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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Community Choices

C. Waiver Number:SC.0405
Original Base Waiver Number: SC.00405.

D. Amendment Number:

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

08/01/15

Approved Effective Date of Waiver being Amended: 07/01/11

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Persons attending adult day health care centers often have skilled medical needs. This service reimburses the facility for providing certain skilled nursing services (ostomy care, urinary catheter care, wound care, tracheostomy care, tube feedings and nebulizer treatments that require medication). This service was a part of the waiver program for a number of years but was removed as a cost saving measure during the Great Recession.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	

☐ **Appendix B – Participant Access and Eligibility**	
☑ **Appendix C – Participant Services**	C-1a; C-1
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	J-2d, 9 of

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

  Specify:
  Language clarification to billing claims and processing, the State's organizational structure and other necessary changes to clarify language

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Community Choices

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: SC.00405
Draft ID: SC.016.02.05

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/11
Approved Effective Date of Waiver being Amended: 07/01/11

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

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

Not applicable

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

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

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

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

SPA SC13-006 was approved by CMS on 1/27/2014, and allows for the enrollment of waiver participants into managed care (e.g. the Healthy Connections Prime Dual Eligible Demonstration) and concurrent authority with South Carolina's State Plan Medicaid services.

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
South Carolina is seeking to amend the Community Choices waiver. The Community Choices waiver provides participant directed options for supervision of services. The Community Choices waiver offers a continuum of service options capable of meeting the needs of all waiver participants, both those who choose agency directed services and those who choose self-directed services.

The Community Choices waiver serves the 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 service 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.

Description of Phoenix and Care Call
Phoenix is South Carolina's automated web-based case management system. This includes all tools used by nurses and case managers to assess and manage care of waiver participants. Some components are:
• Demographic information
• Applications for waivers and current status of applications
• All assessments conducted, including level of care determination
• Service Plans
• Service referrals/authorizations for waiver services
• Documentation of other community supports
• Home assessment component including documentation of bathroom safety, ramp and home modification needs
• Caregiver supports section indicating available supports and level of stress and burnout in support system
• Care Call summary information
Phoenix has a number of features included in the software to ensure compliance with federal requirements. Examples include:
• Not allowing assessments to be conducted of any applicant not meeting intake criteria (e.g., not old enough to enroll in the waiver, does not live in state and has not indicated intent to move)
• Not allowing waiver enrollment to anyone without an appropriate level of care within 30 days of waiver enrollment
• Not allowing any waiver service to be authorized that is not indicated in the service plan
• Flagging and recording all cases where any federal regulations or state policies are not being followed appropriately.

Care Call is an Electronic Voice Verification System (EVV)used by providers to record service provision.Care Call receives information from Phoenix, such as authorized services, schedule and frequency of authorizations, phone numbers of waiver participants and information about providers and provider workers.

When workers provide in-home services, they call a toll-free number to utilize the IVRS or use the mobile application to indicate the agency, worker and service being performed and for which waiver participant. This is compared with the service authorization to ensure that claims are made only for authorized services and only up to the authorized amount. The Care Call system now also captures the tasks performed and observations by in-home workers.

Providers use the Phoenix system to produce reports regarding the provision of service. In addition, claims are now submitted

to MMIS for payment by Phoenix daily (except Mondays). This results in a quick turnaround in payments to providers because the claims are always submitted with the correct procedure code, amount, etc. The Financial Management Service (FMS) provider no longer produces paper checks and mails them to attendants. All attendants must now use electronic funds transfer (EFT) to their banking institution or receive their funds on a debit card.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the

Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
This amendment was presented to the MCAC, which included Tribal Notification, on November 12,2014 and was shared during the agency's monthly Indian Health Services conference call on October 29,2014.

Public Notice of intent to amend this waiver was sent to the agency listserv of interested stakeholders and posted to the agency website on November 10, 2014. Additionally, four (4) public meetings were held through out the State and one webinar to address proposed waiver changes.

A summary of proposed waiver amendment changes were posted to the agency website on November 10, 2014.

Based on further guidance from CMS, this waiver amendment was posted to the SCDHHS website on March 20,2015 for public comments and/questions. Additionally, hardcopies of the waiver amendment were placed in the SCDHHS lobby and the 10 SCDHHS Regional Offices and 2 Satellite Offices on March 20, 2015 for public review and comments.

Public Notice of the waiver amendment postings (electronic and hardcopies) was conducted through SCDHHS website; e-mail to the agency's listserv of interested stakeholders, MCAC and Tribbal Notification and other relevant organizations on Macrh 20, 2015. Also, hardcopy public notices were placed in each of the 10 SCDHHS Area and 2 Satellite Offices and the lobby of the SCDHHS on March 20, 2015.

This waiver amendment will allow the State to offer an additional service to participants in need of it (ADHC/N). Therefore, the State does not foresee that participants will be adversely impacted with this waiver amendment.

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

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

7. Contact Person(s)

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

Last Name: Smith

First Name: Roy

Title: Division Director, Waiver Management

Agency: South Carolina Department of Health and Human Services

Address: P.O. Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202-9206

Phone: (803) 898-2721 **Ext:** ☐ **TTY**

Fax: (803) 255-8209

E-mail: Smithroy@scdhhs.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **South Carolina**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Soura

First Name: Christian

Title: Director

Agency: South Carolina Department of Health and Human Services

Address: P.O. Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202-9206

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

Fax: (803) 255-8209

E-mail: christian.soura@scdhhs.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**

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

Specify the transition plan for the waiver:

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

Some participants in this waiver reside in Community Residential Care Facilities (CRCFs). Therefore, for these settings the general processes (e.g. assessment of system-wide regulations, policies, procedures, licensing standards, and other regulation; and assessment of settings)and timelines described in the Statewide Transition Plan (which was submitted February 2015) will be followed for these CRCFs. Additionally,the general Adult Day Health Care (ADHC)Facilities processes and timelines in the Statewide Transition Plan will apply to this waiver, as many participants attend ADHC facilities.

The Transition Plan for this waiver:

Introduction

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

CMS requires that each state submit a “Transition Plan” for each waiver renewal or amendment between March 2014 and March 2015. The Transition Plan outlines how the state will come into conformance and compliance with the HCBS Rule settings requirements. Once any waiver renewal or amendment is submitted to CMS with the waiver specific Transition Plan, the state must then submit, 120 days later, a “Statewide Transition Plan” that outlines how the state will come into conformance with the new requirements of the HCBS Rule. States must come into full compliance with HCBS Rule requirements by Mar. 17, 2019.

This is the Transition Plan for the CC Waiver Amendment. Per CMS requirements, this is available for the public to read and comment on before being submitted to CMS for review when the amendment is submitted.

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

and input.

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

Communications and Outreach – Public Notice Process

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

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

Public Notice and Comment on Waiver Amendment
SCDHHS has developed policy to provide multiple methods of public notice and input on waiver amendments which also includes its accompanying transition plan.
• The Medical Care Advisory Committee (MCAC) was provided advisories on the HCBS Rule and the CC waiver amendment on November 12, 2014 and September 10, 2014.
• Per 42 CFR 441.304 (f)(4), Tribal Notification was provided on November 12, 2014 and September 10, 2014. A Tribal Notification conference call for the waiver amendment and transition plan was held October 29, 2014.
• Public notice for comment on the CC waiver amendment and transition plan was posted on the SCDHHS website on November 10, 2014.
• Public notice for comment on the CC waiver amendment and transition plan was sent out via the SCDHHS listserv on November 10, 2014.
• Four public meetings were held to discuss the CC waiver amendment and its transition plan, as well as the HCBS Rule and what it means for South Carolina beneficiaries. These meetings were held in November and December 2014 in the following cities:
o Florence, SC Nov. 13, 2014
o Greenville, SC Nov. 18, 2014
o Charleston, SC Dec. 2, 2014
o Columbia, SC Dec. 4, 2014

• Public notice on the CC waiver amendment and revised waiver transition plan, including the draft waiver amendment document and the revised waiver transition plan document, was posted on the following website on March 20, 2015:
o SCDHHS website (scdhhs.gov)
• Public notice on the CC draft waiver amendment document and revised waiver transition plan was sent out via the SCDHHS listserv on March 20, 2015.
• Public notice on the CC draft waiver amendment document and revised waiver transition plan was sent out via e-mail to pertinent organizations, including MCAC and Tribal Notification on March 20, 2015
• Printed public notice on the CC draft waiver amendment document and revised waiver transition plan was posted at SCDHHS Jefferson Square/Headquarters Lobby on March 20, 2015.
• Printed copy of the CC draft waiver amendment document and revised waiver transition plan document were made available for public view and comment at SCDHHS Jefferson Square/Headquarters Lobby on March 20, 2015.
• Printed copies of public notice on the CC waiver amendment and revised waiver transition plan, including a printed copy of the draft waiver amendment document and revised waiver transition plan document, were provided in all 10 Community Long Term Care Area Offices and 2 satellite offices on March 20, 2015.
• Public comments were gathered from the public meetings listed above, from electronic communications sent to SCDHHS and from communications mailed to SCDHHS.

SCDHHS will review all comments from public meetings and public postings and incorporate any appropriate changes to the waiver amendment and its transition plan based on public comments.

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

Process of System-Wide Review
As part of the larger scope of the Statewide Transition Plan, SCDHHS reviewed the regulations, policies, standards, and other provider requirements that directly impact home and community-based settings. The list of regulations, policies, etc., was separated according to HCB setting. They were read and reviewed to determine that the regulation, policy, etc. is not a barrier to the settings standards outlined in the HCBS Rule.
The list of laws, regulations, etc., was separated according to HCB setting. They were read and reviewed to determine that the law, regulation, etc. is not a barrier to the settings standards outlined in the HCBS Rule. The settings for South Carolina are divided as follows:
• Most of the CC participants reside in their own homes, which are presumed to meet the home and community based setting requirements
• Adult Day Health Care Centers
• Residential settings (serving some elderly and disabled individuals that are served through the CC Waiver):
o Community Residential Care Facilities

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

Outcomes of System-Wide Review
As part of the Statewide Transition Plan, the following standards, rules, requirements, law, regulations, and policies were assessed:
1. Adult Protection, S.C. Code Ann. §§ 43-35-5 et seq.
2. Department of Health and Human Services, S.C. Code Ann. §§ 44-6-10 et seq.
3. Community Residential Care Facilities, S.C. Regs. 61-84
4. Day Care Facilities for Adults, S.C. Regs. 61-75
5. Department of Health and Human Services S.C. Regs. Chapter 126
6. SCDHHS Provider Manuals
a. CLTC Provider Manual
b. SC Medicaid Policy and Procedures Manual
After a review of these sources, SCDHHS has identified the following areas as not being fully compliant with the Federal settings regulations and will seek specific action to come into compliance:
1. SC Code Ann. § 44-20-420: “The director or his designee may designate the service or program in which a client is placed. The appropriate services and programs must be determined by the evaluation and assessment of the needs, interests, and goals of the client.”
a. This law is only partially compliant with 42 C.F.R. 441.301(c)(4)(iv). Having the director or his designee designate the services or program in which a client is placed does not optimize an individual’s initiative, autonomy, and independence in

making life choices. However, this law only gives the director the authority to designate services or programs for an individual and does not mandate that they do so, and because of that, SCDHHS does not foresee having to ask the South Carolina General Assembly to make changes to this law. Additionally, the effect of this law is mitigated by the person-centered service process that places an individual in the center of the service planning process and empowers them to make their own choices as to which services they are provided and by whom.

2. SCDHHS Policy, Waiver Documents, and SCDDSN Medicaid Waiver Policy Manuals Medicaid HCB Waiver Policy Regarding Waiver Services Provided while Clients Travel Out-of-State: "[…] Waiver participants may travel out of state and retain a waiver slot under the following conditions: the trip is planned and will not exceed 90 consecutive days; the participant continues to receive a waiver service consistent with SCDDSN policy; the waiver service received is provided by a South Carolina Medicaid provider; South Carolina Medicaid eligibility is maintained. During travel, waiver services will be limited to the frequency of service currently approved in the participant's plan. Services must be monitored according to SCDDSN policy. The parameters of this policy are established by SCDHHS for all HCB Waiver participants."
a. This policy does not specifically touch on any of the home and community-based settings requirements, but it may be an unnecessary restriction on an individual with disabilities. This policy may need further review.
All other laws, regulations, standards, directives, and policies reviewed were either supporting of or not objecting to the home and community-based settings regulations and no further action needs to be taken.

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

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

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

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

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

Assessment of Settings

Setting Types
The majority of CC participants reside in their own homes; therefore participant's home is the primary setting where home and community-based services are provided in the CC waiver. However, a few participants reside in Community Residential Care Facilities and some attend Adult Day Health Care (ADHC).

Adult Day Health Cares (ADHC). There are currently 82 Adult Day Health Care facilities that are available for CC waiver participants to use across the state and approximately 2,314 waiver participants who use ADHC as part of their service plan.
Community Residential Care Facility (CRCF). This model offers the opportunity to live in the community in a homelike environment under the supervision of qualified, trained caregivers. Care, supervision and skills training are provided according to identified needs as reflected in the service plan.

Setting Assessment Process
The setting assessment process is part of the overall process detailed in the Statewide Transition Plan. The C4 Individual Facilities/Settings Assessment process and the Waiver Participant Surveys are detailed here.
C4 Individual Facilities/Settings Assessment. The C4 assessment is designed to evaluate individual facilities to determine compliance with the HCBS criteria outlined in 42 CFR Part 441.301(c)(4).
Development of the assessment tools and criteria. Two assessment tools were developed for individual facilities: one for residential facilities and another for day (non-residential) facilities. The criteria used to create these tools is outlined in the 42 CFR Part 441.301(c)(4). Additionally, SCDHHS used the exploratory questions issued by CMS for the settings requirements.
The assessment tools will be used in two ways to measure individual facilities. First, they will be used by providers to complete the self-assessment of individual facilities. Second, SCDHHS or a contracted vendor will use the tools as an

independent assessment during site visits. The setting-specific assessments are online tools. For providers who may not have internet access, SCDHHS will provide paper copies.
SCDHHS will pilot test the setting-specific assessment tools to determine reliability and decide if any revisions need to be made prior to distributing to providers. Testing the pilot will be conducted with providers who own or operate home and community-based settings. The testing process will also aid in the development of clear instructions on how to complete the assessment. Pilot testing began in January 2015; the agency anticipates this will be completed in early March 2015.
Resources to conduct assessments and site visits. Resources to conduct the assessments will come from SCDHHS personnel and financial resources as well as individual provider personnel and financial resources.
SCDHHS anticipates that electronic notification of the individual facility assessment process will be sent to providers in spring of 2015. Following the notification the agency will send individual letters to providers with instructions on how to conduct the setting-specific assessments. For providers who may not have internet access, paper copies of the assessment tools will be mailed to them.
Individual letters will be sent to all residential and non-residential providers with instructions on how to complete that assessment within a 45 calendar day time frame. The deadline will be established based on the letter's approximate day of delivery to providers. All day (non-residential) settings will be assessed. Due to the large number of residential settings and limited SCDHHS resources, each residential provider will conduct a self-assessment of a representative sample of their residential settings, as determined by SCDHHS. It is expected that each residential provider conduct a self-assessment on all of their residential settings to determine its level of compliance and establish any steps that may be needed to come into compliance if there are deficiencies.
Individual site visits will occur during that same time as the provider self-assessments. These site visits will be on individual settings and will be conducted by SCDHHS or a contracted vendor. All day (non-residential) settings will be subject to an independent site visit. Providers of residential services will only complete self-assessments on a representative sample of their settings as determined by SCDHHS. Any residential setting from a provider may be subject to a site visit. Any setting, residential or non-residential, that self-identified through the C5 assessment as potentially being subject to the heightened scrutiny process will be subject to an independent site visit.
Timeframe to conduct assessments and site visits. Each part of the assessment process has an estimated time for completion. These time frames are based on personnel and financial resources and may vary.
Providers have 45 calendar days to complete and return the self-assessment for the settings they own and/or operate to SCDHHS. The deadline will be established based on the letter's approximated day of delivery to providers.
Independent site visits are anticipated to take approximately 12 months to complete. This timeframe will begin once either SCDHHS or a contracted vendor is confirmed as the entity who will conduct the site visits. The site visits may start later than the provider self-assessment time frame.
Assessment review. SCDHHS will individually review all setting-specific assessments to determine if each setting is or is not in compliance. To determine the level of compliance or non-compliance, SCDHHS will use the data collected during both the provider self-assessment and the independent site visit assessment. Providers will receive written feedback from SCDHHS on each setting after the assessments are reviewed. SCDHHS' goal is to complete the assessment review within 12 months from the start of the independent site visits.

Waiver Participant surveys. Waiver participant experience and satisfaction surveys are waiver specific and ask questions directly of the waiver participant/Primary Contact about their experiences with services in the waiver and their satisfaction level with those services. There is a survey for CC waiver participants.
Development of the assessment tools and criteria. This survey is created and conducted by an external contracted entity. The survey will be reviewed and any supplemental questions may be added as they relate to the standards listed in 42 CFR Part 441.301(c)(4).
Resources to conduct assessments. Resources to conduct the surveys will come from SCDHHS personnel and financial resources as well as the contracted vendor's personnel and financial resources.
SCDHHS has contracted with an external entity and they are currently developing the CC waiver participant experience and satisfaction survey.
Timeframe to conduct assessments. Each part of the assessment process has an estimated time for completion. These time frames are based on personnel and financial resources and may vary.
The agency anticipates that the CC waiver participant experience and satisfaction survey will be completed in 2015 per the contract requirements.
Assessment review. SCDHHS will review all relevant data gathered from the CC waiver participant experience and satisfaction survey to aid in determining where settings may or may not be in compliance.

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   (●) **The waiver is operated by the State Medicaid agency.**

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

   (●) **The Medical Assistance Unit.**

   Specify the unit name:
   Division of Community Long Term Care Waiver Management
   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

- ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
- ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

- ◉ **Not applicable**
- ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the

local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

☐ **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:

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency
Participant waiver enrollment	☑
Waiver enrollment managed against approved limits	☑

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state retains full operational and administrative authority of this waiver. There are no other contracted entities performing operational or administrative functions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			

☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Not applicable. If the disabled individual reaches the age of 64 they remain in the waiver under the aged category.

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

Other

Specify:

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

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	14520
Year 2	14762
Year 3	16577
Year 4	17729
Year 5	18394

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	12000
Year 2	12200
Year 3	14000
Year 4	14800
Year 5	15300

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

SCDHHS has a policy to enroll applicants into this waiver without placing them on a waiting list. This means that all fully qualified applicants are able to access the home and community-based services available in this waiver. In the past, applicants were subject to being placed on a waiting list which limited the number of people served. In addition, the agency has adopted policies which serve to expedite enrollment into the waiver.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (•) **Yes**

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

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

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

Select one:

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

Specify percentage:

- [x] **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)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All other mandatory and optional groups included under the State Plan.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

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

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

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

Select one:

- (•) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

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

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

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

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

- ◉ **Use spousal post-eligibility rules under §1924 of the Act.** *(Complete Item B-5-b (SSI State) and Item B-5-d)*
- ○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)** *(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse

who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- (●) **The following standard included under the State plan**

  Select one:

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

    (*select one*):

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

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the State Plan**

    Specify:

    [ ]
- ( ) **The following dollar amount**

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

  Specify:

  [ ]
- ( ) **Other**

  Specify:

  [ ]

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

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

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party,

specified in 42 §CFR 435.726:

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

Select one:

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

Specify:

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.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:
- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the

State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the

near future (one month or less), but for the availability of home and community-based waiver services.

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 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 tool are used for nursing facility placement and waiver enrollment.

Residential Personal Care II (formerly known as Community Residential Personal Assistance -CRPA) is a waiver service. This service is being created for the waiver. Therefore, no individuals are currently receiving it.

The State does not anticipate that individuals receiving this service will lose this service due to not being eligible for

the waiver. This service is being developed specifically for the waiver. The state is committed to funding personal care services in the Optional Supplemental Care of Assisted Living Program (OSCAP) which does not require a nursing facilities level of care .

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 the other schedule:

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

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

Specify the qualifications:

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 managers meeting the qualifications outlined in the Scope of Services for Case Management.

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, Phoenix, 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 §92.42. 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: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
The number and percent of applicants who had a LOC determination that indicated a need for institutional LOC prior to waiver enrollment and receipt of services

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of all applicants who received a LOC determination.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of participants who received a re-evaluation within 365 days of their last LOC evaluation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Waiver Data Software System

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
The number and percent of all LOC determinations completed using the appropriate forms/instruments as required by SMA

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Waiver Data Software System

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of a1 and b1 LOC determinations where LOC criteria was accurately applied

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Waiver Data Software System

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

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

Data Aggregation and Analysis:

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

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

Waiver functions are performed by eleven (11) area SCDHHS offices and two satellite offices. Each area and satellite office has state employees (Area Administrators, Lead team case managers and Lead team nurse consultants and other nurse consultants) that manage and supervise the daily operations of the waiver. Initial assessments and level of care determinations are performed by state senior case managers. On-going case management services are performed by contracted case managers and a limited number of state case managers. Services provided by contracted case managers are monitored by area office state staff. Services provided by state employees are monitored by area office supervisors and during central office quality assurance reviews.

The Phoenix Case Management data entry system will not allow entry into the waiver without a LOC determination within 30 days. The State pulls a 100% sample size report for designated review periods to assure Phoenix performed as programmed. Any errors found in the sample size report would be addressed immediately by determining if the participant is waiver appropriate. Applicants meeting intake criteria are given a phone assessment within state time frames. In-home assessments are conducted when it can be reasonably expected that waiver enrollment can occur in the near future. Phoenix tracks all applicants on the waiting list so that SCDHHS workers can assure that people requesting assessments receive one in a timely manner. Phoenix identifies, prior to the due date, all participants due for annual re-evaluations and notes upcoming re-evaluation/LOC re-determination on case managers' dashboard. Phoenix provides management reports of any LOC re-evaluation determinations not completed timely.

The approved waiver assessment tool is part of the Phoenix waiver data software system, and waiver participation (at entry or re-evaluation) is not possible without completion of this assessment tool in Phoenix. Further, all modules of the assessment must be completed before the assessor is allowed to enter a LOC.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If an Area Office worker does not enter a participant into the waiver within 30 days of the LOC determination, Phoenix will deny waiver enrollment. The field nurse must update the assessment and LOC then enter the data into Phoenix before the particpant can enter the waiver.

If during the Central Office 100% Review an error is found, the LOC for the participant in question would be updated immediately. The assessment and LOC will be updated by conducting a home visit or telephone contact, whichever is appropriate per policy. The data in Phoenix would then be updated as necessary.

A problem, which is logged and tracked in the Phoenix system, would be reported to the Phoenix technical support group, for follow-up. They would determine and correct any issue allowing waiver entry outside of 30 day LOC determination.

Central Office or Area Office supervisory staff reviews Phoenix data (narrative, check lists, care call, etc) to discover any late LOC reevaluation problems. Once any problems have been identified by DHHS staff the information is forwarded (via complaint log format in Phoenix) to the compliance department for recoupmement. The CLTC Area Office notifies the case manager and his/her agency through webmail requesting remediation in order to bring the LOC current and any other corrective action that may be necessary. Corrective Action Plans are forwarded to Central Office using the Agency groupwise electronic mail system. Area Offices will monitor and follow-up with case manager on data generated through Phoenix quality assurance system on a weekly basis for effectiveness of Corrective Action Plans. Anything not meeting stated goals will be reported to Central Office for further remediation such as further training, suspension of new referrals/cases, reduction of case loads, recoupments of payments, and termination.

ii. Remediation Data Aggregation

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

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

☐ **Other**
Specify:

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

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 or participant's situation changes. If the participant lacks the physical or mental ability required to make a written choice regarding his/her care, a representative may sign the Service Choice form.

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

Participant Service Choice forms are maintained indefinitely in the Phoenix case management software.

Appendix B: Participant Access and Eligibility

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

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

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Health Care
Statutory Service	Case Management
Statutory Service	Personal Care/ Personal Care I + II
Statutory Service	Respite
Other Service	Adult Care Home Service
Other Service	Adult Companion Care
Other Service	Adult Day Health Care Transportation
Other Service	Adult Day Health Care-Nursing
Other Service	Attendant Care
Other Service	Home Accessibility Adaptations
Other Service	Home delivered meals
Other Service	Nursing Home Transition Service
Other Service	Personal Emergency Response System
Other Service	Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)
Other Service	Specialized Medical Equipment and Supplies
Other Service	Telemonitoring

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

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

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

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

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

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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Adult Day Health Provider

Provider Qualifications

License *(specify):*
Yes, Chapter 33 40-33-10 SC Code of laws

Certificate *(specify):*

Other Standard *(specify):*
Enrolled and contracted with the Medicaid agency for Adult Day Health Care

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Environmental Control, Medicaid Agency

Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 on-going service that is billed in 15 minute increments. It is broken into 2 components: Case Management face to face visit and Case Management contact.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid Agency
Agency	Case Management Agency
Individual	Individual Case Manager

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Medicaid Agency
Provider Qualifications
License *(specify):*
Registered Nurse or Licensed Social Worker. Code of laws 40-33-10 et seq
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment and at least once every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Case Management Agency
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Upon enrollment and at least once every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Individual

Provider Type:
Individual Case Manager

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
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.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Upon enrollment and at least once every 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Care/ Personal Care I + II

HCBS Taxonomy:

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

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

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

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

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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Agency
Agency	County Councils on Aging
Agency	Personal Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care/ Personal Care I + II

Provider Category:
Agency
Provider Type:

Nursing Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid agency

Frequency of Verification:

Upon enrollment and at least once every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care/ Personal Care I + II

Provider Category:

Agency

Provider Type:

County Councils on Aging

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract scope of service

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid agency

Frequency of Verification:

Upon enrollment and at least once every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care/ Personal Care I + II

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospital
Agency	Community Residential Care Facility
Agency	Agency Respite Provider
Individual	Individual Respite Provider
Agency	Nursing Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Hospital
Provider Qualifications
License *(specify):*
Yes, SC Code, Sec. 44-7-260 Reg. #61-16, Equivalent for NC & GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency, Department of Health and Environmental Control
Frequency of Verification:
Upon enrollment; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Residential Care Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency, Department of Health and Environmental Control

Frequency of Verification:

Upon Enrollment; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid agency

Frequency of Verification:

At least once every eighteen months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency

Frequency of Verification:

Upon Enrollment; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency, Department of Health and Environmental Control

Frequency of Verification:

Upon enrollment, annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Adult Care Home Service

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Adult Care Home service providers assist with activities of daily living (ADL's) and instrumental activities of daily living (IADL's) in a home setting for vulnerable adults in the community. Vulnerable adults are defined as adults who are in need of supervised living arrangements to prevent institutionalization. The Adult Care Home service shall be designed to meet the needs of the vulnerable adult with impairments through individual plans of care, which provide a variety of health, social and related support services in a protective setting, enabling participants to live in the community.

The Adult Care Home service provides care and supportive services (e.g., homemaker, chore, attendant care, companion, and medication oversight to the extent permitted under State law) provided in a private home by a principal care provider where the vulnerable adult resides. Separate payment is not made for homemaker or chore services furnished to a participant receiving the Adult care home service, since these services are integral to and inherent in the provision of Adult care home service.

Payments for the Adult Care Home service are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for the Adult Care Home service does not include payments made, directly or indirectly, to members of the participant's family. The methodology by which the costs of room and board are excluded from payments for adult care home service is described in Appendix I.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title

Agency	Adult Care Home Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Care Home Service

Provider Category:
Agency
Provider Type:
Adult Care Home Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract scope of services
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Companion chosen by participant
Agency	Companion Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Care

Provider Category:
Individual

Provider Type:
Individual Companion chosen by participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Care

Provider Category:
Agency
Provider Type:
Companion Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contracted scope of services
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*
Service offered in order to enable waiver participants to gain access to adult day health services. This service is offered to participants residing with 15 miles of the adult day health site. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends or community agencies, which can provide this service without charge, are utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The transportation service is offered to participants who reside within 15 miles of the adult day health site.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Adult Day Health Care
Provider Qualifications
License *(specify):*
Yes, Chapter 33 40-33-10 SC Code of laws
Certificate *(specify):*
Other Standard *(specify):*
Enrolled and contracted with the Medicaid agency for Adult Day Health Care Transportation
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Environmental Control, Medicaid Agency
Frequency of Verification:
Annually and at least once every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day Health Care-Nursing

HCBS Taxonomy:

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

Service Definition *(Scope):*

This service is provided at Adult Day Health Care Centers (ADHC) by a licensed nurse, on a day that the participant is attending Medicaid sponsored ADHC. Nursing service procedures are limited to ostomy care, urinary catheter care, decubitus and/or wound care, tracheostomy care, tube feedings, and nebulizer treatments that require medication. This service must be ordered by a physician to meet the participant's care needs.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Adult Day Health Care

Provider Qualifications

License *(specify):*
Yes, Code of laws 40-33-10 et seq

Certificate *(specify):*

Other Standard *(specify):*
Contract Scope of Services

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Human Services

Frequency of Verification:
Upon Enrollment; Annually/Biannually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Attendant Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Attendant chosen by waiver participant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care

Provider Category:
Individual

Provider Type:
Individual Attendant chosen by waiver participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
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

Entity Responsible for Verification:
Licensed nurse under a contract with state Medicaid agency

Frequency of Verification:
Upon Enrollment; Annually

Appendix C: Participant Services

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

Service Type:

Other Service

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

Service Title:

Home Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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, and 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.

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. 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 is done as needed up to a maximum of quarterly and is excluded from the lifetime cap.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Volunteer
Agency	Licensed Business
Agency	Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Volunteer
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Work performed by volunteers, not meeting state licensure requirements, must meet all applicable local and state codes.
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Licensed Business
Provider Qualifications
License *(specify):*
code of laws for businesses in the state of South Carolina.
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Building Contractor
Provider Qualifications
License *(specify):*
Code of laws, 1976 as amended 40-59-15 et seq.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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 14 meals per week may be provided to a waiver participant.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Meals providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home delivered meals

Provider Category:
Agency
Provider Type:
Meals providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contracted Scope of Service
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nursing Home Transition Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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. Nursing home transition services include appliances, furniture, security deposits, and other one-time items necessary to re-establish the individual in the community.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Nursing Home Transition provider
Agency	Nursing Home Transition provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Home Transition Service

Provider Category:
Individual

Provider Type:
Nursing Home Transition provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Medicaid enrolled provider

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid agency

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Home Transition Service

Provider Category:
Agency

Provider Type:
Nursing Home Transition provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Medicaid enrolled provider

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid agency

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

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

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

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

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

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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Response provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:
Emergency Response provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A service designed to enable waiver participants living in Community Residential Care Facility (CRCF) 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.). Residential Personal Care II services may be provided on an intermittent or on a continuing basis.

This service (Residential Personal Care II, formerly known as Community Residential Personal Assistance - CRPA)is added instead of adding the provider as a provider type under Personal Care services because providing care in this setting does have differences from providing care in a home setting. For example, personal care providers include substantial travel time in their caregiving. Also, some components of the personal care service are provided as part of routine CRCF care and we do not want to duplicate those features. Also, provider requirements for personal care will be slightly different to reflect the different setting of services.

The service is not available to people not in the RCF setting. People not in this setting can receive personal care services which provide the same assistance with activities of daily living.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Residential Care Facility (CRCF)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)

Provider Category:
Agency
Provider Type:
Community Residential Care Facility (CRCF)
Provider Qualifications
License *(specify):*
1.Meet all current state licensure standards and maintain a current license from the Department of Health and Environmental Control (DHEC) as a CRCF
Certificate *(specify):*
None
Other Standard *(specify):*
Contract Scope of Services
Verification of Provider Qualifications
Entity Responsible for Verification:
State Medicaid Agency

Frequency of Verification:
A minimum of 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Specialized medical equipment and supplies include transfer benches, shower chairs, raised toilet seats, hand held shower heads, which are necessary medical supplies, used to address participants' functional limitations but not offered under the State plan. Up to two cases of oral nutritional supplements per month may be provided based on state defined medical necessity criteria. (Effective 4/1/13 or upon approval of the waiver amendment, incontinence supplies including underpads and wipes will no longer be provided as a waiver service. At that time they will be available in the same frequency as a State Plan Home Health benefit.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nutritional Supplements: Up to two cases per month based on State defined medical necessity criteria.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Licensed Business
Provider Qualifications
License *(specify):*
licensed to do business in the state of South Carolina
Certificate *(specify):*

Other Standard *(specify):*
Criteria established in Community Long Term Care provider manual
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Telemonitoring is a daily monitoring service that utilizes innovative technologies that measure and monitor the health status of at-risk waiver participants. This is done remotely by utilizing either existing phone lines or wireless communication technology for collecting and transmitting physiological data between the provider and participant. Home telemonitoring equipment must be able to record, at a minimum, body weight, blood pressure, oxygen saturation, blood sugar, and basic heart rate information. The data must be transmitted via telephone. Any transmission to a remote computer must be toll-free and automatically alerts monitoring staff to abnormal readings. The waiver participants receiving this service must receive at least a monthly call to ensure the information received from the system is accurate and that appropriate follow up is completed to avoid medical complications.

Telemonitoring equipment must be located in the participant's residence and must be, at a minimum, an FDA Class II Hospital grade medical device that includes a computer monitor that is programmable for a variety of disease states and for rate and frequency. It must also have a digital scale that measures accurately to 500 lbs, be adaptable to fit a glucometer and a blood pressure cuff. It must also contain the ability to measure oxygen saturation. Telephones, facsimile machines, and electronic mail systems do not alone meet the requirements of the definition of telemonitoring, but may be utilized as a component of the telemonitoring system. The maintenance, repair and/or replacement of any damaged telemonitoring equipment is the sole responsibility of the provider and is not a reimbursable Medicaid service. The daily reimbursement rate for this service is inclusive of monitoring of data, charting data from the monthly monitoring, visits or calls made to the home to follow up with participants, phone calls made to primary care physician(s) that are necessary while the participant is receiving the telemonitoring service, all installation of the equipment in the home, and training on its use and care while the equipment is in the participant's residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
1. Providers of the telemonitoring service must be located within the state of South Carolina or within 25 miles of the border and be contracted with the state Medicaid agency to provide the telemonitoring service.
2. Participants receiving the telemonitoring service must have a primary care physician that approves the use of the telemonitoring service and is solely responsible for receiving and acting upon the information received via the telemonitoring service.
3. Participants must be waiver eligible and meet State established medical criteria.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Agency
Agency	Personal Care Agency
Agency	Home Health Agency
Agency	Telemonitoring Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Telemonitoring

Provider Category:
Agency
Provider Type:
Nursing Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract scope of services
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment and at least one every 18 months.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Telemonitoring

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

Certificate *(specify):*

Other Standard *(specify):*
Contract scope of service
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment and at least once every 18 months

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Telemonitoring

Provider Category:

Agency

Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract scope of service
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Telemonitoring

Provider Category:
Agency
Provider Type:
Telemonitoring Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Scope of services
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Upon enrollment and at least once every 18 months.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:

- [x] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- [ ] **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- [ ] **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- [ ] **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

- ( ) **No. Criminal history and/or background investigations are not required.**
- (•) **Yes. Criminal history and/or background investigations are required.**

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

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.

For the services of Personal Care, Companion, Attendant, Chore, Adult Care Home, Telemonitoring, and Case Management the contract or enrollment agreement signed by the provider requires state level background checks for administrative and direct care personnel. In all cases the nurse reviewing waiver service providers reviews records to ensure background checks have been preformed by the agencies.

All personal care agency providers must perform criminal background checks for any new hires providing direct care services. Potential employees with felony convictions cannot be hired. Hiring of employees with misdemeanor convictions will be at the discretion of the personal care provider.

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

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

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

Appendix C: Participant Services

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

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

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

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

Facility Type	
CRCF	

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.

A Community Residential Care Facility is a homelike, non-institutional setting that includes a 24-hour on-site response capability to meet resident's personal care and other assistance as needed with ADLs and IADLs, but does not provide round-the-clock skilled nursing services. CRCF generally provide less intensive care than nursing facilities and emphasize resident privacy. The regulations for Personal Care Homes and Community Homes include requirements to ensure a homelike, social model, community-based environment.

Requirements include:
•A common living room with adequate space for all residents;
•A dining area and kitchen;
•Double occupancy bedrooms, with requirements for adequate bedroom space
•Provides for privacy and easy access to resources and unscheduled activities in the community.
•Residents should have the opportunity for visitors at times of preference and convenience to them.
•As a CRCF resident you have the right to be treated with dignity and respect, to have freedom of choice, and a physical environment that is safe, secure, sanitary and well maintained.

Through the Optional State Supplementation Program room and board payments are made to contracted facilities on behalf of the residents.

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county,city or other designated entity.

Units have lockable entrance doors, with appropriate staff having keys to doors.

Residents have the freedom of choice to request a room change. State licensure requirements Reg.61-84. Please see link
http://www.scdhec.gov/administration/regs/docs/61-84.pdf
Section 2702 Residents Room

Individual rooms are available for those who wish to pay the additional amount.

Individuals have the freedom to furnish and decorate their sleeping or living units. Please see South Carolina Regs.61-84. Website listed above.

Residents have the choice to have their own dorm room size refrigerator or freedom of support from facility staff. Individuals have access to food at all times.

Individuals have the freedom to choose and control their own activities and individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

Facilities have to complete an ADA compliance list in order to participate in the waiver. The setting is physically accessible to individuals.

All facilities receive an onsite visit to ensure compliance with HCBS setting standards prior to enrollment into the waiver to any one residing in the facility. Periodic follow up visits are made.

Under the respite service in the waiver RCFs are one allowable place for respite care. This is intended for people who live in their own homes and need respite; not for those in RCFs.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

CRCF

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Day Health Care-Nursing	☐
Home Accessibility Adaptations	☐
Respite	☐
Adult Care Home Service	☐
Case Management	☑
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response System	☐
Telemonitoring	☐
Adult Day Health Care Transportation	☐
Home delivered meals	☐
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)	☑
Adult Companion Care	☐
Attendant Care	☐
Nursing Home Transition Service	☐
Adult Day Health Care	☐

Personal Care/ Personal Care I + II	☑

Facility Capacity Limit:

200

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

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

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

Appendix C: Participant Services

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

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

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they

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

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

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

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

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

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

- **Other policy.**

Specify:

Reimbursement for services may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members 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: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
For all applicable providers, the number and percent of potential providers who meet the initial application criteria.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Prior to becoming a Medicaid provider.	

Data Aggregation and Analysis:

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

Performance Measure:
For all applicable providers, the number and percent of potential provider applicants that meet initial contractual requirements (e.g., liability, workers compensation insurance, documentation of financial stability, nursing licenses).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pre-screening applications received by SCDHHS to contract for services with CLTC.

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

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Prior to becoming a Medicaid provider.	

Data Aggregation and Analysis:

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

Performance Measure:
For all applicable providers, the number and percent of potential providers that receive an on-site review by an area office administrator checking office space, secured filing cabinets and a valid business license.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Prior to enrollment as a Medicaid provider.	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of providers monitored on an ongoing basis through unannounced on-site reviews by waiver staff.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: All providers are reviewed within 18 months of the previous review. Reviews are done more frequently as warranted by results of prior reviews.	

Data Aggregation and Analysis:

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

	☑ **Continuously and Ongoing**
	☑ **Other** Specify: All providers are reviewed within 18 months of the previous review. Reviews are done more frequently as warranted by results of prior reviews.

Performance Measure:
The number and percent of Program Integrity post-payment reviews done on a random basis, by complaint, and/or at the request of waiver program staff.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Random samples are taken of waiver participant records. Actions are taken only upon events found in the sample and not extrapolated to the universe.
	☑ **Other**	

	Specify: Random samples are taken of waiver participant records. Actions are taken only upon events found in the sample and not extrapolated to the universe.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Random samples are taken of waiver participant records. Actions are taken only upon events found in the sample and not extrapolated to the universe.

Performance Measure:
For all applicable providers, the number and percent of providers monitored by case managers through the use of Care Call.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percentage of specialized ad-hoc reviews done in response to specific complaints about providers. These reviews use all available data to determine if allegations are substantiated.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Ad-hoc review based on indications from various sources of inappropriate service delivery. Non random review based on complaints and allegations from a specific provider.	

Data Aggregation and Analysis:

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

	Specify: Ad-hoc review based on indications from various sources of inappropriate service delivery. Non random review based on complaints and allegations from a specific provider.

Performance Measure:
The number of complaints and the percentage of those complaints that were acted on that were logged in the State's case management system, Phoenix, which is utilized to document complaints.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Ad-hoc reporting and collection based on complaints that are registered within the Phoenix system.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each*	**Frequency of data aggregation and analysis***(check each that applies):*

that applies):	
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Ad-hoc reporting and collection based on complaints that are registered within the Phoenix system.

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

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

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

Performance Measure:
For all applicable providers the number and percent of potential providers who meet the initial application criteria and attend a mandatory training at SCDHHS.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Prior to contracting with the potential provider.	

Data Aggregation and Analysis:

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

Performance Measure:
For all applicable providers, the number and percent of potential provider applicants that meet initial contractual requirements (e.g., liability, workers compensation insurance, documentation of financial stability, nursing licenses).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pre-screening applications received by SCDHHS to contract for services with CLTC.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid**	☐ **Weekly**	☑ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Prior to contracting to become a Medicaid provider.	

Data Aggregation and Analysis:

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

Performance Measure:
For all applicable providers, the number and percent of potential providers that receive an on-site review by an area office administrator checking office space, secured filing cabinets and a valid business license.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

	Prior to becoming a Medicaid provider

Performance Measure:
The number and percent of providers monitored on an ongoing basis through unannounced on-site reviews by waiver staff.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: All providers are reviewed within 18 months from previous review.	

Data Aggregation and Analysis:

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

☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: All providers are reviewed within 18 months from previous review.

Performance Measure:
The number and percent of Program Integrity post-payment reviews done on a random basis, by complaint, and/or at the request of waiver program staff.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Random samples are taken of waiver participant records. Actions are taken only upon events found in the sample and not extrapolated to the universe.
	☑ **Other** Specify:	

	Random samples are taken of waiver participant records. Actions are taken only upon events found in the sample and not extrapolated to the universe.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Random samples are taken of waiver participant records. Actions are taken only upon events found in the sample and not extrapolated to the universe.

Performance Measure:
For all applicable providers, the number and percent of providers monitored by case managers through the use of Care Call.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percentage of specialized ad-hoc reviews done in response to specific complaints about providers. These reviews use all available data to determine if allegations are substantiated.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Ad-hoc review based on indications from various sources of inappropriate service delivery.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Ad-hoc review based on indications from various sources of inappropriate service delivery.

Performance Measure:

The number and percentage of complaints from the automated complaint log in the State's case management system Phoenix.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Ad-hoc reporting and collection based on complaints that are registered within the Phoenix system.	

Data Aggregation and Analysis:

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

	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Ad-hoc reporting and collection based on complaints that are registered within the Phoenix system.

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

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

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

Performance Measure:
The number and percentage of potential providers who meet the initial application criteria and attend a mandatory training at SCDHHS prior to receiving a contract.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

	☑ **Other** Specify: Prior to becoming a Medicaid provider.	

Data Aggregation and Analysis:

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

Performance Measure:
The number of provider meetings held to review state and waiver policies and procedures.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Bi-annual provider meetings	

Data Aggregation and Analysis:

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

Performance Measure:
The number of bulletins, memos and other correspondence both electronically and in writing educating providers on waiver and state policies and procedures.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Policy clarifications and amendments are shared as needed with providers.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Policy clarifications and amendments are shared as needed with providers.

Performance Measure:
The number of meetings held with providers requesting education or training, including trainings held when major policy changes are enacted.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Any time a provider requests education or training SCDHHS is available and will provide training.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Any time a provider requests education or training SCDHHS is

	available and will provide training.

Performance Measure:
The number of trainings conducted by various state and contracted entities encompassing medicaid waiver and state policies and procedures.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
For all applicable providers, the number of providers doing in-service trainings for staff and the percentage not completing trainings.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: All providers reviewed every 18 months.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: All providers reviewed every 18 months.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Waiver Management within the SCDHHS has a dedicated position to review Medicaid provider records every 18 months at a minimum, or more often as needed, to ensure that proper service authorizations are on file and provider personnel continue to meet standards required in provider contracts. Additionally all providers are required to complete training with SCDHHS before their enrollment with South Carolina Medicaid.

The reviewer completes a preliminary report of findings. The findings are considered by SCDHHS, and then a written response of explanation and corrective action is requested from the provider. SCDHHS then reviews and approves the corrective action plan. Providers who fail to meet the contract requirements may be suspended from accepting new waiver referrals, or, if the deficiencies warrant, may be terminated. Suspension for new referrals will be for a defined time period depending upon the severity of the identified deficiencies. In all cases providers must submit a Plan of Correction prior to the suspension being lifted. Corrective action plans are reviewed and approved if appropriate. Each contract period, provider meetings are held to discuss contract changes and to review appropriate provider conduct. The state utilizes a database, Phoenix, to document provider reviews.

ii. Remediation Data Aggregation

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

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

- [x] **Continuously and Ongoing**
- [ ] **Other**
  Specify:

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

- (•) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- (•) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

Furnish the information specified above.

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The majority of participants in this waiver reside in their own private homes. Therefore, it is presumed that these settings meet the home and community based setting requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☑ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

SCDHHS currently operates under a participant-centered philosophy in all stages of 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 during each contact by the case manager. This includes monthly phone contacts and quarterly home visits. The service plan agreement form is signed by the participant at the first visit after entry into the waiver and the first visit after annual reevaluation.

For all participants, the State retains final authority for care plan development. For participants in Healthy Connections Prime, the CICOs will have formal input in care plans and service authorizations with an arbitration process for disputes through the independent ombudsman program. This will ensure that optimal levels of home and community based services are provided to persons enrolled in Healthy Connections Prime.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the

services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Service planning encompasses a comprehensive review of the participant's needs, preferences, goals, health staus and strengths. Goals are set based on the participant's identified needs. This service planning process allows for participation of the participant and/or family caregivers, 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, implementation, and monitoring of the service plan is a function of the case manager. 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, needs, preferences, personal goals and health status 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 is 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.

The components included in the Service Plan are medical, skin/nutritional, activities of daily living, instrumental activities of daily living, psychosocial, caregiver supports, and home environment.

In order to develop a plan for intervention, deficits must be identified in the assessment. When the service plan is created, only deficits identified in the assessment, home assessment, and caregiver supports can be included in the service plan. The participant needs listed on the Service Plan are those with which the CLTC staff, participant, and caregivers are actively working. Each listed need has corresponding goals and interventions.

When the case manager identifies services that are needed but unavailable, they are included in the Service Plan as a need and identified as unmet under the intervention. The Service Plan addresses all areas in which the participant requires at least limited assistance.

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 need has a related goal.

A goal is:
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.

Once a goal has been established, interventions are selected to reach the goal.

Ensuring the service plan's effectiveness and accuracy is an on-going process. Phoenix assures waiver services cannot be authorized without a completed service plan.

At a minimum a new service plan is required upon re-evaluation. All new service plans must be staffed with and approved by DHHS staff. The service plan agreement form is signed by the participant at the first visit after entry into the waiver and the first visit after annual reevaluation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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 Phoenix. 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 case manager 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participants are given a list of waiver providers who serve in the area in which they reside. This list includes phone numbers, city and state of the provider. 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 given to participants.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A state case manager and/or nurse oversees and approves all service plans as appropriate. The case manager and/or nurse is an employee of the State Medicaid agency. Services cannot be authorized until the service plan is approved by the state case manager and/or nurse. Phoenix requires the signature of both parties the case manager and state reviewer prior to service plan implementation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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 D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants' reviewed whose needs and personal goals identified in the assessment were addressed in the service plan

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System which included an update to the wizard, CMS Best Practice: Improving Responsiveness of Service Managers to Persons' Needs dated 12/3/04

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of participants' reviewed whose needs were identified regarding caregiver support was addressed in the service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

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

Data Aggregation and Analysis:

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

Performance Measure:

The number and percent of participants'reviewed whose home environmental needs were addressed in the Service Plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of Service Plans completed in Phoenix and team staffed within required time frames.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of service plans developed that involved participants and/or caregivers in the development process.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Waiver Data System

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:

The number and percent of Service Plans updated as needed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of Service Plans revised on or before the annual review date.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
The number and percent of participants who received services based on type, amount, frequency and duration as delineated in his/her service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants who received all services identified in his/her service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Care Call System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State

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

Performance Measure:
The number and percent of participants with an appropriately completed Service Choice Form that offered choice of institutional care or waivered services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of participants afforded choice of all qualified waiver service providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Service plan updates and annual revisions are performed by contracted case managers and monitored by area office supervisory staff and central office staff. The Phoenix data system monitors to ensure that a service plan has been completed annually and within required time frames. All service plans are teamed staffed and signed in Phoenix by state SCDHHS workers. The service plan is not considered complete without the signature of the state SCDHHS worker.

All data are aggregated in Phoenix and can be reviewed statewide, regionally by area office or individually by case manager on a daily basis.

The Phoenix system links needs(including caregiver supports, home environment, personal goals and other needs)identified in the assessment to the service plan. Before this link occurs, errors discovered by state workers during assessment team staffing are remediated prior to service plan development. Phoenix will not allow service plan completion until all needs identified in the assessment are addressed.

Phoenix captures all waivered services as identified in the service plan. Phoenix will not allow authorization of services that are not identified. Authorization levels are prior approved by SCDHHS workers. Phoenix also allows SCDHHS workers to identify services included in the service plan not currently authorized.

If the need for a new service is identified, the Phoenix data system will only allow authorizations if the service plan is updated to include an intervention for the service. Phoenix is also able to monitor when interventions are no longer needed and have been removed from the service plan.

Phoenix generates a list of qualified providers upon request. The list is generated in random order so as to not bias choice. Selections are recorded in Phoenix which generates a referral to the chosen provider. If the first choice declines the referral, Phoenix automatically sends a referral to the next chosen provider(s).

All authorizations are monitored to ensure services are recieved. Care Call is an automated monitoring system whose real time data allows for monitoring and verification of the providers delivering services. The toll-free number allows providers to document service delivery. Services not delivered in accordance with the authorization are identified.

For Healthy Connections Prime participants, the CICO’s care coordinator can report significant changes in the participant’s condition and make recommendations about changes to the service plan and service

authorizations as part of the demonstration's fully coordinated and integrated model of care.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Once a problem has been discovered, the Lead team case manager will review the problem with the case manager and notify the provider agency. Problems that can be corrected are considered pending until amended. If they are not amended timely, the Lead team case manager can take further designated action. If they cannot be corrected they are sent to provider compliance for recoupment. All CM Provider agencies are expected to file corrective action plans with CLTC Area Offices of case manager non compliance. Area Offices are expected to monitor and report back to Central Office on progress. If the problem is with a state worker it is remediated by the supervisor, reported to Central Office and monitored for improvement. Further actions are taken as necessary.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

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

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

Indicate whether Independence Plus designation is requested *(select one):*

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

The waiver offers the opportunity for participants to self-direct personal assistance services and respite. The three services, attendant care, companion care, and respite are self-directed services that provide assistance with ADL's and IADL's. Participants choose who will be providing these services, negotiate a weekly schedule and may terminate the service provider if dissatisfied with the care being received.

Participants must demonstrate that they are capable of acting as employer of record. This includes being able to negotiate a schedule, assess the work being done, and determine that needs are being met. If unable to do so, a representative of the participant may assume the responsibilities of employer of record.

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.

A financial management service is coupled with the self-directed services. This is treated as an administrative function for this waiver. 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.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (•) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

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.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Waiver applicants are given a brochure that provides an overview of all waiver services, including the participant directed services of Attendant and Companion care. Participants expressing an intrest in self-directed services are given additional information about self-direction and the benefits and responsibilities of self-directed services. Participants who wish to receive this service after getting this information are visited by a registered nurse who gives detailed information about the service.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant may choose to have waiver services directed by a representative 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, be at least 18 years of age, and must sign off on service logs weekly and observe care given on at least a monthly basis. A representative may not be paid to be a representative, and may not be paid to provide waiver services to the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☑	☐
Adult Companion Care	☑	☐
Attendant Care	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

- ◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

- ☐ **Governmental entities**
- ☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

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 monthly per participant fee is charged for financial management services.

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**
- [x] **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 or the CICO twice a week for the amount of service provided. Weekly payments are transmitted from MMIS or the CICO to FMS, including a detailed breakdown of each worker's payments. FMS makes weekly payments and posts electronically to the Medicaid agency on a twice a week. 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.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

- [x] **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, and develop a service plan. If the participant requests budget authority then the case manager will review with the participant how the services upon which the budget is developed. 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 following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health Care-Nursing	

	☐
Home Accessibility Adaptations	☐
Respite	☐
Adult Care Home Service	☐
Case Management	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response System	☐
Telemonitoring	☐
Adult Day Health Care Transportation	☐
Home delivered meals	☐
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)	☐
Adult Companion Care	☐
Attendant Care	☐
Nursing Home Transition Service	☐
Adult Day Health Care	☐
Personal Care/ Personal Care I + II	☐

☐ **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:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Participants may be involuntarily terminated from the use of participant directed services when they are unable to direct their own care and have no representative willing and/or able to do so. 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.

Participants who are involuntarily terminated are given written appeal rights.

Participants in Healthy Connections Prime have additional resources available to help in their appeal, including their care coordinator and access to the independent ombudsman's arbitration process

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	2100	
Year 2	2300	
Year 3	2500	
Year 4	2700	
Year 5	2900	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☐ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Prospective employees must provide acceptable background checks to be employed. Prospective employees pay for these background checks.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s)

that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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 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.

All participants have access to the State-operated appeals and Fair Hearing process. Participants in Healthy Connections Prime also have access to the Demonstration's ombudsman for disputes related to service authorizations and service levels to ensure that optimal community based services are provided in the best interest of each participant.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

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

All participants will use the State-operated appeals and Fair Hearing process. Participants in Healthy Connections Prime have access to an additional independent ombudsman representative to assist in the arbitration process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

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, neglect, and exploitation; and any other complaint about services received under the waiver.

The staff member receiving the complaint fills out an electronic complaint form located in Phoenix, initiates action to address the complaint and tries to reach resolution. Complaint forms are sent electronically to the quality assurance (QA) and provider compliance departments. 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 via the phoenix case management system.

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.

In addition, complaints and grievances for Healthy Connections Prime participants will be forwarded to the Healthy Connections Prime ombudsman program to track and trend for reporting purposes. This information will be reported to demonstration stakeholders quarterly. In addition, the ombudsman can help participants begin the integrated appeals and grievances process, if necessary.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The South Carolina 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.

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

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.

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

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.

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

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: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The 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.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The 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.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

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

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:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

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

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

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 G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
The number of abuse, neglect and/or exploitation complaints reported in the complaint system and the percentage of those complaints resulting in referrals to Adult Protective Services (APS).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Waiver Data Software System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of referred APS complaints substantiated by APS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Waiver Data Software System

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of unsubstantiated APS referrals resolved effectively.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Waiver Data Software System

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards***

based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
During orientation and training contract case managers are informed of their responsibility (as a mandated reporter) to make APS referrals. An APS power point has been developed and placed on the internal website for training purposes. In addition, contract case managers are trained on the appropriate process for recording APS referrals and the instrument (Phoenix) to record, update and track APS referrals. In addition, SCDHHS central office and regional office staff have been trained on the process for reporting, and tracking APS referrals in the SC Phoenix data system.

Contract case managers and SCDHHS staff are required to make APS referrals as appropriate and record all APS known referrals, regardless of reporter, in the SC Phoenix data system. Progress toward case resolution is recorded and tracked in Phoenix.

Contract case managers and SCDHHS workers are required to record APS decisions on all referrals and final resolution on all cases not substantiated by APS. All information is recorded and tracked in the SC Phoenix data system.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
South Carolina Department of Health and Human Services staff monitors the progress of APS referrals and assist with resolution, when necessary. When problems are discovered with the progress of APS referrals, appropriate person (APS worker and/or contract case manager) are contacted for immediate follow up and updates. Difficult cases that are not substantiated by APS are discussed at Central Office bi-monthly Quality Assurance Task Force Meetings to assist with effective resolutions.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

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

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated,

analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Phoenix data system provides 100% reporting on specified performance measures (i.e. monthly contact/visit activities, including initial/re-evaluation assessments and LOC determinations; documentation of activities; service plan development, and care call activity logs for each case manager). Phoenix generates reports regionally and/or statewide. Data can be generated by individual case managers and/or case management agency. Data can be trended by specified performance measures regionally or statewide. This process allows a thorough assessment of areas needing improvement and areas of best practice.

Prioritizing and implementing system improvements is based on the severity of identified problem(s) and the frequency of duplicated errors. Waiver assurances that fall below 100% and issues that show as a statewide problem are top priority and would result in immediate system improvement. Systems Improvement for waiver assurances below 100% may involve the following: 1. Revisions to the training program 2. Revision of policy and procedure for clarification 3. Modifications to expand/improve the Phoenix data system

Statewide areas needing improvement, even if not one of the six assurances, would become a top priority based on the prevalence of the problem. Systems improvement for statewide problems can be addressed through any of the following: 1. Revisions to the training program 2. Revision of policy and procedure for clarification 3. Modifications to improve the Phoenix data system

Throughout the demonstration, efforts will be made to carefully monitor each CICO's performance as outlined in the three-way contract and its ability to fully assume responsibilities for care coordination and integration. Any early indicators of performance concerns will lead the State's contracted EQRO to design and implement a Quality Improvement Plan (QIP), including remediation if needed, for the affected CICO(s).

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☐ **Annually**

☐ **Other** Specify:	☑ **Other** Specify: On-going

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The following process is used for monitoring and analyzing system design and data: Central Office gathers information from the 11 field offices and 2 satellite offices through various Phoenix generated reports on case management, other waivered service providers, complaint reports and adult protective service referrals/critical incidents. Regional office supervisory staff submit the appropriate Phoenix data reports (noted above) weekly and monthly to designated SCDHHS staff. However, provider compliance reports and APS/critical incidents are submitted, via Phoenix, on a daily or as needed basis.

Central Office staff gathers and compiles information from the following data sources: Client Satisfaction Survey conducted by Winthrop University; Provider Compliance Reports from SCDDHS staff; Annual Case Manager reviews conducted by SCDHHS staff; APS/critical incident reports; provider reviews conducted at least every 18 months by SCDHHS staff; participant appeals and dispositions; management reviews; quality assurance reviews on selected case managers as needed; and area office quarterly reports on case management agencies that are non-compliant with corrective action plans.

Information gathered from the first two paragraphs is taken to the Quality Improvement Task Force, which is scheduled to meet bi-monthly. The Task Force will meet more frequently, as needed. This Task Force is comprised of staff from three (3) bureaus within SCDHHS. These staff members have waiver responsibilities and/or responsibilities that relate to waiver participants. Data is reviewed and discussed for discovery of noncompliance and strategies for remediation. Reports and trends are shared with area offices and providers as appropriate. Provider reviews are given to providers onsite. Anything requiring corrective action generates a report and request for corrective action plan to the area office administrator. All corrective action plans, developed by area office administrators and/or agency providers, are submitted to central office staff. Other remediation strategies could also result in recoupment, suspension, or other corrective actions. If corrective action plans are not adhered to, further action such as case load reduction, suspensions, up to termination may result. All reports, corrective action plans, appeals and dispositions are brought to the Quality Improvement Task Force to review outcomes. Outcomes would assist in determining necessary policy or system changes. Field offices and providers are notified of changes though e-mail and Phoenix.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The process to evaluate the quality improvement strategy is discussed at regularly scheduled central office staff meetings and field office staff meetings. Input and feedback are sought to determine if the process is working properly, and systems are functioning as designed.

There is also the capability to report problems in the Phoenix case management system that allows issues discovered by users to be submitted to the Phoenix helpdesk for consideration or correction. This allows on-going quality improvement within the Phoenix system.

All quality improvement strategies are discussed at the bi-monthly task force meetings.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services,

including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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 all providers of personal care, adult day health care, telemonitoring, adult care home, agency companion, and nursing services at least once every eighteen months, 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: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
The number and percent of claims for waiver services submitted with the correct service code.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Automated telephone and billing system

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent waiver claims submitted with the correct rate as specified in the waiver application.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Automated telephone and billing system

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percentage of waiver claims submitted for participants enrolled in the waiver program.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Paid claims in the Medicaid Management Information System

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percentage of claims submitted timely with accurate payment information

Data Source (Select one):
Other
If 'Other' is selected, specify:
Automated telephone and billing system

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

☐ **Other**
Specify:

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Phoenix automated case management system automatically ties the needs identified in the assessment to the service plan. This ensures that any services billed for a participant are identified as a need on the assessment.

All claims for waiver services are submitted to the State's MMIS system for payment via Phoenix. Providers of waiver services are required to utilize the Phoenix or Care Call system to document service delivery. Phoenix compares service documents in both systems and only allows for billing up to the authorized service limits and if the service is provided in the required time period.

The state's Medicaid Management Information System ensures that claims submitted via Phoenix are for participants in a waiver program, that the service is paid at the appropriate rate and that the participant is Medicaid eligible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual problems may arise if either the Phoenix case management system and/or Medicaid Management Information System are not updated correctly. Any errors identified by workers utilizing the systems are notified and corrections are made and claims are reprocessed appropriately. Provider trainings are done on a as needed basis and biannually. SCDHHS staff training is also done on a periodic basis to ensure the latest methods are covered.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

The 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, Adult Day Health Care Transportation, and Home Delivered Meals. 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).

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.

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.

The agency is making an effort to standardize case management. This means using similar rules and reimbursement for different types of case management. The model is reimbursing case management in 15 minute increments. Effective 11/1/2013 two types of CM will be authorized: Case Management Visit and Case Management Contact. Rates have been determined for these two components of Case Management based on a market based analysis of CM rates. These rates are consistent with other Case Management Medicaid rates.

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.

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.

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

Telemonitoring rates were established based on a review of other state reimbursement methodologies for this service.

Adult Care Home rates were based on the cost of roughly three hours of in-home services which is the average amount of care received by a Community Choices 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 and Phoenix systems to document delivery of services. This is done through adding claims through the EVV or web entry of claims in Phoenix. 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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

All claims for waiver services are submitted to MMIS through Phoenix. For all claims submitted through Phoenix, a pre-payment review is conducted. Phoenix only submits claims to MMIS for services that were prior authorized by the case manager and are included in the participant's service plan. Phoenix compares services documented by providers to the amount, frequency, and duration prior authorized by the case manager. Only service claims that meet these conditions are 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.

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 §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  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 for Healthy Connections Prime participants are made by the CICOs. The CICOs are paid a monthly capitated payment per eligible enrollee.
- ○ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☑ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A financial management services entity is used to make payments for self-directed services (attendant and companion). Weekly data and payments are transmitted from MMIS to the FMS, including a detailed breakdown of each worker's claims. 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 reimburses providers weekly and transmits this information to the Phoenix system. 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.

All services are included in the contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

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.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

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

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- ( ) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- (●) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

This waiver includes both FFS and monthly capitated service payments. The monthly capitated payment is not reduced or returned to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

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

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

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

The State and CMS contract with health plans, known as CICOs, for the provision of coordinated and integrated health care services under a federal financial alignment demonstration. This program is known as Healthy Connections Prime. Waiver participants who meet eligibility criteria may enroll in Healthy Connections Prime. During Phase 1 of the demonstration, anticipated to last its first six months, the CICOs will be required to contract with the State's existing waiver providers.

The State anticipates the CICOs operating state-wide.

The CICOs' capitated payment convers all waiver services, as well as all Medicaid and Medicare benefits, for Healthy Connections Prime participants.

Payment to the CICOs is made by an approved MMIS. Payments to CICOs will be made generally once a month based on each individual's capitation rate group assignment, which is communicated and verified between the State and the CICOs.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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 State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ○ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ◉ **The following source(s) are used**

Check each that applies:

- ☑ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

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.

Appendix I: Financial Accountability

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

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

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

Payments are only paid for the provision of waiver services. The facility could be a provider of CRPA,an hourly service providing direct hands on assistance to waiver participants. No other payments will be made to the facilities using waiver funds.

FFS payments do not include a component for room and board.

Appendix I: Financial Accountability

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

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

No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

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

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

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

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: 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 (Col 7 less Column4)
1	9699.00	4738.00	14437.00	33240.00	1465.00	34705.00	20268.00
2	10008.28	4975.00	14983.28	34901.00	1538.00	36439.00	21455.72
3	9962.92	5224.00	15186.92	36647.00	1615.00	38262.00	23075.08
4	10411.26	5485.00	15896.26	38478.00	1696.00	40174.00	24277.74
5	10698.52	5760.00	16458.52	40403.00	1780.00	42183.00	25724.48

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	14520	14520
Year 2	14762	14762
Year 3	16577	16577
Year 4	17729	17729
Year 5	18394	18394

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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

The most recent CMS 372 report for South Carolina's Community Choices Waiver shows a length of stay of 300 days. This is consistent with previous years. Our estimate is 10 months based upon these data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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

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

Community Choice 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 a 5% inflation factor for the last four years of the waiver.

For waiver enrollees in the Healthy Choices Prime demonstration, services in the J-2(d) table are marked as capitated and developed as follows:
Total capitated Factor D expenditures were estimated by multiplying the capitation rate by projected number of member months for demonstration enrollees.
Component cost: capitated expenditures were allocated by service line to be proportional to expenditures projected for non-demonstration waiver enrollees.
For each service line, #users was developed from the 372 report, but reduced to be proportional to the number of unique participants enrolled in the demonstration.
Average units per user was developed from the 372 report, but adjusted to be proportional to the length of stay for demonstration participants.
Finally, average cost per unit on each service line was calculated as Component cost/#users/average units per user.

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 Community Choices waiver. A 5% inflation factor is used for all years of the waiver.

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.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Health Care
Case Management
Personal Care/ Personal Care I + II
Respite
Adult Care Home Service
Adult Companion Care
Adult Day Health Care Transportation
Adult Day Health Care-Nursing
Attendant Care
Home Accessibility Adaptations
Home delivered meals
Nursing Home Transition Service
Personal Emergency Response System
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)
Specialized Medical Equipment and Supplies

Telemonitoring

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**16007625.00**
Adult Day Health Care	☐	Day	2325	153.00	45.00	**16007625.00**	
Adult Day Health Care	☐	Day	0	0.01	0.01	**0.00**	
Case Management Total:							**7695600.00**
Case Management Visit	☐	Month	0	0.01	0.01	**0.00**	
Case Management Contact	☐	Month	0	0.01	0.01	**0.00**	
Case Management	☐	Month	14520	10.00	53.00	**7695600.00**	
Case Management Visit	☐	Month	0	0.01	0.01	**0.00**	
Case Management Contact	☐	Month	0	0.01	0.01	**0.00**	
Personal Care/ Personal Care I + II Total:							**73009360.00**
Personal Care I	☐	hour	4440	202.00	12.00	**10762560.00**	
Personal Care II	☐	hour	10105	385.00	16.00	**62246800.00**	
Personal Care I	☐	hour	0	0.01	0.01	**0.00**	
Personal Care II	☐	hour	0	0.01	0.01	**0.00**	
Respite Total:							**131450.00**
Institutional	☐	day	58	10.00	155.00	**89900.00**	
Community Residential Care Facility	☐	day	25	15.00	50.00	**18750.00**	
In-home	☐	day	30	8.00	95.00	**22800.00**	
Institutional	☐	day	0	0.01	0.01	**0.00**	
Community Residential Care						**0.00**	

Facility		day	0	0.01	0.01		
In-home		day	0	0.01	0.01	**0.00**	
Adult Care Home Service Total:							**75000.00**
Adult Care Home Service		day	10	150.00	50.00	**75000.00**	
Adult Care Home Service		day	0	0.01	0.01	**0.00**	
Adult Companion Care Total:							**4725396.00**
Adult Companion Care		hour	1756	299.00	9.00	**4725396.00**	
Adult Companion Care		hour	0	0.01	0.01	**0.00**	
Adult Day Health Care Transportation Total:							**3745665.00**
Adult Day Health Care Transportation		Event	1771	141.00	15.00	**3745665.00**	
Adult Day Health Care Transportation		Event	0	0.01	0.01	**0.00**	
Adult Day Health Care-Nursing Total:							**0.00**
Adult Day Health Care-Nursing		Day	0	0.01	0.01	**0.00**	
Adult Day Health Care-Nursing		Day	0	0.01	0.01	**0.00**	
Attendant Care Total:							**14028888.00**
Attendant Care		hour	2120	538.00	12.30	**14028888.00**	
Attendant Care		hour	0	0.01	0.01	**0.00**	
Home Accessibility Adaptations Total:							**2594880.00**
Pest Control		Event	3832	2.00	45.00	**344880.00**	
Home Adaptations		Event	2250	1.00	1000.00	**2250000.00**	
Pest Control		Event	0	0.01	0.01	**0.00**	
Home Adaptations		Event	0	0.01	0.01	**0.00**	
Home delivered meals Total:							**10530382.50**
Home delivered meals		Event	7065	271.00	5.50	**10530382.50**	
Home delivered meals		Event	0	0.01	0.01	**0.00**	
Nursing Home Transition Service Total:							**15000.00**
Nursing Home Transition Service		Event	20	1.00	750.00	**15000.00**	
Nursing Home Transition Service		Event	0	0.01	0.01	**0.00**	
Personal Emergency Response System Total:							**1782432.00**
PERS Installation		Event				**28872.00**	

			802	1.00	36.00		
PERS Monitoring		Month	4871	10.00	36.00	**1753560.00**	
PERS Installation		Event	0	0.01	0.01	**0.00**	
PERS Monitoring		Month	0	0.01	0.01	**0.00**	
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA) Total:							**0.00**
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)		hour	0	0.00	0.01	**0.00**	
Community Residential Personal Assistance (CRPA)		hour	0	0.01	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:							**6426858.00**
Diapers		Diaper	7000	960.00	0.60	**4032000.00**	
Pads		Case	7000	10.00	26.19	**1833300.00**	
wipes		Box	7000	10.00	4.66	**326200.00**	
Shower Chair		Item	527	1.00	60.00	**31620.00**	
Transfer Bench		Item	344	1.00	150.00	**51600.00**	
Hand Held Shower		Item	544	1.00	50.00	**27200.00**	
Raised Toilet Seat		Item	363	1.00	46.00	**16698.00**	
Nutritional Supplements		case	1640	2.00	33.00	**108240.00**	
Diapers		Diaper	0	0.01	0.01	**0.00**	
Pads		Case	0	0.01	0.01	**0.00**	
wipes		Box	0	0.01	0.01	**0.00**	
Shower Chair		Item	0	0.01	0.01	**0.00**	
Transfer Bench		Item	0	0.01	0.01	**0.00**	
Hand Held Shower		Item	0	0.01	0.01	**0.00**	
Raised Toilet Seat		Item	0	0.01	0.01	**0.00**	
Nutritional Supplements		case	0	0.01	0.01	**0.00**	
Telemonitoring Total:							**60590.00**
Telemonitoring		day	83	73.00	10.00	**60590.00**	
Telemonitoring		day	0	0.01	0.01	**0.00**	

GRAND TOTAL:	**140829126.50**
Total: Services included in capitation:	
Total: Services not included in capitation:	140829126.50
Total Estimated Unduplicated Participants:	**14520**
Factor D (Divide total by number of participants):	**9699.00**
Services included in capitation:	
Services not included in capitation:	9699.00
Average Length of Stay on the Waiver:	300

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**17089947.00**
Adult Day Health Care	☐	Day	2364	153.00	47.25	**17089947.00**	
Adult Day Health Care	☐	Day	0	0.01	0.01	**0.00**	
Case Management Total:							**8215053.00**
Case Management Visit	☐	Month	0	0.01	0.01	**0.00**	
Case Management Contact	☐	Month	0	0.01	0.01	**0.00**	
Case Management	☐	Month	14762	10.00	55.65	**8215053.00**	
Case Management Visit	☐	Month	0	0.01	0.01	**0.00**	
Case Management Contact	☐	Month	0	0.01	0.01	**0.00**	
Personal Care/ Personal Care I + II Total:							**77941264.80**
Personal Care I	☐	hour	4514	202.00	12.60	**11489032.80**	
Personal Care II	☐	hour	10274	385.00	16.80	**66452232.00**	
Personal Care I	☐	hour	0	0.01	0.01	**0.00**	
Personal Care II	☐	hour	0	0.01	0.01	**0.00**	
Respite Total:							**147577.50**
Institutional	☐	day	59	10.00	162.75	**96022.50**	
Community							

Residential Care Facility		day	30	15.00	52.50	**23625.00**	
In-home		day	35	8.00	99.75	**27930.00**	
Institutional		day	0	0.01	0.01	**0.00**	
Community Residential Care Facility		day	0	0.01	0.01	**0.00**	
In-home		day	0	0.01	0.01	**0.00**	
Adult Care Home Service Total:							**118125.00**
Adult Care Home Service		day	15	150.00	52.50	**118125.00**	
Adult Care Home Service		day	0	0.01	0.01	**0.00**	
Adult Companion Care Total:							**5046432.30**
Adult Companion Care		hour	1786	299.00	9.45	**5046432.30**	
Adult Companion Care		hour	0	0.01	0.01	**0.00**	
Adult Day Health Care Transportation Total:							**3999570.75**
Adult Day Health Care Transportation		Event	1801	141.00	15.75	**3999570.75**	
Adult Day Health Care Transportation		Event	0	0.01	0.01	**0.00**	
Adult Day Health Care-Nursing Total:							**0.00**
Adult Day Health Care-Nursing		Day	0	0.01	0.01	**0.00**	
Adult Day Health Care-Nursing		Day	0	0.01	0.01	**0.00**	
Attendant Care Total:							**14986269.76**
Attendant Care		hour	2156	538.00	12.92	**14986269.76**	
Attendant Care		hour	0	0.01	0.01	**0.00**	
Home Accessibility Adaptations Total:							**2166032.00**
Pest Control		Event	3896	2.00	47.25	**368172.00**	
Home Adaptations		Event	1865	1.00	964.00	**1797860.00**	
Pest Control		Event	0	0.01	0.01	**0.00**	
Home Adaptations		Event	0	0.01	0.01	**0.00**	
Home delivered meals Total:							**11251307.54**
Home delivered meals		Event	7183	271.00	5.78	**11251307.54**	
Home delivered meals		Event	0	0.01	0.01	**0.00**	
Nursing Home Transition Service Total:							**18000.00**
Nursing Home		Event				**18000.00**	

Transition Service			24	1.00	750.00		
Nursing Home Transition Service	☐	Event	0	0.01	0.01	**0.00**	
Personal Emergency Response System Total:							**1949535.00**
PERS Installation	☐	Event	835	1.00	37.80	**31563.00**	
PERS Monitoring	☐	Month	5074	10.00	37.80	**1917972.00**	
PERS Installation	☐	Event	0	0.01	0.01	**0.00**	
PERS Monitoring	☐	Month	0	0.01	0.01	**0.00**	
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA) Total:							**0.00**
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)	☐	hour	0	0.00	0.01	**0.00**	
Community Residential Personal Assistance (CRPA)	☐	hour	0	0.01	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:							**4748801.70**
Diapers	☐	Diaper	7293	720.00	0.60	**3150576.00**	
Pads	☐	Case	7293	6.00	26.19	**1146022.02**	
wipes	☐	Box	7293	6.00	4.66	**203912.28**	
Shower Chair	☐	Item	536	1.00	63.00	**33768.00**	
Transfer Bench	☐	Item	350	1.00	157.50	**55125.00**	
Hand Held Shower	☐	Item	553	1.00	52.50	**29032.50**	
Raised Toilet Seat	☐	Item	369	1.00	48.30	**17822.70**	
Nutritional Supplements	☐	case	1624	2.00	34.65	**112543.20**	
Diapers	☐	Diaper	0	0.01	0.01	**0.00**	
Pads	☐	Case	0	0.01	0.01	**0.00**	
wipes	☐	Box	0	0.01	0.01	**0.00**	
Shower Chair	☐	Item	0	0.01	0.01	**0.00**	
Transfer Bench	☐	Item	0	0.01	0.01	**0.00**	
Hand Held Shower	☐	Item	0	0.01	0.01	**0.00**	
Raised Toilet Seat	☐	Item	0	0.01	0.01	**0.00**	
Nutritional							

Supplements	☐	case	0	0.01	0.01	**0.00**	
Telemonitoring Total:							**64386.00**
Telemonitoring	☐	day	84	73.00	10.50	**64386.00**	
Telemonitoring	☐	day	0	0.01	0.01	**0.00**	

GRAND TOTAL:	**147742302.35**
Total: Services included in capitation:	
Total: Services not included in capitation:	147742302.35
Total Estimated Unduplicated Participants:	**14762**
Factor D (Divide total by number of participants):	**10008.28**
Services included in capitation:	
Services not included in capitation:	10008.28
Average Length of Stay on the Waiver:	300

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**19294618.86**
Adult Day Health Care	☐	Day	2542	153.00	49.61	**19294618.86**	
Adult Day Health Care	☐	Day	0	0.01	0.01	**0.00**	
Case Management Total:							**10703255.01**
Case Management Visit	☐	Month	16577	7.23	20.00	**2397034.20**	
Case Management Contact	☐	Month	16577	20.55	15.00	**5109860.25**	
Case Management	☐	Month	16577	3.30	58.43	**3196360.56**	
Case Management Visit	☐	Month	0	0.01	0.01	**0.00**	
Case Management Contact	☐	Month	0	0.01	0.01	**0.00**	
Personal Care/ Personal Care I + II Total:							**88012971.90**
Personal Care I	☐	hour	4855	202.00	13.23	**12974793.30**	
Personal Care II	☐	hour	11049	385.00	17.64	**75038178.60**	
Personal Care I						**0.00**	

		hour	0	0.01	0.01		
Personal Care II		hour	0	0.01	0.01	**0.00**	
Respite Total:							**164292.89**
Institutional		day	63	10.00	170.88	**107654.40**	
Community Residential Care Facility		day	31	15.00	55.13	**25635.45**	
In-home		day	37	8.00	104.74	**31003.04**	
Institutional		day	0	0.01	0.01	**0.00**	
Community Residential Care Facility		day	0	0.01	0.01	**0.00**	
In-home		day	0	0.01	0.01	**0.00**	
Adult Care Home Service Total:							**173659.50**
Adult Care Home Service		day	21	150.00	55.13	**173659.50**	
Adult Care Home Service		day	0	0.01	0.01	**0.00**	
Adult Companion Care Total:							**5694873.60**
Adult Companion Care		hour	1920	299.00	9.92	**5694873.60**	
Adult Companion Care		hour	0	0.01	0.01	**0.00**	
Adult Day Health Care Transportation Total:							**4517355.18**
Adult Day Health Care Transportation		Event	1937	141.00	16.54	**4517355.18**	
Adult Day Health Care Transportation		Event	0	0.01	0.01	**0.00**	
Adult Day Health Care-Nursing Total:							**0.00**
Adult Day Health Care-Nursing		Day	0	0.01	0.01	**0.00**	
Adult Day Health Care-Nursing		Day	0	0.01	0.01	**0.00**	
Attendant Care Total:							**16917754.32**
Attendant Care		hour	2319	538.00	13.56	**16917754.32**	
Attendant Care		hour	0	0.01	0.01	**0.00**	
Home Accessibility Adaptations Total:							**2446244.04**
Pest Control		Event	4191	2.00	49.61	**415831.02**	
Home Adaptations		Event	2006	1.00	1012.17	**2030413.02**	
Pest Control		Event	0	0.01	0.01	**0.00**	
Home Adaptations		Event	0	0.01	0.01	**0.00**	
Home delivered							

meals Total:							**12688100.76**
Home delivered meals	☐	Event	7726	271.00	6.06	**12688100.76**	
Home delivered meals	☐	Event	0	0.01	0.01	**0.00**	
Nursing Home Transition Service Total:							**22500.00**
Nursing Home Transition Service	☐	Event	30	1.00	750.00	**22500.00**	
Nursing Home Transition Service	☐	Event	0	0.01	0.01	**0.00**	
Personal Emergency Response System Total:							**2255888.79**
PERS Installation	☐	Event	877	1.00	41.67	**36544.59**	
PERS Monitoring	☐	Month	5326	10.00	41.67	**2219344.20**	
PERS Installation	☐	Event	0	0.01	0.01	**0.00**	
PERS Monitoring	☐	Month	0	0.01	0.01	**0.00**	
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA) Total:							**1834560.00**
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)	☐	hour	700	182.00	14.40	**1834560.00**	
Community Residential Personal Assistance (CRPA)	☐	hour	0	0.01	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:							**280335.19**
Diapers	☐	Diaper	0	0.00	0.01	**0.00**	
Pads	☐	Case	0	0.00	0.01	**0.00**	
wipes	☐	Box	0	0.00	0.01	**0.00**	
Shower Chair	☐	Item	576	1.00	66.15	**38102.40**	
Transfer Bench	☐	Item	376	1.00	165.38	**62182.88**	
Hand Held Shower	☐	Item	595	1.00	55.13	**32802.35**	
Raised Toilet Seat	☐	Item	397	1.00	50.72	**20135.84**	
Nutritional Supplements	☐	case	1747	2.00	36.38	**127111.72**	
Diapers	☐	Diaper	0	0.01	0.01	**0.00**	
Pads	☐	Case	0	0.01	0.01	**0.00**	
wipes	☐	Box	0	0.01	0.01	**0.00**	

Shower Chair	☐	Item	0	0.01	0.01	**0.00**	
Transfer Bench	☐	Item	0	0.01	0.01	**0.00**	
Hand Held Shower	☐	Item	0	0.01	0.01	**0.00**	
Raised Toilet Seat	☐	Item	0	0.01	0.01	**0.00**	
Nutritional Supplements	☐	case	0	0.01	0.01	**0.00**	
Telemonitoring Total:							**148905.00**
Telemonitoring	☐	day	90	150.00	11.03	**148905.00**	
Telemonitoring	☐	day	0	0.01	0.01	**0.00**	

GRAND TOTAL:	**165155315.04**
Total: Services included in capitation:	
Total: Services not included in capitation:	165155315.04
Total Estimated Unduplicated Participants:	**16577**
Factor D (Divide total by number of participants):	**9962.92**
Services included in capitation:	
Services not included in capitation:	9962.92
Average Length of Stay on the Waiver:	300

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**21173726.81**
Adult Day Health Care	☐	Day	2622	153.00	52.09	**20896736.94**	
Adult Day Health Care	☑	Day	115	51.51	46.76	**276989.87**	
Case Management Total:							**12536698.17**
Case Management Visit	☐	Month	17353	10.83	21.00	**3946592.79**	
Case Management Contact	☐	Month	17353	30.83	15.75	**8426139.59**	
Case Management	☐	Month	0	0.01	0.01	**0.00**	
Case Management Visit	☑	Month	758	3.65	18.91	**52318.30**	
Case Management Contact	☑	Month	758	10.38	14.19	**111647.49**	

Personal Care/ Personal Care I + II Total:							**96560053.51**
Personal Care I	☐	hour	5007	202.00	13.89	**14048540.46**	
Personal Care II	☐	hour	11395	385.00	18.52	**81248629.00**	
Personal Care I	☑	hour	219	68.01	12.50	**186177.38**	
Personal Care II	☑	hour	498	129.62	16.68	**1076706.68**	
Respite Total:							**180197.41**
Institutional	☐	day	65	10.00	179.42	**116623.00**	
Community Residential Care Facility	☐	day	32	15.00	57.89	**27787.20**	
In-home	☐	day	38	8.00	109.98	**33433.92**	
Institutional	☑	day	3	3.37	151.96	**1536.32**	
Community Residential Care Facility	☑	day	1	5.05	73.62	**371.78**	
In-home	☑	day	2	2.69	82.75	**445.20**	
Adult Care Home Service Total:							**193515.54**
Adult Care Home Service	☐	day	22	150.00	57.89	**191037.00**	
Adult Care Home Service	☑	day	1	50.50	49.08	**2478.54**	
Adult Companion Care Total:							**6250654.78**
Adult Companion Care	☐	hour	1980	299.00	10.42	**6168848.40**	
Adult Companion Care	☑	hour	86	100.66	9.45	**81806.38**	
Adult Day Health Care Transportation Total:							**4958280.93**
Adult Day Health Care Transportation	☐	Event	1998	141.00	17.37	**4893441.66**	
Adult Day Health Care Transportation	☑	Event	87	47.47	15.70	**64839.27**	
Adult Day Health Care-Nursing Total:							**0.00**
Adult Day Health Care-Nursing	☐	Day	0	0.01	0.01	**0.00**	
Adult Day Health Care-Nursing	☐	Day	0	0.01	0.01	**0.00**	
Attendant Care Total:							**18560553.55**
Attendant Care	☐	hour	2391	538.00	14.24	**18317737.92**	
Attendant Care	☑	hour	104	181.13	12.89	**242815.63**	
Home Accessibility Adaptations Total:							**2684168.13**
Pest Control	☐	Event	4321	2.00	52.09	**450161.78**	

Home Adaptations	☐	Event	2069	1.00	1062.78	**2198891.82**	
Pest Control	☑	Event	189	0.67	47.12	**5966.81**	
Home Adaptations	☑	Event	90	0.34	952.54	**29147.72**	
Home delivered meals Total:							**13915262.29**
Home delivered meals	☐	Event	7968	271.00	6.36	**13733326.08**	
Home delivered meals	☑	Event	348	91.24	5.73	**181936.21**	
Nursing Home Transition Service Total:							**27132.58**
Nursing Home Transition Service	☐	Event	34	1.00	787.50	**26775.00**	
Nursing Home Transition Service	☑	Event	1	0.34	1051.71	**357.58**	
Personal Emergency Response System Total:							**2475112.48**
PERS Installation	☐	Event	904	1.00	43.75	**39550.00**	
PERS Monitoring	☐	Month	5493	10.00	43.75	**2403187.50**	
PERS Installation	☑	Event	39	0.34	39.55	**524.43**	
PERS Monitoring	☑	Month	240	3.37	39.38	**31850.54**	
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA) Total:							**4499591.65**
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)	☐	hour	979	300.00	15.12	**4440744.00**	
Community Residential Personal Assistance (CRPA)	☑	hour	43	101.00	13.55	**58847.65**	
Specialized Medical Equipment and Supplies Total:							**307582.51**
Diapers	☐	Diaper	0	0.00	0.01	**0.00**	
Pads	☐	Case	0	0.00	0.01	**0.00**	
wipes	☐	Box	0	0.00	0.01	**0.00**	
Shower Chair	☐	Item	594	1.00	69.46	**41259.24**	
Transfer Bench	☐	Item	388	1.00	173.65	**67376.20**	
Hand Held Shower	☐	Item	614	1.00	57.89	**35544.46**	
Raised Toilet Seat	☐	Item	409	1.00	53.26	**21783.34**	
Nutritional Supplements	☐	case	1801	2.00	38.20	**137596.40**	

Diapers	☑	Diaper	0	0.01	0.01	**0.00**	
Pads	☑	Case	0	0.01	0.01	**0.00**	
wipes	☑	Box	0	0.01	0.01	**0.00**	
Shower Chair	☑	Item	26	0.34	61.88	**547.02**	
Transfer Bench	☑	Item	17	0.34	154.35	**892.14**	
Hand Held Shower	☑	Item	27	0.34	51.30	**470.93**	
Raised Toilet Seat	☑	Item	18	0.34	47.19	**288.80**	
Nutritional Supplements	☑	case	79	0.67	34.46	**1823.97**	
Telemonitoring Total:							**258720.48**
Telemonitoring	☐	day	147	150.00	11.58	**255339.00**	
Telemonitoring	☑	day	6	50.50	11.16	**3381.48**	

GRAND TOTAL:	**184581250.83**
Total: Services included in capitation:	2414168.12
Total: Services not included in capitation:	182167082.70
Total Estimated Unduplicated Participants:	**17729**
Factor D (Divide total by number of participants):	**10411.26**
Services included in capitation:	136.17
Services not included in capitation:	10275.09
Average Length of Stay on the Waiver:	300

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**22389609.49**
Adult Day Health Care	☐	Day	2473	133.62	54.70	**18075191.62**	
Adult Day Health Care	☑	Day	614	146.88	47.84	**4314417.87**	
Case Management Total:							**13460495.47**
Case Management Visit	☐	Month	16619	9.46	22.05	**3466607.07**	
Case Management Contact	☐	Month	16619	26.92	16.54	**7399722.76**	

Case Management	☐	Month	0	0.01	0.01	**0.00**	
Case Management Visit	☑	Month	4129	10.40	19.27	**827484.63**	
Case Management Contact	☑	Month	4129	29.59	14.46	**1766681.01**	
Personal Care/ Personal Care I + II Total:							**102123209.33**
Personal Care I	☐	hour	4723	176.41	14.59	**12156160.83**	
Personal Care II	☐	hour	10748	336.23	19.45	**70288410.78**	
Personal Care I	☑	hour	1173	193.92	12.76	**2902493.72**	
Personal Care II	☑	hour	2670	369.60	17.00	**16776144.00**	
Respite Total:							**190999.60**
Institutional	☐	day	61	8.73	188.40	**100328.65**	
Community Residential Care Facility	☐	day	31	13.10	60.78	**24682.76**	
In-home	☐	day	36	6.99	115.48	**29059.39**	
Institutional	☑	day	15	9.60	167.57	**24130.08**	
Community Residential Care Facility	☑	day	8	14.40	50.68	**5838.34**	
In-home	☑	day	9	7.68	100.70	**6960.38**	
Adult Care Home Service Total:							**206670.27**
Adult Care Home Service	☐	day	21	131.00	60.77	**167178.27**	
Adult Care Home Service	☑	day	5	144.00	54.85	**39492.00**	
Adult Companion Care Total:							**6609695.30**
Adult Companion Care	☐	hour	1868	261.13	10.94	**5336431.79**	
Adult Companion Care	☑	hour	464	287.04	9.56	**1273263.51**	
Adult Day Health Care Transportation Total:							**5241377.43**
Adult Day Health Care Transportation	☐	Event	1884	123.14	18.24	**4231602.66**	
Adult Day Health Care Transportation	☑	Event	468	135.36	15.94	**1009774.77**	
Adult Day Health Care-Nursing Total:							**190152.45**
Adult Day Health Care-Nursing	☐	Day	124	80.20	15.00	**149172.00**	
Adult Day Health Care-Nursing	☑	Day	31	88.13	15.00	**40980.45**	
Attendant Care Total:							**19630798.28**
Attendant Care	☐	hour	2256	469.85	14.95	**15846724.92**	

Attendant Care	☑	hour	561	516.48	13.06	**3784073.36**	
Home Accessibility Adaptations Total:							**2832351.11**
Pest Control	☐	Event	4077	1.75	54.70	**390270.82**	
Home Adaptations	☐	Event	1952	0.87	1115.92	**1895099.98**	
Pest Control	☑	Event	1013	1.92	47.80	**92969.09**	
Home Adaptations	☑	Event	485	0.96	975.11	**454011.22**	
Home delivered meals Total:							**14717478.66**
Home delivered meals	☐	Event	7515	236.67	6.68	**11880881.33**	
Home delivered meals	☑	Event	1867	260.16	5.84	**2836597.32**	
Nursing Home Transition Service Total:							**26721.29**
Nursing Home Transition Service	☐	Event	30	0.87	826.88	**21581.57**	
Nursing Home Transition Service	☑	Event	7	0.96	764.84	**5139.72**	
Personal Emergency Response System Total:							**2614915.28**
PERS Installation	☐	Event	853	0.87	45.94	**34092.53**	
PERS Monitoring	☐	Month	5182	8.73	45.94	**2078273.23**	
PERS Installation	☑	Event	212	0.96	40.14	**8169.29**	
PERS Monitoring	☑	Month	1282	9.60	40.17	**494380.22**	
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA) Total:							**6055069.52**
Residential Personal Care II (formerly titled Community Residential Personal Assistance - CRPA)	☐	hour	1175	262.00	15.88	**4888658.00**	
Community Residential Personal Assistance (CRPA)	☑	hour	292	288.00	13.87	**1166411.52**	
Specialized Medical Equipment and Supplies Total:							**325593.50**
Diapers	☐	Diaper	0	0.00	0.01	**0.00**	
Pads	☐	Case	0	0.00	0.01	**0.00**	
wipes	☐	Box	0	0.00	0.01	**0.00**	
Shower Chair	☐	Item	560	0.87	72.93	**35531.50**	
Transfer Bench	☐	Item	366	0.87	182.33	**58057.52**	

Hand Held Shower	☐	Item	579	0.87	60.78	**30616.71**	
Raised Toilet Seat	☐	Item	386	0.87	55.92	**18779.05**	
Nutritional Supplements	☐	case	1699	1.75	40.11	**119257.06**	
Diapers	☑	Diaper	0	0.01	0.01	**0.00**	
Pads	☑	Case	0	0.01	0.01	**0.00**	
wipes	☑	Box	0	0.01	0.01	**0.00**	
Shower Chair	☑	Item	139	0.96	68.83	**9184.68**	
Transfer Bench	☑	Item	91	0.96	159.21	**13908.59**	
Hand Held Shower	☑	Item	144	0.96	53.08	**7337.78**	
Raised Toilet Seat	☑	Item	96	0.96	48.80	**4497.41**	
Nutritional Supplements	☑	case	422	1.92	35.08	**28423.22**	
Telemonitoring Total:							**173507.84**
Telemonitoring	☐	day	88	131.00	12.16	**140180.48**	
Telemonitoring	☑	day	22	144.00	10.52	**33327.36**	

GRAND TOTAL:	**196788644.83**
Total: Services included in capitation:	37926091.54
Total: Services not included in capitation:	158862553.28
Total Estimated Unduplicated Participants:	**18394**
Factor D (Divide total by number of participants):	**10698.52**
Services included in capitation:	2061.87
Services not included in capitation:	8636.65
Average Length of Stay on the Waiver:	300