. PCP offers the individual to be empowered by creating a plan that views the individuals/families/legal guardians in the context of their culture and in the context of plain language. All of the elements that compose a person's individuality and a family's uniqueness are acknowledged and valued in the planning process. PCP supports mutually respectful partnerships between individuals/families/legal guardians and providers/professionals, and recognizes the legitimate contributions of all parties involved. During the planning process the participant, his/her legal guardians, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The WCM/EI providers use the information obtained by all parties involved in order to develop a person-centered service plan. The person receiving services is required to sign and date the PCP indicating the confirmation of the agreement with the services and supports detailed and confirmation of choice of qualified service providers. All individuals/providers involved are encouraged to sign the person-centered service plan confirming participation and agreement with the services and supports as detailed in the plan. The participant/legal guardians will receive a copy of the service plan upon completion and additional copies will also be provided to participating qualified service providers of the participant's/legal guardian's choosing.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The person centered service plan is directed by the participant/legal guardian/parent and developed by the WCM/EI qualified provider based on the comprehensive assessment of the waiver participant's strengths, needs, and personal priorities (goals) and preferences. The participant, family, legal guardian, caregivers, professional service providers (including physicians) and others of the participant's choosing may provide input. Service Plans are individualized for each waiver participant, stressing the importance of community support. An initial Plan is developed prior to the waiver enrollment, updated as needed, and a new Plan is completed within 365 days.

Parents/legal guardians are informed in writing at the time of enrollment of the names and definitions of waiver services that can be funded through the waiver when the WCM/EI qualified provider has identified the need for the service.

Participation in the planning process (assessment, plan development, implementation) by the participant, parent/legal guardian, knowledgeable professionals and others of the participant, parent/legal guardian's choosing, helps to assure that the participant's personal priorities and preferences are recognized and addressed by the person-centered service plan. All needs identified during the assessment process must be addressed. As part of the support plan development process, it is determined if the participant has health care needs that require consistent, coordinated care by a physician, therapist, or other health care professionals. The WCM/EI qualified provider must utilize information about the participant's strengths, priorities and preferences to determine how those needs (to include health care needs) will be addressed. The plan will include a statement of the participant's need; indication of whether or not the need relates to a personal goal; the specific service to meet the need; the amount, frequency, duration of the service; and the type of provider who will furnish the service.

The plan will include the roles and responsibilities of the WCM/EI, participant, the parent/legal guardian for each service included in the plan. The WCM/EI qualified provider will have primarily responsibility for coordinating

services but must rely on the participant, parent/legal guardian to choose a service provider from among those available, avail him/herself for, and honor appointments that are scheduled with providers when needed for initial service implementation and ongoing monitoring of services. The appointments must be of convenient times, and locations to the participant in order to coordinate an effort of collaborative cooperation with all parties who are involved with the development and ongoing monitoring of the service plan.

WCM/EI providers are responsible for locating and coordinating other community or State Plan services. The objectives of waiver case management are to counsel, support and assist participants/families with all activities related to the IDRD waiver program. WCM/EI providers must provide ongoing problem solving to address participant/family needs. They must coordinate community-based support, provide referrals to other agencies and participate in interagency case staff meetings as needed. These activities must be fully documented in the participant's waiver record.

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

Every calendar month the WCM/EI provider will contact the participant/family to conduct non face to face monitoring of the Plan or waiver services/other services. Non face-face contacts are required during months in which a face-to-face contact is not conducted. Based on the results of the monitoring, amendments may be needed to update the Plan.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participants' needs, including potential risks associated with their situations, are assessed and aimed at minimizing risks as addressed in the plan and during the annual plan process by helping an individual/legal guardian/caregiver view ways to be safe and within the choices made. The service plan includes a section for a description of the plan to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver/supporter.

A standardized assessment tool is used for all waiver participants. This tool assesses the person's current situation, health and safety risk factors, and his/her personal preferences. The plan of service document includes sections that outline the responsibilities of the waiver participant, family, legal guardian and/or representative, and the responsibilities of the WCM. The WCM/EI provider agency also conducts training with staff annually to review proper reporting procedures for abuse, neglect, exploitation, and unexplained deaths.

Additionally, WCM/EI providers will encourage parents/legal guardians/responsible parties to make back-up plans for emergencies when they take vacations or are away from home for extended periods of time.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

WCM/EI providers share information about available qualified providers of needed services to help participants make an informed choice. Annually, upon request or as service needs change, participants/family/legal guardians are given a list of providers of specified waiver services for which a change is requested or needed in order to select a provider. This list includes phone numbers. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers, and utilize other information sources in order to select a provider.

Participants/family/legal guardians are encouraged to ask friends and peers about provider websites, and other resources of information to assist them in choosing a provider. Additionally, participants/family/legal guardians are supported in choosing qualified providers by being encouraged to contact support and advocacy groups. Participants, families, legal guardians and/or representatives may request a list of providers of specified waiver services when service needs change, or when a change is requested, or when selection of another provider is needed. Participants/families/legal guardians and/or representatives can contact their WCM/EI provider with questions about available providers and/or check the below websites for the most current listing of qualified providers in South Carolina.

-SCDHHS Medicaid Qualified Provider Directory website @ http://www1.scdhhs.gov/search4aprovider/

-SCDDSN Qualified Provider Directory website @ http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The person-centered service plan documents and the description of the planning process are approved by DHHS prior to implementation and whenever any changes are made to the planning document/process. Waiver Service Plans are maintained either electronically in accordance with DDSN policy or by the WCM/EI provider in the participant's record but are available to DHHS for review at any time.

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

At their discretion, the DHHS Division of Medicaid Program Integrity makes scheduled and unannounced visits to review waiver records based on referrals from DHHS waiver staff, advocates, families, internal claims reports, etc. These record reviews compare the participant's Service Plan, WCM/EI provider narrative notes, waiver service authorizations, and MMIS claims history to detect or identify any anomalies, ensure appropriateness of services authorized and verify documentation of services billed to DHHS. Recoupment of Federal Financial Participation (FFP) may occur as needed. Additionally, DHHS waiver staff also review waiver Service Plans during quality assurance reviews. These reviews focus on the appropriateness of participant Service Plans as well as timeliness standards, documentation to support Medicaid claims and provider qualifications.

A sample of participants plans are reviewed by DDSN using a standardized review instrument and the findings shared with the WCM/EI provider and his/her supervisor so corrections can be made. The results are shared with DHHS in an annual report.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 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:

Within 365 days of the previous plan.

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

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

Specify:

Early Interventionist (EI)

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

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

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

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Policy dictates the minimum frequency with which monitoring must occur and the elements (service effectiveness/usefulness, service providers, service delivery and participant/family satisfaction with services) that must be included. Annually or more often as concerns are noted, information about available providers or needed services including WCM/EI is shared with participants/families. Changes to the plan will be made when information obtained from the participant, parent/legal guardian, and/or service providers indicate the need for a change to the plan to ensure that monitoring safeguards are conducted in the best interest of the participant. Waiver service monitoring is reviewed by the QIO.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Plans for ID/RD waiver participants include services, supports and goals that are consistent with assessed needs in accordance with waiver policy. N = the number of ID/RD participant plans reviewed that include services, supports and goals consistent with assessed needs. D = the total number of ID/RD waiver files reviewed.

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

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

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

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
The plans for newly enrolled ID/RD participants are updated to include waiver services prior to authorization in accordance with waiver policy. N = the number of newly enrolled ID/RD participants whose plans were updated to include waiver

services prior to authorization. D = the total number of ID/RD files reviewed.

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

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

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:
Support plans for ID/RD waiver participants are developed at least annually and revised when warranted by a change in participant needs. N = the number of ID/RD participants whose new support plans were developed at least annually and revised when warranted by a change in participant needs. D = the total number of ID/RD files reviewed.

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Participants receive services and supports in the type, amount, frequency, and duration as specified in their plans, in accordance with waiver policy. N = the number of ID/RD participants who are receiving services and supports in the type, amount, frequency, and duration as specified on the plan. D = the total number of ID/RD waiver files reviewed.

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Waiver Case Managers complete the first required non-face-to-face contact with the waiver participant/family within 30 days of waiver enrollment per policy. N = the number of required first non-face-to-face ID/RD contacts completed per policy. D = the total number of first required non-face-to-face contacts for waiver records reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Waiver Case Managers complete four (4) quarterly face-to-face visits with the ID/RD waiver participant/family during each plan year per policy. N = the number of completed quarterly face-to-face visits in the plan year. D = the total number of all face-to-face visits required in the plan year per policy.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Waiver Case Managers complete two (2) quarterly face-to-face visits with the participant/family in the home/natural environment during each plan year per policy. N = the number of completed quarterly face-to-face visits in the home/natural environment in the plan year. D = total number of required quarterly face-to-face visits in the home/natural environment in the plan year per policy.

Data Source (Select one):

Other
If 'Other' is selected, specify:
DDSN QIO Reports

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
ID/RD waiver participants are offered choice among qualified providers. N = the number of ID/RD participants who were offered choice of qualified providers. D = the total number of ID/RD waiver files reviewed.

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

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
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 provided to DHHS. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are provided to DHHS upon completion.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

This waiver offers participants the opportunity to direct Attendant Care with employer authority. The participant or his/her responsible party (RP) can choose to direct the participant’s care. Participants/RP must have no communication or cognitive deficit that would interfere with their ability to self-direct.

The WCM/EI provider will provide detailed information to the participant or RP about participant/RP direction as an option including the benefits and responsibilities of the option. If the participant/RP wants to pursue this service, additional information about the risks, responsibilities and liabilities of the option will be shared by the WCM/EI provider. Information about the hiring, management and firing of workers as well as the role of the Financial Management System (FMS) is also provided. Once the participant has chosen to direct their services, WCM/EI providers 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*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

The participant or responsible party (RP) must have no communication or cognitive deficits that would interfere with participant or RP direction. The WCM/EI provider will assess and determine if these criteria are met. Participants interested in self-directed care are pre-screened to assure capability utilizing a standardized pre-screen form. The pre-screening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare of the participant.

These include: communication, cognition patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/RP to make themselves understood and the ability of others to understand the participant/RP. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the participant/RP. Finally, the assessment tool reviews the mood and behavior patterns

of the participant/RP to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the participant/RP. If the participant/RP disagrees with the results they may appeal the decision. The RN match visit is completed prior to service authorization.

WCM/EI providers assess the cognitive and communication abilities of participants/family members who wish to direct some of their waiver services. This process is consistent for all waiver participants meeting the ICF/IID Level of Care. If self-directed or family-directed attendant care is not an appropriate option for individuals in the ID/RD waiver, the participant is referred to (agency provided) personal care services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

At the time of the initial assessment, the WCM/EI provider will introduce participant direction of Attendant Care services and provide a brochure giving information about this option. If the participant/RP is interested, the WCM/EI provider will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The WCM/EI provider will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant direction. If not initially interested, the WCM/EI provider will continue to assess the participant’s interest on an annual basis.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

A participant may choose to have waiver services directed by a representative but he/she must choose an individual (subject to SCDDSN or Medicaid Policy) willing to understand and assume the risks, rights and responsibilities or directing the participant’s care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant’s preferences. The representative must be willing to complete the necessary paperwork and serve as the Employer of Record. The representative must be at least 21 years of age.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each

waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Adult Attendant Care Services	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ **Governmental entities**
☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

SCDDSN currently uses an FMS to provide these services to participants in the ID/RD waiver. This is a sole source procurement with a government entity.

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

The State compensates the FMS entity through an administrative grant from SCDDSN. The payment to the FMS does not affect the participant's waiver budget. The percentage of FMS costs relative to service costs is estimated to be 4%.

SCDDSN monitors the performance of the FMS monthly by monitoring expenditures. Additionally, an independent audit of the FMS is conducted yearly.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

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

Specify:

The FMS will verify the participant's verification of the worker's minimum qualifications. University Affiliated Programs/USC (UAP) conducts all required background checks.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing

their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

For the adult attendant care service, WCM/EI providers will provide detailed information to the participant or responsible party (RP) about participant/RP direction as an option including the benefits and responsibilities of the option. If the participant/RP wants to pursue this service, additional information about the risks, responsibilities and liabilities of the option will be shared by the WCM/EI provider. Information about the hiring, management and firing of workers as well as the role of the Financial Management System is also provided. Once the participant/RP has chosen to direct their services, WCM/EI providers continue to monitor service delivery and the status of the participant's health and safety.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Private Vehicle Modifications	☐
Personal Care 2, Personal Care 1	☐
Pest Control Treatment	☐
Adult Companion Services	☐
Nursing Services	☐
EMPLOYMENT SERVICES	☐
Incontinence Supplies	☐
Day Activity	☐
Prescribed Drugs	☐
Personal Emergency Response System (PERS)	☐
Behavior Support Services	☐
Respite Care	☐
Adult Dental Services	☐
Pest Control Bed Bugs	☐
COMMUNITY SERVICES	☐
Specialized Medical Equipment, Supplies and Assistive Technology	☐
Adult Day Health Care Nursing	☐
Adult Vision	☐
Adult Day Health Care Transportation	☐
CAREER PREPARATION SERVICES	☐
Specialized Medical Equipment and Assistive Technology Assessment/Consultation	☐

Residential Habilitation	☐
Private Vehicle Assessment/Consultation	☐
Environmental Modifications	☐
Adult Attendant Care Services	☑
Audiology Services	☐
Waiver Case Management (WCM)	☐
Support Center Services	☐
Adult Day Health Care, Adult Day Health Care Services	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

One of the operating agency's disabilities and special needs boards was selected through a sole source procurement to serve as the FMS. SCDDSN has 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. SCDDSN assesses 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:

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 WCM/EI provider will accommodate the participant by providing a list of qualified providers from which a provider can be selected in order to maintain service delivery. The WCM/EI provider and SCDDSN will work together to ensure the health and safety of the participant in this transition and will work to avoid any break in service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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

When it is determined that participant/family direction of services is no longer appropriate, alternate, provider-directed services will be authorized to ensure continuity of care and assure participant health and welfare. This waiver targets only those individuals who elect to self-direct the attendant care service or have an appropriate family member to do so. However, if waiver participants/family members become unable/unwilling to direct the attendant care service and it becomes necessary to terminate the service, agency-directed personal care services are available to ensure continuity of care.

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	32	
Year 2	34	
Year 3	36	
Year 4	38	
Year 5	40	

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 costs for background checks will be handled by UAP (University Affiliated Programs/USC).

- ☑ **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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The WCM/EI provider will provide written notification and verbal explanation to the individual applicant or the legal guardian during a meeting concerning the SCDDSN Reconsideration and SCDHHS Appeal (Fair Hearing) prior to enrollment when the individual applicant signs the Freedom of Choice (FOC) form.

The waiver participant or the parents/legal guardian of the waiver participant is informed in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of the SC Code Ann. §1-23-310 thru 1-23-400, (Supp 2007) and 27 SC Code Ann. Regs. 126-150 thru 126-158 (1976).

Whenever there is an adverse decision or action related to enrollment in the ID/RD Waiver or subsequent receipt of services, the WCM/EI provider must provide written notification to the applicant or participant or the legal guardian, including reason for the adverse decision or action. The WCM/EI provider will assist in filing a written request for reconsideration if necessary.

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

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

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

The notice states the following:
"A request for reconsideration of an adverse decision must be sent in writing to: SC Department of Disabilities and Special Needs, Attn: State Director, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process must be completed in its entirety before appealing to 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 individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for benefits/services to continue during the reconsideration/appeal process, the participant/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 participant/representatives may be required to repay benefits received during the reconsideration/appeal process.

The State Director or his/her 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 individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/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 individual/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 individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/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 individual/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:

SCDDSN 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).

The operating agency responds to grievances/ complaints, when the participant who receives services or their representative indicates their concerns have not been satisfied through informal or routine contact with staff directly associated with the service, support or program. Contact with DDSN staff outside of the situation provides an opportunity for objective and impartial review of the concern.

The operating agency has a Department Directive, 535-08-DD, that 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 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.

Additionally, contacts typically are made when the participant who receives services or their representative feel their concerns have not been satisfied through informal or routine contact with staff directly associated with the service, support or program. Contact with someone outside of the situation provides an opportunity for objective and impartial review of the concern.

All WCM/EI providers have a procedure for participants who receive services and supports or representatives acting on their behalf that assures their right to voice concerns without actions being taken against them for doing so. The procedure is reflective of the values and principles of DDSN and clearly delineates all steps in the process. Participants who receive services and their representatives are provided with information about the process in a manner that is understandable to the individual. Supports are provided, if needed, to participants 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. Efforts are made to promote trust and open communication at the local service level whenever possible. Concerns involving health and safety of participants receiving services receive immediate review and necessary action is taken if the individual's health or safety is at risk.

-Participants who receive services and/or their representatives expressing concerns are encouraged to seek remediation through their direct service provider's policy regarding concerns. If the concern is unable to be resolved at this level, then the matter may be referred to the DDSN Office of Consumer Affairs.

-Follow-up to a concern includes contact with the participant or representative expressing the concern, review and research of the concern, efforts to mediate resolution, and documentation of all actions taken. Executive Directors/CEOs will be notified whenever a participant's concern involves their service area.

-The WCM/EI provider is responsible for communicating to the participant that their decision to file a grievance or make a complaint is not a pre-requisite for a Fair Hearing. The State has indicated in the application (F-3 b) that filing a grievance or making a complaint is not a pre-requisite or a substitute for a Fair Hearing. These are two totally separate processes as aforementioned.

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 SC Department of Social Services (DSS)/Child Protective Services (CPS) and local/state law enforcement(South Carolina Law Enforcement Division/SLED). The South Carolina Omnibus Adult Protection Act requires the reporting and investigating of suspected ANE of a vulnerable adult (age 18 and above)to the DSS/Adult Protective Services (APS) and local/state law enforcement (SLED). 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.

The reporting of Critical Incidents (100-09-DD) must be followed. A critical incident is an "unusual, unfavorable

occurrence that is: a) not consistent with routine operations; b) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and c) occurs in a SCDDSN Regional Center, DSN Board facility, other service provider facility, or during the provision of waiver case management services. An example of a critical incident includes but is not limited to possession of firearms, weapons or explosives or consumer accidents which result in serious injury requiring hospitalization or medical treatment from injuries received. Reports of critical incidents are required to be made to the operating agency within 24 hours or the next business day of the event.

In addition, DDSN Directive 534-02-DD specifically addresses the procedures for preventing and responding to ANE. This directive sets forth the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identified administrative and management functions of DDSN and its network of contracted services providers.

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

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

Waiver participants and/or their family members and legal representatives are provided written information about what constitutes abuse, neglect, and exploitation, how to report, and to whom to report. They are informed of their rights, annually and this information is explained by their waiver case managers.

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.

SCDDSN Directives 100-09-DD and 534-02-DD require the service provider to make an initial report of the incident within 24 hours or the next business day. The provider must then complete an internal review of the incident within 10 working days. The internal review is submitted to DDSN for acceptance by the Statewide Incident Management Coordinator. DDSN policies require the provider, upon completion of the internal review, to notify the participant and/or responsible party of the outcome of the review. The Case Management provider is also informed in order to ensure that any health and safety concerns are addressed. DDSN Directives 534-02-DD and 100-09-DD set forth the reporting requirements of state law and also specifically address the procedures for preventing, responding, and reporting critical incidents and ANE. These directives also identify the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE. Further, the Directives (100-09-DD and 534-02-DD)outline the administrative and management functions of DDSN and its network of contracted service providers.

When there is reason to believe that a child has been abused, neglected or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. DSS is the mandated agency to investigate suspected ANE in these settings. DDSN and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN to assist contract provider agencies in resolving issues with DSS regarding intake referrals and investigations. DSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification is sent to appropriate agencies for personnel and other required actions to be taken. If the alleged perpetrator is also employed by DDSN, a contract provider agency, or the family, and ANE is substantiated, the employee will be terminated.

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

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

Vulnerable Adult Fatalities (VAF)Review
The VAF Review Office of 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 or upon request.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses*

regarding seclusion appear in Appendix G-2-c.)

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

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

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

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

In accordance with DDSN policy, restraints may be employed only for the purpose of protecting the person or others from harm only when it is determined to be the least restrictive alternative possible to meet the person's needs. The use of restraints will ensure an individual's rights of privacy, dignity and respect, and freedom from coercion.

Types of restraints that may be used include the following:
•1. Planned restraint manual is defined as a procedure that involves holding an individual.
2. Planned mechanical restraint is defined by applying a device that restricts free movement of or normal access to a portion or portions of an individual's body. •
3. Psychotropic medication is defined as any medication used for the primary purpose of affecting overt maladaptive behavior, mood, thought process, or alleviating symptoms related to a specific diagnosed psychiatric conditions.

Use of restraint is limited to a maximum of one (1) continuous hour. Release from restraint must occur when the person is calm and is no longer a danger to self or others. If the person becomes aggressive again, a new restraint can be implemented.A physician's order for restraint is needed but not required at the time of each use. The order may be included in the routine medical orders which are renewed per state licensure requirements.

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

Psychotropic medications should be used only with appropriate consent and reviewed based on the person's needs as determined by the psychiatrist or physician at least quarterly in a psychotropic drug review process.

Types of restraints that are prohibited by DDSN policy include the following:
• Procedures, devices, or medication used for disciplinary purposes, for the convenience of the staff or as a substitute for necessary supports for the person;
• Seclusion (defined as the placement of an individual alone in a locked room);
•Enclosed cribs;
•Programs that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
• Having a service recipient discipline other people with disabilities;
•Prone (i.e., face down on the floor with arms folded under the chest) basket-hold restraint;
• Timeout rooms; and,
• 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.

Psychotropic medication may not be used for disciplinary purposes, for the convenience of staff, as a substitute for a habilitative training program, or in quantities that interfere with a person's quality of life.

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. 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 (HRC). 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. All restraint procedures that are used on the participant must be documented in the participant's record and updated as necessary.

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 upon completion of the reviews.

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

DDSN is responsible for oversight of the use of restraints. DDSN policies dictate the responsibilities of service providers and the HRC regarding monitoring programs that include restraint. DDSN monitors compliance with policies through its compliance reviews conducted by the QIO and through its licensing reviews.

Contract compliance reviews and licensing review reports are provided to SCDHHS per the requirements of the MOA and the Administrative contract. 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, within six months. DDSN must share all review information with DHHS upon completion.

The SCDDSN Standard or Directive referenced include the following:
600-05-DD Behavior Support, Psychotropic Medications and Prohibited Practices
567-04 DD Preventing and Responding to Disruptive Behavior and Crisis Situations

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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

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

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

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

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

DDSN is the operating agency that implements policy that allows the use of appropriate restrictive interventions based on the person centered service planning.

•Restrictive procedures or non-aversive methods 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,or HRC;

•Averse consequences which are defined as startling, unpleasant or painful consequences, or 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 individual needs of the person. Aversive methods may only be employed as a last resort.

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 the operating agency responsible for oversight of the use of restrictive procedures. DDSN policies dictate the responsibilities of service providers and 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 averse consequences are approved, in addition to monitoring through contractual compliance and licensing reviews, the procedures are monitored by a DDSN State office staff person.

The SCDDSN Standards or Directives referenced include the following:
535-02-DD Human Rights Committee
600-05-DD Behavior Support, Psychotropic Medications and Prohibited Practices
567-04-DD Preventing and Responding to Disruptive Behavior and Crisis Situations

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

Seclusion (defined as the placement of an individual alone in a locked room), enclosed cribs, and timeout rooms are prohibited by State DDSN policy.

DDSN utilizes a QIO to conduct contract compliance reviews every 12- 18 months which include direct observation of service provision and record reviews. The QIO reviews include, but not limited to, determining if staff are appropriately trained, that risk management and quality assurance systems are implemented consistent with policy, and that abuse and critical incidents are reported and responded to in accordance with policy.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

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

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/waiver participants. 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/incident reporting, analyzing, and follow up capability, as part of their overall risk management program. Safe medication administration 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, see 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; distribution; 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 certification), 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 SCDDSN Standards or Directives referenced include:
-Employee Orientation, Pre-Service and Annual Training (567-01-DD)
-Residential Certification Standards
-Day Facilities Licensing Standards
-Medication Error/ Vent Reporting (100-29-DD)
-Medication Technician Certification (603-13-DD)

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

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Significant Medication Errors are reported to SCDDSN as a Critical Incident. All Medication Error/Event reports are subject to periodic review by SCDDSN or its QIO.

SCDDSN has adopted the NCC MERP definition of Medication Errors: “A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer.” SCDDSN has followed the general guidelines of the NCC MERP “Taxonomy of Medication Errors” in developing a Medication Error/Event Report Form. SCDDSN Service Providers are required to develop their own data collection system to track, monitor and analyze medication errors/events. At the provider level reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (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 QIO 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 SCDDSN 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 meeting minutes of risk management/quality assurance. This information must be included as part of the data collection system related to medication error/event reporting.

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

DDSN is responsible for monitoring the performance of waiver providers in the administration of medications. DDSN requires all providers to follow the policy/procedures outlined in the previous responses. DDSN may request all data related to medication error/event reporting at any time or during any of the service provider's reviews. In addition, DHHS may review the provider documentation at any time.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Incidents of abuse, neglect, or exploitation (ANE) and unexplained deaths (UD) for ID/RD waiver participants are reported within the required timeframe. N = the number of ID/RD waiver incidents of ANE and UD that were reported within the required timeframe. D = total number of ID/RD waiver reports of ANE and UD.

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

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

Data Aggregation and Analysis:

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

DDSN report

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

Data Aggregation and Analysis:

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

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

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

Data Aggregation and Analysis:

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

	Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Critical incidents for ID/RD waiver participants are reported on the incident management system. N = the number of ID/RD participants with critical incidents reported on the incident management system. D = the total number of critical incidents for all waiver participants using the incident management system.

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
ID/RD waiver participants with reported incidents of restrictive interventions that are inconsistent with policy. N = the number of ID/RD waiver participants with reported incidents of restrictive interventions that are inconsistent with policy. D = the total number of all waiver cases in DDSN-operated waivers with reported

incidents of restrictive interventions that are inconsistent with policy.

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
ID/RD waiver participants report access to healthcare services as listed on the person-centered plan/assessment per waiver policy. N = the number of ID/RD waiver participants who report access to healthcare services. D = the total number of ID/RD waiver files reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
As abuse, neglect, exploitation, and unexplained deaths are identified, action is taken to protect the health and welfare of the participant. Data is collected and analyzed for trends, and strategies are developed and implemented to prevent future occurrences. This information will be shared with DHHS.

ii. Remediation Data Aggregation

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

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

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The objective of the Quality Management Systems is to identify trends to enhance the overall performance of the system. Improvement activities are designed to ensure that they address all six (6) CMS assurances based on performance measures. Timely discovery of aggregated data allows the State to take the necessary action to correct the system's performance, thereby learning how to improve meaningful outcomes for waiver participants. Information related to each approved waiver program can be stratified by provider and service group.

SCDHHS reviews the submitted results of quality assurance review activities throughout the year. This includes, but is not limited to, LOC Determination reviews, critical incident reports, ANE reports, results of QIO provider reviews, licensing/certification reviews and any received participant complaints.

The State maintains a MOA and is implementing an Administrative Contract with the operating agency (SCDDSN) to outline the responsibilities regarding quality improvement and trend analysis.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**

☑ **Other** Specify: DDSN QIO Contractor; DHHS QIO Contractor	☑ **Other** Specify: DDSN QIO Reviews are conducted every 12-18 months. DHHS QIO LOC Reviews are conducted monthly.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

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

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

DHHS and DDSN meet periodically to discuss the effectiveness of Quality Improvement initiatives implemented by both state agencies. Needed changes can be discussed at any time.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

DHHS and DDSN both use CMS-approved Quality Improvement Organizations for different aspects of quality management reviews, all of which contribute to financial integrity and accountability. The DDSN QIO provider reviews consist of three components: staffing reviews, administrative reviews and participant reviews. The staffing reviews sample staff members at different levels of the organization to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and all other specified requirements. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of waiver services have been met.

DDSN's Internal Audit Division conducts periodic reviews of the billing systems and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS. DDSN Internal Audit Division will also conduct special request audits, investigate fraud cases, provide training and technical assistance, and review the audited financial statements of the local DSN Boards. All findings will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will conduct a review of the contracted fiscal agent, and likewise, all findings related to waiver participants will be shared with DHHS within 30 days of completion. DHHS will review DDSN Internal Audit Division annual reports, special request audits, and fraudulent case investigations and request remedial action(s) as determined necessary.

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

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number of ID/RD participant claims paid in accordance with waiver or Medicaid policies. N = the number of ID/RD participant waiver claims that paid correctly as determined through record reviews. D = the total number of claims for ID/RD waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Adjustment Logs

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN/QIO Recoupment Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☑ **Other** Specify: DDSN QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk Reviews

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DDSN QIO Contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate***

methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number of ID/RD waiver service rates that remain consistent with approved methodology. N = the number of ID/RD service rate changes. D = the total number of ID/RD waiver service rates.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Rate Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DDSN's Internal Audit Division conducts periodic reviews of the billing systems and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS in a timely manner.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHHS financial policy requires DDSN to void/replace incorrect claims using the web-based system. DDSN reviews and amends its financial policies and procedures upon review and approval by DHHS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As warranted

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The SCDHHS Bureau of Reimbursement Methodology and Policy is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public meetings, or through meetings with association representatives.

Effective October 1, 2012, waiver service fixed rates were established based upon the projected costs of the service to be provided. Projected costs used in the determination of the waiver rates effective October 1, 2012 were based on FY2010 Medicaid waiver cost reports adjusted for a trend factor to closely approximate allowable Medicaid reimbursable costs for the services provided at October 1, 2012. Both SCDDSN and SCDHHS, Bureau of Reimbursement Methodology perform financial reviews to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers maintain the option of billing directly to SCDHHS or they may voluntarily reassign their right to direct payments to SCDDSN. Providers billing SCDHHS directly may bill either by use of a CMS 1500 claim form or by the SCDHHS electronic billing system/web-tool.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ( ) **No. State or local government agencies do not certify expenditures for waiver services.**
- (●) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [x] **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

(a) – The South Carolina Department of Disabilities and Special Needs (SCDDSN).
(b) – SCDDSN files annual cost reports that report the total costs incurred for both their institutional services (i.e., ICF/IID) and all waiver services providers.
(c) – SCDDSN receives state appropriations for these waiver services. The contract between SCDHHS and SCDDSN applicable to these services requires the following contract language:
"SCDDSN agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable, and necessary cost for the provision of services to be provided to Medicaid recipients under the contract prior to submitting claims under the contract." Additionally, the Internal Audit Division within the SCDHHS has included in its audit plan planned audits of State Agency Medicaid contracts.

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for waiver services are submitted to MMIS through either the use of a CMS 1500 claim form or through the SCDHHS electronic billing system. Providers of most waiver services are given a service authorization which reflects the service identified on the service plan. This authorization form is produced by the WCM/EI provider and contains the frequency, date and type of service authorized along with a unique authorization number. Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is a special indicator in MMIS that indicates the participant is enrolled in the waiver program.

This recipient special program (RSP) indicator and Medicaid eligibility is required for payment of all waiver claims. Other waiver services, such as extra prescription drugs, are authorized simply by the presentation of the waiver participant's Medicaid card. When the Medicaid number is entered into the proper electronic system, it will identify the waiver benefit available to the individual. This is all linked to the RSP in MMIS identifying an individual as a waiver participant.

The SCDHHS Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized.

The SCDDSN Internal Audit Division periodically conducts audits of SCDDSN's billing system to ensure billing is appropriate for the service provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

  A financial management services entity is used to make payments for in-home services delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed

periodically.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

SCDDSN will receive payment for waiver services and will provide the following waiver services: residential habilitation, respite care, environmental modifications, private vehicle modifications, adult companion, adult attendant care, specialized medical equipment, supplies and assistive technology, career preparation, day activity, community services, support center services, and employment services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ◉ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Effective with the October 1, 2012 methodology revision, SCDDSN waiver services are paid prospectively. No supplemental payments are provided to SCDDSN subsequent to the claims payments. At fiscal year-end, a cost report is required that reflects the total costs incurred by SCDDSN and / or its local Boards for the discrete services provided under this waiver. SCDHHS reviews the cost report to substantiate CPE and to verify the actual expenditures of the individual services. Upon completion of the review, actual expenditures of the waiver, in the aggregate, are compared to total claims payment for the waiver (i.e. in the aggregate). If SCDDSN has been overpaid based on the aggregate comparison. SCDHHS will recoup the federal portion of the overpayment from SCDDSN and return it to CMS via the quarterly expenditure report. It should be noted that the comparison noted above is specific to each wavier operated by SCDDSN. That is the aggregation of expenditures and claims payments is made per waiver and does not consolidate all waivers together.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

SCDDSN

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:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

SCDDSN receives state appropriations to provide services under this waiver. A portion of these funds will be transferred to the SCDHHS via an IDT for payments that will be made directly to private providers enrolled with the SCDHHS. For services provided by SCDDSN, these funds will be directly expended by SCDDSN as CPE.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Residential habilitation is provided in this waiver and costs associated with room and board are excluded from Medicaid reimbursement. Guidance is provided to residential providers to identify costs that are considered room and board and which are to be excluded from reimbursable cost. Continual monitoring and training is provided to assure that room and board costs are excluded. Through annual audits, financial testing of residential cost is performed by independent CPA firms to assure that these costs are excluded.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable

to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	46843.13	9137.00	55980.13	97434.00	3695.00	101129.00	45148.87
2	47466.92	9411.00	56877.92	100357.00	3806.00	104163.00	47285.08
3	47865.77	9693.00	57558.77	103368.00	3920.00	107288.00	49729.23
4	49304.78	9984.00	59288.78	106469.00	4038.00	110507.00	51218.22
5	51076.95	10284.00	61360.95	109543.00	4159.00	113702.00	52341.05

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	7830	7830
Year 2	8630	8630
Year 3	9230	9230
Year 4	9630	9630
Year 5	9830	9830

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimate for the average length of stay is based on the most recent approved #0237 waiver 372 report (2012), which is 349 days per person.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates are based on the most recently approved #0237 waiver 372 report (2012), with an inflation factor of 3% per year.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates are based on the most recently approved #0237 waiver 372 report (2012), with an inflation factor of 3% per year.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates are based on actual 2012 ICF/IID expenditure data, with an inflation factor of 3% per year.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates are based on actual 2012 ICF/IID expenditure data, with an inflation factor of 3% per year.

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, Adult Day Health Care Services
Personal Care 2, Personal Care 1
Residential Habilitation
Respite Care
Waiver Case Management (WCM)
Adult Dental Services
Adult Vision
Audiology Services
Incontinence Supplies
Prescribed Drugs
Adult Attendant Care Services
Adult Companion Services
Adult Day Health Care Nursing
Adult Day Health Care Transportation
Behavior Support Services
CAREER PREPARATION SERVICES
COMMUNITY SERVICES
Day Activity
EMPLOYMENT SERVICES
Environmental Modifications
Nursing Services
Personal Emergency Response System (PERS)
Pest Control Bed Bugs
Pest Control Treatment
Private Vehicle Assessment/Consultation
Private Vehicle Modifications
Specialized Medical Equipment and Assistive Technology Assessment/Consultation
Specialized Medical Equipment, Supplies and Assistive Technology
Support Center Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care, Adult Day Health Care						

Services Total:						**2338065.00**
Adult Day Health Care, Adult Day Health Care Services	Day	251	207.00	45.00	**2338065.00**	
Personal Care 2, Personal Care 1 Total:						**23863648.00**
Personal Care 1	15 Minutes	78	1196.00	3.00	**279864.00**	
Personal Care 2	15 Minutes	1057	5578.00	4.00	**23583784.00**	
Residential Habilitation Total:						**246829833.36**
Daily Residential Habilitation	Day	4463	334.00	163.08	**243093897.36**	
Hourly Residential Habilitation	Hour	235	368.00	43.20	**3735936.00**	
Respite Care Total:						**9148313.00**
Nursing Facility Respite	Day	47	23.00	120.00	**129720.00**	
Respite - In-home hourly	Hour	1175	575.00	11.07	**7479168.75**	
ICF/MR Respite	Day	157	35.00	280.15	**1539424.25**	
Waiver Case Management (WCM) Total:						**24802934.40**
Waiver Case Management - Face to Face Contact	15 minute	7830	32.00	36.23	**9077788.80**	
Waiver Case Management - Non Face to Face Contact	15 minute	7830	64.00	31.38	**15725145.60**	
Adult Dental Services Total:						**720744.00**
Adult Dental Services	Visit	4072	2.00	88.50	**720744.00**	
Adult Vision Total:						**131600.00**
Adult Vision	visit	940	1.00	140.00	**131600.00**	
Audiology Services Total:						**15756.00**
Audiology Services	visit	78	1.00	202.00	**15756.00**	
Incontinence Supplies Total:						**1033200.00**
Incontinence Supplies	Month	861	12.00	100.00	**1033200.00**	
Prescribed Drugs Total:						**1368960.00**
Prescribed Drugs	Item	1488	23.00	40.00	**1368960.00**	
Adult Attendant Care Services Total:						**177444.54**
Adult Attendant Care Services	Hour	39	322.00	14.13	**177444.54**	
Adult Companion Services Total:						**383089.84**
Adult Companion Services	Hour	98	322.00	12.14	**383089.84**	
Adult Day Health Care Nursing Total:						**39675.00**

Adult Day Health Care Nursing	Day	23	115.00	15.00	**39675.00**	
Adult Day Health Care Transportation Total:						**308957.16**
Adult Day Health Care Transportation	One Way Trip	157	276.00	7.13	**308957.16**	
Behavior Support Services Total:						**1653102.00**
Behavior Support Services	30 Minute	1331	46.00	27.00	**1653102.00**	
CAREER PREPARATION SERVICES Total:						**14263409.88**
CAREER PREPARATION SERVICES	Unit	1566	334.00	27.27	**14263409.88**	
COMMUNITY SERVICES Total:						**1966930.56**
COMMUNITY SERVICES	Unit	392	184.00	27.27	**1966930.56**	
Day Activity Total:						**16944078.15**
Day Activity	Unit	1801	345.00	27.27	**16944078.15**	
EMPLOYMENT SERVICES Total:						**6994352.90**
Group	Unit	666	311.00	27.27	**5648326.02**	
Individual	Hour	352	58.00	65.93	**1346026.88**	
Environmental Modifications Total:						**585000.00**
Environmental Modifications	Item	78	1.00	7500.00	**585000.00**	
Nursing Services Total:						**2993054.40**
RN Nursing	hour	39	483.00	31.36	**590728.32**	
LPN Nursing	hour	157	644.00	23.76	**2402326.08**	
Personal Emergency Response System (PERS) Total:						**15210.00**
Installation	Item	39	1.00	30.00	**1170.00**	
Monthly Monitoring	Month	39	12.00	30.00	**14040.00**	
Pest Control Bed Bugs Total:						**191022.00**
Pest Control Bed Bugs	Item	237	1.00	806.00	**191022.00**	
Pest Control Treatment Total:						**810540.00**
Pest Control Treatment	6 x year	3002	6.00	45.00	**810540.00**	
Private Vehicle Assessment/Consultation Total:						**23400.00**
Private Vehicle Assessment/Consultation	Item	39	1.00	600.00	**23400.00**	
Private Vehicle Modifications Total:						**292500.00**
Private Vehicle						

Modifications	Item	39	1.00	7500.00	**292500.00**	
Specialized Medical Equipment and Assistive Technology Assessment/Consultation Total:						**469800.00**
Specialized Medical Equipment and Assistive Technology Assessment/Consultation	Item	1566	1.00	300.00	**469800.00**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**7830000.00**
Specialized Medical Equipment, Supplies and Assistive Technology	Item	3132	1.00	2500.00	**7830000.00**	
Support Center Services Total:						**587068.56**
Support Center Services	Unit	78	276.00	27.27	**587068.56**	
				GRAND TOTAL:		**366781688.75**
				Total Estimated Unduplicated Participants:		**7830**
				Factor D (Divide total by number of participants):		**46843.13**
				Average Length of Stay on the Waiver:		349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care, Adult Day Health Care Services Total:						**2657662.65**
Adult Day Health Care, Adult Day Health Care Services	Day	277	207.00	46.35	**2657662.65**	
Personal Care 2, Personal Care 1 Total:						**27094805.08**
Personal Care 1	15 Minute	87	1196.00	3.09	**321520.68**	
Personal Care 2	15 Minute	1165	5578.00	4.12	**26773284.40**	
Residential Habilitation Total:						**280246749.60**
Daily Residential Habilitation	Day	4920	334.00	167.97	**276021741.60**	
Hourly Residential Habilitation	Hour	258	368.00	44.50	**4225008.00**	
Respite Care Total:						**10380878.05**

Nursing Facility Respite	Day	51	23.00	123.60	**144982.80**	
Respite - In-home hourly	Hour	1295	575.00	11.40	**8488725.00**	
ICF/MR Respite	Day	173	35.00	288.55	**1747170.25**	
Waiver Case Management (WCM) Total:						**21427254.40**
Waiver Case Management - Face to Face Contact	15 minute	8630	32.00	30.71	**8480873.60**	
Waiver Case Management - Non Face to Face Contact	15 minutes	8630	64.00	23.44	**12946380.80**	
Adult Dental Services Total:						**818252.16**
Adult Dental Services	Visit	4488	2.00	91.16	**818252.16**	
Adult Vision Total:						**149391.20**
Adult Vision	Visit	1036	1.00	144.20	**149391.20**	
Audiology Services Total:						**17477.04**
Audiology Services	Visit	84	1.00	208.06	**17477.04**	
Incontinence Supplies Total:						**1174200.00**
Incontinence Supplies	Month	950	12.00	103.00	**1174200.00**	
Prescribed Drugs Total:						**1553116.40**
Prescribed Drugs	Item	1639	23.00	41.20	**1553116.40**	
Adult Attendant Care Services Total:						**201459.30**
Adult Attendant Care Services	Hour	43	322.00	14.55	**201459.30**	
Adult Companion Services Total:						**434700.00**
Adult Companion Services	Hour	108	322.00	12.50	**434700.00**	
Adult Day Health Care Nursing Total:						**46195.50**
Adult Day Health Care Nursing	Day	26	115.00	15.45	**46195.50**	
Adult Day Health Care Transportation Total:						**350470.32**
Adult Day Health Care Transportation	One Way Trip	173	276.00	7.34	**350470.32**	
Behavior Support Services Total:						**1820386.98**
Behavior Support Services	30 Minutes	1423	46.00	27.81	**1820386.98**	
CAREER PREPARATION SERVICES Total:						**16193435.56**
CAREER PREPARATION SERVICES	Unit	1726	334.00	28.09	**16193435.56**	
COMMUNITY SERVICES Total:						**2232817.92**
COMMUNITY						

SERVICES	Unit	432	184.00	28.09	**2232817.92**	
Day Activity Total:						**19227043.20**
Day Activity	Unit	1984	345.00	28.09	**19227043.20**	
EMPLOYMENT SERVICES Total:						**7944402.08**
Group	Unit	734	311.00	28.09	**6412216.66**	
Individual	Hour	389	58.00	67.91	**1532185.42**	
Environmental Modifications Total:						**672075.00**
Environmental Modifications	Item	87	1.00	7725.00	**672075.00**	
Nursing Services Total:						**3397090.34**
RN Nursing	Hour	43	483.00	32.30	**670838.70**	
LPN Nursing	Hour	173	644.00	24.47	**2726251.64**	
Personal Emergency Response System (PERS) Total:						**17273.10**
Installation	Item	43	1.00	30.90	**1328.70**	
Monthly Monitoring	Month	43	12.00	30.90	**15944.40**	
Pest Control Bed Bugs Total:						**215016.62**
Pest Control Bed Bugs	Item	259	1.00	830.18	**215016.62**	
Pest Control Treatment Total:						**911889.90**
Pest Control Treatment	6 x year	3279	6.00	46.35	**911889.90**	
Private Vehicle Assessment/Consultation Total:						**26574.00**
Private Vehicle Assessment/Consultation	Item	43	1.00	618.00	**26574.00**	
Private Vehicle Modifications Total:						**332175.00**
Private Vehicle Modifications	Item	43	1.00	7725.00	**332175.00**	
Specialized Medical Equipment and Assistive Technology Assessment/Consultation Total:						**533334.00**
Specialized Medical Equipment and Assistive Technology Assessment/Consultation	item	1726	1.00	309.00	**533334.00**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**8888900.00**
Specialized Medical Equipment, Supplies and Assistive Technology	Item	3452	1.00	2575.00	**8888900.00**	
Support Center Services Total:						**674497.08**

Support Center Services	Unit	87	276.00	28.09	**674497.08**	
				GRAND TOTAL:		**409639522.48**
				Total Estimated Unduplicated Participants:		**8630**
				Factor D (Divide total by number of participants):		**47466.92**
				Average Length of Stay on the Waiver:		349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care, Adult Day Health Care Services Total:						**2925125.28**
Adult Day Health Care, Adult Day Health Care Services	Day	296	207.00	47.74	**2925125.28**	
Personal Care 2, Personal Care 1 Total:						**29842349.60**
Personal Care 1	15 Minutes	92	1196.00	3.18	**349901.76**	
Personal Care 2	15 Minutes	1247	5578.00	4.24	**29492447.84**	
Residential Habilitation Total:						**306205372.38**
Daily Residential Habilitation	Day	5261	334.00	173.01	**304008673.74**	
Hourly Residential Habilitation	Hour	277	173.00	45.84	**2196698.64**	
Respite Care Total:						**11434924.40**
Nursing Facility Respite	Day	55	23.00	127.31	**161047.15**	
Respite - In-home hourly	Hour	1385	575.00	11.74	**9349442.50**	
ICF/MR Respite	Day	185	35.00	297.21	**1924434.75**	
Waiver Case Management (WCM) Total:						**16599232.00**
Waiver Case Management - Face to Face Contact	15 minute	9230	32.00	25.20	**7443072.00**	
Waiver Case Management - Non Face to Face Contact	15 minute	9230	64.00	15.50	**9156160.00**	
Adult Dental Services Total:						**901344.00**
Adult Dental Services	Visit	4800	2.00	93.89	**901344.00**	

Adult Vision Total:						**164571.24**
Adult Vision	Visit	1108	1.00	148.53	**164571.24**	
Audiology Services Total:						**19715.60**
Audiology Services	Visit	92	1.00	214.30	**19715.60**	
Incontinence Supplies Total:						**1292176.20**
Incontinence Supplies	Month	1015	12.00	106.09	**1292176.20**	
Prescribed Drugs Total:						**1712114.48**
Prescribed Drugs	Item	1754	23.00	42.44	**1712114.48**	
Adult Attendant Care Services Total:						**226858.66**
Adult Attendant Care Services	Hour	47	322.00	14.99	**226858.66**	
Adult Companion Services Total:						**476946.40**
Adult Companion Services	Hour	115	322.00	12.88	**476946.40**	
Adult Day Health Care Nursing Total:						**51230.20**
Adult Day Health Care Nursing	Day	28	115.00	15.91	**51230.20**	
Adult Day Health Care Transportation Total:						**386013.60**
Adult Day Health Care Transportation	One Way Trip	185	276.00	7.56	**386013.60**	
Behavior Support Services Total:						**2067063.36**
Behavior Support Services	30 Minute	1569	46.00	28.64	**2067063.36**	
CAREER PREPARATION SERVICES Total:						**17837196.52**
CAREER PREPARATION SERVICES	Unit	1846	334.00	28.93	**17837196.52**	
COMMUNITY SERVICES Total:						**2459281.44**
COMMUNITY SERVICES	Unit	462	184.00	28.93	**2459281.44**	
Day Activity Total:						**21189344.55**
Day Activity	Unit	2123	345.00	28.93	**21189344.55**	
EMPLOYMENT SERVICES Total:						**8741581.92**
Group	Unit	784	311.00	28.93	**7053828.32**	
Individual	Hour	416	58.00	69.95	**1687753.60**	
Environmental Modifications Total:						**732021.00**
Environmental Modifications	Item	92	1.00	7956.75	**732021.00**	
Nursing Services Total:						**3757590.27**

RN Nursing	Hour	47	483.00	33.27	**755262.27**	
LPN Nursing	Hour	185	644.00	25.20	**3002328.00**	
Personal Emergency Response System (PERS) Total:						**19448.13**
Installation	Item	47	1.00	31.83	**1496.01**	
Monthly Monitoring	Month	47	12.00	31.83	**17952.12**	
Pest Control Bed Bugs Total:						**236859.93**
Pest Control Bed Bugs	Item	277	1.00	855.09	**236859.93**	
Pest Control Treatment Total:						**1004545.08**
Pest Control Treatment	6 x year	3507	6.00	47.74	**1004545.08**	
Private Vehicle Assessment/Consultation Total:						**29917.38**
Private Vehicle Assessment/Consultation	Item	47	1.00	636.54	**29917.38**	
Private Vehicle Modifications Total:						**373967.25**
Private Vehicle Modifications	Item	47	1.00	7956.75	**373967.25**	
Specialized Medical Equipment and Assistive Technology Assessment/Consultation Total:						**587526.42**
Specialized Medical Equipment and Assistive Technology Assessment/Consultation	item	1846	1.00	318.27	**587526.42**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**9792107.00**
Specialized Medical Equipment, Supplies and Assistive Technology	Unit	3692	1.00	2652.25	**9792107.00**	
Support Center Services Total:						**734590.56**
Support Center Services	Unit	92	276.00	28.93	**734590.56**	
				GRAND TOTAL:		**441801014.85**
				Total Estimated Unduplicated Participants:		**9230**
				Factor D (Divide total by number of participants):		**47865.77**
				Average Length of Stay on the Waiver:		349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care, Adult Day Health Care Services Total:						**3145060.71**
Adult Day Health Care, Adult Day Health Care Services	Day	309	207.00	49.17	**3145060.71**	
Personal Care 2, Personal Care 1 Total:						**32069137.36**
Personal Care 1	15 Minutes	97	1196.00	3.28	**380519.36**	
Personal Care 2	15 Minutes	1300	5578.00	4.37	**31688618.00**	
Residential Habilitation Total:						**329110901.28**
Daily Residential Habilitation	Day	5490	334.00	178.20	**326758212.00**	
Hourly Residential Habilitation	Hour	288	173.00	47.22	**2352689.28**	
Respite Care Total:						**12285098.33**
Nursing Facility Respite	Day	57	23.00	131.13	**171911.43**	
Respite - In-home hourly	Hour	1445	575.00	12.09	**10045278.75**	
ICF/MR Respite	Day	193	35.00	306.13	**2067908.15**	
Waiver Case Management (WCM) Total:						**17842464.00**
Waiver Case Management - Face to Face Contact	15 Minute	9630	32.00	25.96	**7999833.60**	
Waiver Case Management - Non Face to Face Contact	15 Minute	9630	64.00	15.97	**9842630.40**	
Adult Dental Services Total:						**968647.36**
Adult Dental Services	Visit	5008	2.00	96.71	**968647.36**	
Adult Vision Total:						**176856.44**
Adult Vision	Visit	1156	1.00	152.99	**176856.44**	
Audiology Services Total:						**21410.81**
Audiology Services	Visit	97	1.00	220.73	**21410.81**	
Incontinence Supplies Total:						**1389914.40**
Incontinence Supplies	Month	1060	12.00	109.27	**1389914.40**	
Prescribed Drugs Total:						**1838748.57**
Prescribed Drugs	Item	1829	23.00	43.71	**1838748.57**	
Adult Attendant Care Services Total:						**238640.64**
Adult Attendant Care Services	Hour	48	322.00	15.44	**238640.64**	

Adult Companion Services Total:						**512752.80**
Adult Companion Services	Hour	120	322.00	13.27	**512752.80**	
Adult Day Health Care Nursing Total:						**54660.65**
Adult Day Health Care Nursing	Day	29	115.00	16.39	**54660.65**	
Adult Day Health Care Transportation Total:						**414957.72**
Adult Day Health Care Transportation	One Way Trip	193	276.00	7.79	**414957.72**	
Behavior Support Services Total:						**2222766.00**
Behavior Support Services	30 Minutes	1638	46.00	29.50	**2222766.00**	
CAREER PREPARATION SERVICES Total:						**19169863.20**
CAREER PREPARATION SERVICES	Unit	1926	334.00	29.80	**19169863.20**	
COMMUNITY SERVICES Total:						**2642902.40**
COMMUNITY SERVICES	Unit	482	184.00	29.80	**2642902.40**	
Day Activity Total:						**22762134.00**
Day Activity	Unit	2214	345.00	29.80	**22762134.00**	
EMPLOYMENT SERVICES Total:						**9390524.10**
Group	Unit	818	311.00	29.80	**7581060.40**	
Individual	Hour	433	58.00	72.05	**1809463.70**	
Environmental Modifications Total:						**794958.65**
Environmental Modifications	Item	97	1.00	8195.45	**794958.65**	
Nursing Services Total:						**4021136.00**
RN Nursing	Hour	48	483.00	34.27	**794515.68**	
LPN Nursing	Hour	193	644.00	25.96	**3226620.32**	
Personal Emergency Response System (PERS) Total:						**20454.72**
Installation	Item	48	1.00	32.78	**1573.44**	
Monthly Monitoring	Month	48	12.00	32.78	**18881.28**	
Pest Control Bed Bugs Total:						**254533.86**
Pest Control Bed Bugs	Item	289	1.00	880.74	**254533.86**	
Pest Control Treatment Total:						**1079478.18**
Pest Control Treatment	6 x year	3659	6.00	49.17	**1079478.18**	
Private Vehicle Assessment/Consultation						

Total:						**31470.72**
Private Vehicle Assessment/Consultation	Item	48	1.00	655.64	**31470.72**	
Private Vehicle Modifications Total:						**393381.60**
Private Vehicle Modifications	Item	48	1.00	8195.45	**393381.60**	
Specialized Medical Equipment and Assistive Technology Assessment/Consultation Total:						**631381.32**
Specialized Medical Equipment and Assistive Technology Assessment/Consultation	item	1926	1.00	327.82	**631381.32**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**10522970.64**
Specialized Medical Equipment, Supplies and Assistive Technology	Item	3852	1.00	2731.82	**10522970.64**	
Support Center Services Total:						**797805.60**
Support Center Services	Unit	97	276.00	29.80	**797805.60**	

GRAND TOTAL:	**474805012.06**
Total Estimated Unduplicated Participants:	**9630**
Factor D (Divide total by number of participants):	**49304.78**
Average Length of Stay on the Waiver:	349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care, Adult Day Health Care Services Total:						**3334542.75**
Adult Day Health Care, Adult Day Health Care Services	Day	315	209.00	50.65	**3334542.75**	
Personal Care 2, Personal Care 1 Total:						**33995134.44**
Personal Care 1	15 Minute	98	1206.00	3.38	**399475.44**	
Personal Care 2	15 Minute	1327	5626.00	4.50	**33595659.00**	
Residential Habilitation Total:						**348049389.60**

Daily Residential Habilitation	Day	5603	336.00	183.55	**345552698.40**	
Hourly Residential Habilitation	Hour	295	174.00	48.64	**2496691.20**	
Respite Care Total:						**13008313.87**
Nursing Facility Respite	Day	59	23.00	135.06	**183276.42**	
Respite - In-home hourly	hour	1475	580.00	12.45	**10650975.00**	
ICF/MR Respite	Day	197	35.00	315.31	**2174062.45**	
Waiver Case Management (WCM) Total:						**18760358.40**
Waiver Case Management - Face to Face Contact	15 minute	9830	32.00	26.74	**8411334.40**	
Waiver Case Management - Non Face to Face Contact	15 minute	9830	64.00	16.45	**10349024.00**	
Adult Dental Services Total:						**1018412.64**
Adult Dental Services	Visit	5112	2.00	99.61	**1018412.64**	
Adult Vision Total:						**185944.40**
Adult Vision	Visit	1180	1.00	157.58	**185944.40**	
Audiology Services Total:						**22280.30**
Audiology Services	Visit	98	1.00	227.35	**22280.30**	
Incontinence Supplies Total:						**1459998.60**
Incontinence Supplies	month	1081	12.00	112.55	**1459998.60**	
Prescribed Drugs Total:						**1934239.28**
Prescribed Drugs	Item	1868	23.00	45.02	**1934239.28**	
Adult Attendant Care Services Total:						**253207.50**
Adult Attendant Care Services	hour	49	325.00	15.90	**253207.50**	
Adult Companion Services Total:						**542015.50**
Adult Companion Services	hour	122	325.00	13.67	**542015.50**	
Adult Day Health Care Nursing Total:						**56784.32**
Adult Day Health Care Nursing	Day	29	116.00	16.88	**56784.32**	
Adult Day Health Care Transportation Total:						**439223.32**
Adult Day Health Care Transportation	One Way Trip	197	278.00	8.02	**439223.32**	
Behavior Support Services Total:						**2335957.74**
Behavior Support Services	30 Minute	1671	46.00	30.39	**2335957.74**	
CAREER PREPARATION SERVICES Total:						**20273077.44**

CAREER PREPARATION SERVICES	Unit	1966	336.00	30.69	**20273077.44**	
COMMUNITY SERVICES Total:						**2808503.28**
COMMUNITY SERVICES	Unit	492	186.00	30.69	**2808503.28**	
Day Activity Total:						**24147751.32**
Day Activity	Unit	2261	348.00	30.69	**24147751.32**	
EMPLOYMENT SERVICES Total:						**9933038.48**
Group	Unit	836	313.00	30.69	**8030590.92**	
Individual	Hour	442	58.00	74.21	**1902447.56**	
Environmental Modifications Total:						**827248.38**
Environmental Modifications	Item	98	1.00	8441.31	**827248.38**	
Nursing Services Total:						**4266420.90**
RN Nursing	hour	49	487.00	35.30	**842363.90**	
LPN Nursing	hour	197	650.00	26.74	**3424057.00**	
Personal Emergency Response System (PERS) Total:						**21505.12**
Installation	Item	49	1.00	33.76	**1654.24**	
Monthly Monitoring	Month	49	12.00	33.76	**19850.88**	
Pest Control Bed Bugs Total:						**267612.20**
Pest Control Bed Bugs	Item	295	1.00	907.16	**267612.20**	
Pest Control Treatment Total:						**1135066.50**
Pest Control Treatment	6 x year	3735	6.00	50.65	**1135066.50**	
Private Vehicle Assessment/Consultation Total:						**33090.19**
Private Vehicle Assessment/Consultation	Item	49	1.00	675.31	**33090.19**	
Private Vehicle Modifications Total:						**413624.19**
Private Vehicle Modifications	Item	49	1.00	8441.31	**413624.19**	
Specialized Medical Equipment and Assistive Technology Assessment/Consultation Total:						**663819.90**
Specialized Medical Equipment and Assistive Technology Assessment/Consultation	item	1966	1.00	337.65	**663819.90**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**11063743.64**

Specialized Medical Equipment, Supplies and Assistive Technology	Item	3932	1.00	2813.77	**11063743.64**	
Support Center Services Total:						**836118.36**
Support Center Services	Unit	98	278.00	30.69	**836118.36**	

GRAND TOTAL:	**502086422.56**
Total Estimated Unduplicated Participants:	**9830**
Factor D (Divide total by number of participants):	**51076.95**
Average Length of Stay on the Waiver:	349