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:	March 30, 2006

CMS Receipt Date *(CMS Use)*	

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

Brief Description:
This is a request to renew South Carolina's Independence Plus waiver, *South Carolina Choice*. As part of this request we will be combining our existing Elderly/Disabled Waiver with this one.

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

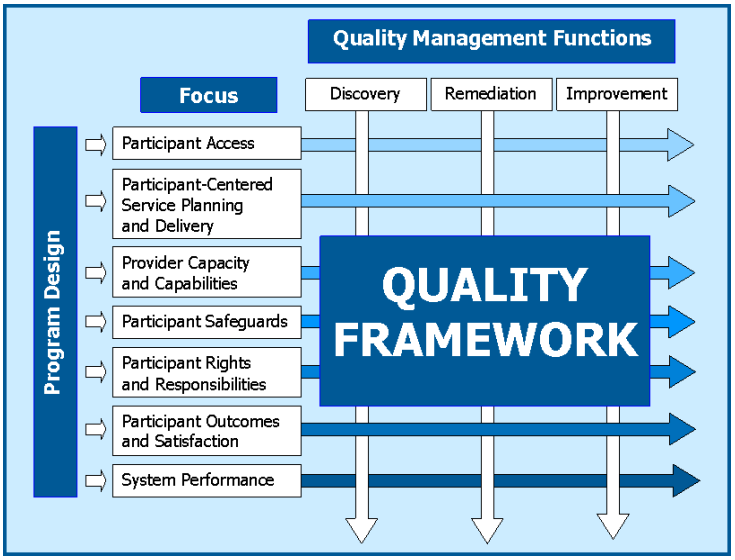
PURPOSE OF THE HCBS WAIVER PROGRAM

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.

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*): Community Choices

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

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
■	**Renewal (5 Years) of Waiver #**	00405-IP	
○	**Amendment to Waiver #**		

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

○	**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.
■	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2006

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)*:

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

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)*:

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

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 *South Carolina Choice*, its Independence Plus Waiver. In so doing, the State proposes to expand the self-direction option and combine its existing home and community-based waiver for elderly and disabled recipients with South Carolina Choice. The combined waiver will be named *Community Choices.*

SC Choice has provided participant directed options for both supervision of services and budget authority. The existing Elderly/Disabled Waiver has offered participant direction of some services but without budget authority. By combining these two waivers, it is our goal that *Community Choices* will present a true continuum of self-direction capable of meeting the needs of all waiver participants, from those choosing agency directed services to those who desire to fully oversee their services.

Community Choices will serve frail elderly and persons with physical disabilities who meet the nursing facility level of care criteria. The direct administration comes through thirteen regional offices around the State, each of which covers designated counties of South Carolina. Case managers working in these 13 areas are responsible for ensuring that participants are aware of their self-direction options and can make informed choices as to which form of service delivery they prefer.

Along with other services in the waiver, South Carolina offers a nursing home transition service which is designed to ease the transition back to the community for nursing home residents. This service reflects the State's commitment to offer viable community options to institutional placement.

3. Components of the Waiver Request

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

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

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

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

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

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

●	The waiver provides for participant direction of services. *Appendix E is required*.
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

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)*:

○	Yes
●	No
○	Not applicable

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

○	**Yes** *(complete remainder of item)*
●	**No**

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

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

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

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

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

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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:

South Carolina secured input through a public meeting on March 7, 2006 with advocates, consumers, providers and state agencies. Key stakeholders were invited to attend and/or provide written comments about the proposed renewal, and a public notice of the meeting was posted on the agency's website. This meeting described the proposed components of the waiver and how it addresses participant direction of services. Seventeen people attended the meeting, and written comments were received from two organizations. The waiver application is also expected to be posted on the agency's website on or around April 1, 2006.

In addition, this renewal was presented to and approved by the agency's Medical Care Advisory Committee on March 21, 2006.

Input from all sources was used to direct development of the waiver and inform policy decisions. The State receives ongoing input from these sources and uses it to address potential changes in waiver operations.

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	
Fax Number	

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: __Robert Kerr_
State Medicaid Director or Designee

Date:	**March 30, 2006**

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

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

This waiver will combine two of South Carolina's existing waivers and provide the participant-directed option statewide, thereby offering a continuum of participant-directed opportunities. In no cases will participants in a current waiver have a service choice that is more limited by entering this waiver program.

Participants in South Carolina's Elderly/Disabled Waiver will be transitioned to this waiver on the first day of renewal, July 1, 2006. The transition will be effectively invisible to participants at first, as all existing service authorizations will be effective after the transition. Case managers will inform participants of their enhanced participant direction options during their next scheduled home visits.

Appendix A: Waiver Administration and Operation

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

●	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):		
	●	The Medical Assistance Unit *(name of unit)*:	Division of Community Long Term Care Waiver Management
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	
○	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. *Complete item A-2.*		

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:

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)*:

○	**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. *Complete Items A-5 and A-6.*
●	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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)*:

☐	**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). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
■	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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:

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	■	☐	☐	☐
Assist individuals in waiver enrollment	■	☐	☐	☐
Manage waiver enrollment against approved limits	■	☐	☐	☐
Monitor waiver expenditures against approved levels	■	☐	☐	☐
Conduct level of care evaluation activities	■	☐	☐	☐
Review participant service plans to ensure that waiver requirements are met	■	☐	☐	☐
Perform prior authorization of waiver services	■	☐	☐	☐
Conduct utilization management functions	■	☐	☐	☐
Recruit providers	■	☐	☐	☐
Execute the Medicaid provider agreement	■	☐	☐	☐
Determine waiver payment amounts or rates	■	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	■	☐	☐	☐

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
●	**Aged or Disabled, or Both**			
■	Aged (age 65 and older)			☐
■	Disabled (Physical) (under age 65)	18		
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

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

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

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

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)*:

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

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:

All waiver applicants receive a full assessment by a registered nurse prior to waiver entrance. This assessment includes all components necessary to make a level of care determination. It also includes information regarding specific needs and desires of the applicant. The RN discusses these needs and desires with a licensed social worker so as to assess service needs. Should these needs provide a likelihood of exceeding the individual cost limit, the regional director is consulted. The individual is informed of the limit of available waiver services and makes an informed decision as to whether the waiver is the appropriate form of long term care services. It should be noted that this procedure, while available, has not been needed to date. The service needs identified have been within the individual cost limit. Any participant denied admission to the waiver is given the opportunity to appeal this decision.

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

☐	The participant is referred to another waiver that can accommodate the individual's needs.
■	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	Additional services may be authorized based on changing needs of the participant using the standardized assessment process. Once changes are indicated, the reevaluation will occur in a reasonable time period. If the waiver is unable to meet assessed needs, the participant will receive assistance with transitioning to another form of long term care services.
☐	Other safeguard(s) *(specify)*:

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	14,375
Year 2	15,000
Year 3	15,625
Year 4 (renewal only)	16,250
Year 5 (renewal only)	16,875

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

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
●	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	11,500
Year 2	12,000
Year 3	12,500
Year 4 (renewal only)	13,000
Year 5 (renewal only)	13,500

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

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

Waiver Year	Purpose:	Purpose:
	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):*

●	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

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

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

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

For most waiver participants, entry to the waiver is based upon their date of application for the waiver (subject to meeting all waiver enrollment criteria). Some applicants will be able to bypass this process

under an expedited system. Those include persons transitioning from a nursing home, transplant cases, waiver participants whose Medicaid eligibility has been terminated for less than 30 days and waiver participants who have been terminated due to lengthy hospitalization. South Carolina is utilizing a Real Choice Systems Change Grant to investigate a method to prioritize waiver admissions based upon assessed criteria of applicants. This is not expected to be in place before the third year of the renewal period.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

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

○	Phased-in
○	Phased-out

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

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

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

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

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

Phase-In or Phase-Out Schedule			
		Waiver Year:	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

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

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

●	§1634 State
○	SSI Criteria State
○	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:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
■	Low income families with children as provided in §1931 of the Act		
■	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☐	Optional State supplement recipients		
■	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	●	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
■	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
■	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy		
☐	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) *specify*:		

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*		
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.	
●	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*	
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217

	●	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
		■	A special income level equal to (select one):		
			●	300% of the SSI Federal Benefit Rate (FBR)	
			○	%	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: *(select one)*		
			●	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) *specify*:		

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)*:

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

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

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

ii. <u>Allowance for the spouse only</u> (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$2,416	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	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.
○	The amount is determined using the following formula:		
○	Other (specify): If a minor is in the home, $2,416. If responsible for a minor living outside the home, $398.		
○	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. *Select one:*

○	The State does not establish reasonable limits.
○	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

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

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

○	The following dollar amount:	$	The amount specified cannot exceed the higher
○	The amount is determined using the following formula:		
○	Other (specify):		
○	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. *Select one:*

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

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. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	●	The special income level for institutionalized persons *(select one):*		
		●	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	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:			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
●	Not applicable			

iii. Allowance for the family *(select one)*:	
○	AFDC need standard
○	Medically needy income standard
○	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.
○	The amount is determined using the following formula:
●	Other (specify):
	Procedure to Determine the Amount of Income Allowances for Other Family Members • 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.
○	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. *Select one:*	
○	The State does not establish reasonable limits.
●	The State establishes the following reasonable limits *(specify)*:

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 (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.

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

ii. <u>Allowance for the spouse only</u> (*select one*):

○	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:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable		

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard
○	Medically needy income standard
○	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.
○	The amount is determined using the following formula:
○	Other (specify):
○	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. *Select one:*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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

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

i. Allowance for the personal needs of the waiver participant *(select one)*:	
○	SSI Standard
○	Optional State Supplement standard
○	Medically Needy Income Standard
○	The special income level for institutionalized persons
●	300% of the Federal Poverty Level
○	The following dollar amount: ____ If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:
○	Other (*specify*):
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*	
●	Allowance is the same
○	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified 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. *Select one:*	
○	The State does not establish reasonable limits.
●	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-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 *(insert number):* 1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	●	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

●	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other (*specify*):

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 auspices of a Registered Nurse.

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)*:

●	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The same process 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)*:

○	Every three months
○	Every six months
●	Every twelve months
○	Other schedule (*specify*):

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

○	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
●	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

Individuals may be:

1) Registered Nurse licensed by the State
2) Licensed Practical Nurse working under the auspices of a Registered Nurse
3) Licensed Social Worker
4) Case manager with a Bachelor's Degree in health or social science field with two years experience in social science or health area.

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.

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

The case manager or 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.

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 and case managers 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.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

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

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	■	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	■	Personal Care I and Personal Care II
Adult Day Health	■	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	■	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
●	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Attendant Care
b.	Adult Companion Care

c.	Chore Service
d.	Adult Day Health Care Nursing
e.	Home Delivered Meals
f.	Home Accessibility Adaptations and Appliances
g.	Specialized Medical Supplies and Equipment
h.	Personal Emergency Response System
i.	Nursing Home Transition Services

Extended State Plan Services *(select one)*

●	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(select one)*

●	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	■	
Financial Management Services	■	Note: Financial Management Services are offered as an administrative function rather than as a waiver service.

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

a.	
b.	
c.	

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)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☐	As an administrative activity. *Complete item C-1-c.*
■	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

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

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)*:

●	**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):
	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.
○	**No**. Criminal history and/or background investigations are not required.

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)*:

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

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

●	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**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). *Complete Items C-2-c.i –c.iii.*

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

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

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

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

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

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

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

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

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

	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.

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.

Appendix C-3: Waiver Services Specifications

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

Service Specification	
Service Title:	Case Management
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for ongoing monitoring and the coordination of the provision of services included in the participant's plan of care. The state will claim the cost of case management furnished to institutionalized individuals prior to their transition to the waiver. Case management services for transitioning institutionalized participants may be billed up to 180 days in advance of a transition to waiver services and will be billed upon the participant's entry into the waiver.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Case management is an ongoing service that is billed in monthly increments.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Independent Case Managers		Case Management Agencies	
	Registered Nurse		Health and Human Services	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Independent Case Manager			Bachelor's degree in humanities, social science or a related field plus two years of experience in social or community work pertaining to adults with chronic conditions and disabilities or a related field.
Registered Nurse	Yes, Code of laws 40-33-10 et seq		
Case Management Agency			Bachelor's degree in humanities, social science or a related field plus two years of experience in social or community work pertaining to adults with chronic conditions

			and disabilities or a related field. Enrolled and contracted with the Medicaid agency.
Medicaid Agency	Registered Nurse or Licensed Social Worker		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Independent Case Manager	**Medicaid Agency**	**Upon Enrollment; Annually**
Registered Nurse	**Medicaid Agency, State Board of Nursing**	**Upon Enrollment; Annually**
Case Management Agency	**Medicaid Agency**	**Upon Enrollment; Annually**
Medicaid Agency	**Medicaid Agency**	**Upon Enrollment; Annually**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Personal Care/ Personal Care I + II
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.
Service Definition (Scope)**:**	
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 case managers.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	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 *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Care Agency			Contract Scope of services
Nursing Agency			Contract Scope of services
Home Health Agency			Contract Scope of services
County Council			Contract Scope of services

on Aging			
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 *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Adult Day Health Care
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.
Service Definition (Scope)**:**	
Services generally furnished five or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a licensed non-institutional, community based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Transportation between the participant's place of residence and the adult day health site is provided as a component of adult day health services and the cost of this transportation is included in the rate paid to adult day health providers only if the participant lives within 15 miles of the adult day care center. Meals provided as a part of these services shall not constitute a "full nutritional regimen" (3 meals per day).	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Adult Day Health Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Health Provider	Yes, Chapter 33 40-33-10 SC Code of laws		Enrolled and contracted with the Medicaid agency for Adult Day Health Care

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Adult Day Health Provider	**Department of Health and Environmental Control, Medicaid Agency**	**Upon Enrollment Annually/biannually**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Respite Care Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	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, hospital or community residential care facility. 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. In home respite is participant-directed and available only to participants already directing other waiver services.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Individual respite provider		Nursing Facility
				Hospital
				Community Residential Care Facility
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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		

Community Residential Care Facility	Yes, SC Code, Sec. 44-7-260 Reg. #61-84, 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 free from communicable diseases, and be able to demonstrate a competency in caring for the participant.

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	**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**
	Residential Care Facilities	**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 *(check each that applies)*:	■	Participant-directed as specified in Appendix E – **This applies to in-home respite only**	■	Provider managed

Service Specification	
Service Title:	Attendant Care Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
●	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) *(check one or both)***:**	■	Individual. List types:	☐	Agency. List the types of agencies:
		Individual chosen by the waiver participant		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	Adult Companion Care
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
●	Service is not included in the current waiver.
Service Definition (Scope)**:**	
Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan. The state ensures that there is no overlap or duplication of the adult companion service with other services. This is done through the use of several automated systems.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Individual chosen by the waiver participant		Agency Providing Adult Companion Services
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual chosen by waiver participants			Companions 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.
Agency providing Adult Companion Services			Contracted scope of services

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Individual Chosen by waiver participants	**Medicaid Agency**	**Upon Enrollment;**

	Agency Providing Adult Companion Services	Medicaid Agency	Upon Enrollment; Annually/biannually
Service Delivery Method			
Service Delivery Method *(check each that applies)*:	■ Participant-directed as specified in Appendix E	■ Provider managed	

Service Specification	
Service Title:	Chore Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
●	Service is not included in the current waiver.
Service Definition (Scope)**:**	
Services needed to maintain the participant in a clean, sanitary and safe environment. These services are paid by a negotiated fixed amount rather than by an hourly rate.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	☐	Agency. List the types of agencies:
	Individual(s) selected by the participant/representative to work on their behalf.			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual age 18 and older selected by the participant/representative.			The participant and/or his/her representative or family may furnish supervision of services. Participant/representative serves as the employer of record and develops a work agreement with his/her selected providers. The provider agreement is with the Medicaid agency.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Individual selected by the participant/representative to work on their behalf.	**Medicaid Agency**	**Upon Enrollment;**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	Adult Day Health Care Nursing
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.
Service Definition (Scope)**:**	
A service utilized for the provision of nursing care limited to ostomy care, urinary catheter care, decubitus/wound care, tracheostomy care, and tube feeding provided by a licensed nurse at the adult day health center.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Adult Day Health Care Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Health Care Agency	Yes, Chapter 33 40-33-10 SC Code of laws		Enrolled and Contracted with the Medicaid agency for Adult Day Health Care nursing.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Adult Day Health Care Agency	**Department of Health and Environmental Control, Medicaid Agency**	**Upon Enrollment; Annually/biannually**

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Home Delivered Meals
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.
Service Definition (Scope)**:**	
Meals delivered to the participant's residence providing a minimum of one-third of the current recommended dietary allowance. These can be hot, bag lunch or blast frozen meals.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
A maximum of two meals per day may be provided to a waiver participant.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Contracted Home Delivered Meals Providers
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Contracted Home Delivered Meals Providers			Contracted Scope of Service

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Contracted Home Delivered Meals Providers	**Medicaid Agency**	**Upon Enrollment; Annually/biannually**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Home Accessibility Adaptations and Appliances
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

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.

The following household appliances will be offered to participants directing their own care and managing their own budget under this service: refrigerators, washers and dryers, and microwave ovens. Approved appliances must be specified in the participant's plan of care, which enable individuals to increase their abilities to perform activities of daily living and are necessary for individuals to maintain independence and avoid institutional care. Prior authorization from the case manager for these purchases will be required. Purchase of these appliances must be based upon a corresponding decrease in the needs of personal assistance services.

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.

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

There is a lifetime cap of $7,500 per participant. Pest control, refrigerators, washers and dryers, and microwave ovens are excluded from this cap. In addition, there is a limit of one refrigerator, washer, dryer and/or microwave oven for participants eligible to receive those items.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Volunteer		Building contractor	
			Licensed Business	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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		

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Building Contractor	**Medicaid Agency**	**Upon Enrollment; Annually**
	Volunteer	**Medicaid Agency**	**Upon Enrollment**
	Licensed Business	**Medicaid Agency**	**Upon Enrollment**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Specialized Medical Equipment and Supplies
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	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:	
Incontinence Supplies: One case per month Underpads: 1 case per month Nutritional Supplements: two cases per month Wipes: One box per month	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Enrolled DME Provider
				Licensed Business
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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				
	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Personal Emergency Response System
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	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)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Emergency Response Provider

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Nursing Home Transition Service
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
●	Service is not included in the current waiver.
Service Definition (Scope)**:**	
A combined set of services designed to meet one-time needs of participants transitioning from the nursing home to the community waiver program. To qualify, the participant must have been in the nursing home at least 90 consecutive days. These services include deposits, basic furniture and appliances.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Services are available for one transition per participant. The total cost of these services shall not exceed $1,000. Appliances are limited to washing machines, dryers, microwaves and refrigerator. Furniture is limited to dinette (table and chairs), bed (twin or double), dresser or chest of drawers, night stand, sofa or chair, security, water, electricity, gas and land-line phone deposits.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Medicaid enrolled provider		Medicaid enrolled provider	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
			Enrolled Medicaid providers

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Enrolled Provider	Medicaid agency	**Upon enrollment**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

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.

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

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

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)*:

■	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
■	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

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

●	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

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.

Based on the experiences of our S C Choice (the Independence Plus designated program), we successfully are operating under a participant-centered philosophy in all stages of our program design. Participants maintain a high level of choice and control particularly under the participant-directed option. 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.

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 case management team. 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 case manager.

Development of the Service Plan

The case manager and nurse consultant must meet to discuss the assessment information for service plan development and to enter the participant into community case management. The Service Plan is developed by the case manager from the assessment information, information obtained from the team conference with the nurse consultant, 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 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 case manager 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 CLTC case management team. 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 case manager, 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.

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 case manager 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 case manager 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.

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 casemanager 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 case managers choose a provider for a participant. Also, brochures giving tips on provider selection are currently being developed and will be given to participants when available.

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 regional office oversees waiver operations in a specific geographic area of 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:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
●	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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)*:

■	Medicaid agency
☐	Operating agency
☐	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

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

Case managers 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:*

●	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

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)*:

●	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

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

●	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
○	**No.** Independence Plus designation is not requested.

Appendix E-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.

The waiver offers a full range of opportunities for participant direction, depending on the amount of risk and responsibility each participant wishes to assume. Participants may choose to receive all agency directed services; a mix of agency and participant directed services; or they may choose to direct their entire package of waiver services. Participants may choose to receive such services as attendant and companion care with employer authority only, or they may choose to exercise both employer and budget authority over attendant and companion care, in-home respite, and chore services. They may also choose to exercise budget authority and receive such services as home accessibility adaptations and appliances.

Participants may direct their own services 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 their own care. 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 case managers provide more detailed information concerning the benefits and responsibilities of the option. Case managers visit participants who want to pursue participant direction and provide extensive information about the risks, responsibilities and liabilities of the option. Case managers assist each participant to list and prioritize individual needs, decide how he/she wants to get needs met, develop a service plan, and

determine the level of participant direction he/she wants to exercise. The case manager 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, who he/she would like to provide each service, and the rate he/she wants to pay for the service. If the participant has chosen services with budget authority, the case manager discusses the budget amount and the services upon which the budget was developed, and assists the participant with costing out the services he/she has decided should be paid for out of his/her budget. Information about the role of the FMS is given, as well as an explanation of the Care Call system that documents service delivery. Information is provided to participants about the hiring, management and firing of workers. In addition, the case manager also ensures that employment packets are 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.

The 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. For each participant exercising budget authority, the FMS tracks and reports participant funds, disbursements and balance of participant funds, processes and pays invoices for goods and services, and provides the participant with real time reports of expenditures and the status of his/her budget.

Once a participant has chosen a level of participant direction and is receiving services, case managers continue to monitor service delivery and the status of the participant's health and safety. Web-based budget expenditure reports are monitored and the amount of the budget period passed is compared to the amount of the budget dollars remaining, to ensure that the participant has enough money left to pay for services for the entire budget period, and that services are being used at an adequate level to ensure 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 and that the budget and expenditures are still in line with the services provided. Any time a participant is hospitalized or institutionalized for a period of time, his/her needs are reviewed and any changes are addressed in the participant's budget and cost out.

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

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

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

■	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

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

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
●	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:
	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, when and how they want services to be given, and how they want to spend the budget for their services. Case Managers provide this information and brochure to participants on an ongoing basis. Participants who express an interest in self-direction are referred to case managers with special expertise in self-direction, who will then follow up with a telephone call to the participant to discuss the benefits and responsibilities of participant direction in more detail, and determine continued interest.

Case managers visit participants who remain interested, and provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant direction. For new participants, the initial visit by the case manager is made prior to slot availability, to afford sufficient

time to consider and weigh the benefits against the added responsibilities and to make an informed decision about whether to choose participant direction.

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: *(check each that applies)*:	
	■	Waiver services may be directed by a legal representative of the participant.
	■	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		A participant may choose to have waiver services directed by a representative and he/she may choose anyone 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)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Respite Care Services (In-Home Respite)	■	□
Attendant Care	■	■
Adult Companion Care	■	■
Chore Services	■	■
Home accessibility adaptations and appliances	□	■

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

●	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	☐	Governmental entities
	■	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.	

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

○	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3.
●	FMS are provided as an administrative activity. *Provide the following information:*

i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	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.
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	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.
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

■	Assist participant in verifying support worker citizenship status
■	Collect and process timesheets of support workers
■	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
☐	Other *(specify):*

Supports furnished when the participant exercises budget authority:

☐	Maintain a separate account for each participant's participant-directed budget
■	Track and report participant funds, disbursements and the balance–of participant funds
■	Process and pay invoices for goods and services approved in the service plan
■	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
☐	Other services and supports *(specify)*:

Additional functions/activities:

☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
■	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	Other *(specify):*

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

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

■	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	A case manager visits the participant and discusses what is involved in participant direction. The case manager helps the participant list individual needs, decide how to get needs met, develop a service plan, and decide how to spend the budget. The functions of the FMS are explained and when providers are identified, the case manager may arrange for assistance with completing necessary paperwork. The use of the Care Call system is discussed, and budget activity reports are explained. The case manager also explains how the participant can review budget activity reports through the website, and encourages him/her to do so. The case manager helps the participant identify what is important for him/her to remain at home, how often the service is needed, who might be available to provide the service, and how much the participant wants to pay for the service. The budget amount and the services upon which the budget is developed are reviewed. The participant receives assistance with costing out the services paid for out of the budget.
☐	**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:
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

●	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
	South Carolina Protection and Advocacy for People with Disabilities, Inc. will provide independent advocacy for participants. Contact information is provided as part of the overall information packet. Their website is located at www.protectionandadvocacy-sc.org.
○	**No.** Arrangements have not been made for independent advocacy.

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:

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.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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 a pattern of overspending or underutilizing their budget, or 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.

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	600	300
Year 2	625	340
Year 3	650	360
Year 4 (renewal only)	675	380
Year 5 (renewal only)	700	400

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:*

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

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

■	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
■	Select staff from worker registry
■	Hire staff (common law employer)
■	Verify staff qualifications
■	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	Background checks are paid for by the Medicaid Agency as administrative costs.
■	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.
■	Determine staff duties consistent with the service specifications in Appendix C-3.
■	Determine staff wages and benefits subject to applicable State limits
■	Schedule staff
■	Orient and instruct-staff in duties
■	Supervise staff
■	Evaluate staff performance
■	Verify time worked by staff and approve time sheets
■	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

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*:

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

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.

Prior to visiting with a participant, the case manager meets with the nurse who assessed the participant and reviews the assessment, and together they discuss service needs and identify the services which would best meet those needs. The participant is also consulted as to what his/her most pressing needs are. The budget is based upon a percentage of the cost of services that would be used to address those needs. The percentage reduction is based upon the recognition that not all authorized services would actually be delivered. This is an individual amount specific to the circumstances of each participant. The budget is reviewed semi-annually or more often if there is a change in the condition of the participant. The waiver application is available on the DHHS website. Policies are available upon request.

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.

The participant's total budget amount is provided to the participant during the initial guide visit. During later planning visits, the participant prioritizes his/her needed services and the costs of those services, as well as the numbers of hours and rates of pay for personal care workers, are factored into the cost out so that the total amount of the services is within the total budget amount. The participant can identify additional needs that would affect the overall budget amount. If these needs are ones that would have increased service levels in a traditional agency directed service system, the budget will be increased to reflect these needs. If a participant's request for a budget adjustment is denied, the participant will be informed in writing which will include a right to appeal.

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

○	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:
●	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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

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 Care Call system produces real time reports showing the percentage of budget period passed and the percentage of budget amount remaining for each participant's budget. Case managers monitor budget expenditure reports bi-weekly and more often if needed to ensure that each participant's budget amount remaining is enough to cover the remaining budget period, and that the participant is not using such a low level of services as to jeopardize health and safety. Participants also have access to their own budget reports and are also encouraged to monitor the use of their budgets.

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 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.

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*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
●	**No**. This Appendix does not apply (*do not complete Item b)*

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

Appendix F-3: State Grievance/Complaint System

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

●	**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 *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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).

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.

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.

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.

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.

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. Case managers 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

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 Dept of Disabilities and Special Needs, Attorney General, Protection and Advocacy, Dept 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. 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 CLTC. It requires both agencies to work together toward identifying those programs and services operated or contracted for operation by CLTC that should report alleged abuse, neglect, or exploitation to SCDSS and to establish cooperative relationships for the purpose of training and technical assistance to CLTC staff and/or its contracts.

DHHS 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

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:*

●		This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(complete only Item G-2-c-ii)*
○		This Appendix applies. Check each that applies:
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete item G-2-c.*

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.

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.

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:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
●	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

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

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*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

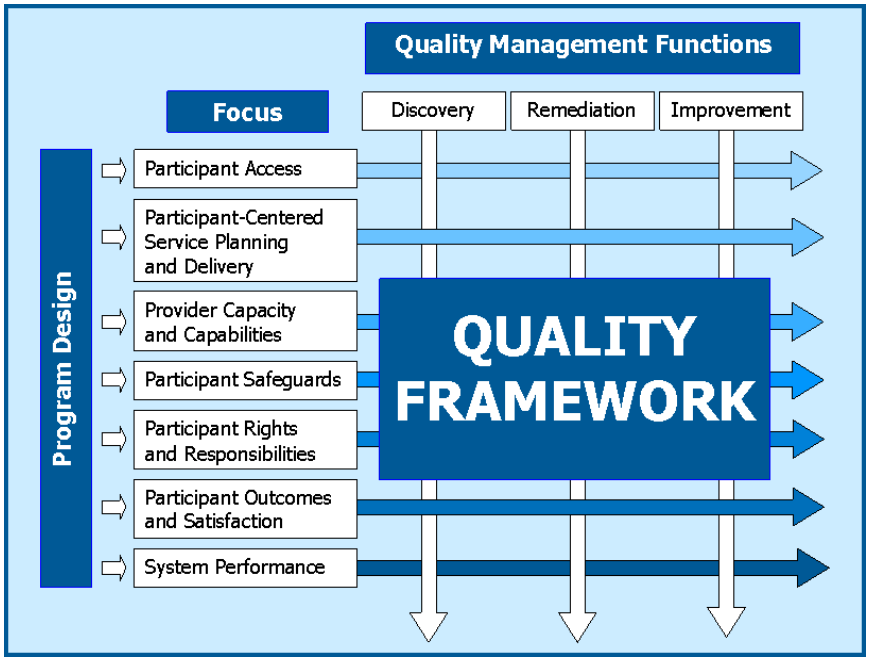
ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider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

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

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

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.

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.

Quality Management Strategy: Minimum Components

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

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

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

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

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. Case managers 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. Case managers 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. Case manager reviews start at the regional offices. Each month, senior case managers review a sample of participant records to ensure case managers complete and document monthly contacts with participants. Case management supervisors perform a more in-depth monthly review of two participants' records for each case manager. The reviews include verification that the case manager contacts each person monthly as required, the service plan addresses identified needs, and the case manager has reassessed participants and updated their service plans as appropriate. Case management supervisors also annually visit one or two participants per case manager in person to ask them about the assistance the case manager is providing. Case managers are notified of problems when they are identified, and receive training if they do not meet required performance levels. If a case manager 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 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
- Agency Companion
- Medicaid Nursing
- Adult Day Care

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 delivered meals are monitored by the State Unit on Aging. SCDHHS has a formal memorandum of agreement with the State Unit on Aging to perform this function.

Environmental modification 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 case manager consults with the participant at least monthly to ensure that services are being provided appropriately.

Individual companion services are provided to participants capable of self-directing their care, who can terminate companions for any reason. In addition, case managers check monthly with participants regarding companion as well as all other services.

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 environmental modification 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 and individual companion services, 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.

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, companion 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. Case managers 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 implemented a Central Office QA Task Force to review all data accumulated through supervisory reviews, timeliness reports, peer review, case reviews, participant satisfaction surveys, administrative reviews, care call system reports, provider compliance reviews, participant complain log reports Adult Protective Services reports, program CMS reports, and other QA activities. This data is analyzed to identify training needs, areas requiring policy clarification and to determine area office strengths. 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.

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, adult day health care, companion, 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. In this capacity Audits is currently conducting a compliance review of the Fiscal Management Service used for participant directed care in the CLTC waiver program.

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. Payment rates are made available to waiver participants by the case manager for those participants who have chosen to utilize the budgeting process in their receipt of services.

A large majority 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 and II, Adult Day Health Care, Home Delivered Meals, and Adult Day Health Care 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 E/D 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. Respite care services provided to waiver participants in a Community Residential Care Facility is established at $50 per day which is significantly less than the average Medicaid nursing facility rate. It is higher than the daily CRCF rate to reflect the administrative costs of short term stays.

Environmental Accessibility waiver service rates for environmental 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. Appliances are available for participants with budget authority and are based upon retail pricing.

Case management service rates provided to E/D waiver recipients were calculated based upon payments made to DHHS employees providing case management. At one time all case management was done by state employees. When this changed, cost analyses were conducted to determine the payment per participant and this rate was set for non-state case management entities.

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.

Attendant and companion services are primarily by individuals. The attendant 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. Participants with budget authority can negotiate a lower rate. Companion services provide no hands-on care and the rate is established at a lower level than the Personal Care I rate.

Chore services are available only for participants with budget authority and are negotiated between the participant and the provider. Rates are reviewed by the case manager.

Nursing Home transition services are based upon individual needs and will vary determining upon the particular needs of the participant.

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 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)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):	
	☐	**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). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**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). (*Indicate source of revenue for CPEs in Item I-4-b.*)
●	**No**. Public agencies do not certify expenditures for waiver services.	

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 case manager 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 case manager. 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.

APPENDIX I-3: Payment

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

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
●	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) 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.
	CLTC case management costs for services are allocated by taking the percentage of case management to total salary costs in the CLTC field offices. At present the cost is being allocated at 43.946%. These costs are then allocated to the case management service in the CLTC waivers. The office and administrative costs are captured using specific project codes on agency financial reports. These allocations are made based on financial expenditure reports, which are transcribed onto a spreadsheet for calculation using the aforementioned percentage for services and another calculation is made to spread office and administrative costs by waiver. The spreadsheet is included in our work papers, which is claimed for reimbursement on the CMS-64 and audited by CMS quarterly.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

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

■	The Medicaid agency makes payments directly to providers of waiver services.
□	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
■	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

	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.
☐	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:*

●	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made 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.*

●	**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. *Complete item I-3-e.*
	Some County Councils on Aging are public providers (many others are not). They receive payments for the provision of home delivered meals, personal care I, companion services and adult day health services. The contractual process is the same for these as for all other providers of these services.

○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

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*:

●	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	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.
○	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:*

●	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	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.):
○	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:*

○	**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.

●	**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:*

○	**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:
●	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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

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

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:*

■	**Appropriation of State Tax Revenues to the State Medicaid agency**
■	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the 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.
☐	**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:*

☐	**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:
☐	**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:
■	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

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.*

■	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	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.
☐	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

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

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

●	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

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:

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:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
●	**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.

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:*

●	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

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

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

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

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

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	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:*

●	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income 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:

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 *(specify)*:			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	$7,430	$4,659	$12,089	$25,636	$2,839	$28,475	$16,386
2	$7,822	$4,892	$12,714	$26,918	$2,981	$29,899	$17,185
3	$8,227	$5,136	$13,363	$28,264	$3,130	$31,394	$18,031
4	$8,658	$5,393	$14,052	$29,677	$3,286	$32,963	$18,911
5	$9,107	$5,663	$14,770	$31,161	$3,451	$34,612	$19,842

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	14,375		
Year 2	15,000		
Year 3	15,625		
Year 4 (renewal only)	16,250		
Year 5 (renewal only)	16,875		

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 Elderly/Disabled Waiver shows a length of stay of 297 days. This is consistent with previous years. Our estimate is 10 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:

This waiver combines the State's Independence Plus waiver with its waiver for elderly and disabled participants. In the case of services available in the elderly/disabled waiver, the CMS 372 reports 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. In the case of services available through the Independence Plus waiver, the CMS 372 report has been used as the basis of estimates, with the waiver reflecting increasing utilization of participant directed services over the course of the waiver renewal period.

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 elderly/disabled 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 just begun and no data are available to more precisely estimate the effect on D'.

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:

Even though the CMS 372 report requires estimates rather than actual data for Factor G, the State has continued to collect these data on an annual basis. The estimates are based upon these actual figures. 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:

Even though the CMS 372 report requires estimates rather than actual data for Factor G', the State has continued to collect these data on an annual basis. The estimates are based upon these actual figures. A 5% inflation factor is used for each year of the waiver.

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

●	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

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

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. Case Management	Month	14,375	10	$74.55	$10,716,563
2. Personal Care I	Hour	3,594	135	$10.10	$4,900,419
3. Personal Care II	Hour	10,638	285	$14.80	$44,871,084
4. Home Delivered Meals	Meal	4,792	215	$4.75	$4,893,830
5. Adult Day Health Care	Day	2,717	145	$43	$16,940,495
6. ADHC Nursing	Day	144	100	$15	$216,000
7. Attendant Care	Hour	1,200	365	$11.30	$4,949,400
8. a. Respite – Institutional	Day	69	10	$125	$86,250
8. b. Respite – CRCF	Day	65	15	$50	$48,750
8. c. Respite – In-Home	Day	200	8	$95	$152,000
9. Adult Companion Care	Hour	1,294	226	$7.50	$2,193,330
10. Chore Service	Event	45	78	$10	$35,100
11. Pers. Emerg. Resp. System	Month	4,792	10	$35	$1,677,200
12. Nursing Home Trans Serv	Event	100	1	$750	$75,000
13. Home Accessibility Adaptations and Appliances					
a. Pest Control – Initial	Event	3,035	1	$60	$182,100
b. Pest Control – Followup	Event	2,317	2	$30	$139,020
c. Home Adaptations	Event	1,725	1	$1,000	$1,725,000
d. Appliances	Item	30	1	$500	$15,000
14. Specialized Medical Supplies and Equipment					
a. Adult diapers	Diaper	8,288	960	$0.92	$7,319,962
b. Pads	Case	6,358	7	$45	$2,002,770
c. Wipes	Box	8,288	10	$16	$1,326,080
d. Shower Chair	Item	1,000	1	$35	$35,000
e. Transfer Bench	Item	1,000	1	$160	$160,000
f. Hand Held Shower	Item	2,000	1	$50	$100,000
g. Nutritional Supplements	Item	2,875	20	$35	$2,012,500
h. Raised Toilet Seat	Item	500	1	$65	$32,500
GRAND TOTAL					$106,805,352
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					14,375
FACTOR D (Divide grand total by number of participants)					$7,430
AVERAGE LENGTH OF STAY ON THE WAIVER					10 months

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. Case Management	Month	15,000	10	$78.28	$11,742,000
2. Personal Care I	Hour	3,750	135	$10.61	$5,371,313
3. Personal Care II	Hour	11,100	285	$15.54	$49,160,790
4. Home Delivered Meals	Meal	5,000	215	$4.99	$5,364,250
5. Adult Day Health Care	Day	2,835	145	$45.15	$18,560,036
6. ADHC Nursing	Day	150	100	$15.75	$236,250
7. Attendant Care	Day	1,300	365	$11.87	$5,632,315
8. a. Respite – Institutional	Day	72	10	$131.25	$94,500
8. b. Respite – CRCF	Day	68	15	$52.50	$53,550
8. c. Respite – In-Home	Hour	300	8	$99.75	$239,400
9. Adult Companion Care	Activity	1,350	226	$7.88	$2,404,188
10. Chore Service	Month	55	78	$10.50	$45,045
11. Pers. Emerg. Resp. System	Activity	5,000	10	$36.75	$1,837,500
12. Nursing Home Trans Serv	Activity	100	1	$787.50	$78,750
13. Home Accessibility Adaptations and Appliances					
a. Pest Control – Initial	Activity	3,167	1	$63.00	$199,521
b. Pest Control – Followup	Activity	2,418	2	$31.50	$152,334
c. Home Adaptations	Item	1,800	1	$1,050.00	$1,890,000
d. Appliances	Item	40	1	$525.00	$21,000
14. Specialized Medical Supplies and Equipment					
a. Adult diapers	Diaper	8,648	960	$0.97	$8,053,018
b. Pads	Case	6,634	7	$47.25	$2,194,196
c. Wipes	Box	8,648	10	$16.80	$1,452,864
d. Shower Chair	Item	1,000	1	$36.75	$36,750
e. Transfer Bench	Item	1,000	1	$168.00	$168,000
f. Hand Held Shower	Item	2,000	1	$52.50	$105,000
g. Nutritional Supplements	Item	3,000	20	$36.75	$2,205,000
h. Raised Toilet Seat	Item	500	1	$68.25	$34,125
GRAND TOTAL					$117,331,694
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					15,000
FACTOR D (Divide grand total by number of participants)					$7,822
AVERAGE LENGTH OF STAY ON THE WAIVER					10 months

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. Case Management	Month	15,625	10	$82.19	$12,842,188
2. Personal Care I	Hour	3,906	135	$11.14	$5,874,233
3. Personal Care II	Hour	11,563	285	$16.32	$53,781,826
4. Home Delivered Meals	Meal	5,208	215	$5.24	$5,867,333
5. Adult Day Health Care	Day	2,953	145	$47.41	$20,300,251
6. ADHC Nursing	Day	156	100	$16.54	$258,024
7. Attendant Care	Hour	1,400	365	$12.46	$6,367,060
8. a. Respite – Institutional	Day	75	10	$137.81	$103,358
8. b. Respite – CRCF	Day	71	15	$55.13	$58,713
8. c. Respite – In-Home	Day	400	8	$104.74	$335,168
9. Adult Companion Care	Hour	1,406	226	$8.27	$2,627,842
10. Chore Service	Activity	65	78	$11.03	$55,922
11. Pers. Emerg. Resp. System	Month	5,208	10	$38.59	$2,009,767
12. Nursing Home Trans Serv	Activity	100	1	$826.88	$82,688
13. Home Accessibility Adaptations and Appliances					
a. Pest Control – Initial	Activity	3,299	1	$66.15	$218,229
b. Pest Control – Followup	Activity	2,519	2	$33.08	$166,657
c. Home Adaptations	Activity	1,875	1	$1,102.50	$2,067,188
d. Appliances	Item	50	1	$551.25	$27,563
14. Specialized Medical Supplies and Equipment					
a. Adult diapers	Diaper	9,009	960	$1.01	$8,735,126
b. Pads	Case	6,910	7	$49.61	$2,399,636
c. Wipes	Box	9,009	10	$17.64	$1,589,188
d. Shower Chair	Item	1,000	1	$38.59	$38,590
e. Transfer Bench	Item	1,000	1	$176.40	$176,400
f. Hand Held Shower	Item	2,000	1	$55.13	$110,260
g. Nutritional Supplements	Item	3,125	20	$38.59	$2,411,875
h. Raised Toilet Seat	Item	500	1	$71.66	$35,830
GRAND TOTAL					$128,540,913
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					15,625
FACTOR D (Divide grand total by number of participants)					$8,227
AVERAGE LENGTH OF STAY ON THE WAIVER					10 months

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. Case Management	Month	16,250	10	$86.30	$14,023,750
2. Personal Care I	Hour	4,063	135	$11.69	$6,412,023
3. Personal Care II	Hour	12,025	285	$17.13	$58,706,651
4. Home Delivered Meals	Meal	5,417	215	$5.50	$6,405,603
5. Adult Day Health Care	Day	3,071	145	$49.78	$22,166,785
6. ADHC Nursing	Day	163	100	$17.36	$282,968
7. Attendant Care	Hour	1,500	365	$13.08	$7,161,300
8. a. Respite – Institutional	Day	78	10	$144.70	$112,866
8. b. Respite – CRCF	Day	74	15	$57.88	$64,247
8. c. Respite – In-Home	Day	500	8	$109.97	$439,880
9. Adult Companion Care	Hour	1,463	226	$8.68	$2,869,938
10. Chore Service	Activity	75	78	$11.58	$67,743
11. Pers. Emerg. Resp. System	Month	5,417	10	$40.52	$2,194,968
12. Nursing Home Trans Serv	Activity	100	1	$868.22	$86,822
13. Home Accessibility Adaptations and Appliances					
a. Pest Control – Initial	Activity	3,431	1	$69.46	$238,317
b. Pest Control – Followup	Activity	2,620	2	$34.73	$181,985
c. Home Adaptations	Activity	1,950	1	$1,157.63	$2,257,379
d. Appliances	Item	60	1	$578.81	$34,729
14. Specialized Medical Supplies and Equipment					
a. Adult diapers	Diaper	9,369	960	$1.07	$9,623,837
b. Pads	Case	7,187	7	$52.09	$2,620,596
c. Wipes	Box	9,369	10	$18.52	$1,735,139
d. Shower Chair	Item	1,000	1	$40.52	$40,520
e. Transfer Bench	Item	1,000	1	$185.22	$185,220
f. Hand Held Shower	Item	2,000	1	$57.88	$115,760
g. Nutritional Supplements	Item	3,250	20	$40.52	$2,633,800
h. Raised Toilet Seat	Item	500	1	$75.25	$37,625
GRAND TOTAL					$140,700,450
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					16,250
FACTOR D (Divide grand total by number of participants)					$8,658
AVERAGE LENGTH OF STAY ON THE WAIVER					10 months

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. Case Management	Month	16,875	10	$90.62	$15,292,125
2. Personal Care I	Hour	4,219	135	$12.28	$6,994,258
3. Personal Care II	Hour	12,488	285	$17.99	$64,027,849
4. Home Delivered Meals	Meal	5,625	215	$5.77	$6,978,094
5. Adult Day Health Care	Day	3,189	145	$52.27	$24,169,909
6. ADHC Nursing	Day	169	100	$18.23	$308,087
7. Attendant Care	Hour	1,600	365	$13.74	$8,024,160
8. a. Respite – Institutional	Day	81	10	$151.94	$123,071
8. b. Respite – CRCF	Day	76	15	$60.78	$69,289
8. c. Respite – In-Home	Day	600	8	$115.47	$554,256
9. Adult Companion Care	Hour	1,519	226	$9.12	$3,130,841
10. Chore Service	Activity	85	78	$12.16	$80,621
11. Pers. Emerg. Resp. System	Month	5,625	10	$42.54	$2,392,875
12. Nursing Home Trans Serv	Activity	100	1	$911.63	$91,163
13. Home Accessibility Adaptations and Appliances					
a. Pest Control – Initial	Activity	3,563	1	$72.93	$259,850
b. Pest Control – Followup	Activity	2,721	2	$36.47	$198,470
c. Home Adaptations	Activity	2,025	1	$1,215.51	$2,461,408
d. Appliances	Item	70	1	$607.75	$42,543
14. Specialized Medical Supplies and Equipment					
a. Adult diapers	Diaper	9,730	960	$1.12	$10,461,696
b. Pads	Case	7,463	7	$54.70	$2,857,583
c. Wipes	Box	9,730	10	$19.45	$1,892,485
d. Shower Chair	Item	1,000	1	$42.54	$42,540
e. Transfer Bench	Item	1,000	1	$194.48	$194,480
f. Hand Held Shower	Item	2,000	1	$60.78	$121,560
g. Nutritional Supplements	Item	3,375	20	$42.54	$2,871,450
h. Raised Toilet Seat	Item	500	1	$79.01	$39,505
GRAND TOTAL					$153,680,167
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					16,875
FACTOR D (Divide grand total by number of participants)					$9,107
AVERAGE LENGTH OF STAY ON THE WAIVER					10 months