

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

South Carolina Department of Health and Human Services (SCDHHS)

Submission Date: August, 2007

CMS Receipt Date (CMS Use)

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

Brief Description:

This is a request to renew South Carolina's Mechanical Ventilator Waiver. The current waiver serves individuals who meet the Nursing Facility Level of care and are ventilator dependent. The services offered in this waiver include Nursing, Personal Care, Respite, Home Accessibility Adaptations, Specialized Medical Supplies and Equipment, Personal Emergency Response Systems, Attendant Care, and two extra prescription medications above what is allowed through the state plan for those individuals not currently eligible for Medicare coverage.

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Effective Date	July 1, 2006

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

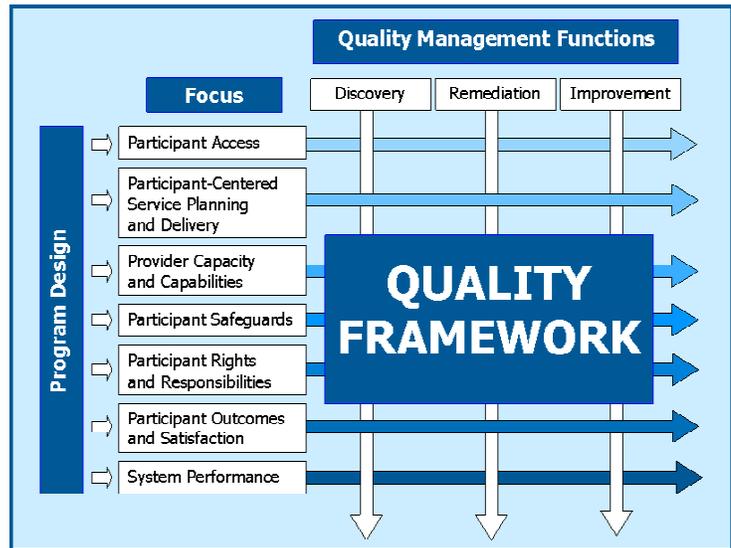
The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other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

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

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

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

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



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1. Request Information

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

B. Waiver Title (optional): **Mechanical Ventilator Waiver**

C. Type of Request (select only one):

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input checked="" type="checkbox"/>	Renewal (5 Years) of Waiver #	40181	
<input type="radio"/>	Amendment to Waiver #		

D. Type of Waiver (select only one):

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

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

E.2 Approved Effective Date (CMS Use):

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

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="checkbox"/>	Nursing Facility (select applicable level of care)
<input type="radio"/>	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

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

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

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2. Brief Waiver Description

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

South Carolina is seeking to renew *the Mechanical Ventilator waiver*. This waiver will serve the frail elderly and persons with physical disabilities that require mechanical ventilation who meet the nursing facility level of care criteria. The existing waiver and renewal proposal will offer participant direction of the attendant care service without budget authority. All other services within this waiver are primarily provider managed.

The direct administration of this waiver comes through thirteen regional South Carolina Department of Health and Human Service (SCDHHS) offices around the State, each of which covers designated counties of South Carolina. Nurses working in these 13 areas are responsible for ensuring that participants are aware of their options within the waiver and can make informed choices as to which service(s) they prefer.

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3. Components of the Waiver Request

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

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

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

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

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

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

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

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

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

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

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

A public forum was held with interested parties including advocates, providers, state agencies and other entities on August 28th 2007. This renewal application was also approved by the South Carolina Department of Health and Human Services (SCDHHS) Medical Care Advisory Committee. Finally, a draft of the application was posted on the SCDHHS website, the SCAARP website and the SC Access (the states web-based information and referral system) with an opportunity for public input. We recieved written comments and responded to the concerned citizens.

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

7. Contact Person(s)

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

First Name:	Roy
Last Name	Smith
Title:	Director, Division of Community Long Term Care Waiver Management
Agency:	South Carolina Department of Health and Human Services
Address 1:	P.O. Box 8206
Address 2:	
City	Columbia
State	South Carolina
Zip Code	29202-9206
Telephone:	(803) 898-2721
E-mail	smithroy@scdhhs.gov
Fax Number	(803) 255-8209

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	

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[Redacted area]

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8. Authorizing Signature

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

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

Signature: Ms. Emma Forkner
 State Medicaid Director or Designee

Date:	August 30, 2007
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First Name:	Emma
Last Name	Forkner
Title:	Director
Agency:	South Carolina Department of Health and Human Services
Address 1:	P.O. Box 8206
Address 2:	
City	Columbia
State	South Carolina
Zip Code	29202-8206
Telephone:	(803) 898-2500
E-mail	Forkner@scdhhs.gov
Fax Number	(803) 255-8235

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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Appendix A: Waiver Administration and Operation

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

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

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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

<input type="radio"/>	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
<input checked="" type="radio"/>	No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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Appendix A: Waiver Administration and Operation

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

<input type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	<p>Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>
<input checked="" type="checkbox"/>	<p>Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.</p>

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

- 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:

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Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

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

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Appendix B: Participant Access and Eligibility

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

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

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input checked="" type="radio"/>	Aged or Disabled, or Both			
<input checked="" type="checkbox"/>	Aged (age 65 and older)			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Disabled (Physical) (under age 65)	21		
<input type="checkbox"/>	Disabled (Other) (under age 65)			
Specific Aged/Disabled Subgroup				
<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Technology Dependent	21		<input type="checkbox"/>
<input type="radio"/>	Mental Retardation or Developmental Disability, or Both			
<input type="checkbox"/>	Autism			<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/>	Mental Illness			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)			

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

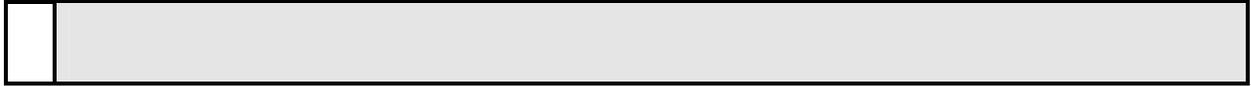
Admission to the waiver is restricted to participants who meet NF level of care and who are dependent on life sustaining mechanical ventilation.

- 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*):

<input checked="" type="radio"/>	Not applicable – There is no maximum age limit
<input type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (<i>specify</i>):

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Appendix B-2: Individual Cost Limit

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

<input checked="" type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>			
<input type="radio"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>			
<input type="radio"/>	The cost limit specified by the State is (<i>select one</i>):		
<input type="radio"/>	The following dollar amount: \$		
<input type="radio"/>	The dollar amount (<i>select one</i>):		
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input type="radio"/>			
<input type="radio"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="radio"/>	Other – <i>Specify</i> :		
<input type="radio"/>			

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

--

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

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual’s needs.
<input type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	60
Year 2	68
Year 3	76
Year 4 (renewal only)	84
Year 5 (renewal only)	92

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

<input checked="" type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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

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

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

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

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

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

All individuals may enroll in the waiver as soon as all financial and level of care determinations have been done. There is no waiting list for this waiver.
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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

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

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

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input checked="" type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input type="checkbox"/>	Optional State supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input checked="" type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input checked="" type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
<input type="checkbox"/>	Medically needy
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
<i>Special home and community-based waiver group under 42 CFR §435.217</i> Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	
<input type="radio"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
<input checked="" type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217

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	●	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):
	■	A special income level equal to (select one):
	●	300% of the SSI Federal Benefit Rate (FBR)
	○	% of FBR, which is lower than 300% (42 CFR §435.236)
	○	\$ which is lower than 300%
	□	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: (<i>select one</i>)
	●	100% of FPL
	○	% of FPL, which is lower than 100%
	□	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :

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Appendix B-5: Post-Eligibility Treatment of Income

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

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

<input checked="" type="radio"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):
<input checked="" type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. <i>Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

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

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

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

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<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$2,416	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable (see instructions)	
iii. Allowance for the family (select one):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify): If a minor is in the home, \$2,416. If responsible for a minor living outside the home, \$398.	
<input type="radio"/>	Not applicable (see instructions)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits (specify):	

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based

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waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

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<input type="radio"/>	The following dollar amount: \$		The amount specified cannot exceed the higher
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (see instructions)		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:			
a. Health insurance premiums, deductibles and co-insurance charges			
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>			
<input type="radio"/>	The State does not establish reasonable limits.		
	The State establishes the following reasonable limits (<i>specify</i>):		

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):		
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)	
	<input type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input checked="" type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):
	<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
	C	% of the FBR, which is less than 300%
	C	\$ which is less than 300%.
	<input type="radio"/>	% of the Federal poverty level
	<input type="radio"/>	Other (specify):
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (<i>select one</i>):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
	<input type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.
	<input type="radio"/>	The amount is determined using the following formula:
<input checked="" type="radio"/>	Not applicable	

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iii. Allowance for the family <i>(select one):</i>	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: <input style="width: 50px; border: 1px solid black;" type="text" value="\$"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="radio"/>	Other (specify): <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;">Procedure to Determine the Amount of Income Allowances for Other Family Members</p> <ul style="list-style-type: none"> • Determine the gross income of each family member. • Total the family's gross income. • Subtract the total gross income from \$2,416. • One third of the remaining amount is each family member's income allowance. • Add each family member's income allowance together to determine the total family income allowance. • This is the amount allowed for allocation to family members. Note: If the dependent children live with the community spouse, allocation of income is based on the above standard. If the dependent children do not live with the community spouse, the allocation is made based on TANF/FI standards. </div>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input checked="" type="radio"/>	The State establishes the following reasonable limits <i>(specify):</i>

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1. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of \$70 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.
2. Dentures
 - A one-time expense
 - Not to exceed \$225 per plate or \$450 for one full pair of dentures.
 - A licensed dental practitioner must certify necessity.
 - An expense for more than one pair of dentures must be prior approved by State DHHS.
3. Denture Repair
 - Justified as necessary by a licensed dental practitioner.
 - Not to exceed \$37 per occurrence.
4. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed \$20 per visit.
5. Hearing Aids
 - A one-time expense.
 - Not to exceed \$380.
 - Necessity must be certified by a licensed practitioner.
 - An expense for more than one hearing aid must be prior approved by State DHHS.
6. Other non-covered medical expenses that are recognized by State law but not covered by Medicaid, not to exceed \$20 per item/service. These non-covered medical expenses must be prescribed by a licensed practitioner and prior approved by State DHHS.

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

i. Allowance for the needs of the waiver participant <i>(select one):</i>			
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i>		
<input type="radio"/>	300%		of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	%		of the FBR, which is less than 300%
<input type="radio"/>	\$		which is less than 300% of the FBR
<input type="radio"/>	%		of the Federal poverty level
<input type="radio"/>	Other (specify):		
<input type="radio"/>	The following dollar amount: \$		
			If this amount changes, this item will be revised.

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<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	The following standard under 42 CFR §435.121:	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ <input style="width: 50px;" type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable	
iii. Allowance for the family (select one)		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ <input style="width: 50px;" type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (see instructions)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:		
	a. Health insurance premiums, deductibles and co-insurance charges	
	b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of	

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these expenses. *Select one:*

- The State does not establish reasonable limits.
- The State establishes the following reasonable limits (*specify*):

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

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

i. Allowance for the personal needs of the waiver participant <i>(select one):</i>	
<input type="radio"/>	SSI Standard
<input type="radio"/>	Optional State Supplement standard
<input type="radio"/>	Medically Needy Income Standard
<input type="radio"/>	The special income level for institutionalized persons
<input checked="" type="radio"/>	300% of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: <input style="width: 100px;" type="text"/> If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance: <input style="width: 100%; height: 20px;" type="text"/>
<input type="radio"/>	Other <i>(specify):</i> <input style="width: 100%; height: 20px;" type="text"/>
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. <i>Select one:</i>	
<input checked="" type="radio"/>	Allowance is the same
<input type="radio"/>	Allowance is different. Explanation of difference: <input style="width: 100%; height: 20px;" type="text"/>
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges.	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input checked="" type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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

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

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

i.	Minimum number of services.	The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is <i>(insert number)</i> :
	1	
ii.	Frequency of services.	The State requires <i>(select one)</i> :
<input checked="" type="radio"/>		The provision of waiver services at least monthly
<input type="radio"/>		Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

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

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

Registered Nurse licensed by the State or Licensed Practical Nurse working under the supervision of a Registered Nurse.

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

A standardized instrument is utilized to gather assessment information necessary for level of care determinations. The same level of care criteria and assessment form are used for nursing facility placement and waiver enrollment.

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

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The same process is used. The same instrument and level of care are used.

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

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

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

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

An automated tickler system produced by the State's Case Management System (CMS) is used to ensure timely reevaluations.

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

Records are housed with the Medicaid Agency.

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Appendix B-7: Freedom of Choice

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

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

The Registered Nurse discusses long term care options with potentially eligible individuals (or their legal representatives) during the assessment and subsequent visits.

The Registered Nurse secures a freedom of choice form (Service Choice Form) from each waiver participant to ensure that the participant is involved in planning his/her long term care. This choice will remain in effect until such time as the participant changes his/her mind. If the participant lacks the physical or mental ability required to make a written choice regarding his/her care, a responsible party may sign the Service Choice form.

- b. Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Participant Service Choice forms are maintained for a minimum three years in the participant record located in the regional offices.

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

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

DHHS is in compliance with Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons by contracting with the University of South Carolina for a telephone interpreter service line; “Language Line”. Each regional office has this equipment available for use by nurses during home visits. The agency also has a contract with the University of South Carolina for a written material translation service. In addition, there is a Spanish speaking staff member employed by the waiver program who is available for interpreter services.

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Appendix C-1: Summary of Services Covered

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

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

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c.	Home Accessibility Adaptations and Appliances	
d.	Specialized Medical Supplies and Equipment	
e.	Personal Emergency Response System	
Extended State Plan Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	The following extended State plan services are provided (<i>list each extended State plan service by service title</i>):	
a.	Prescription Drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits.	
b.		
c.		
Supports for Participant Direction (select one)		
<input checked="" type="radio"/>	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.	
<input type="radio"/>	Not applicable	
	Included	
Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	■	
Financial Management Services	■	Note: Financial Management Services are offered as an administrative function rather than as a waiver service.
Other Supports for Participant Direction (<i>list each support by service title</i>):		
a.		
b.		
c.		

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

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

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

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

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Appendix C-2: General Service Specifications

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

<input checked="" type="radio"/>	<p>Yes. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):</p> <p>Nursing Homes, Community Residential Care Facilities, Home Health Agencies and Adult Day Health Care agencies are all required by law to have background checks done on direct care staff. These are state level investigations performed by South Carolina Law Enforcement (SLED checks) for each of the agencies above that hire and recruit direct care staff. The State Health Department performs licensure inspections incorporating the requirement that all direct care staff of these agencies have the required background check.</p> <p>Personal Care Agencies and Attendants are required by the SCDHHS to have a background check completed for anyone providing direct care to a waiver participant.</p>
<input type="radio"/>	<p>No. Criminal history and/or background investigations are not required.</p>

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

<input type="radio"/>	<p>Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):</p>
<input checked="" type="radio"/>	<p>No. The State does not conduct abuse registry screening.</p>

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

<input checked="" type="radio"/>	<p>No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input type="radio"/>	<p>Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i – c.iii.</i></p>

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

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

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

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

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

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

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

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

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

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

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Reimbursement for services may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members may not be reimbursed: the spouse of a Medicaid participant; a parent of a minor Medicaid participant; a step-parent of a minor Medicaid participant; a foster parent of a minor Medicaid participant; and, any other legally responsible guardian of a Medicaid participant. 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. South Carolina monitors the provision of services through a phone monitoring system linked directly to the service authorization in place for anyone receiving services to verify that payments are only made for services that are rendered to the participant.

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

Potential providers are given the opportunity to enroll/contract with the South Carolina Medicaid agency. Potential providers are made aware of the requirements for enrollment through: (1) The agency's website and, (2) contacting the Medicaid agency directly. Potential providers are given a packet of information that is used in the enrollment process. Some services specified in this waiver require a pre-contractual review and signed contract for enrollment as a provider. Once a potential provider has signed a contract or an enrollment application, enrollment with DHHS occurs within 14 days.

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Appendix C-3: Waiver Services Specifications

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

Service Specification			
Service Title:	Personal Care/ Personal Care I + II		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
<p>A service designed to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (performing a task for the person) or cuing to prompt the participant to perform a task. Such assistance may include assistance in activities of daily living (bathing, dressing, toileting, transferring, maintaining continence, etc.). These services in activities of daily living are referred to as Personal Care II services. This assistance may also include assistance with instrumental activities of daily living (light housework, laundry, meal preparation, grocery shopping, and using the telephone). These services are referred to as Personal Care I. South Carolina has established different rates for these two components of personal care. Personal care services may be provided on an episodic or on a continuing basis. Personal care services may be furnished outside the home, and/or to assist a person to function in the work place or as an adjunct to the provision of employment services, based on the determination of its need by nurses.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Personal Care Agency
			Nursing Agency
			Home Health Agency
			County Council on Aging
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Personal Care Agency			Contract Scope of services
Nursing Agency			Contract Scope of services

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Home Health Agency			Contract Scope of services
County Council on Aging			Contract Scope of services
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Personal Care Agency	Medicaid agency	Annually/biannually
	Nursing Agency	Medicaid agency	Annually/biannually
	Home Health Agency	Medicaid agency	Annually/biannually
	County Council on Aging	Medicaid agency	Annually/biannually
Service Delivery Method			
Service Delivery Method (<i>check each that applies</i>):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification

Service Title:	Respite Care Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in current waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the current waiver.

Service Definition (Scope):

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal financial participation is not being 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 and federal financial participation for room and board may be furnished and claimed in a Medicaid certified nursing facility, or hospital. Respite may also be provided in the participant's home but federal financial participation for room and board will not be claimed in the in-home setting.

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

This service is limited to 28 days of respite per year outside of the home. Of those 28 days, no more than 14 will be allowed in a hospital or nursing facility.

In-home respite will not exceed two days in a week and no more than eight total days of in-home respite will be allowed in any year.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individual respite provider		Nursing Facility
				Hospital
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Nursing Facility	Yes, SC Code, Sec. 44-7-250 Reg. #61-17, Equivalent for NC & GA		
Hospital	Yes, SC Code, Sec. 44-7-260 Reg. #61-16, Equivalent for NC & GA		
Individual Respite Provider			Respite caregivers must be at least 18 years of age, capable of following a plan of service with minimal supervision, be

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			free from communicable diseases, and be able to demonstrate a competency in caring for the participant.
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Nursing Home	Medicaid Agency, Department of Health and Environmental Control	Upon Enrollment; Annually
	Hospitals	Medicaid Agency, Department of Health and Environmental Control	Upon Enrollment; Annually
	Individual respite provider	Medicaid Agency	Upon Enrollment; Annually
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E – This applies to in-home respite only	<input type="checkbox"/> Provider managed

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Service Specification				
Service Title:	Private Duty Nursing			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input checked="" type="radio"/>	Service is included in current waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the current waiver.			
Service Definition (Scope):				
Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to a participant at home.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Nursing services are limited to 60 hours of LPN services per week and 45 hours of RN services per week.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Medicaid enrolled nurse		Nursing Agency
				Home Health Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Nursing Agency	Yes, Code of laws 40-33-10 et seq		Contract Scope of services	
Home Health Agency	Yes, Code of laws 40-33-10 et seq		Contract Scope of services	
Medicaid Enrolled Nurse	Yes, Code of laws 40-33-10 et seq		Contract Scope of services	
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:		Frequency of Verification
	Nursing Agency	Medicaid Agency		Upon Enrollment Annually/Biannually
	Home Health Agency	Medicaid Agency		Upon Enrollment Annually/Biannually
	Medicaid Enrolled Nurse	Medicaid Agency		Upon Enrollment Annually/Biannually
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Service Specification			
Service Title:	Attendant Care Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
Hands-on care of both a supportive and health related nature. 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, which are incidental to the performance of care, may also be furnished as part of this activity.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>
	Individual chosen by the waiver participant		Agency. List the types of agencies:
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual chosen by the waiver participant			Attendants will be at least 18 years of age, capable of following a plan of service with minimal supervision, be free from communicable diseases, and be able to demonstrate a competency in caring for the participant.
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Individual chosen by the waiver participant	Licensed nurse under a contract with state Medicaid agency	Upon Enrollment; Annually
Service Delivery Method			
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>
			Provider managed

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Service Specification			
Service Title:	Home Accessibility Adaptations		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
<p>Those physical adaptations, including pest control, to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, heating and air units, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.</p> <p>Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations are prior authorized and are based on the cost effectiveness of the purchase. Experimental or prohibited treatments are not covered.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types: Volunteer	<input checked="" type="checkbox"/> Agency. List the types of agencies: Building contractor Licensed Business	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Building Contractor	Code of laws, 1976 as amended 40-59-15 et seq.		Work will be provided in accordance with appropriate local and state codes
Volunteer			Work performed by volunteers, not meeting state licensure requirements, must meet all applicable local and state codes.
Licensed Business	Code of Laws		

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	Building Contractor	Medicaid Agency	Upon Enrollment; Annually
	Volunteer	Medicaid Agency	Upon Enrollment
	Licensed Business	Medicaid Agency	Upon Enrollment
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Specialized Medical Equipment and Supplies		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
Specialized medical equipment and supplies include incontinence supplies, under pads, wipes, transfer benches, shower chairs, raised toilet seats, hand held shower heads and nutritional supplements, which are necessary medical supplies, used to address participants' functional limitations but not offered under the State plan.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
		Enrolled DME Provider	
		Licensed Business	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Licensed Business	Yes		
DME Provider	Yes		
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Licensed Business	Medicaid Agency	Upon Enrollment
	DME Provider	Medicaid Agency	Upon Enrollment
Service Delivery Method			
	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed	

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Service Specification			
Service Title:	Personal Emergency Response System		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a “help” button is activated. The service includes installation, participant instruction and maintenance of devices/systems. The response center is staffed by trained professionals.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Participants must be alone six or more hours of the day. In extraordinary cases, exceptions may be made to allow for participants not meeting the six hour requirement.			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
		Emergency Response Provider	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Emergency Response provider			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	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Emergency Response providers	Medicaid Agency	Upon Enrollment
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed	

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Service Specification			
Service Title:	Prescription Drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits.		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
Services that are provided when the limits of prescription drugs under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from prescription drug services furnished under the State plan. The provider qualifications specified in the State plan apply. Two additional prescription drugs will be allowed above the state plan limit under this waiver.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Two additional prescription drugs above the state plan limit.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
	Pharmacists	Pharmacy Providers	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Pharmacy Providers	Pharmacy permit chapter 43 section 40-43-10 et.seq. SC code of laws. Equivalent in NC and GA		
Pharmacists	Pharmacy permit chapter 43 section 40-43-10 et.seq. SC code of laws. Equivalent in NC and GA		
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Pharmacy Providers	Medicaid Agency	Upon Enrollment
	Pharmacists	Medicaid Agency	Upon Enrollment

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Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Appendix C-4: Additional Limits on Amount of Waiver Services

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

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

<input type="checkbox"/>	Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>
<input checked="" type="checkbox"/>	Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

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

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

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

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

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

Each participant is involved in the service planning and implementation process and may also include any other person(s) of their choice in this process. Also the service plan is reviewed with the participant at each quarterly visit and annual reevaluation. The service plan agreement form is signed by the participant at the first quarterly visit after entry into the waiver and each annual reevaluation.

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- 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):

Service planning encompasses a comprehensive review of the participant's problems and strengths. Goals are set based on the participant's identified needs. This service planning process allows for participation of the participant and/or responsible party, physician, service providers, and CLTC nurse. Service planning provides the involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized.

Service planning includes service coordination with other involved agencies, i.e., home health, case management hierarchy agencies, etc., to ensure all services are considered in the development of the service plan.

Completion and implementation of the service plan is a function of the nurse.

Development of the Service Plan

The Service Plan is developed by the nurse from the assessment information, input from the participant, responsible party, and/or knowledgeable others, and agencies providing services to the participant.

Active participation and planning with the participant and/or the responsible party regarding the participant's long term care is an integral part of the CLTC Program. Development of a realistic and thorough Service Plan and its implementation in the community involves numerous contacts and extensive planning and coordination.

Service planning must address strengths and problems identified through the assessment process as well as viable solutions. It must include resources currently utilized by the participant, both formal and informal, as well as those additional services which may be available to meet the participant's needs.

All payment sources, where appropriate, should be considered prior to using Medicaid services (including waiver services) in the Service Plan.

Each Service Plan should be individualized for a particular participant and completed so that a service professional unfamiliar with the participant can have, by reading the plan, a clear picture of

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what is being done for the participant.

Service Plan Components

There are five (5) components identified on the Service Plan. These components have applicable information which can be identified through the assessment instrument as follows:

- I. Medical Status -
- II. Skin/Nutrition -
- IIIA. Functional Activities of Daily Living (ADL) -
- IIIB. Instrumental Activities of Daily Living (IADL)
- IV. Psychosocial Information
- V. Environmental and Social Supports -

Problems

In order to develop a plan for intervention, a problem must be defined clearly. The problems listed on the Service Plan should be those problems with which the CLTC staff, participant, and responsible party are actively working. Each listed problem should have corresponding goals and interventions.

When the nurse identifies services that are needed but unavailable, they should be noted in the body of the Service Plan as a problem and identified as an unmet need under the intervention. The Service Plan must address all areas in which the participant requires at least limited/moderate assistance.

Goals

To evaluate the effectiveness of a Service Plan, the expected outcome or goal for an intervention must be identified. A goal may be rehabilitative, maintenance, participant or caregiver oriented, as appropriate. A goal is developed as a joint effort between the participant, responsible party, physician, and nurse. Each problem must have a related goal.

A goal must be:

1. Limited in time, so it is known when to expect and measure an achievement;
2. Stated in positive terms, not in terms of what should be avoided;
3. Defined in terms of the expected outcome (a result or condition to be achieved) rather than an activity to be performed;
4. Written in quantifiable (measurable) terms, so that all involved persons may know when the goal is reached;
5. Achievable, taking into consideration known resources;
6. Designed as a joint commitment between the participant and the nurse, taking into account the participant's wishes and priorities; and,
7. Written to achieve a single end, not a conglomerate of expected outcomes.

Planned Intervention

Once a goal has been established, an intervention should be selected to reach the goal.

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Service Plan Completion and Implementation

The completed Service Plan must be printed and placed in the participant's permanent record. A copy of the Service Plan must be routed to all waiver service providers within five (5) working days of completion.

Service Plan Evaluation

After the service plan is completed and implemented, it must be evaluated. Ensuring the service plan's effectiveness and accuracy is an on-going process.

A formal evaluation includes a review of the previously set goals to determine if they have been met. This review should determine if the stated problem is still a problem, if the activities to be implemented were carried out, and if the activities to be implemented are still appropriate.

The time frame for the formal evaluation depends on many factors and will vary, but it must be completed at the 365-day re-evaluation, the date established at the time the Service Plan is finalized. However, should significant changes occur in a participant's condition or location, or in the status of the responsible party, an immediate evaluation of the Service Plan's appropriateness must be completed. The participant who is unstable and who has a limited support system may need evaluating more frequently than every 365 days. Should the participant have significant changes resulting in the need for a CCM re-evaluation of the 1718, a formal evaluation of the Service Plan must take place.

After a formal or on-going evaluation is completed, a new Service Plan is generated and routed to all appropriate waiver service providers within five (5) working days of completion and/or revision.

Service Plan Agreement Sheet

The Service Plan Agreement Sheet is part of the current Service Plan and is presented to the participant, responsible party, and/or knowledgeable other as the last page of the Plan. The Service Plan Agreement Sheet serves as a written record that the Service Plan has been developed, reviewed, and evaluated with the participant, responsible party, and/or knowledgeable other is signed and dated by both the nurse and the participant, responsible party, and/or knowledgeable other.

- 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.

At the time of the initial assessment as well as at reevaluations, participants are assessed for risks. If risks are identified, these are discussed with the participant/responsible party. Where feasible and appropriate, interventions or strategies to reduce risks will be negotiated. If the probability of high risk cannot be successfully negotiated, the nurse will remind the participant/responsible party of the statement he or she has signed acknowledging the rights, responsibilities and risks of residing and receiving services in a non institutional setting. In some instances, additional monitoring may be required to ensure the health and welfare of the participant.

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Participants are designated for being at-risk for a missed provider visit and being at-risk during a natural disaster. These are part of the assessment and service plan in the automated computer system. Interventions are included in the service plan to address identified risks.

Agency and participant directed in-home services providing assistance with activities of daily living are required to have a backup plan to address emergencies and missed visits. Interventions in the service plan include backup services utilizing informal supports when formal supports are unavailable. If the back-up system is not working appropriately, the participant can notify the nurse and they can work on revising the backup system. If problems continue, traditional agency directed services can be utilized and Adult Protective Services will be contacted for intervention as needed.

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

Participants are given a list of providers of waiver services in order to select a provider. This list includes phone numbers. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider. In no case will the nurse choose a provider for a participant. Also, brochures giving tips on provider selection have been developed for some services and are under development for other services.

- 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):

A supervisor in the state office oversees waiver operations across the state and is charged with overview and approval of all service plans as appropriate. The supervisor is an employee of the State Medicaid agency.

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

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

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- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

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

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Appendix D-2: Service Plan Implementation and Monitoring

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

Nurses monitor the service plan on a monthly basis. This is performed by monthly phone calls and quarterly visits. This monitoring also includes obtaining information about the participant's health, safety and welfare as well as information about service delivery and appropriateness of interventions.

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

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>

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Appendix E: Participant Direction of Services

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

Applicability (select one):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

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

Appendix E-1: Overview

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

Participants may choose to receive all agency directed services; or a mix of agency and participant directed services. Participants may choose to receive the attendant care service with employer authority.

Participants may direct the attendant care service if they have no communication or cognitive deficits which make them unable to make independent decision in their own best interest. Participants may also choose a representative to act on their behalf if they are unable or unwilling to take on the additional risks and responsibilities of directing this service. Representatives must also have no communicative or cognitive deficit that would interfere with their representation of the participant. They must also be willing to direct the participant’s care, must demonstrate that they are familiar with the participant’s needs and desires, and must be able to act in the best interest of the participant.

Nurse Consultants introduce participant direction as an option and provide more detailed information concerning the benefits and responsibilities of the option. Nurses visit participants who want to pursue participant direction and provide extensive information about the risks, responsibilities and liabilities of the option. The nurse assists each participant to list and prioritize individual needs, decide how he/she wants to get needs met, develop a service plan, and determine whether or not the self-direction option is an appropriate choice. The nurse facilitates the decision-making process as the participant identifies what is important for him/her to stay at home, how often each service is needed, and who he/she would like to provide each service. Information is provided to participants about the hiring, management and firing of workers. In addition, the nurse also ensures that employment packets are

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completed and forwarded to the FMS and that provider agreements are in place for both workers and vendors of goods and services prior to the authorization of services. Independent advocacy is available to participants who feel the need for additional support.

SCDHHS' Care Call system tracks the delivery of services and transfers data and claims to MMIS weekly for the amount of services provided. Weekly payments are transferred from MMIS to the FMS, who is then responsible for processing payroll, withholding, filing and payment of applicable employment-related taxes and insurances. These services are provided for each participant with employer authority over his/her care.

Once a participant is receiving services, the nurse continues to monitor service delivery and the status of the participant's health and safety. Care Call reports are monitored monthly for service delivery, and monthly contacts ensure that care is being provided and that the participant is receiving appropriate care. Quarterly visits are also made to ensure that the appropriate services are being provided.

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

<input checked="" type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

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

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available

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	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. <i>Specify the criteria:</i>
	Using the assessment instrument, participants are evaluated on the basis of communication and cognitive patterns to determine their ability to self-direct their own care. If a participant is unable to self-direct or chooses to have a representative direct his/her care, the representative is also evaluated to determine his/her knowledge of the participant's medical condition, needs and preferences, as well as his/her ability to communicate and make the participant's needs understood, and to advocate for the participant. Anyone denied full participant direction may choose to appeal the decision.

- 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 assessment, Nurse Consultants introduce participant direction as an option and provide a brochure giving participants basic information about the opportunities available to them for directing their own care. Participants are told that under certain circumstances they may elect to direct some of their services by determining who will provide their care, and when and how they want services to be given. Nurses provide this information and brochure to participants on an ongoing basis.

- 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 a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
■	Waiver services may be directed by a legal representative of the participant.
■	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant: A participant may choose to have waiver services directed by a representative and he/she may choose anyone willing to understand and assume the risks, rights and responsibilities of directing the participant's care. A representative may be a legal guardian, family member, or a friend of the participant. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant's preferences, and must agree to a predetermined frequency of contact with the participant. A representative may not be paid to be a representative, and may not be paid to provide waiver services to the participant.

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

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Participant-Directed Waiver Service	Employer Authority	Budget Authority
Respite Care Services (In-Home Respite)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Attendant Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

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

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

<input type="radio"/>	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3.								
<input checked="" type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>								
i.	<p>Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:</p> <p>South Carolina contracts for Care Call services through award of a bid submitted in response to a Request for Proposals (RFP) by the State. The FMS are included as a component of this contract.</p>								
ii.	<p>Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:</p> <p>A minimum monthly per participant fee is charged for financial management services. Additional fees are charged per check above a set number of checks per month.</p>								
iii.	<p>Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i></p> <p><i>Supports furnished when the participant is the employer of direct support workers:</i></p> <table border="1"> <tr> <td><input checked="" type="checkbox"/></td> <td>Assist participant in verifying support worker citizenship status</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Collect and process timesheets of support workers</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Other <i>(specify):</i></td> </tr> </table> <p><i>Supports furnished when the participant exercises budget authority:</i></p>	<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status	<input checked="" type="checkbox"/>	Collect and process timesheets of support workers	<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance	<input type="checkbox"/>	Other <i>(specify):</i>
<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status								
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers								
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance								
<input type="checkbox"/>	Other <i>(specify):</i>								

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<input type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
<input type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other services and supports (<i>specify</i>):
<i>Additional functions/activities:</i>	
<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
<input type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other (<i>specify</i>):
iv.	<p>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.</p> <p>The Medicaid Agency's Care Call system documents the delivery of services by providers and compares the claims to authorizations to ensure appropriate service provision. The system transfers data and submits claims to MMIS weekly for the amount of service provided. Weekly payments are transmitted from MMIS to FMS, including a detailed breakdown of each worker's checks. FMS makes weekly payments and posts electronically to the Medicaid agency on a weekly basis. Daily, the monies received are reviewed and compared to the amount of monies being paid out. CLTC staff, providers and participants access web-based reports to monitor service delivery. Financial audits are performed periodically.</p>

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

<input type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p>
<input type="checkbox"/>	<p>Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: _____</p>
<input checked="" type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p> <p>A nurse visits the participant and discusses what is involved in participant direction. The nurse helps the participant list individual needs, decide how to get needs met and develop a service plan. The functions of the FMS are explained and, when providers are identified, the nurse may arrange for assistance with completing necessary paperwork. The nurse helps the participant identify what is important for him/her to remain at home, how often the service is needed, and who might be available to provide the service.</p>

k. Independent Advocacy (*select one*).

<input checked="" type="radio"/>	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p> <p>South Carolina Protection and Advocacy for People with Disabilities, Inc. will provide independent advocacy for participants upon request. Their website is located at www.protectionandadvocacy-sc.org.</p>
<input type="radio"/>	<p>No. Arrangements have not been made for independent advocacy.</p>

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

<p>Participants may elect to voluntarily discontinue participant direction at any time and may choose agency-driven options. The termination of participant directed services and authorization of agency driven services are coordinated to assure continuity of services.</p>

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-

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managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants may be involuntarily terminated from the use of participant directed services when they are unable to direct their own care or have no representative willing and/or able to do so. They may also be unable to participate if they display an inability or reluctance to supervise their workers. Participants who are involuntarily terminated from participant directed services are given the option of receiving agency directed services. If a participant is involuntarily terminated from participant directed services, the termination of participant directed services and the authorization of agency directed services are coordinated to assure continuity of services.

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- n. Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	2	0
Year 2	4	0
Year 3	8	0
Year 4 (renewal only)	12	0
Year 5 (renewal only)	16	0

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Appendix E-2: Opportunities for Participant-Direction

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

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

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

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

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

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

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

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

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

N/A

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.

N/A

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

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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

N/A

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Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Any waiver participant has the right to request an appeal of any decision that adversely affects his/her eligibility status and/or receipt of services and/or assistance. Participants are informed of this decision verbally and in writing when an adverse decision is made. The responsible party for the participant is copied on the written communication. The formal process of review and adjudication of CLTC actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et.seq.

A participant who is dissatisfied with a level of care decision by CLTC has the right to request an appeal of the action. A participant has the right to request an appeal of CLTC's decision to reduce, suspend, or terminate a waiver service.

The participant or designated representative must write a letter requesting an appeal within 30 days of the date of the official written notification issued by CLTC. If the appeal is filed within ten (10) days, services may continue pending the outcome of the hearing.

Information regarding the participant's right to appeal and instructions for initiating an appeal are printed on the Level of Care Certification Letter, DHHS Form 185, and the CLTC Notification. Also included on these forms is the information on requesting continuing services until the outcome of the hearing.

Once an appeal has been arranged, the appeals examiner will notify the participant and CLTC Regional office and/or the Central Office of the date, time, and location of the hearing via certified letter. The letter also contains a toll free number to call for assistance.

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Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

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

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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Appendix F-3: State Grievance/Complaint System

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

<input checked="" type="radio"/>	Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver (<i>complete the remaining items</i>).
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>)

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

The State Medicaid agency operates the Complaint/Grievance System.
--

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

<p>Complaints are taken at the CLTC area office, central office and state agency level. Participants are notified of their right to complain/grieve through a Participant’s Rights and Responsibilities statement reviewed and signed at the initial visit after waiver entry. When a participant elects to file a grievance or make a complaint, the participant is informed that doing so is not a pre-requisite or substitute for a Fair Hearing.</p> <p>Types of complaints taken include complaints against providers; complaints about reduction or termination of services; complaints regarding unmet needs; complaints regarding the waiting list; allegations of abuse; and any other complaint about services received under the waiver.</p> <p>The staff member receiving the complaint fills out the complaint form, initiates action to address the complaint and tries to reach resolution. Complaint forms are forwarded to the quality assurance (QA) department monthly. The expectation is that complaints will be resolved immediately if possible, and always within the month of receipt. Pending actions and complaint data are tracked and compiled by the QA department.</p> <p>Actions taken to resolve complaints may include contact with provider, referrals to supervisors and/or referral to adult protective agencies. In addition to the above, the State Medicaid agency has a mechanism for receiving complaints through their website. These complaints are filtered to the correct division for resolution. Responses must be submitted to appropriate agency personnel within seven (7) days of receipt of the complaint.</p>

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

The South Carolina Omnibus Adult Protection Act, SC Code of Laws, Section 43, Chapter 35, requires reporting of abuse, neglect and exploitation to either the South Carolina Department of Social Services, Long Term Care Ombudsman Office or the State Law Enforcement Division. These reports can be made by phone or written form. These incidents are defined as physical abuse, psychological abuse, neglect, and physical and financial exploitation. Mandatory reporters have a duty to report if they have reason to believe that a vulnerable adult is being abused, exploited or neglected. Mandated reporters include medical personnel, physicians' nurses, Christian Science practitioners and religious healers, law enforcement officers, those in school settings such as teachers and counselors, mental health counselors and mental retardation specialists, social workers and public assistance workers, adult day care staff, caregivers and volunteers. Mandated reporters must make the report within 24 hours or the next business day after discovery of the abuse, neglect or exploitation.

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

Upon waiver enrollment, participants and family members are provided written information about reporting abuse, neglect and exploitation of the elderly and other vulnerable adults. The material provided explains who are vulnerable adults, what is abuse, and providers' phone numbers of where to report suspected abuse cases if they occur in a private home or nursing home. Nurses explain this information to participants during the initial visit.

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

Reports of incidents occurring in facilities are reported to the State's Long Term Care Ombudsman's office (43-35-25). Incidents in other settings are reported to the Adult Protective Services Program and the county Department of Social Services. Reports can always be made to law enforcement. SCDSS initiates an investigation upon information alleging abuse, neglect or exploitation in all settings other than facilities. They contact law enforcement if criminal violation is suspected. They initiate protective measures either through Ex Parte order or Emergency

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Protective Custody. They conduct complete investigation. The Long Term Care Ombudsman initiates investigation of suspected abuse, neglect or exploitation occurring in facilities. They contact law enforcement if criminal violation is suspected. They conduct complete investigation and if substantiated, notification is sent to appropriate agencies. Law Enforcement contacts appropriate social service agency, completes reports, initiates emergency protective custody if required, investigates, and if substantiated, prosecutes or forwards for prosecution. Many agencies have roles: SC department of Disabilities and Special Needs, Attorney General, Protection and Advocacy, and the department of Mental Health. These agencies have specific policies and procedures to follow and regulatory actions that can be taken.

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

SCDHHS has a Memorandum of Agreement with SCDSS which allows for the sharing of information with SCDHHS. The purpose of this agreement is to establish relationships to provide for a system of receiving and investigating reports of alleged abuse, neglect and exploitation occurrences to vulnerable adults receiving services from SCDHHS. It requires both agencies to work together toward identifying those programs and services operated or contracted for operation by SCDHHS that should report alleged abuse, neglect, or exploitation to SCDSS and to establish cooperative relationships for the purpose of training and technical assistance to SCDHHS staff and/or its contracts.

SCDHHS currently conducts face to face meetings or communicates with appropriate DSS staff via e-mail about every 3-4 months to discuss critical incident reporting. State DSS is working on programming and data changes that will allow for monthly data exchange on referrals

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

a. Applicability. Select one:

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

b. Safeguards Concerning Use of Restraints or Seclusion

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

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

c. Safeguards Concerning the Use of Restrictive Interventions

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

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- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The South Carolina Department of Social Services and the Long Term Care Ombudsman are responsible for monitoring the use of restrictive interventions. South Carolina Department of Health and Environmental Control is responsible for all facility licensing.

Complaints about inappropriate use of restraints in nursing homes or assisted living facilities would be referred to DSS and the LTC Ombudsman. Complaints about the use of restrictive interventions for vulnerable adults residing at home would be referred to and investigated by SCDSS.

The State Law 43-35-310 provides for the creation of the Adult Protection Coordinating Council. The Council coordinates the planning and implementation efforts of entities involved in the adult protection system. Members facilitate problem resolution and develop action plans to overcome problems identified within the system. They address ongoing needs, including increasing public awareness of adult abuse, neglect and exploitation.

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Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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

c. Medication Administration by Waiver Providers

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

<input type="radio"/>	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. <i>(complete the remaining items)</i>
<input type="radio"/>	Not applicable <i>(do not complete the remaining items)</i>

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

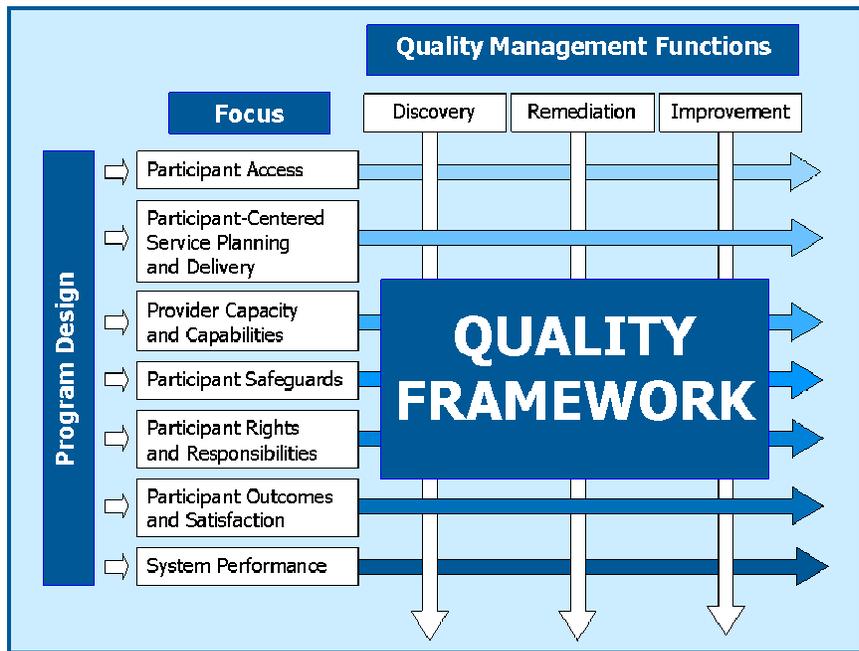
<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify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

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

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Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state’s waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

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

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Quality Management Strategy: Minimum Components

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

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

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

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

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

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

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

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

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

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When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

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Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

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

The State ensures level of care determinations. An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future. All waiver referrals go through an intake process. A Nurse Consultant applies intake criteria and the case is assigned to a Nurse Consultant for assessment. Assessments are keyed into the DHHS's Case Management System (CMS). Individuals that meet the eligibility requirements may enroll. A Nurse Consultant verifies that the participant is Medicaid eligible, meets level of care (LOC) and wants to participate. Justification for level of care determination is documented in the narrative and on the assessment form. Enrolled participants are re-evaluated at least annually. The State's CMS generates reports that indicate participants that are due for re-evaluations are completed timely, are completed within the month due and how many are outstanding. Problems can be identified and policy changes made to reduce any error rate. Re-training is done as needed. The approved assessment instrument is part of the CMS program. CMS ensures that the approved assessment form is used for 100% of applicants. The state monitors level of care decisions and takes action to address inappropriate level of care determinations.

The State ensures the plan of care (POC) address all participant's assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means. The POC is updated/ revised when warranted by changes in waiver participants' needs. Services are delivered in accordance with the POC; and the state monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of the POC.

The State CMS program has a component that links problems identified in the assessment to the plan of care. Nurses use this component to ensure that all problems identified in the assessment are addressed in the plan of care.

The SCDHHS contracts with an outside entity to perform participant experience surveys and focus groups. These are yearly activities. Reports generated from data are shared with staff. Areas of concern are addressed and corrective actions taken.

The CMS will not allow service authorizations that do not contain type, amount, duration, scope and frequency criteria. Care Call report provides evidence of service delivery. Nurses and area management staff monitor Care Call. Future chart reviews will include indicators regarding Care Call monitoring.

The State has a thorough system of process measures. Nurse reviews start at the regional offices. Each month, senior nurses review a sample of participant records to ensure nurses complete and document monthly contacts with participants. Nurse supervisors perform a more in-depth monthly review of participants' records for each nurse. The reviews include verification that the nurse contacts each person monthly as required, the service plan addresses identified needs, and the nurse has reassessed participants and updated their service plans as appropriate. Nurse supervisors also annually visit participants in person to ask them about the assistance the nurse is providing. Nurses are notified of problems when they are identified, and receive training if they do not meet required performance levels. If a nurse does not improve, disciplinary action or removal from case management may occur. Each regional office reports findings quarterly to the central office. State central office staff conducts a second level of review at each regional office annually. When fully staffed, a team reviews a random sample of participants' records. The central office review covers some of the same

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processes reviewed by area supervisors. Central office staff also reviews whether the regional office handles participant complaints appropriately and follows state policies and procedures. Compliance reports are furnished to the area offices. Each year the central office distributes findings from its reviews to all regional offices. Any indicator not meeting required standards requires corrective action. This corrective action is monitored and an analysis of future reviews will determine effectiveness.

The state verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards. It is our intent to verify annually that this license remains current. The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements. SCDHHS employs a licensed nurse to conduct on-site reviews periodically based on past performance of the following services:

- Personal Care II
- Personal Care I
- Medicaid Nursing

The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other requirements as outlined in the contract. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency backup plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

Other services are reviewed by different means.

Home adaptation services require a contractor's license. Along with ensuring that providers have these licenses, the State employs a reviewer who conducts on-site reviews of a sample of modifications and is available upon request.

Attendant care services are provided by individuals directly employed by participants. SCDHHS has a contract to ensure that attendants meet all requirements to provide services. The contractor employs licensed nurses to assess attendants and determine that they are capable of providing all needed care. In addition, the nurse consults with the participant at least monthly to ensure that services are being provided appropriately.

The CLTC Compliance Review Officer monitors contracted providers to ensure compliance with contractual requirements. This person identifies and rectifies situations where providers do not meet requirements.

For services monitored by the SCDHHS licensed nurse, a report is generated listing all deficiencies identified. Based upon the severity and number of the deficiencies and results of prior reviews, sanctions may take place. These may include requiring a written corrective action plan, recoupment of payments, suspension of new referrals and termination of the contract.

For home adaptation services, identified deficiencies will result in requests to correct the deficiencies. If these are not done timely, this may result in recoupment of funds.

For attendants, participants may terminate services for any reason at any time. Any allegations of inappropriate actions would be investigated and could result in termination from the Medicaid program and recoupment of payments.

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The State implements its policies and procedures for verifying that training is provided in accordance with state requirements in the approved waiver. Training requirements are monitored as part of the reviews conducted by the SCDHHS licensed nurse as described above. These include all pre-service requirements, competency evaluations for personal care aides and all ongoing in-service annual requirements. These requirements are specific to the individual services and are included in the service monitoring review. Sanctions taken would include deficiencies in meeting training requirements.

The State, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

CLTC provides new staff orientation every four and six months. Part of the agenda includes training on Adult Protective Services (APS). The State Law, mandatory reporting, importance of referral and narration are stressed.

DHHS also has a Memorandum of Agreement with the SC Department of Social Services (DSS) for the provision of receiving and investigating reports of alleged abuse, neglect and exploitation occurrence to vulnerable adults receiving services. Changes to the APS Reporting Form were discussed at a recent meeting with DSS APS staff. The form and processing changes were agreed upon and DSS will begin capturing and forwarding data related to CLTC participants. CLTC workers are required to complete complaint log forms and submit them to the CLTC Central Office monthly. Central Office compiles forms into a complaint grid, follows-up on unresolved issues and shares summary data with areas annually.

The administering agency engages in routine, ongoing oversight of the waiver program.

Note: The Medicaid agency serves as both Administrative and Operating Authority. Waiver review is part of the overall CLTC Quality Assurance Plan. All QA data are collected and annually shared with Area Office Staff. Discussions are instrumental in policy changes, computer program enhancements (i.e. CMS Triggers for Service Planning), and training.

State financial oversight is the review of claims (to insure that they are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver) is delegated to the operating agency.

Most services, including Medicaid nursing, attendant, and personal care services, in the waiver are paid using the Care Call system. This is a system in which providers make a call to a toll-free number to document service delivery. The claim is recorded and compared against the service authorizations on file for that participant. Service authorizations include the type of service, the authorized provider, the amount or units of service authorized, the procedure code to bill and the timeframe in which the service must be provided. Claims must meet all applicable criteria to be submitted to MMIS for payment at which time the billing code determines the rate of reimbursement.

For other services, South Carolina has developed a system which checks to ensure that the participant was enrolled in the waiver and Medicaid eligible at the time of service. Nurses review service delivery with participants on a monthly basis and check to see that claims are appropriate.

Each and every component of the State's quality assurance activities requires corrective action to address negative findings. SC CLTC has a Central Office QA Task Force to review all data accumulated through supervisory reviews, timeliness reports, case reviews, participant satisfaction surveys, administrative reviews, care call system reports, provider compliance reviews, participant complaint log reports, Adult Protective Services reports, program CMS reports, and other QA activities. These data are analyzed to identify training needs, areas requiring policy clarification and to determine area office strengths.

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The QA Task Force consists of approximately 12 CLTC Central Office staff. These task force members meet routinely throughout the year to identify and pursue action plans for making improvements in the waiver program as well as in the quality management framework and strategy.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

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

The State employs a licensed Registered Nurse to conduct on-site reviews of providers of personal care, respite and nursing services on at least a biannual basis, and usually much more frequently. The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other requirements as outlined in the contract. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

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

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APPENDIX I-2: Rates, Billing and Claims

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

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

Some of the waiver service rates were established based upon the projected costs of the service to be provided. These services would include Personal Care I, II and nursing. Cost reports submitted by the providers of the various services are reviewed "on an as needed basis" to ensure the appropriateness of the rates or to justify any proposed rate increase that may be sought by the appropriate provider organization. Additional financial reviews are performed by the Bureau of Reimbursement Methodology and Policy on an as needed basis to ensure that funding provided by the South Carolina General Assembly was appropriately expended by the providers (eg. targeted funding for personal care aide services that was to be used to increase the hourly wages of personal care assistants).

Nursing facilities providing institutional respite care for waiver participants receive their contracted Medicaid nursing facility rate. Hospitals receive the average nursing facility rate. In addition, nursing facilities and hospitals receive a one-time payment for their administrative costs in caring for short-term residents.

Home adaptation waiver service rates for modifications are manually priced based upon the provider's cost estimate. Competitive bids are solicited for all modifications and the lowest responsive bid is accepted. Pest control services are based upon established private pay rates.

Incontinence supplies and Personal Emergency Response systems service rates were calculated based upon established prices for these goods and services. Specialized equipment and supplies use established Durable Medical Equipment pricing. Nutritional supplements are priced based upon existing market rates.

The attendant service rate is an intermediate rate between Personal Care II and Personal Care I and contains elements of both of those services and is provided by individuals rather than agencies.

- 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:

Provider billings flow directly from providers to the State's claim payment system. For many services, the provider uses the Care Call system to document delivery of services. This is done through adding claims to Care Call either through the interactive voice response system or through

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web entry of claims. For services not using the Care Call system, providers may bill either by use of a CMS 1500 form or by the State’s electronic billing system.

c. Certifying Public Expenditures (select one):

<input type="radio"/>	Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (<i>check each that applies</i>):
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)
<input checked="" type="radio"/>	No. Public agencies do not certify expenditures for waiver services.

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

Almost all claims for waiver services are submitted to MMIS through South Carolina’s Care Call system. For all claims submitted through Care Call, a pre-payment review is conducted. Care Call only submits claims to MMIS for services that were prior authorized by the nurse and are included in the participant’s service plan. Care Call compares services documented by providers to the amount, frequency, and duration prior authorized by the nurse. If the claim does not meet all these criteria, the claim is not submitted to MMIS for payment.

Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is an indication in MMIS that the participant is enrolled in the waiver program. This is the case for all claims, regardless of whether they are submitted through the Care Call system.

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

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

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APPENDIX I-3: Payment

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

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

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

<input checked="" type="checkbox"/>	The Medicaid agency makes payments directly to providers of waiver services.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input checked="" type="checkbox"/>	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent: A financial management services entity is used to make payments for in-home services delivered by individuals rather than agencies. In-home providers utilize the Medicaid Agency's Care Call system, which documents the delivery of services on a daily basis. The system transfers data and submits claims to MMIS weekly for the amount of service provided. Weekly data and payments are transmitted from MMIS to the FMS, including a detailed breakdown of each worker's checks. From these transmittals, the FMS collects and processes the time worked for each worker, processes payroll, withholds, files and pays all applicable employment-related taxes and insurance. The FMS cuts checks weekly and mails them directly to workers, and posts electronically to the Medicaid agency on a weekly basis. Daily, the monies received are reviewed and compared to the amount of monies being paid. Financial audits are performed periodically.

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<input type="checkbox"/>	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

<input checked="" type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

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

<input checked="" type="radio"/>	Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i>
Some County Councils on Aging are public providers (many others are not). They receive payments for the provision of personal care I. The contractual process is the same for these as for all other providers of these services.	
<input type="radio"/>	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

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

<input checked="" type="radio"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

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<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

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

g. Additional Payment Arrangements

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

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

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

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<input type="radio"/>	<p>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:</p>
<input checked="" type="radio"/>	<p>No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.</p>

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

<input type="radio"/>	<p>The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.</p>
<input type="radio"/>	<p>This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.</p>
<input checked="" type="radio"/>	<p>The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.</p>

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APPENDIX I-4: Non-Federal Matching Funds

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

<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c: The State Housing and Development Authority provides \$250,000 annually as match via an intergovernmental transfer for environmental modification waiver services.
<input type="checkbox"/>	Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

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

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

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

<input checked="" type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
<input type="checkbox"/>	For each source of funds indicated above, describe the source of the funds in detail: The Community Long Term Care Waiver Services Program budget line receives an allocation of a hospital provider tax that was implemented in order to expand Medicaid eligibility. All South Carolina general hospitals are subject to the tax.
<input type="checkbox"/>	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

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

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

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

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

--

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

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

Select one:

<input type="radio"/>	<p>Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver’s home or in a residence that is owned or leased by the provider of Medicaid services. <i>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</i></p> <div style="border: 1px solid black; height: 50px; width: 100%; background-color: #e0e0e0; margin-top: 5px;"></div>
<input checked="" type="radio"/>	<p>No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.</p>

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

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

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

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

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

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

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

Waiver Service	Amount of Charge	Basis of the Charge

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

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

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

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

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

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Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care (<i>specify</i>):			Nursing Facility				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	\$27,172.58	\$21,779.00	\$48,951.58	\$58,695.00	\$15,681.00	\$74,376.00	\$25,424.42
2	\$28,780.09	\$22,867.00	\$51,647.09	\$61,630.00	\$16,465.00	\$78,095.00	\$26,447.91
3	\$30,748.52	\$24,010.00	\$54,758.52	\$64,711.00	\$17,288.00	\$81,999.00	\$27,240.48
4	\$32,281.28	\$25,211.00	\$57,492.28	\$67,947.00	\$18,153.00	\$86,100.00	\$28,607.72
5	\$34,299.64	\$26,471.00	\$60,770.64	\$71,344.00	\$19,060.00	\$90,404.00	\$29,633.36

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Appendix J-2 - Derivation of Estimates

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

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	60	60	
Year 2	68	68	
Year 3	76	76	
Year 4 (renewal only)	84	84	
Year 5 (renewal only)	92	92	

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

The most recent CMS 372 report for South Carolina’s Mechanical Vent Waiver shows a length of stay of 273 days. This is consistent with previous years. Our estimate is 9 months based upon these data.

- 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 CMS 372 reports for the Mechanical Ventilator waiver have been used to provide estimates of participants receiving each service and the average number of units. In some cases, the average number of units increases based upon changing limits to certain services (e.g., incontinence supplies). Rates are based upon existing rates with an annual 5% inflation factor for each year of the waiver after Year 1.

- 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:

Estimates are based upon the CMS 372 report for the Mechanical Ventilator waiver. A 5% inflation factor is used for all years of the waiver. The figures reflect a 50% reduction in pharmacy costs due to the initiation of Medicare Part D. This projection is tentative since Medicare Part D has only one year of data to estimate the effect on D’.

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- 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:

Estimates were derived by using the current average length of stay figure in the waiver of 273 days multiplied by the sub-acute rate. A 5% inflation factor is used for each year of the waiver.

- 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:

Estimates were derived by utilizing acute care information obtained for all nursing facility participants and comparing it to acute care waiver costs in the Community Choices waiver which utilizes the same level of care. It was determined that the acute care expenditures for participants in a nursing facility are ¾ of the expenditures of participants in the Community Choices waiver. This ratio was then applied to the Mechanical Ventilator waiver to arrive at the estimation of factor G'. A 5% inflation factor is used for each year of the waiver.

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

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

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

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. a. Personal Care I	Hour	6	284	\$12.00	\$20,448.00
2. b. Personal Care II	Hour	30	470	\$16.00	\$225,600.00
3. a. Respite – Institutional	Day	1	8	\$226.00	\$1,808.00
3. b. Respite – In-Home	Day	1	11	\$95.00	\$1,045.00
4. Private Duty Nursing RN	Hour	15	819	\$33.00	\$405,405.00
4. Private Duty Nursing LPN	Hour	36	985	\$25.00	\$886,500.00
5. Attendant Care	Hour	2	651	\$12.30	\$16,014.60
6. Home Accessibility Adaptations					
a. Pest Control	Event	6	4	\$45.00	\$1,080.00
c. Home Adaptations	Event	3	1	\$2,200.00	\$6,600.00
7. Specialized Medical Equipment and Supplies					
a. Adult diapers	Diaper	33	1008	\$0.97	\$32,266.08
b. Pads	Case	30	7	\$47.00	\$9,870.00
c. Wipes	Box	24	11	\$17.00	\$4,488.00
d. Nutritional Supplements	Item	6	16	\$35.00	\$3,360.00
8. Pers. Emerg. Resp. System	Month	6	7	\$35.00	\$1,470.00
9. 2 Prescription Drugs	Unit	30	2	\$240.00	\$14,400.00
GRAND TOTAL					\$1,630,354.68
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					60
FACTOR D (Divide grand total by number of participants)					\$27,172.58
AVERAGE LENGTH OF STAY ON THE WAIVER					273 days

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Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. a. Personal Care I	Hour	7	284	\$12.60	\$25,048.80
2. b. Personal Care II	Hour	34	470	\$16.80	\$268,464.00
3. a. Respite – Institutional	Day	1	11	\$237.04	\$2,607.44
3. b. Respite – In-Home	Day	1	8	\$99.75	\$798.00
4. Private Duty Nursing RN	Hour	17	819	\$34.65	\$482,431.95
4. Private Duty Nursing LPN	Hour	41	985	\$26.25	\$1,060,106.25
5. Attendant Care	Hour	4	651	\$12.92	\$33,643.68
6. Home Accessibility Adaptations					
a. Pest Control	Event	7	4	\$47.25	\$1,323.00
c. Home Adaptations	Event	3	1	\$2,310	\$6930.00
7. Specialized Medical Equipment and Supplies					
a. Adult diapers	Diaper	37	1008	\$1.01	\$37,668.96
b. Pads	Case	32	7	\$49.61	\$11,112.64
c. Wipes	Box	26	11	\$17.64	\$5,045.04
d. Nutritional Supplements	Item	5	16	\$36.75	\$2,940
8. Pers. Emerg. Resp. System	Month	5	7	\$36.75	\$1286.25
9. 2 Prescription Drugs	Unit	35	2	\$252	\$17,640.00
GRAND TOTAL					\$1,957,046.01
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					68
FACTOR D (Divide grand total by number of participants)					\$28,780.09
AVERAGE LENGTH OF STAY ON THE WAIVER					273

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Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. a. Personal Care I	Hour	8	284	\$13.23	\$30,058.56
2. b. Personal Care II	Hour	38	470	\$17.64	\$315,050.40
3. a. Respite – Institutional	Day	2	11	\$248.49	\$5,466.78
3. b. Respite – In-Home	Day	2	8	\$104.74	\$1,675.84
4. Private Duty Nursing RN	Hour	19	819	\$36.38	\$566,109.18
4. Private Duty Nursing LPN	Hour	46	985	\$27.56	\$1,248,743.60
5. Attendant Care	Hour	8	651	\$13.56	\$70,620.48
6. Home Accessibility Adaptations					
a. Pest Control	Event	8	4	\$49.61	\$1,587.52
c. Home Adaptations	Event	3	1	\$2,425.50	\$7,276.50
7. Specialized Medical Equipment and Supplies					
a. Adult diapers	Diaper	42	1008	\$1.07	\$45,299.52
b. Pads	Case	36	7	\$52.09	\$13,126.68
c. Wipes	Box	29	11	\$18.52	\$5,907.88
d. Nutritional Supplements	Item	6	16	\$38.59	\$3,704.64
8. Pers. Emerg. Resp. System	Month	6	7	\$38.59	\$1,620.78
9. 2 Prescription Drugs	Unit	39	2	\$264.60	\$20,638.80
GRAND TOTAL					\$2,336,887.16
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					76
FACTOR D (Divide grand total by number of participants)					\$30,748.52
AVERAGE LENGTH OF STAY ON THE WAIVER					273

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Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. a. Personal Care I	Hour	8	284	\$13.89	\$31,558.08
2. b. Personal Care II	Hour	42	470	\$18.52	\$365,584.80
3. a. Respite – Institutional	Day	2	11	\$261.33	\$5,749.26
3. b. Respite – In-Home	Day	2	8	\$109.97	\$1,759.52
4. Private Duty Nursing RN	Hour	21	819	\$38.20	\$657,001.80
4. Private Duty Nursing LPN	Hour	50	985	\$28.94	\$1,425,295.00
5. Attendant Care	Hour	12	651	\$14.24	\$111,242.88
6. Home Accessibility Adaptations					
a. Pest Control	Event	8	4	\$52.09	\$1,666.88
c. Home Adaptations	Event	3	1	\$2,546.78	\$7,640.34
7. Specialized Medical Equipment and Supplies					
a. Adult diapers	Diaper	46	1008	\$1.12	\$51,932.16
b. Pads	Case	39	7	\$54.70	\$14,933.10
c. Wipes	Box	32	11	\$19.45	\$6,846.40
d. Nutritional Supplements	Item	7	16	\$40.52	\$4,538.24
8. Pers. Emerg. Resp. System	Month	7	7	\$40.52	\$1,985.48
9. 2 Prescription Drugs	Unit	43	2	\$277.83	\$23,893.38
GRAND TOTAL					\$2,711,627.32
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					84
FACTOR D (Divide grand total by number of participants)					\$32,281.28
AVERAGE LENGTH OF STAY ON THE WAIVER					273

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Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. a. Personal Care I	Hour	9	284	\$14.59	\$37,292.04
2. b. Personal Care II	Hour	46	470	\$19.45	\$420,509.00
3. a. Respite – Institutional	Day	2	11	\$274.40	\$6,036.80
3. b. Respite – In-Home	Day	2	8	\$115.47	\$1,847.52
4. Private Duty Nursing RN	Hour	23	819	\$40.11	\$755,552.07
4. Private Duty Nursing LPN	Hour	55	985	\$30.39	\$1,646,378.25
5. Attendant Care	Hour	16	651	\$14.95	\$155,719.20
6. Home Accessibility Adaptations					
a. Pest Control	Event	9	4	\$54.70	\$1,969.20
c. Home Adaptations	Event	4	1	\$2,674.11	\$10,696.44
7. Specialized Medical Equipment and Supplies					
a. Adult diapers	Diaper	51	1008	\$1.17	\$60,147.36
b. Pads	Case	43	7	\$57.43	\$17,286.43
c. Wipes	Box	35	11	\$20.42	\$7,861.70
g. Nutritional Supplements	Item	7	16	\$42.54	\$4,764.48
8. Pers. Emerg. Resp. System	Month	7	7	\$42.54	\$2,084.46
9. 2 Prescription Drugs	Unit	47	2	\$291.72	\$27,421.68
GRAND TOTAL					\$3,155,566.63
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					92
FACTOR D (Divide grand total by number of participants)					34,299.64
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	South Carolina
Effective Date	July 1, 2006