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 waivers 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:
HIV/AIDS Waiver

C. Waiver Number:SC.0186
Original Base Waiver Number: SC.0186.

D. Amendment Number:SC.0186.R07.02

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

07/01/22

Approved Effective Date: 07/01/22
Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

South Carolina Department of Health and Human Services (SCDHHS) is seeking to amend this waiver to raise payment rates for the following services: Attendant Care, Home Delivered Meals, Personal Care I/II, Companion-Agency, Companion-Individual, Medicaid Nursing-RN, and Medicaid Nursing-LPN.

Section 9817 of ARPA provides states with a temporary 10% increase to the federal medical assistance percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS). This funding is intended to enhance, strengthen, and improve HCBS beyond what was available April 1, 2021. SCDHHS is amending the waiver to update the rate methodology to reflect that HCBS provider pay increases may be funded through the the temporary 10% increased FMAP.

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	
☐ 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	I-2-a
☒ Appendix J Cost-Neutrality Demonstration	J-2-d

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:

Revise rate methodology to reflect use of enhanced FMAP through ARPA.

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*):

HIV/AIDS Waiver

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.0186
Waiver Number:SC.0186.R07.02
Draft ID: SC.017.07.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21
Approved Effective Date of Waiver being Amended: 07/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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:

Not applicable.

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The waiver serves participants with HIV/AIDS who meet level of care criteria. The waiver offers an alternative option to nursing home residence by providing qualified individuals the choice to receive assistive services at home rather than in an institutional setting.

The waiver serves individuals with a diagnosis of HIV or AIDS who are currently located in S.C. or intend to locate in S.C. and who meet at-risk of hospitalization level of care criteria. Through individualized, person-centered service planning, this waiver's primary goal is to promote the best possible health for its participants within their chosen setting for as long as the individual chooses to participate and remains both financially and medically qualified to do so.

Direct administration of the waiver is performed through thirteen regional offices of the State Medicaid Agency (SMA), each of which has responsibility for designated counties of South Carolina. Regional offices of the SMA are supported by a central office in addition. SMA staff assigned to regional offices provide information and support to individuals seeking access to waiver participation, with assistance provided by central office staff as needed. Regional office staff are also responsible for ensuring that participants are made aware of service options available and that participants are able to make informed choices as to which form of service delivery they prefer. Regional and central office SMA staff collectively provide various forms of quality assurance to waiver providers in pursuit of protecting participants' health and welfare, as well as ensuring the program meets both Federal and programmatic standards.

In administering the waiver, the SMA contracts with providers to perform waiver services (such as case management and assistance with personal care). These services are provider-directed; however, the waiver participant maintains the right to choose or change their service provider at their discretion as a condition of waiver participation. There exist two participant-directed service options within the waiver in the form of Attendant Care and Companion-Individual . This service provides home support, medical monitoring, and assistance with activities of daily living.

Some waiver participants may also elect to enroll in the agency's Medicaid Medicare Plan (MMP) demonstration, known as Healthy Connections Prime. This option offers a combined plan for individuals aged 65 or older who qualify for the waiver and have Medicare benefits. As a result of including these additional benefits, the service package involved with MMP enrollment differs from that of waiver enrollment alone. With this option, the SMA collaborates with Coordinated and Integrated Care Organizations (CICOs) to provide health services. CICOs play a direct role in care planning and service authorization, along with contractual oversight of the network of waiver providers. Ultimately, the SMA retains administrative authority in waiver issues involving MMP demonstration members, as well as provider compliance quality assurance monitoring functions.

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:

On February 8, 2022 this amendment was presented to the SCDHHS Medical Care Advisory Committee, which included tribal notification. In addition, the amendment was shared during the agency's monthly Indian Health Services conference call on January 26, 2022.

Public Notice of intent to amend this waiver was e-mailed to the agency listserv of interested stakeholders and group distribution which included MCAC members and Indian Health Services on February 25, 2022.

Public Notice of intent to amend this waiver was posted to the agency website at https://www.scdhhs.gov/public-notices on February 25, 2022.

This waiver amendment was posted to the agency website at https://www.scdhhs.gov/service/waiver-management-field-management on February 25, 2022.

Hard copies of the waiver amendment were placed in the SMA Central Office lobby and the 13 SMA offices around the state on February 25, 2022 for public review and comments.

Additionally, two public webinars were held February 28, 2022 and March 3, 2022 respectively, to address the proposed waiver amendment. A recording of the March 3, 2022, webinar was posted to the agency's website at https://www.scdhhs.gov/service/waiver-management-field-management

Individuals were able to submit electronic comments to comments@scdhhs.gov and non-electronic comments to Division of Health Programs, South Carolina Department of Health and Human Services, Post Office Box 8206, Columbia, SC 29202-8206, Attention: Mark Collins. Both methods of comment submission are included in all public notices.

Public Webinar Comments:
February 28, 2022 -
No public questions or comments were received by the SMA.

March 3, 2022 -
No public questions or comments were received by the SMA.

Electronic Comments:
No public questions or comments were received by the SMA.

Non-Electronic Comments:
No public questions or comments were received by the SMA.

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: Alewine

First Name: Margaret

Title: Program Manager II, Community Options, Office of Health Programs

Agency: South Carolina Department of Health and Human Services

Address: 1801 Main Street

Address 2: Post Office Box 8206

City: Columbia

State: **South Carolina**

Zip: 29202-8206

Phone: (803) 898-0047 **Ext:** ☐ **TTY**

Fax: (803) 255-8209

E-mail: Margaret.Alewine@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: Robert Kerr

State Medicaid Director or Designee

Submission Date: May 16, 2022

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

Last Name: Kerr

First Name: Robert

Title: Director

Agency: South Carolina Department of Health and Human Services

Address: 1801 Main Street

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29201

Phone: (803) 898-2507 **Ext:** **TTY**

Fax:

(803) 255-8209

E-mail:

rkerr@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:

Removing the Extra Prescription Drugs benefit from this waiver:

The Extra Prescription Drugs benefit in this waiver provided two (2) additional prescription drugs above the State Plan limits when the limits under the State Plan were exhausted. Effective July 1, 2017, the State Plan no longer limits participants to four (4) prescriptions per month which allows for the two (2) additional prescriptions which have been covered under this waiver, making this service redundant.

Removal of Items from Specialized Medical Equipment and Supplies service:

Items from the Specialized Medical Equipment and Supplies waiver service, consisting of transfer shower bench (regular and bariatric), shower chair (regular and bariatric), and raised toilet seat (regular and bariatric), have been removed from availability under the waiver. These items have been transitioned to availability under the home health state plan benefit. Participants will continue to maintain access to these items as a result of this transition.

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.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the states most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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:

Health Programs

(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.:*

In conjunction with CMS, the State Medicaid Agency (SMA) contracts with Coordinated and Integrated Care Organizations (CICOs) for the provision of coordinated and integrated health care services under a federal financial alignment demonstration known as Healthy Connections Prime Medicare-Medicaid Plan (MMP). Waiver participants meeting qualifying eligibility criteria may elect to enroll in the MMP; waiver participants who do not choose to enroll in the MMP will continue to have all associated waiver functions performed by the SMA.

Prior to providing services, reviews of CICO for qualifying standards are performed by SMA staff and its agent (a third party contractor). As the MMP demonstration develops over time, CICOs are evaluated on the basis of their compliance with benchmark standards. Success in meeting benchmark review standards allows a CICO to moving forward to the next identified phase of the Home and Community Based Services (HCBS) transition and may impact a CICO's eligibility for future passive enrollment of participants.

The MMP has incorporated assurances within a three way contract between CMS, SMA, and each CICO to ensure the CICO contracts with provider case managers approved by the SMA. Within this agreement it is established case managers must remain independent of service delivery and must otherwise meet all requirements outlined within the conflict-free modality operated by the SMA. Attenuation to these requirements by enrolled CICO are monitored on a consistent basis by the SMA to ensure compliance.

Once enrolled with the MMP, CICOs are empowered to conduct several waiver functions with oversight applied. During the HCBS transition phase continuing in this waiver renewal's time frame, Phase II, qualified MMP CICOs may review participant service plans as well as prior-authorize waiver services for participants enrolled in the MMP, adhering to approval criteria no more restrictive than SMA policies for participants who are not enrolled in the MMP. Person centered planning is assured within this process through contact between the MMP-contracted CICO case manager and the waiver participant/authorized representative during the development phase of the service plan. The SMA will formally review all service plans and may object to CICO proposed changes. CICOs qualified to do so may establish a rate methodology for waiver services providers serving participants enrolled in the MMP. However, all rates determined must, at minimum, equal rates the SMA pays providers for waiver participants not enrolled in the MMP. Rate exceptions requested are only granted following SMA approval informed by documented justification from the CICO indicating no diminishment in quality of services.

If an enrolled CICO fails to adequately meet benchmark standards, a corrective action plan, including specific dates, must be submitted to a review team at the SMA.
The benchmark review will evaluate the following:
• Demonstrated competency of case management and nursing staff in conducting reassessments,
• Network capacity for HCBS, including case management, with the exception of self-directed services, in that an enrolled CICO must have sufficient providers in each geographic area sufficient to meet the needs of the target population and provide meaningful choice of providers for each service,
• Ability to fully manage and integrate the continuum of Medicare and Medicaid services, as evidenced by HCBS care coordination infrastructure, integration of HCBS into multidisciplinary team, policies in support of these integrated functions,
• Ability to process and pay claims in a timely manner, proposed HCBS rate setting methodology for aforementioned services for SMA review, and understanding of the credentialing and monitoring process,
• Demonstrated competency in HCBS rate setting methodology
• Demonstrated competency in HCBS credentialing and monitoring process

○ **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:

Participants not enrolled in the MMP will continue to have all functions performed by the SMA.

For all phases of the HCBS transition under the MMP Demonstration, the SMA will assess the performance of contracted CICO.

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:

Contracted entities will only perform waiver operational and administrative functions for participants in the MMP Demonstration. On an ongoing basis, performance by an enrolled CICO will be assessed in the following areas:
• Review of timeliness of all activities of service plan development
• Review of timeliness on prior authorizations
• Review of service plans to determine if level of authorization is consistent with waiver fee-for-service participants; and
• Review of case managers' service level request versus CICO approval levels

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of annual case management activity quality assurance reviews completed as required by policy. N: Number of case management activity quality assurance

reviews completed D: Number of case management quality assurance reviews required by SMA policy.

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of MMP Demonstration service plans for waiver participants meeting established SMA policy and procedure N: Total number of MMP Demonstration service plans for waiver participants completed in accordance with SMA policy and procedure. D: Total number of waiver service plans completed for the MMP Demonstration.

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 SMA retains full operational and administrative authority of this waiver. The SMA will continue its oversight of all cases and intervene where there are concerns or disputes about services and authorization levels. The MMP Advocate is available to mitigate unresolved disputes between the state and enrolled CICO concerning services and authorization levels. Waiver participants also have access to an appeals process through the SMA to formally dispute authorization levels and/or level of care determinations. The MMP Advocate is empowered to provide support to enrolled MMP participants throughout this process.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☒	HIV/AIDS	0		☒
	☐	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:

Not applicable

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

All waiver applicants receive a full assessment by SMA staff (a Nurse Consultant and/or social worker licensed by the state 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 state nurse consultant/social worker discusses these needs and desires with qualified team members. Should these needs indicate a likelihood of exceeding the individual cost limit, the regional director is consulted. The applicant 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 service. This consultation, while available, has not been required to date. Service needs identified have remained within the constraints of individual cost limit consistently.

Any applicant denied admission to the waiver may appeal the 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:

☒ **Other safeguard(s)**

Specify:

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 in transitioning to a different form of long term care.

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	889
Year 2	889
Year 3	889

Waiver Year	Unduplicated Number of Participants
Year 4	889
Year 5	889

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	
Year 2	
Year 3	
Year 4	
Year 5	

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:

The SMA evaluates status of waiver applicants at the time of waiver application. Waiver applicants who are not current Medicaid beneficiaries, and applicants who require additional financial determination are placed on a processing list until financial eligibility has been determined. Applicants who are fully financially qualified Medicaid beneficiaries are evaluated for waiver enrollment without placement on a waiting list. MMP participants qualified for this waiver will also have access to HCBS under the MMP demonstration without placement on a waiting list.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

◉ **§1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

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

○ **No**

◉ **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☒ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

Other caretaker relatives specified at 42 CFR §435.110; pregnant women specified at 42 CFR §435.116, and children specified at 42 CFR §435.118.

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42**

CFR §435.320, §435.322 and §435.324)

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☒ **Aged and disabled individuals who have income at:**

Select one:

◉ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 $108 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 $651.00 per plate or $1320.00 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 $77.00 per occurrence.
4. Hearing Aids. A one-time expense. Not to exceed $1000.00 for one or $2000.00 for both. Necessity must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by State DHHS.
5. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69 per visit.
6. Other non-covered medical expenses that are recognized by State law but not covered by Medicaid. These non-covered medical expenses must be prescribed by a licensed practitioner and prior approved by State DHHS.
7. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

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 the selections in B-5-b also apply to B-5-e.

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-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 (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 the selections in B-5-d also apply to B-5-g.

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 a government agency 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, Licensed Practical Nurse working under the auspices of a Registered Nurse, or Social Worker licensed by the State.

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

The level of care utilized in the waiver is At Risk for Hospitalization. The purpose of the waiver is to reduce or eliminate hospitalizations. The At Risk for Hospitalization level of care requires a diagnosis of HIV positive or AIDS, a CD4 count below 500 or a history of a CD4 count below 500, and at risk for hospitalization certification by the applicant/ participant's medical doctor, nurse practitioner or physician's assistant. In addition, if the diagnosis is HIV positive and no AIDS, the applicant/ participant must have two of the HIV related conditions specified in the HIV/AIDS Waiver Policy and Procedure Manual. Exceptions to the level of care criteria may be granted by the SMA if the applicant/ participant has a diagnosis of HIV positive or AIDS and the medical doctor, nurse practitioner or physician's assistant certify the applicant/ participant is at risk for hospitalization but does not meet the other level of care criteria.

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.

A standardized instrument is utilized to gather assessment information necessary for level of care determinations. The HIV Physician's Information Form is an addendum to this instrument which is used to verify the applicant/participant's diagnosis of HIV or AIDS, at risk for hospitalization status, most recent CD4 count, and HIV related conditions.

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 utilized. For MMP participants enrolled with CICOs that have passed the necessary benchmark reviews and obtained the ability to perform reevaluations, reevaluations will be conducted by CICO resources meeting the same qualifications and using the same instrument and level of care criteria. The SMA retains final authority for all level of care evaluations and re-evaluations.

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:
• Social Workers licensed by the state of South Carolina
• Individuals with a Bachelor's degree or Master's degree with at least two (2) years of assessment and care planning experience.
• Registered Nurses currently licensed by the state of South Carolina or by a state that participates in the Nursing Compact
• Licensed Practical Nurses working under the auspices of a Registered Nurse
• Certified Geriatric Care Managers with two years of assessment and care planning experience with clients
• Certified Case Managers with two years of assessment and care planning experience with clients

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):*

Automated reminders presented through user interface in the Phoenix system are utilized to ensure timeliness of reevaluations. System functioning is monitored on a constant basis by SMA personnel. In addition, regular reporting on timeliness of level of care re-evaluations is provided by SMA staff to assist in identifying needed action.

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 electronically with the SMA.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 all applicants who received a LOC determination. N: The number of applicants who received a LOC determination. D: The total number of applicants

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:

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
The number and percent of waiver applicants who enter the waiver with an initial LOC completed within past 30 days or less. N: Number of waiver applicants who enter the waiver with an initial LOC completed within past 30 days or less. D: Total number of waiver applicants who enter the waiver

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:

Performance Measure:
The number and percent of all LOC determinations completed using the appropriate instruments required by the SMA. N: Number of determinations completed using the appropriate instruments. D: Total number of determinations.

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of conflicts between assessor-recommended and Phoenix recommended levels of care that are resolved by SMA staff according to policy. N: The number of conflicts between assessor-recommended and Phoenix-recommended levels of care that are resolved by SMA staff according to policy. D: The number of conflicts between assessor-recommended and Phoenix-recommended levels of care.

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.

Waiver functions are performed by thirteen SMA offices throughout the state, with assistance provided by SMA Central Office staff as needed. Each Area Office is staffed with SMA employees (Area Administrators, Lead Team Case Managers, Case Manager IIs, Lead Team Nurse Consultants, additional Nurse Consultants, and Administrative Support staff). Initial assessments and LOC determinations are performed by Nurse Consultants and/or social workers licensed by the state. On-going case management services are performed by contracted case managers and a limited number of case managers employed by the state. Services provided by contracted case managers are monitored by SMA staff located regionally and within SMA Central Office. Services provided by state employees are monitored by Area Administrators, Lead Team Staff, and SMA Staff located within SMA Central Office.

Phoenix tracks all applicants on the processing list to ensure eligible applicants requesting evaluations are assessed timely and that 100% of waiver participants are assessed using the standardized assessment instrument. Phoenix recommends LOC based on the assessment data entered. This data is coded to the state's level of care criteria. If the LOC recommended by Phoenix differs from the LOC indication determined by team staffing, additional review by a Lead Team Nurse Consultant, Lead Team Case Manager, or Area Administrator is required. If SMA Area Office staff are unable to resolve a determination for appropriate LOC, the case may be referred to SMA Central Office for further review/medical consultation. If the LOC is determined to be medically ineligible, input is sought from the applicant/participant's medical primary care provider. Upon review, if the primary care provider indicates the applicant/participant's medical condition is unstable or the applicant/ participant has skilled needs or requires skilled services without a required functional deficit, the issue is referred to the SMA Central Office for final LOC review by the agency's medical advisor. Through Phoenix, SMA staff have the capability to produce reporting upon request to determine timeliness of LOC evaluations and/or LOC reevaluations. This data is utilized in quality assurance and compliance activities.

Neither waiver participation (at the point of entry or during re-evaluation) nor LOC determination are possible without completion of required modules within the assessment tool in Phoenix. The Phoenix system will not allow waiver entry if the initial assessment was completed more than 30 days prior. The State pulls a 100% sample size report for designated review periods to ensure programming applied to Phoenix performed as intended. Any errors found in this report are addressed upon discovery by designated SMA staff.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 Phoenix technical support group determines causality and corrects any issue allowing inappropriate waiver data entry. If an applicant is allowed entry into the waiver outside of a 30 day LOC determination, Phoenix flags this issue as a problem. The problem is logged, tracked, and reported to the Phoenix technical support group for follow-up investigation. Assigned SMA staff review associated Phoenix data to discover LOC reevaluation timeliness issues. Once a problem has been identified by SMA staff, this information is forwarded (via complaint log format in Phoenix) to the compliance department for review, resolution and/or recoupment of funds paid.

In addition to SMA Central Office staff, SMA Area Office staff statewide are empowered to monitor and follow-up with case managers on data generated through Phoenix entry. SMA staff notify the associated case manager and their agency of the noted issue via electronic mail. SMA Area Offices statewide are empowered to monitor and follow-up with case managers regarding Phoenix data entry. Results of such quality assurance and compliance efforts determining provider failure to meet outlined agency policy/procedure may result in the issuing of a Corrective Action Plan for the provider involved. Actions or activities not meeting goals required in a presented Corrective Action Plan are further remediated via escalation to identified staff at SMA Central Office. This may involve further training, suspension of new referrals/cases, reduction of caseloads, recoupment 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 Nurse Consultant, licensed social worker, and/or case manager expressly discuss long term care options with potentially eligible individuals (or their legal representatives) during the assessment visit, as well as during subsequent contacts as required. During waiver assessment/entry activities, assessing staff secure a freedom of choice form (CLTC Service Choice Form) designating choice between HCBS or institutional care from each waiver participant/authorized representative to ensure involvement in planning their long term care. This choice will remain in effect until the SMA is advised otherwise by the participant/authorized representative.

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.

CLTC Service Choice forms are maintained indefinitely in Phoenix.

Appendix B: Participant Access and Eligibility

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

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

The SMA is in compliance with Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons by contracting with an outside entity for a telephone interpreter service line. Each SMA Area Office statewide has this equipment available for use by SMA staff and case managers during participant contacts. When necessary, the SMA also contracts with an outside entity for written material translation.

For participants enrolled in the MMP, availability of interpretation services provided through CICO meet those provided by the SMA. Based upon the three-way contract between the CICOs, CMS and the SMA, CICOs must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency/reading skills, and culturally diverse/ethnic backgrounds. Interpreter services must be available for participants who are not proficient in English at no cost. CICOs must also have a process to measure the time from which the telephone is answered to the point at which an individual reaches a member service representative capable of responding to the member's question in the member's primary language or another mode of communication in a manner that is sensitive to the member's cultural needs.

The CICO will also ensure that Network Providers and interpreters/translators are available for those individuals within the CICO's Service area who are deaf, or vision, or hearing impaired. Also, member material includes information on how members access oral interpretation services.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Case Management**		
Statutory Service	**Personal Care I**		
Statutory Service	**Personal Care II**		
Other Service	**Attendant Care Services**		
Other Service	**Companion Care - Agency**		
Other Service	**Companion Care - Individual**		
Other Service	**Home Accessibility Adaptations - Environmental Modifications**		
Other Service	**Home Delivered Meals**		
Other Service	**Medicaid Nursing - LPN**		
Other Service	**Medicaid Nursing - RN**		
Other Service	**Pest Control**		
Other Service	**Specialized Medical Equipment and Supplies**		

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:
01 Case Management	01010 case management
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 accessed. Case managers are responsible for ongoing monitoring and the coordination of the provision of services included in the participant's person centered service plan. 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.

At a minimum, case management activities include: initial visit, monthly contact, quarterly visit, and re-evaluation visit. At least one of these case management activities must be completed every month and documented appropriately.

Case management providers are not permitted to provide other direct waiver services or other services that are part of a participant's person centered service plan. Case managers are not allowed to receive any gifts or anything else of value from providers of waiver services. During case management orientation training, case managers are informed of conflict of interest requirements and must sign a disclosure form indicating understanding and agreement.

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

The case management service is provided on the basis of a monthly unit of service paid at an agreed-upon rate to all providers. There are no limits to the amount, duration, or frequency 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	State Medicaid Agency
Agency	Case Management Agency

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:

State Medicaid Agency

Provider Qualifications

License *(specify):*

SC Code of Laws §40-33-10 et. seq.(Registered Nurse)
SC Code of Laws §40-63-5 et. seq. (Social Worker)

Certificate *(specify):*

Other Standard *(specify):*

The Provider must have demonstrated experience providing Case Management in a health and human services setting.

The Provider must be licensed to operate a business in the State of South Carolina and be in good standing with the State and counties served.

The provider must demonstrate knowledge of the SC long-term care continuum and community resources.

The Provider must have four or more employees, two of which must be a licensed Social Worker; or have a bachelor's degree or master's degree with at least two years of assessment and care planning experience with clients. Providers contracted prior to September 1, 2016, may continue to provide case management activities to participants served under this waiver.

Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by the SMA to enroll as a case management provider.

Case Management providers must employ a Supervisor(s) who meets the qualifications of a Case Manager and who will provide technical assistance, perform quality assurance, and provide training to all Case Managers employed by the agency

The Provider must ensure that Case Managers and Case Management Supervisors do not have a felony conviction of any kind. A South Carolina Law Enforcement Division (SLED) background check must be completed and maintained in the personnel record for all case managers and Case Management Supervisors and made available to the SMA upon request.

Providers must check the Office of Inspector General (OIG) exclusions list at least once a year for all staff. A copy of the search results page must be maintained in each employee's personnel file.

The Provider must ensure that Routine ongoing Case Management activities are conducted by one of the following:
a. Social Workers licensed by the state of South Carolina,
b. Individuals with a Bachelor's or Master's degree in a health or human services field from an accredited college or university, months of internship),
c. Registered nurses currently licensed by the state of South Carolina or by a state that participates in the Nursing Compact,
d. Certified Geriatric Care Managers with two years of assessment and care planning experience with clients,
e. Certified Case Managers with two years of assessment and care planning experience with clients. All Case Managers who have professional licenses must comply with the continuing education requirements necessary for their specific licensure.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

Upon enrollment and at least once every 24 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):*

SC Code of Laws §40-33-10 et. seq.(Registered Nurse)
SC Code of Laws §40-63-5 et. seq. (Social Worker)

Certificate *(specify):*

Other Standard *(specify):*

The Provider must have demonstrated experience providing Case Management in a health and human services setting.

The Provider must be licensed to operate a business in the State of South Carolina and be in good standing with the State and counties served.

The provider must demonstrate knowledge of the SC long-term care continuum and community resources.

The Provider must have four or more employees, two of which must be a licensed Social Worker; or have a bachelor's degree or master's degree with at least two years of assessment and care planning experience with clients. Providers contracted prior to September 1, 2016, may continue to provide case management activities to participants served under this waiver.

Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by the SMA to enroll as a case management provider.

Case Management providers must employ a Supervisor(s) who meets the qualifications of a Case Manager and who will provide technical assistance, perform quality assurance, and provide training to all Case Managers employed by the agency

The Provider must ensure that Case Managers and Case Management Supervisors do not have a felony conviction of any kind. A South Carolina Law Enforcement Division (SLED) background check must be completed and maintained in the personnel record for all case managers and Case Management Supervisors and made available to the SMA upon request.

Providers must check the Office of Inspector General (OIG) exclusions list at least once a year for all staff. A copy of the search results page must be maintained in each employee's personnel file.

The Provider must ensure that Routine ongoing Case Management activities are conducted by one of the following:
a. Social Workers licensed by the state of South Carolina,
b. Individuals with a Bachelor's or Master's degree in a health or human services field from an accredited college or university, months of internship),
c. Registered nurses currently licensed by the state of South Carolina or by a state that participates in the Nursing Compact,
d. Certified Geriatric Care Managers with two years of assessment and care planning experience with clients,
e. Certified Case Managers with two years of assessment and care planning experience with clients. All Case Managers who have professional licenses must comply with the continuing education requirements necessary for their specific licensure.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

Upon enrollment, at least once every 12 months thereafter

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:

Homemaker

Alternate Service Title (if any):

Personal Care I

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08060 chore
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Performance of light housekeeping tasks and/or heavy household chores provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with activities of daily living, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).

Services are designed to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Personal care services in the State Plan are only available to children. All medically necessary personal care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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 Personal Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care I

Provider Category:

Agency

Provider Type:

Licensed Personal Care Agency

Provider Qualifications

License *(specify):*

SC Code of Laws §44-70-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Agencies desiring to be a provider of PC I services must have demonstrated experience in providing home care management.

Pursuant to enactment and implementation of S.C. § Code 44-70-10 all providers of personal care services are required to attain a license to provide personal care services. Providers are required to renew their license annually.

Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider.

Providers must be able to utilize the automated systems mandated by the SMA to document and bill for the provision of services.

The provider must maintain all of the following (supervisory positions may be sub-contracted):
A supervisor who meets the following requirements:
High school diploma or equivalent.
Capable of evaluating aides in terms of their ability to carry out assigned duties and their ability to relate to the participant.
Able to assume responsibility for in-service training for aides by individual instruction, group meetings, or workshops.

Aides who meet the following minimum qualifications:
Able to read, write and communicate effectively with participant and supervisor.
Able to use the Electronic Visit Verification (EVV) System.
Capable of following a care plan with minimal supervision.
Be at least 18 years of age.
Have documented record of having completed six hours of training prior to providing services or documentation of personal, volunteer or paid experience in the care of adults, families and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing.
Complete at least six hours in-service training per calendar year in the following areas:
Maintaining a safe, clean environment and utilizing proper infection control techniques.
Following written instructions.
Providing care including individual safety, laundry, meal planning,
preparation and serving, and household management.
First aid.
Ethics and interpersonal relationships.
Documenting services provided.
Home support:
Cleaning
Laundry
Shopping
Home safety
Errands
Observing and reporting the participant's condition

The provider must comply with safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

The provider must have an effective written back-up plan in place to ensure that the participant receives the PC I service as authorized.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, SC Department of Health and Environmental Control.

Frequency of Verification:

• Upon enrollment
• Within first year of service
• A sample of providers is reviewed at least every eighteen 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 II

HCBS Taxonomy:

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

Service Definition *(Scope):*

Assistance with activities of daily living and/or health-related tasks provided in a person's home and possibly other community settings. Personal care may include assistance with activities of daily living, monitoring participant's condition, escorting participant on outings, and assistance with home duties.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

Personal care services in the State Plan are only available to children. All medically necessary personal care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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 Personal Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care II

Provider Category:

Agency

Provider Type:

Licensed Personal Care Agency

Provider Qualifications

License *(specify):*

SC Code of Laws §44-70-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Agencies desiring to be a provider of PC II services must have demonstrated experience in In-Home personal care services or a similar service. Owners or administrators of the agency must have at least three years of administrative experience in the health care field. If the owner will also be the administrator, they are required to have at least three years of administrative experience in the health care field.

Pursuant to enactment and implementation of SC Code §44-70-10 all providers of personal care services will require a license to provide personal care services. Providers are required to renew their license annually.

Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by the SMA to enroll as a personal care provider.

Agencies must utilize the automated systems mandated by the SMA to document and bill for the provision of services.

The provider must provide all of the following staff members; supervisory nurses may be provided through subcontracting arrangements:
A registered nurse(s) (RN) or licensed practical nurse(s) (LPN) who meets the following requirements:
Currently licensed by the S.C. State Board of Nursing
Capable of evaluating the aide's competency in terms of his or her ability to carry out assigned duties and his/her ability to relate to the participant
Able to assume responsibility for in-service training for aides by individual instruction, group meetings or workshops
Provider will verify nurse licensure at time of employment and will ensure that the license remains active and in good standing at all times during employment. Provider must maintain a copy of the current license in the employee's personnel file

Aides who meet the following minimum qualifications:
Able to read, write, and communicate effectively with participant and supervisor.
Able to use the Electronic Visit Verification (EVV) System
Capable of assisting with the activities of daily living
Capable of following a care plan with minimal supervision.
Have a valid driver's license if transporting participants. The provider must ensure the employee's license is valid while transporting any participants by verifying the official highway department driving record of the employed individual initially and every two years during employment.
Are at least 18 years of age
Have passed competency testing or successfully completed a competency training and evaluation program performed by a RN or LPN prior to providing services to Home and Community-Based waiver participants. The competency evaluation must contain all elements of the PC II services in the Description of Services listed above. The competency training should also include training on appropriate record keeping and ethics and interpersonal relationships.

Have a minimum of ten (10) hours relevant in-service training per calendar year.

Aides must complete a training program in the following areas:
Confidentiality, accountability and prevention of abuse and neglect
Fire safety/disaster preparedness related to the specific location of services
First aid for emergencies, monitoring medications, and basic recognition of medical problems
Documentation and record keeping
Ethics and interpersonal relationships
Orientation to traumatic brain injury, spinal cord injury and similar disability
Training in lifting and transfers

A SC Law Enforcement Division (SLED) criminal background check is required for all employees prior to hire and at least every two years thereafter to include employees who will provide direct care to SMA

participants and all administrative/office employees (office employees required to have SLED background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions).

Providers are required to check the CNA registry and the Office of Inspector General (OIG) exclusions lists for all staff prior to hire then at least every two years thereafter.

As part of the conduct of service, PC II services must be provided under the supervision of a RN or LPN who meets the requirements as stated.

The provider agency shall acquire and maintain liability insurance and worker's compensation insurance

The provider must comply with safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

The provider must have an effective written back-up plan in place to ensure that the participant receives the PC II services as authorized. Whenever the provider determines that services cannot be provided as authorized, the Case Manager must be notified immediately.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, SC Department of Health and Environmental Control.

Frequency of Verification:

• Upon enrollment
• Within the first year of service
• A sample of providers is reviewed at least every eighteen 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:

Attendant Care Services

HCBS Taxonomy:

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

08 Home-Based Services | 08050 homemaker

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

08 Home-Based Services | 08060 chore

Service Definition *(Scope):*

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

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. Limited housekeeping activities, which are incidental to the performance of care, may also be furnished as part of this activity.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Attendant designated by waiver participant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services

Provider Category:

Individual

Provider Type:

Attendant designated 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 competency in caring for the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Nurse licensed by the State of South Carolina and employed by a contracted entity

Frequency of Verification:

Upon Enrollment and annually thereafter

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:

Companion Care - Agency

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the participant with light housekeeping tasks. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of companion services does not entail hands-on care or assistance with activities of daily living; the Companion Care - Agency service does not duplicate the provision of the Personal Care II service. This service is provided in accordance with a therapeutic goal in the service plan.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Companion Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Care - Agency

Provider Category:

Agency

Provider Type:

Companion Provider

Provider Qualifications

License *(specify):*

Providers of Companion Care-Agency services must meet the standards for licensing in-home care providers as outlined in SC Code of Laws §44-70-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Companions must be able to read, write and communicate effectively with the participant; capable of following a care plan with minimal supervision; and must complete four hours of in-service training per calendar year related to:

- Maintaining a safe, clean environment and utilizing proper infection control techniques
- Following written instructions
- Ethics and interpersonal relationships
- Documenting services provided;
- Other areas of training as appropriate

Agencies must utilize the automated systems mandated by the SMA to document and bill for the provision of services.

Pursuant to enactment and implementation of S.C. Code 44-70-10 all providers of personal care services will require a license to provide personal care services. Providers are required to renew their license annually.

Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a companion provider.

1. The Provider must maintain the following (supervisory positions may be sub-contracted):
a. A supervisor who meets the following requirements:
i. High school diploma or equivalent;
ii. Capable of evaluating companions in terms of their ability to carry out assigned duties and their ability to relate to the participant; and
iii. Able to assume responsibility for in-service training for companions.
b. Companions who meet the following minimum qualifications:
i. Able to read, write and communicate effectively with participant and supervisor;
ii. Able to use the Electronic Visit Verification (EVV) System;
iii. Capable of following a care plan with minimal supervision; and
iv. At least eighteen years of age.
c. Companions must complete four hours of relevant in-service training per calendar year in the following areas:
i. Maintaining a safe, clean environment and utilizing proper infection control techniques;
ii. Following written instructions;
iii. Ethics and interpersonal relationships;
iv. Documenting services provided; and
v. Other areas of training as appropriate.

A South Carolina Law Enforcement Division (SLED) criminal background check is required for all employees prior to hire and at least every two years thereafter to include employees who will provide direct care to CLTC participants and all administrative/office employees (office employees required to have SLED background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions).

Providers are required to check the CNA registry and the Office of the Inspector General (OIG) exclusions lists for all staff prior to hire then at least every two years thereafter.

The Provider shall acquire and maintain liability insurance and workers' compensation insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, SC Department of Health and Environmental Control

Frequency of Verification:

• Upon enrollment
• Within the first year of service
• A sample of providers are reviewed every eighteen months thereafter

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:

Companion Care - Individual

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the participant with light housekeeping tasks. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of companion services does not entail hands-on care or assistance with activities of daily living; the Companion Care - Agency service does not duplicate the provision of the Personal Care II service. This service is provided in accordance with a therapeutic goal in the service plan.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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	Individual Selected by Participant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Care - Individual

Provider Category:

Agency

Provider Type:

Individual Selected by Participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual companions must meet the following minimum qualifications:
1. Demonstrate an ability to read, write and speak English;
2. Fully ambulatory;
3. Capable of performing all companion care duties;
4. Capable of following a service plan with participant and/or representative supervision;
5. Be at least 18 years of age;
6. Capable of following billing procedures and completing required paperwork;
7. No known conviction of abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Ann. Title 63, Chapter 7);
8. No known conviction for any crime against another person;
9. No known felony conviction of any kind;
10. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);
11. No record of exclusion or suspension from the Medicare or Medicaid Programs;
12. All Companions shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Companions Medicaid enrollment date.
13. The companion must adhere to basic infection control procedures at all times when providing companion services.
14. All new companion providers must complete companion/Electronic Visit Verification (EVV) System training in the CLTC area office prior to or during the first week of authorized companion services.

The companion is responsible for giving participants a written description of the state law concerning advance directive in accordance with the Patient Self Determination Act. USC-CDR will assist companions in meeting this requirement.

The companion shall adhere to all SMA policies, procedures and SMA provider manuals. Companions will be 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:

Nurse licensed by the state of South Carolina and employed by a contracted entity

Frequency of Verification:

Upon enrollment and at least annually thereafter

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 Accessibility Adaptations - Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Those physical adaptations 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, provision of air conditioning units, and installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies required for the welfare of participants.

These services may only be authorized based on a health and/or safety related issue. Case managers must evaluate the expressed need prior to authorizing the service. During this process, the case manager determines that there is an assessed need for the items, updates appropriate sections of Phoenix to indicate the need for the items, updates the participant's service plan, and requests prior approval in the service approval section of the service plan (including date the last item was received (if applicable)).

Per policy, the service justification for air conditioning units must emphasize need based on health and safety related issues with specific information provided associating requests with a medical condition. The provision of air conditioning units is not intended for general utility and shall not be executed as such.

SMA Regional Office staff review related requests and either approve or deny, utilizing medical expertise offered through Lead Team Nurses in Regional SMA offices, and/or SMA's Medical Director in SMA Central Office, as needed. Following SMA approval the case manager may begin the authorization process.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

There is a lifetime cap of $7,500 per participant.

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
Agency	Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations - Environmental Modifications

Provider Category:

Agency

Provider Type:

Licensed Business

Provider Qualifications

License *(specify):*

Business license

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, SC Department of Labor, Licensing, and Regulation

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 - Environmental Modifications

Provider Category:

Agency

Provider Type:

Building Contractor

Provider Qualifications

License *(specify):*

SC Code 40-59-5

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, SC Department of Labor, Licensing, and Regulation

Frequency of Verification:

Upon enrollment and at least once every eighteen months thereafter

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:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Prepared meals sent to a participant's residence providing a minimum of one-third of the current recommended dietary allowance, but not comprising a full nutritional regimen. These can be hot, shelf-stable, refrigerator-fresh, 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**
- ☒ **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	Home Delivered Meals

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:

Home Delivered Meals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies desiring to be a provider of Home Delivered Meals (HDM) Services must have at least one (1) year of demonstrated experience in food service meal planning and preparation.

Providers must use the automated systems mandated by the SMA to document and bill for the provision of services.

Providers must accept or decline referrals from the SMA or SCDDSN within two working days. Failure to respond will result in the loss of the referral.

The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for SMA participants in the Phoenix Provider Portal on their dashboard.

Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down. Providers may use paperless filing systems. Provider must obtain approval from SMA Central Office prior to initiating any electronic documentation and/or filing systems

The Unit of Service is one meal delivered to a participant's residence, or other location, as agreed to by the provider and as indicated on the service authorization. Each meal must provide a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as adopted by the United States Department of Agriculture. The number of units of service provided to each participant is determined by the participant's service plan, which is established by the case manager in consultation with the participant.

Modified Diet menus must be developed using Dietary Guidelines for Americans and must be reviewed and approved by a registered dietitian. The provider must have procedures in place to assure that each participant requiring a modified meal receives only the meal ordered for that individual.

Home delivered meals are made available at a minimum Monday through Friday.

The provider must obtain the authorization from the SMA case manager prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's service plan which will be developed in consultation with the participant and/or responsible party. More than one meal for each day's consumption may be delivered if authorized by the SMA. The authorization will indicate if the person requires a modified diet due to diabetes or some other condition.

The provider will initiate home delivered meals on the date negotiated with the case manager and indicated on the service authorization. Services must not be provided prior to the authorized start date as stated on the service authorization.

Each provider must offer one (1) hot meal per day, five (5) or more days each week, and any additional authorized meals may be hot or cold. Shelf stable meals may be provided if authorized by the Case Manager and the participant or responsible party requests this type of meal. A hot meal, for the purposes of this program, is one in which the main food item is hot at the time of serving. A blast-frozen meal, if authorized, meets the hot meal requirement for this standard. (If the participant or responsible party agrees and/or requests shelf stable meals, we will allow this option in lieu of hot or frozen meals.)

No home-canned or home-prepared food shall be used in the preparation and service of the meals.

The facility at which the meals are prepared and/or packaged, as well as the manner of handling, transporting, serving and delivery of these meals must meet all applicable health, fire safety and sanitation regulations.

Only single service covered aluminum foil or Styrofoam divided containers can be used for hot food. Each tray compartment must be large enough to contain the required portions without spillover.

Unless providing a blast frozen meal or shelf stable meal, hot and cold food shall be portioned and packed separately to ensure retention of heat or cold and shall be transported in approved insulated carriers which will maintain the required hot (135 degrees Fahrenheit or above) and cold (41 degrees Fahrenheit or below) temperatures until the time of delivery to the participant. Blast frozen meals must be transported in approved insulated carriers which will maintain the meals in a frozen state until the time of delivery to the participant.

Delivery routes must be clearly established. No more than three (3) hours shall elapse between the time of packaging and the time of delivery of the last hot meal on the route. Delivery of a cold meal beyond the three (3) hour limit for a participant who lives too far away may be made upon written approval of the Head of the Provider Relations and Compliance Department, Division of Waiver Management.

Meals must be received, in hand, by an individual at the participant's door or at another location as agreed to by the provider and as indicated on the service authorization.

The provider shall give initial and on-going training in the proper service, handling, and delivery of food to all staff, both volunteer and paid.
The provider will maintain a record keeping system which establishes an eligible participant profile in support of units of Home Delivered Meal service provided, based on the service authorization.

The provider shall regularly observe, or at a minimum inquire about, the participant's condition and will confirm at least monthly that the participant continues to reside in the home and is available to receive the meals. The provider will notify the case manager as soon as possible, but no more than two (2) working days, after the provider becomes aware of the following participant changes:
a. Participant's condition has changed or participant no longer appears to need home delivered meal services; or,
b. Participant is institutionalized, dies or moves out of service area; or,
c. Participant no longer wishes to receive home delivered meal services; or,
d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

The provider must inform the SMA of the Provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider shall notify the SMA within three working days in the event of a change in or the extended absence of the personnel with the above listed authority.

The provider must provide the SMA a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to the SMA . It is recommended that this document be readily accessible to all staff.

Administrative and supervisory functions must not be delegated to another agency or organization.

The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list the SMA as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

The provider must update their holidays in Phoenix. The provider is not required to furnish services on those days.

Unless providing a blast frozen meal or shelf stable meal, hot and cold food shall be portioned and packed separately to ensure retention of heat or cold and shall be transported in approved insulated carriers which will maintain the required hot (135 degrees Fahrenheit or above) and cold (41 degrees Fahrenheit or below) temperatures until the time of delivery to the participant. Blast frozen meals must be transported in approved insulated carriers which will maintain the meals in a frozen state until the time of delivery to the participant.

Delivery routes must be clearly established. No more than three (3) hours shall elapse between the time of packaging and the time of delivery of the last hot meal on the route. Delivery of a cold meal beyond the three (3) hour limit for a participant who lives too far away may be made upon written approval of the Head of the Provider Relations and Compliance Department, Division of Waiver Management.

Meals must be received, in hand, by an individual at the participant's door or at another location as agreed to by the provider and as indicated on the service authorization.

The provider shall give initial and on-going training in the proper service, handling, and delivery of food to all staff, both volunteer and paid.
The provider will maintain a record keeping system which establishes an eligible participant profile in support of units of Home Delivered Meal service provided, based on the service authorization.

The provider shall regularly observe, or at a minimum inquire about, the participant's condition and will confirm at least monthly that the participant continues to reside in the home and is available to receive the meals. The provider will notify the case manager as soon as possible, but no more than two (2) working days, after the provider becomes aware of the following participant changes:
a. Participant's condition has changed or participant no longer appears to need home delivered meal services; or,
b. Participant is institutionalized, dies or moves out of service area; or,
c. Participant no longer wishes to receive home delivered meal services; or,
d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

The provider must inform the SMA of the Provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider shall notify the SMA within three working days in the event of a change in or the extended absence of the personnel with the above listed authority.

The provider must provide the SMA a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to the SMA . It is recommended that this document be readily accessible to all staff.

Administrative and supervisory functions must not be delegated to another agency or organization.

The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list the SMA as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

The provider must update their holidays in Phoenix. The provider is not required to furnish services on those days.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

Upon enrollment and at least once every twenty-four months thereafter

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:

Medicaid Nursing - LPN

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Continuous and individual skilled care provided by a Licensed Practical Nurse, licensed in accordance with the State Nurse Practice Act, in accordance with the participant's plan of care as deemed medically necessary by a physician. Services are provided in the participant's place of residence. Services are not allowable when a participant is in an institutional setting.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

The provision of Medicaid Nursing services under the State Plan is only available to children.

All medically necessary Medicaid Nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medicaid Nursing - LPN

Provider Category:

Agency

Provider Type:

Nursing Agency

Provider Qualifications

License *(specify):*

SC Code of Laws §44-33-10, et. Seq

Certificate *(specify):*

Other Standard *(specify):*

Agencies desiring to be a provider of Medicaid Nursing services must have demonstrated experience in providing Nursing services or a similar service. Experience must include at least three (3) years of health care experience, one of which must be in administration.

The provider must employ a RN or LPN that meets the following requirements:

a. Supervised by an RN. Nurse supervisor must be accessible by phone during any hour services are being provided under this contract. If the nurse supervisor position becomes vacant, the SMA must be notified no later than the next business day.
b. Licensed to practice nursing by the State of South Carolina. Provider will verify nurse licensure at time of employment and ensure that the license remains active and in good standing at all times during employment. A copy of the current license must be maintained in the employee's personnel file.
c. Has at least one (1) year of experience in public health, hospital, or long-term care nursing; and
d. Has a minimum of six (6) hours relevant in-service training per calendar year (The annual in-service requirement will be pro-rated based on the month of hire for the first calendar year of employment). Each staff member's personnel file must contain a summary of their in-service training for the year. The summary must include the date of the training, name and title of trainer, the subject or title of the training and the total number of in-service hours earned.

The provider must conduct a SC Law Enforcement Division (SLED) criminal background check for all employees prior to hire and at least every two years thereafter to include employees who will provide direct care to SMA participants and all administrative/office employees. All SLED criminal background checks must include all data for the individual with no less than a ten (10) year time frame being searched. The SLED criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years.

The provider must check the Office of Inspector General (OIG) exclusions list for all staff prior to hire and at least every two years thereafter. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on this list is not allowed to provide services to waiver participants or participate in any Medicaid funded programs.

In addition, services must also adhere to the following:
a. The RN supervisor must be accessible by phone at all times the RN or LPN is on duty and the RN supervisor must decide the frequency of supervisory visits based on his/her professional knowledge of the participant's situation and health status; however, this may be no less frequently than every ninety (90) days for LPNs and every 180 days for RNs. In the event the participant is inaccessible during the time the visit would have normally been made, the visit must be completed within five (5) working days of the resumption of Nursing services. These visits will include a re-evaluation of the participant's condition as well as updating of the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

• Upon enrollment
• Within first year of service
• A sample of providers is reviewed every eighteen 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:

Medicaid Nursing - RN

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Continuous and individual skilled care provided by a Registered Nurse, licensed in accordance with the State Nurse Practice Act, in accordance with the participant's plan of care as deemed medically necessary by a physician. Services are provided in the participant's place of residence. Services are not allowable when a participant is in an institutional setting.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

The provision of Medicaid Nursing services under the State Plan is only available to children.

All medically necessary Medicaid Nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medicaid Nursing - RN

Provider Category:

Agency

Provider Type:

Nursing Agency

Provider Qualifications

License *(specify):*

SC Code of Laws §44-33-10, et. seq

Certificate *(specify):*

Other Standard *(specify):*

Agencies desiring to be a provider of Medicaid Nursing services must have demonstrated experience in providing Nursing services or a similar service. Experience must include at least three (3) years of health care experience, one of which must be in administration.

The provider must employ a RN or LPN that meets the following requirements:

a. Supervised by an RN. Nurse supervisor must be accessible by phone during any hour services are being provided under this contract. If the nurse supervisor position becomes vacant, the SMA must be notified no later than the next business day.
b. Licensed to practice nursing by the State of South Carolina. Provider will verify nurse licensure at time of employment and ensure that the license remains active and in good standing at all times during employment. A copy of the current license must be maintained in the employee's personnel file.
c. Has at least one (1) year of experience in public health, hospital, or long-term care nursing; and
d. Has a minimum of six (6) hours relevant in-service training per calendar year (The annual in-service requirement will be pro-rated based on the month of hire for te first calendar year of employment). Each staff member's personnel file must contain a summary of their in-service training for the year. The summary must include the date of the training, name and title of trainer, the subject or title of the training and the total number of in-service hours earned.

The provider must conduct a SC Law Enforcement Division (SLED) criminal background check for all employees prior to hire and at least every two years thereafter to include employees who will provide direct care to SMA participants and all administrative/office employees. All SLED criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The SLED criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years.

The provider must check the Office of Inspector General (OIG) exclusions list for all staff prior to hire and at least every two years thereafter. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on this list is not allowed to provide services to waiver participants or participate in any Medicaid funded programs.

In addition, services must also adhere to the following:
a. The RN supervisor must be accessible by phone at all times the RN or LPN is on duty; and, The RN supervisor must decide the frequency of supervisory visits based on his/her professional knowledge of the participant's situation and health status; however, this may be no less frequently than every ninety (90) days for LPNs and every 180 days for RNs. In the event the participant is inaccessible during the time the visit would have normally been made, the visit must be completed within five (5) working days of the resumption of Nursing services. These visits will include a re-evaluation of the participant's condition as well as updating of the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

• Upon enrollment
• Within first year of service
• A sample of providers is reviewed every eighteen 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:

Pest Control

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Pest Control includes services to remove pests, such as cockroaches, from participant's residence. Services are provided based on demonstrated need to ensure participant's health, safety and welfare. Providers inspect participant’s residence, confirm existent pests, and treat the residence (interior and exterior) to eliminate infestation.

Pest Control-Advanced services aid in maintaining an environment free of bed bugs to promote safety, sanitation, and cleanliness of the participant's residence. Once the existence of bed-bugs is established as existent within the home, providers treat the residence to eliminate infestation. The provider must return to the home and provide re-treatment as necessary within a one year warranty time frame from the authorization of initial treatment.

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

For Pest Control, a maximum of six treatments can be authorized within a twelve month period. Pest Control service may be authorized with a frequency of every other month at a maximum.

This service can only be provided in an individual’s own home and be identified as a need to ensure health and safety as identified in the individual’s person centered plan. The provision of this service must not be covered through other resources, such as through a lease agreement.

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	Pest Control Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control

Provider Category:

Agency

Provider Type:

Pest Control Provider

Provider Qualifications

License *(specify):*

SC Code of Laws 46-13-10 et. seq, SC Pesticide Business License

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, Clemson University Department of Pesticide Regulation

Frequency of Verification:

Upon enrollment and annually thereafter

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:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Items available in this service include Nutritional Supplements and Hand Held Shower.

Providers must fill orders from their own inventory or contract with other companies for the purchase items necessary to fill the order. Providers must notify participants of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge SMA-covered items that are under warranty. In addition, providers must employ adequate staff to coordinate service delivery, package products according to service authorizations, and respond to complaints and grievances received from participants.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Nutritional Supplements: up to two cases per month.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Business

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed Business

Provider Qualifications

License *(specify):*

Business licensed as required by the location of the provider in South Carolina

Certificate *(specify):*

Other Standard *(specify):*

Criteria established in SMA provider manual.

Licensed business is the provider type of this service. Providers must be appropriately licensed to do business in the county or municipality where the provider is located in South Carolina. Providers must fill orders from their own inventory or contract with other companies for the purchase items necessary to fill the order. Providers must notify participants of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge SMA-covered items that are under warranty. In addition, providers must employ adequate staff to coordinate service delivery, package products according to service authorizations, and respond to complaints and grievances received from participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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):

Community Residential Care Facilities and Personal Care agencies all are required by law to complete background checks on direct care staff. Personal Care agencies must additionally conduct background checks on all staff. These are state level investigations performed by South Carolina Law Enforcement (SLED) for each of the agencies above that hire and recruit direct care staff. The SC Department of Health and Environmental Control performs licensure inspections incorporating the requirement that all direct care staff of these agencies have the required background check.

Providers are required to check the Certified Nurse Aide (CNA) registry and the Office of Inspector General (OIG) exclusions lists for all staff prior to hire then at least every two years thereafter. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to waiver participants or participate in any SMA-funded programs.

A South Carolina Law Enforcement Division (SLED) criminal background check is required for all employees prior to hire and at least every two years thereafter to include employees who will provide direct care to participants and all administrative/office employees (office employees required to have SLED background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All SLED criminal background checks must include all data for the individual with no less than a ten year time frame being searched. The SLED criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten years cannot provide services to SMA participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten or more years can provide services to SMA participants under the following circumstances: participant/responsible party must be notified of the aide's SLED criminal background, i.e., felony conviction and year of conviction; provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's SLED criminal background and agreement to have the aide provide care (statement must be placed in the participant record); potential administrative/office employees with non-violent felony convictions dating back ten or more years may work in the agency at the provider's discretion.

Companion, attendant, and case management services require state-level background checks through SLED for administrative and direct care personnel, as is affirmed by these service providers in their signed contracts/enrollment agreements. In all cases, the SMA has a staff member devoted to reviewing waiver service providers' records to ensure that background checks have been completed.

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):

Certified Nursing Aides (CNA) must be checked for inclusion on the State's CNA abuse registry, which is maintained by Pearson VUE. Service providers are responsible for conducting screenings for prospective employees. SMA staff are tasked with verifying completion of these screenings during compliance reviews.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residential Care Facilities (CRCF)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Specialized Medical Equipment and Supplies	☐
Companion Care - Agency	☐
Home Delivered Meals	☐
Case Management	☒
Personal Care I	☐
Attendant Care Services	☐
Personal Care II	☐
Medicaid Nursing - LPN	☐
Pest Control	☐
Medicaid Nursing - RN	☐
Home Accessibility Adaptations - Environmental Modifications	☐
Companion Care - Individual	☐

Facility Capacity Limit:

Variable as determined by licensing agency. Capacity limits are indicated on CRCF licenses.

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	☒

Standard	Topic Addressed
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:

Personal Care I and II services and Medicaid Nursing LPN and RN services are no longer provided in a CRCF setting, and Nutritional Supplements will now be provided in a CRCF setting

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.*

☐ **Self-directed**

☐ **Agency-operated**

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 SMA 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. All other qualified family members may be reimbursed for their provision of the following waiver services:

Attendant Care
Companion - Individual and Companion - Agency
Home Accessibility Adaptations - Environmental Modifications
Personal Care I/II
Pest Control
Home Delivered Meals
Specialized Medical Equipment and Supplies
Medicaid Nursing-RN/LPN

Should there be any question as to whether a paid caregiver falls in any of the categories listed above, SMA legal counsel will make a determination. The SMA monitors the provision of in-home services through an electronic visit verification system linked directly to the service authorization in place for anyone receiving services to verify that payments are made only for services rendered to participants.

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 SMA. Potential providers are made aware of the requirements for enrollment through: (1) The agency's website and, (2) contacting the SMA directly. Potential providers are directed to SMA website to complete an online application. Some services specified in this waiver require a precontractual review and signed contract for enrollment as a provider. Once a potential provider has signed a contract or an enrollment application, enrollment with SMA occurs. The time frame established for providers when enrolling is 45 to 60 days after submission of a completed online application.

In order to serve waiver participants enrolled with CICO contracted with the MMP demonstration, providers of waiver services other than self-directed attendant care will also contract with each CICO. However, self-directed attendant care providers will continue to contract only with the SMA. Waiver services providers who do not contract with any CICO may continue to serve waiver participants who are not enrolled in the MMP Demonstration.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Licensed/Certified providers only: Number and percent of newly enrolled licensed and/or certified providers that meet SMA contractual requirements prior to furnishing waiver services. N: The number of all newly enrolled licensed and/or certified providers who meet contractual standards prior to furnishing waiver services. D: All newly enrolled licensed and/or certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider record submissions

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:
Number and percent of provider problems that were resolved within 30 days of discovery. N: Number of provider problems that were resolved within 30 days of discovery. D: Total number of provider problems discovered.

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of required provider reviews conducted by the SMA. N: Number of required reviews conducted. D: Number of required provider reviews.

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:

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:
Non-licensed/Non-certified providers only: Number and percent of newly enrolled providers who complete SMA enrollment validation processes prior to furnishing waiver services. N: The number of newly enrolled providers who complete SMA

enrollment validation processes prior to furnishing waiver services. D: The number of newly enrolled waiver service providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix and/or i-Flow

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**

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

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

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

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

Performance Measure:
For applicable providers reviewed during the waiver year, the number and percent of providers compliant with training requirements. N=Number of providers compliant with training requirements. D: Number of providers with training requirements reviewed during the waiver year.

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:

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

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 States 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 SMA reviews Medicaid provider records regularly/as-needed to ensure that proper service authorizations are on file, provider personnel meet standards required in provider contracts. Additionally, all providers are required to complete training with the SMA before their enrollment as a waiver service provider is established.

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 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.

See Attachment #2

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered 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.

The State Medicaid Agency (SMA) currently operates under a participant-centered philosophy in all stages of program design in which participants maintain a high level of choice and control. Each participant is involved in the service planning and implementation process, which may also include any other person(s) of their choice. Active engagement from participants/authorized representatives is encouraged throughout the service plan development process. During waiver enrollment, the SMA establishes with the participant and/or authorized representative their choice to select in-home care rather than an institutional placement. When home and community based services are chosen, the case manager then informs the participant of available waivered services and waivered service providers for selection, then awaits their choice selections before proceeding. Subsequently, during a participant's initial visit, the case manager reviews the waiver participant's Rights and Responsibilities document with the participant and/or his/her authorized representative. Within this document, participants are advised of their rights to:

• Participate fully in the assessment and develop the person-centered service plan
• Direct services and provider choice
• Assume risk and be willing to assume responsibility for the consequences of that risk
• Report complaints about services/service plan

Following initial service plan development, case managers presentation of the Service Plan Agreement form for review and signature provides another opportunity for the participant and/or their representative to review and engage the service planning process. During the first visit after entry into the waiver and the first visit after an annual reevaluation, case managers present this document for participants'/representatives' consideration. Their signature confirms their participation in the development of their service plan, as well as their right to choose providers that best meet their needs.

In addition, the CM engages the participant/representative in a review of the person-centered service plan during each scheduled contact. During these reviews, the case manager reminds participants/representatives of their right to request changes.

Throughout the person centered planning process, the case manager supports the participant and/or their authorized representative and connects them to necessary resources to address their needs. If the participant/authorized representative is not satisfied with the case manager's performance, they can contact SMA staff. For all participants, the SMA retains final authority for care plan development.

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):

Active participation in service planning with the participant and/or their representative is integral to the waiver. Service planning and implementation involves numerous contacts with the participant/authorized representative as well as extensive planning and coordination with other agencies providing the participant services. This process incorporates the participation of the participant, SMA, authorized representative, physician, service providers, CICO representative(s) for participants enrolled in the MMP demonstration, and any other identified person(s) at the participant's request. Service planning meetings are scheduled at times and places convenient to the participant. Using the assessment tool that encompasses a thorough view of the participant's strengths, goals, health status, needs, and preferences, a comprehensive, person-centered service plan is developed. All payment sources, where appropriate, are considered prior to utilizing Medicaid services (including those offered through the waiver) in the service plan.

Prior to initial service plan development, SMA staff, consisting of the Nurse Consultant/Licensed Social Worker who completed pre-enrollment review and Lead Team Case Manager/Case Manager II, meet to discuss information collected during the assessment process. Subsequently, SMA staff contacts the participant and/or their authorized representative and begins initial service planning. Within this discussion, SMA staff explore existing community services and formal/informal supports with the participant, and discuss appropriate waiver services.

After appropriate services are identified, SMA staff assist the participant with selecting from available qualified providers. Each participant/representative must select a case management provider within a designated time frame after enrollment. This selection, as well as the selection of any other service providers, may be verbal or written. In all cases, SMA staff provide the participant/representative with a list of qualified providers and contact information. The choice of provider may not be influenced by SMA staff and is documented in the participant's record.

After the case management provider is in place, the on-going case manager has an initial visit with the participant within 30 days of enrollment. During the visit, the case manager discusses the service plan and services put in place by SMA staff. The CM and participant/representative make any needed changes and the case manager facilitates the choice of providers for any outstanding services. At each subsequent contact occurring between the initial visit and reevaluation visit, the provider case manager reviews the existing service plan with the participant for potential revision. Thereafter, service plan development with the case manager occurs annually at minimum.

Service planning provides the involved person(s) with information necessary to make an informed choice regarding location of care and services to be utilized. The service counseling process includes educating the participant/representative in the long term care options available to them, thus ensuring the participant's right to be involved in planning their care. Within this process, the case manager discusses the participant's needs and available supports to assist the participant in making informed long term care decisions. Various service options and their expected outcomes are clearly explored with the participant.

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. 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 waivered and non-waivered supports, which may be available to meet the participant's needs.

The service plan is designed to address all areas in which the participant requires at least limited assistance. These needs are identified in the Assessment, Home Assessment, Caregiver Supports, and Personal Goals sections of the plan. Each identified need requires establishing corresponding goals and interventions that the participant, SMA staff, provider case managers, and MMP-CICO (if applicable) work together to meet. Within this context, a goal is developed as a joint effort between the participant/authorized representative, participant's physician, and the case management team. When defining goals, agency guidance provided to those engaged in service planning specifies that goals are:

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;
7. Written to achieve a single end, not a conglomerate of expected outcomes. Once a goal has been established,

interventions are developed to assist in accomplishing the goal.

To ensure the full range of services are considered for a participant's needs, service coordination with other involved providers/agencies is an additional, vital component of the service planning process. Within this effort, the case manager works together with the participant/representative and other providers/agencies involved in the participant's care to ensure services:

• are appropriate for the participant's needs;
• meet acceptable quality standards;
• are not duplicated;
• are cost effective alternatives;
• maximize the utilization of available resources;
• are provided by other agencies in accordance with maintenance of effort agreements; and,
• augment, not replace, the participant's informal support system.

Ensuring the person-centered service plan's effectiveness and accuracy is an on-going process. Through monthly monitoring, the case manager consistently strives to meet the needs of the participant through the exploration of all waiver services and non-waiver supports. Case managers contact waiver providers and non-waiver supports as needed during this monitoring.

As the case manager becomes aware of significant changes in the participant's health, safety, welfare, or personal goals, updates to the service plan are made accordingly. At minimum a new service plan is required upon re-evaluation; however, the service plan can be updated at any time as indicated by a participant's changing needs. Regardless of when during the waiver year cycle a new service plan is developed, all new service plans must be staffed with and approved by SMA 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.

During service plan development case managers assess participants for risks by reviewing information collected during the initial assessment and the reevaluation visit. Among other areas of perceived risk, this process requires case managers to specifically identify participants' risk of harm from missed provider services as well as their risk during an emergency/disaster. When risks are identified, case managers discuss this determination with the participant/representative and explore possible interventions to mitigate negative outcomes. These interventions may be customized to meet participants' expressed preferences and/or concerns. Additionally, case managers are required to discuss suitability of the existing service plan during in-home quarterly visits. During these discussions participants are additionally encouraged to express their preferences and concerns regarding waiver interactions. An example of an assessed risk followed by an intervention determination occurs when in-home providers assisting with activities of daily living are required to document a back-up plan to address their response to missed visits and emergencies.

Additional interventions intended to reduce risk include identifying backup services utilizing non-waivered supports when waivered supports are unavailable. If the identified back-up system is also unavailable, the participant is directed to notify their case manager for guidance and to establish a need to revise the backup system.

When complications occur placing a participant at-risk, and/or if a probability of risk cannot be successfully negotiated with an agreed-upon intervention, providers are directed to exercise professional judgment. Providers are also directed initially to seek guidance from designated SMA staff in these situations. As a result of this guidance case managers may be directed to make referrals to other state agencies as indicated and/or as required by statute. In addition, all case managers and participants are provided instruction in reporting to SC Department of Social Services Adult Protective Services Division.

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.

When a waiver participant/representative is at the point of selecting a provider for an authorized waiver service, they are first encouraged to review brochures provided by the SMA to assist participants in completing this task. SMA staff or the case manager then present a provider list to review. This list, ordered randomly when printed to ensure that choice is not related to name or position, comprehensively represents all qualified providers as of the date of request. It provides providers' name, address, and telephone number. Participants are encouraged to phone providers with questions, inquire within their social networks as to others' experience with providers, and utilize other information sources in order to select a provider with informed choice. Once participant choice has been established and their provider referral accepted, participants are reminded to notify their case manager or SMA staff if not satisfied with their provider or service delivery, as they maintain the right to request changes in service providers. During waiver enrollment, participants are informed of this ability through the 'Rights and Responsibilities' form. When a participant wishes to exercise a change in service provider, the process repeats - the participant contacts the case manager or SMA staff to notify of their interest in making a change, at which time the case manager/SMA staff procure a printed, current list of available service providers to review. This list can either be mailed to participants or read to them over the telephone per participant's stated preference. Throughout the process of provider choice, participants/authorized representatives are reminded that case managers/SMA staff are strictly prohibited from suggesting or otherwise influencing choice of provider.

For waiver participants enrolled in the MMP demonstration, CICOs must have waiver service providers in each county sufficient to meet the needs of the target population to ensure members have meaningful choice of providers for each service offered.

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):

SMA staff oversee waiver operations throughout South Carolina. These staff are charged with overview and approval of service plans. After the provider case manager completes a proposed service plan they are required to meet in a team environment to discuss the plan with designated SMA staff. This team discussion involves review of the service plan while considering applicable policies and procedures. The service plan is not complete until this review occurs as indicated by signatures from both the assessor (provider case manager) and reviewer (SMA staff).

For waiver participants enrolled in the MMP demonstration, Care Coordinators serve in the role of reviewer. For all participants the SMA retains final authority in care plan development.

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 participant service plans by monthly phone calls and quarterly face to face visits as a minimum requirement. Information collected during participant contact is entered into Phoenix. During each contact, case managers discuss with participants whether services are being provided in accordance with the service plan and whether these services are meeting participants' needs. As an additional function of each contact, case managers are required to review provider claims/reports occurring since the past contact and address any variances noted from the service plan with the providers involved. Any identified problems are documented in Phoenix.

In addressing noted variances, case managers determine whether established back-up plans functioned as intended. If some failure of back-up is noted, case managers must evaluate whether this occurrence represents a potential threat to the participants' future health and welfare and if so, work with viable options to mitigate this threat. Such options may include referrals to additional waiver/non-waiver services, exploring a change in provider choice, and reviewing the service plan for informal support systems which could be utilized to assist the participant. When monitoring determines a threat to the participant which may constitute abuse, neglect, or exploitation, case managers/SMA staff are instructed to make a referral to the Adult Protective Services division of SC Department of Social Services.

In addition, SMA Quality Assurance staff monitor case management activities through reports compiled from Phoenix data. Through these reviews staff note any service plan variances, then evaluate whether there exist trends and patterns involving the provider.

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 States quality improvement strategy, provide information in the following fields to detail the States 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 whose personal goals were addressed in their service plan. N: number of participants whose personal goals were addressed in their service plans. D: total number of participants who identified a personal goal.

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:

Performance Measure:
Number and percent of participants with service plans that address needs identified during assessment N: participants with service plans that address needs identified during assessment D: number of participants assessed.

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**	☐ **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:

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.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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 participants with service plans updated/revised annually.
N: the number of participants with service plans updated/revised annually. D: number of participants with service plans.

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:

Performance Measure:
The number and percent of participants with service plans updated/revised when participants' needs changed prior to annual review. N: the number of participants with service plans updated/revised when participants' needs changed prior to annual review. D: number of participants with changed needs prior to annual review.

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

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 = 95/5/50
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **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:
Number and percent of participants who received services as designated in their service plans. N: Number of participants who received services as designated in their service plans. D: Total number of participants with service plans.

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:

e. ***Sub-assurance: Participants are afforded choice: 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 afforded choice of all qualified waiver service providers. N: number of participants afforded choice of all qualified waiver service providers, as signified by their initials/signature D: total number of participants.

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 = 95/5/50
☐ **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 informed of their right to choose waiver services, from those that are available, that will best meet their needs as documented by a signed SMA Rights and Responsibilities form. N: Number of participants informed of their right to choose waiver services D: Total number of participants

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

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 case managers and monitored by SMA designated staff. Phoenix provides reports to assist in monitoring timely completion of service plans. All service plans are reviewed and signed in Phoenix by SMA staff. The service plan is not considered complete without SMA staff signature. The SMA staff signature explicitly indicates the service plan meets the needs/desires/goals of the participant.

All data can be reviewed by SMA staff or individually by case manager. Phoenix links needs (including caregiver supports, home environment, personal goals and other needs) identified in the assessment to the service plan. 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. Service levels are prior approved by SMA staff.

If the need for a new service is identified, Phoenix will only allow authorizations if the service plan is updated to include an intervention for the service. SMA staff can 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 influence 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 received. An EVV system is used for monitoring and verification of providers delivering in-home services. Services not delivered in accordance with the authorization are identified.

For MMP participants, a CICO Care Coordinator can record significant changes in the participant's condition using Phoenix and make 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 States 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 is discovered, designated SMA staff review the issue with the case manager and notify the provider agency. Problems that can be corrected are considered pending until amended. If the problems are not amended timely, SMA staff can take further designated action. If a problem cannot be corrected, the issue is referred to the SMA for sanctioning. All case management provider agencies are expected to file corrective action plans with the appropriate SMA offices following case manager non-compliance. SMA staff are expected to monitor such case managers and report progress in completing assigned corrective action. If a problem is identified as the result of SMA staff action, that issue is remediated by supervisory SMA staff, reported to SMA Central Office, and monitored for improvement. Further actions, including sanctions, are pursued as necessary in the event of continued non-compliance.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☒ **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. The two services, Attendant Care and Companion Care - Individual, are self-directed services that assist participants in completing activities of daily living and independent activities of daily living. Participants select the individual to provide these services, negotiate the provider's weekly schedule, and maintain an ability to terminate the service provider if dissatisfied with provided care. These services are provided with the assistance of a SMA contracted entity.

As a function of waiver entry activities, SMA staff introduce participant direction as a service option to participants. Subsequently, case managers provide more detailed information concerning the benefits and responsibilities of the option during initial service counseling. When participants express an interest in participant direction, nurses employed with a contracted entity visit and directly provide information regarding the risks, responsibilities, and liabilities of the option. Additionally, the Attendant Care service requires nurses licensed by the State to determine the selected provider's ability to administer needed care services. These nurses also provide instruction in care provision when needed.

If a participant wishes to self-direct either of these services as the designated Employer of Record, that participant must demonstrate capability to fulfill associated responsibilities. These responsibilities include the ability to negotiate a schedule, assess the work being done, and determine that the participant's needs are being met. If the participant is either unable to demonstrate capability in these responsibilities or does not wish to serve in the role, a representative chosen by the participant may assume the responsibilities of Employer of Record. This representative is subject to the same determinations of competence to fulfill the role as are applied to a participant wishing to fully self-direct the service. Notably, an individual may not serve as both an Attendant/Companion and as the Employer of Record.

The contracted entity involved in these services provides the participant supporting information in navigating the Financial Management Service (FMS) requirements associated with Attendant/Companion Care – Individual, as well as supportive information guiding selection, management, and termination of Attendants/Companions. The contracted entity additionally assists participants in completing and sending employment packets to FMS. Within their associated role, FMS receives payroll fund transfers from MMIS, then processes payroll as well as the withholding, filing and payment of applicable employment-related taxes/insurances. These services are provided for each participant with employer authority over his/her care.

Once a participant has chosen participant direction and is receiving services, case managers continue to monitor service delivery and the status of the participant's health and safety. Reports are monitored monthly to ensure service delivery and to ensure that the participant is receiving appropriate care. Case managers monitor these services during monthly contacts and quarterly face to face visits.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the 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

Participants are evaluated on the basis of communication and cognitive patterns to determine their ability to self-direct their own care. When a participant is assessed as unable to self-direct or chooses to have a representative direct their care, that representative is also evaluated. This evaluation assesses the representative's knowledge of the participant's medical condition and their ability to advocate for the participant's needs and preferences.

If a participant does not meet criteria to self-direct services, they are allowed to appoint an Employer of Record to manage the Attendant and/or the Companion - Individual service. If no one appropriate is available to serve as Employer of Record, an agency will direct the service (if service still desired).

Any participant denied self-directed services may appeal the decision through a formal process.

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.

Following waiver entry the case manager provides literature offering an overview of all waiver services, including participant directed services (Attendant Care and Companion Care - Individual), during the initial visit for completion of the person centered service plan. Participants expressing an interest in self-directed services are given additional information about self-direction and the benefits and responsibilities of self-directed services. Such literature is available subsequent to the initial visit at the participant's request.

Participants who wish to select a participant-directed service after receiving this information are contacted by a licensed nurse, employed by a contracted entity, who then provides detailed information about the service's scope and associated responsibilities. Case managers work in conjunction with this entity to ensure these service options are fully explored once a participant makes such a request.

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. To qualify for the role of the participant's representative, the interested party must be 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/known acquaintance of the participant. The chosen representative must demonstrate a strong personal commitment to the participant, knowledge of the participant's preferences and medical condition(s), and be at least 18 years of age. The representative must be willing/able to review and approve weekly service logs and observe care provided monthly. A representative will not be receive payment for these services, and may not provide any additional waiver services outside the scope of their responsibilities as the participant's representative.

Once a participant identifies a representative for their services, the participant's case manager completes an initial screening assessment to ensure the representative is capable of functioning in the best interests of the participant. Additionally, the representative is required to acknowledge awareness of the participant's needs in providing their signature on the Rights and Responsibilities form.
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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
Attendant Care Services	☒	☐
Companion Care - Individual	☒	☐

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:

Previously, FMS was included as a component in the State's EVV model. As a cost saving method, the SMA separated EVV and FMS into separate components of the waiver program.

The State provides FMS as an administrative function in response to a Request for Bid (RFB). The SMA leverages the EVV to facilitate documentation of service delivery that needs to be paid by the FMS. The current rate for FMS services is $49 per participant per month. When the transition is complete to the new provider and services are fully implemented, the cost will be $38.50 per participant per month.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

A monthly fee per participant is charged for FMS.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

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

☒ **Assist participant in verifying support worker citizenship status**

☐ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**

☐ **Track and report participant funds, disbursements and the balance of participant funds**

☐ **Process and pay invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

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

In conjunction with interface through EVV, Phoenix documents the delivery of services by providers and compares submitted claims to authorizations to ensure appropriate service provision. The SMA receives files on a regular basis indicating payments that have been made to individuals providing self-directed services. These are compared with claims reports indicating money paid to the provider of FMS.

The SMA has staff charged with ensuring provider payments are timely and accurately. Any discrepancies or other issues are discussed with FMS and resolved as appropriate. Under existing agreement, the SMA may request a complete financial audit at any time. FMS makes payments bi-weekly and posts electronically to the SMA.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

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 develops a person-centered service plan

☒ **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
Specialized Medical Equipment and Supplies	☐
Companion Care - Agency	☐
Home Delivered Meals	☐
Case Management	☒
Personal Care I	☐
Attendant Care Services	☐
Personal Care II	☐
Medicaid Nursing - LPN	☐
Pest Control	☐
Medicaid Nursing - RN	☐
Home Accessibility Adaptations - Environmental Modifications	☐
Companion Care - Individual	☐

☐ **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. Participant health and welfare is assured during the transition period of a voluntary termination of service direction. 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. These safeguards exist to assure participant health and welfare during the transition period of an involuntary termination of service direction.

Participants who are involuntarily terminated are given written appeal rights.

Participants in the MMP demonstration 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	40	
Year 2	40	
Year 3	40	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 4	40	
Year 5	40	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Prospective workers must provide qualifying background checks to secure their position. Prospective employees are responsible for payment of these 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.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **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.

All individuals seeking or receiving HCBS through the SMA maintain the right to request an appeal of any SMA decision adversely affecting their eligibility status and/or receipt of services/assistance, inclusive of the decision to reduce, suspend, or terminate a waiver service, and/or in circumstances where a participant is denied a provider of their choice. The formal process of review and adjudication of SMA actions/determinations is managed under the authority of SC Code §1-23-310 (2013) and SC Code R §126-150 et. seq.

During the initial visit completed by the case manager, the case manager reviews the participant's rights and responsibilities, inclusive of discussing right to a fair hearing when appealing any adverse decision. The case manager also informs of procedures involved in this process at this time. Subsequently, individuals are informed both verbally and in writing (via mail sent through United States Postal Service) by SMA staff and/or case managers when an adverse decision has been made regarding HCBS. At that time, individuals are also provided written guidance in filing an appeal of the decision in a form (Appeals Notice). This form is included with any SMA written notification related to termination, denial, reduction, or suspension of any service/service request. Information outlining individuals' right to appeal and guidance in initiating an appeal are also included other forms of SMA correspondence, including the Level of Care Certification Letter, the CLTC Notification Letter, and the participant's Rights and Responsibilities form. In addition, the SMA Division of Appeals and Hearings has a public-facing website (www.scdhhs.gov/appeals) which offers guidance in the appeals process as well as an online portal through which an appeal may be filed. Appeals may also be filed through written correspondence sent via US Postal Service to SMA Central Office.

At the time they are notified of an adverse decision, individuals seeking/receiving HCBS are also notified of associated time frames. If mitigating circumstances such as medical necessity exist, these individuals may file an expedited appeal request; otherwise, a standard ninety day appeal time frame is presented.

When choosing to appeal, the appellant must do so within thirty days of the date of the official written notification issued by the SMA. If the appeal is filed within ten days of notification to a waiver participant, services may continue pending the outcome of the hearing. Information in maintaining service(s) impacted by an adverse decision within the ten day window of availability is provided in correspondence notifying a participant of an adverse decision.

Once an appeal has been filed, the Appeals Hearing Officer becomes involved. The Hearing Officer is an neutral third party empowered by the State to issue orders, schedule hearings and prehearing conferences, require the submission of briefs, call and cross examine any witnesses, recess or conclude any hearing, and dismiss for failure to comply.

When considering a filed appeal, the Hearing Officer may first elect to order a pre-hearing conference in an attempt to resolve issues under dispute. The Hearing Officer notifies the appellant by certified mail of the deadline for the pre-hearing conference to be completed and the deadline for a summary of the conference to be sent to the Hearing Officer. During this conference, both parties have an opportunity to discuss the issue under appeal in each other’s presence. If the issue is resolved to the participant’s satisfaction during this conference (as evidenced by written acknowledgement from the appellant) the appeal is then dismissed. If there remain outstanding issues which the appellant continues to wish to appeal, the Hearing Officer considers arguments presented and determines whether a formal hearing is suggested. Should the Hearing Officer determine a formal hearing is required, the appellant and the applicable SMA offices all are notified of the date, time, and location of the hearing via certified letter. The appellant may also elect to be notified of appeals-related correspondence through electronic mail.

Formal appeals hearings provide both parties an opportunity to state their positions and question the opposing party. Appellants may elect to retain an attorney to advocate on their behalf during these proceedings, but legal counsel is not required. As a result of this hearing, the Hearing Officer ultimately reviews all information presented and arrives at a decision. This decision is provided to the appellant both through written communication and electronic mail (if so desired).

An appellant who remains dissatisfied with the outcome of an Appeals Hearing is provided information in filing an external legal appeal through the South Carolina Administrative Law Court.

Participants enrolled in the MMP demonstration also have access to an Ombudsperson 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. Again, this arbitration process is not a pre-requisite or substitution for a fair hearing.

Notices of appeals are created and copies are maintained in Phoenix.

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 SMA-administered Appeals and Fair Hearing process. When so utilized, information is provided the participant is informed that the dispute resolution mechanism is not a pre-requisite or substitute for a Fair Hearing.

MMP demonstration participants have access to an additional independent ombudsperson representative to assist in the arbitration process. This ombudsperson would typically assist in disputes regarding service levels.

Any SMA applicant or recipient has the right to request an appeal of any decision by SMA which adversely affects the eligibility status and/or receipt of services and/or assistance. The formal process of review and adjudication of SMA 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.

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:

SMA operates the grievance/complaint 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).

Participants may file complaints at any SMA office throughout the state, whether in person, over the telephone, or through written communication. Participants are notified of their right to grieve/complain through a form (Participant's Rights and Responsibilities) reviewed at the initial visit following waiver entry, the re-evaluation visit, and other times as requested/needed. Phone numbers and addresses are supplied to participants as a part of the initial visit information packet. When a participant elects to file a grievance/complaint, the participant is informed that doing so is not a prerequisite or substitute for a fair hearing.

While any complaint about services provided through the waiver can be filed, complaint examples include those involving provider conduct (including case management providers), reduction or termination of services, unmet needs, and processing list status. In addition, the complaint system can be utilized to notify when allegations of abuse, neglect, or exploitation are existent involving a participant. However, formal notification of abuse, neglect, exploitation, and other identified critical incidents (as indicated/outlined in Appendix G) is required by SMA policy in a separate format.

When a complaint is filed, the receiving SMA worker fills out an electronic complaint form located in Phoenix then initiates action in an attempt to reach complaint resolution. Complaint forms are sent electronically to the SMA Quality Assurance and Provider Compliance personnel. The expectation is the appropriate personnel will acknowledge and resolve the complaint as soon as possible. Pending actions and complaint data are tracked/documented via the Phoenix system.

Typical actions taken to resolve complaints include contacting involved providers, escalating to provider and/or SMA supervisory staff, and providing sanctions to parties non-compliant with SMA policy/procedure.

In addition to the above, the SMA has an additional mechanism for receiving complaints through the agency's public facing website. These complaints are filtered to the correct SMA division for resolution. Responses must be submitted to appropriate agency personnel within seven days of receiving the complaint.

Complaints/grievances involving participants enrolled in the MMP demonstration are forwarded to the MMP Ombudsperson program to track and trend for reporting purposes. This information is reported to demonstration stakeholders quarterly. In addition, the Ombudsperson can help participants begin the integrated Medicare-Medicaid appeals and grievance 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 §43-35-5 et. seq, guides the SMA in its incident reporting requirements for vulnerable adults. Among other guidance offered, this Act defines reportable incidents as well as mandates reporting from certain persons.

The Act specifies that incidents involving alleged abuse, neglect, and exploitation of vulnerable adults, as defined by statute, or the belief that such an event is likely to occur, must be reported by those stipulated as mandated reporters orally or by writing within twenty-four hours or the next working day after becoming aware of the issue. Persons required to report under this statute are: physicians, nurses, dentists, optometrists, medical examiners, coroners, other medical personnel, mental health/allied health professionals, Christian Science practitioners, religious healers, school teachers, counselors, psychologists, mental health or intellectual disability specialists, social or public assistance workers, caregivers, staff or volunteers of an adult day care center or of a facility, and law enforcement officers. Reports must be made in writing or orally by telephone or otherwise to the SC Department of Social Services (DSS) Adult Protective Services (APS) Program for incidents occurring involving waiver participants located within the community. For waiver participants residing in a facility (Community Residential Care Facilities, Assisted Living) reports are to be reported to the SMA's Long Term Care Ombudsman Office instead.

SMA also requires reporting of incidents not included in statutory requirements. These incidents include:
• Falls (resulting in death, requiring hospitalization, resulting in permanent loss of function)
• Unexplained Deaths (reporter has a reasonable suspicion to believe that a vulnerable adult died as a result of abuse or neglect; all deaths involving a vulnerable adult in a facility operated or contracted for operation by SC Department of Mental Health, SC Department of Disabilities and Special Needs, or their contractors)
• Traumatic injuries (resulting in death, requiring hospitalization, resulting in a permanent loss of function)
• Unauthorized restraints (in an institutional setting - whether chemical or physical, resulting in death, resulting in hospitalization, resulting in permanent loss of function)
• Media related events (any media report involving a waiver participant, Home Again participant, or MMP demonstration participant that presents a harmful, or potentially harmful, characterization of the SMA and/or any of its contracted entities)
• Elopement (unexplained absence for more than 24 hours)
• Infectious Disease Outbreak

For those participants enrolled in the MMP demonstration, critical incidents are termed "serious reportable incidents"(SREs). In addition to the aforementioned incidents, CICOs monitor for pressure ulcers that are unstageable or staged III and IV.

The SMA oversees compliance with State and Federal requirements to ensure all reportable critical incidents/SREs are reported to the proper regulatory entity as required. This applies to all enrolled waiver participants, including those participants enrolled in the MMP demonstration.

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.

Following waiver enrollment, case managers provide written guidance to participants/authorized representatives in navigating processes involved with reporting abuse, neglect and/or exploitation of vulnerable adults. This material defines the meaning of "vulnerable adult," provides examples of incidents requiring reporting, and indicates contact information for reporting both locally and state-wide. Case managers present this information to participants/authorized representatives during the initial visit and additionally as needed/requested. All SMA staff, both regional and central, serve as resources available to assist participants with questions involving abuse, neglect, and/or exploitation reporting.

As research shows that caregiver stress is associated with increased risk of ANE, case managers administer a version of the Zarit Burden Interview to all caregivers who are the primary providers of hands-on care for participants. Those who score 8 or higher are considered to be experiencing moderate to severe stress. Case managers incorporate interventions for these caregivers into the participant's service plan in order to alleviate the stress and decrease risk to the participant.

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.

Depending on the nature and location of the event, several state agencies may be involved in the reporting and investigation of a critical incident affecting a waiver participant. The waiver case manager occupies a central role in documenting such incidents and completing required advocacy efforts, while the SMA monitors reports filed for adherence to policy and statute.

Waiver service providers who become aware that a participant has experienced an episode of abuse, neglect, and/or exploitation are required to report such incidents to authorities as required by statute; in addition, providers must then notify the participant's case manager. The case manager then creates a critical incident in Phoenix and tracks this incident until resolution.

During contact with participants/authorized representatives and/or during service coordination with provider agencies, case managers are required to discuss changes noted in reviewing participants' needs and services. Any new critical incidents resulting from these discussions must be documented in Phoenix within 24 hours of this contact or the next business day. Any information mandating reporting to external agencies is required to be completed within the time frame designated by statute. When case managers complete a contact for a participant with an existing, ongoing critical incident, case managers are required to complete documentation within three business days. Case managers are required to follow-up on critical incidents at least monthly until the incident is noted to be resolved by agencies involved. This resolution enables the SMA to then close its associated incident.

When a case manager is unsuccessful in obtaining information from involved agencies, they are first directed to seek assistance from designated SMA staff. When these efforts remain unsuccessful, case managers escalate a referral to designated staff at the central office of the SMA. SMA staff remain involved until acceptable reporting of information is documented.

After a critical incident has been filed in Phoenix, SMA Central Office staff review the documentation to determine if policy and statutory requirements have been met. If not met, the case manager is contacted in writing through Phoenix or by e-mail and directed to resolve the missing information. If documentation presented meets policy and statutory requirements, SMA staff acknowledge this information in a response within the critical incident module in Phoenix.

Both case managers and SMA staff track critical incidents until receiving notification the issue has been resolved.

Reports of critical events or incidents occurring in licensed facilities (CRCF) are reported to the State's Long Term Care Ombudsman's office, as outlined in SC Code of Laws §43-35-25. Case managers are responsible for interacting with any critical incidents involving this office in the same manner as critical incidents involving APS.

State agencies involved in reporting/evaluating critical incidents are listed below. Critical incidents appropriate to be reported to these entities are indicated. While involved state agencies' investigation policies and processes vary, their time frames to begin investigations are specific as noted:

South Carolina Department of Social Services/Adult Protective Services:
Associated Critical Incidents: Abuse, Neglect, Exploitation, Falls, Unexplained Deaths, Traumatic Injuries, Elopement.

Investigations are conducted according to the risk to the adult. Emergency situations are investigated immediately, allegations of abuse are investigated within 24 hours, allegations of neglect by another and exploitation are investigated within 48 hours, and allegations of self- neglect are investigated within 72 hours. Cases that involve suspicion of criminal activity are reported to local law enforcement or to the Vulnerable Adults Investigations Unit of the South Carolina Law Enforcement Division (SLED) within one working day of completing the review. Cases that involve vulnerable adults being taken into protective custody or the need for consent for services or placement have court hearings within forty days.

South Carolina Long Term Care Ombudsman Office:
Associated Critical Incidents: Abuse, Neglect, Exploitation, Falls, Unexplained Deaths, Traumatic Injuries, Elopement ,Critical Incidents in Licensed Facilities

Upon receiving a report, the Long Term Care Ombudsman promptly shall: initiate an investigation or review the report within two working days for the purpose of reporting those cases that indicate reasonable suspicion of criminal conduct to local law enforcement or to the Vulnerable Adults Investigations Unit of SLED. A report to local law enforcement or

SLED must be made within one working day of completing the review.

South Carolina Law Enforcement Division:
Associated Critical Incidents: Abuse, Neglect, Exploitation, Falls, Unexplained Deaths, Traumatic Injuries, Elopement.

The Vulnerable Adults Investigations Unit of the South Carolina Law Enforcement Division receives and coordinates referrals of all reports of alleged abuse, neglect, or exploitation of vulnerable adults in facilities operated or contracted for operation by the Department of Mental Health or the Department of Disabilities and Special Needs. The unit must have a toll free number, which must be operated twenty-four hours a day, seven days a week, to receive the reports. The unit must investigate or refer to appropriate law enforcement those reports in which there is reasonable suspicion of criminal conduct.

Attorney General:
Associated Critical Incidents: Abuse, Neglect, Exploitation, Falls, Unexplained Deaths, Traumatic Injuries, Elopement.

The Attorney General, upon referral from the Long Term Care Ombudsman Program or the Vulnerable Adults Investigations Unit, may bring an action against a person who fails through pattern or practice to exercise reasonable care in hiring, training, or supervising facility personnel or in staffing or operating a facility, and this failure results in the commission of abuse, neglect, exploitation, or any other crime against a vulnerable adult in a facility. A person or facility which verifies good standing of the employee with the appropriate licensure or accrediting entity is rebuttably presumed to have acted reasonably regarding the hiring.

State Medicaid Agency:
Associated Critical Incidents: Media-related events, Infectious Disease Outbreaks

When there is reason to believe that a waiver participant has been abused, neglected, or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. The SMA and its contracted provider agencies shall be available to provide information and assistance to the responsible agency/entity. The identified state agencies and investigatory entities each follow their designated procedures for notifying participants and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, and waiver operating agency) of the investigation results.

Upon receiving a report of these incidents, SMA staff process reports within 72 hours or three business days. Data are collected and analyzed, with guidance provided to the assigned waiver case manager in future reporting expectations until incident may be resolved. As these critical incidents vary in nature, reporting requests vary as well.

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

The SMA is within the process of renewing a Memorandum of Agreement with DSS which allows for the sharing of information. The purpose of this agreement is to provide for a system of receiving and investigating reports of alleged abuse, neglect and exploitation occurrences to vulnerable adults receiving services from the SMA. To identify those programs and services operated or contracted for operation by the SMA that should report alleged abuse, neglect, or exploitation to DSS and to establish cooperative relationships for the purpose of training and technical assistance to SMA staff and/or its contracts.

The SMA is responsible for overseeing the reporting of and response to any reportable incidents. Reportable incident data are monitored on an ongoing basis, as well as reviewed for quality improvement, accountability, public reporting, and improving the overall health and welfare of beneficiaries/participants. At minimum, the SMA conducts bimonthly meetings with internal subject matter experts to discuss trends as well as specific reports requiring follow-up.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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

The use of restraints involving waiver participants is only allowable for those participants who choose to reside in a Community Residential Care Facility (CRCF) as licensed by South Carolina Department of Health and Environmental Control (SCDHEC). Within that environment, per R. 61-84, restraints are allowed with specific parameters designated:

• Mechanical, physical, or chemical restraints may only be utilized in cases of extreme emergency wherein the participant is demonstrating danger to themselves and/or others. No other forms of restraint may be used.
• Restraints must be ordered by a physician or authorized health care provider and are allowed only until appropriate medical care can be secured (with allowed exceptions for Antipsychotic medications administered to individuals with Alzheimer's Disease/Dementia in the routine course of their care). Emergency restraint orders shall specify the reason for the use of the restrai nt, the type of restraint to be used, the maximum time the restraint may be used, and instructions for observing the resident while restrained, if different from the CRCF's written procedures.
• Only devices specifically designated as restraints may be used.
• Residents certified by a physician or other authorized healthcare provider as requiring restraint for more than twenty-four hours shall be transferred to an appropriate facility
• During emergency restraint, residents shall be monitored at least every 15 minutes, and provided with an opportunity for motion and exercise at least every 30 minutes. Prescribed medications and treatments shall be administered as ordered, and residents shall be offered nourishment and fluids and given bathroom privileges.

Also established in R. 61-84 are education and training requirements for CRCF staff, including those who may be involved in administering restraints. All staff employed by CRCFs must have been provided training necessary to perform required duties in an effective manner and must also demonstrate a working knowledge of applicable regulations. They must be documented as capable of providing care and having had sufficient education to perform duties, with the ability to read, write, and speak in English established.

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:

As the licensing and regulating agency for CRCFs, SCDHEC maintains primary oversight of restraint incidents, with the State's Long Term Care Ombudsman (located within the SC Department on Aging) serving as an additional source of advocacy for participants with concerns or complaints regarding their treatment.

To this end, CRCFs are held to the following stipulations by R. 61-84:

• CRCFs are required to maintain a record of each restraint occurring in the facility or on the facility grounds. A record of each restraint shall be documented, reviewed, investigated, with records retained by the facility for six years after the participant terminates residence.
• If a participant is severely injured during use of a restraint, the CRCF must investigate and provide a report providing required details within five days to SCDHEC. A severe injury is defined as a "significant loss of function or damage to a body structure, not related to the natural course of a resident's illness or underlying condition or normal course of treatment."

Within the course of completing routine contacts (occurring monthly at minimum), waiver case managers are required to determine the need for critical incident reporting through discussion with participants/authorized representatives. As "Unauthorized Restraint" exists as a critical incident category, case managers are required by SMA policy to document these incidents with pertinent details, as well as provide continuing reporting on a monthly/as-needed basis until resolved if any injury is sustained during the incident. These incidents are then processed by the SMA as described in Section G-1-d.

An additional entity providing systemic oversight is represented in the State's Adult Protection Coordinating Council (APCC). As outlined in SC Code of Laws §43-35-310, the APCC is composed of more than twenty public and private organizations and two consumers or family members of a consumer, one from the institutional care service provision system and one from the home and community-based service provision system. Involved entities meet at least quarterly, or more often if called by APCC petition, to facilitate problem resolution and develop action plans to overcome problems associated with aging adults and their protection. APCC coordinates data collection and analysis, identifies critical issues occurring, and promotes communication and training between the entities represented. The council additionally promotes public awareness of issues affecting vulnerable adults, including those involving abuse, neglect, and exploitation. Administrative staffing for APCC is provided through the SMA.

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:

South Carolina DSS and the Long Term Care Ombudsman are mutually responsible for monitoring use of restrictive interventions involving waiver participants. South Carolina Department of Health and Environmental Control (DHEC) is responsible for all healthcare facility licensing.

Reports of providers using restrictive interventions on vulnerable adults residing in the community are referred to/investigated by DSS/APS.

Reports of providers using restrictive interventions on vulnerable adults placed in community residential care facilities or assisted living facilities are filed with the Long Term Care Ombudsman and DSS/APS. Per DHEC regulations, any restrictive interventions must be reported to DHEC by facility staff. Staff at DHEC investigate reported incidents and notify appropriate SMA staff. Facility staff are also required to notify appropriate SMA staff of any restrictive interventions incidents occurring.

As is outlined in G-2a, APCC provides additional oversight for detection and advocacy of issues involving vulnerable adults residing in South Carolina, inclusive of issues arising from usage of restrictive interventions.

○ **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:

South Carolina DSS and the Long Term Care Ombudsman are mutually responsible for monitoring the unauthorized use of seclusion involving waiver participants. South Carolina Department of Health and Environmental Control (DHEC) is responsible for all facility healthcare facility licensing.

Reports of providers' unauthorized use of seclusion on vulnerable adults residing in the community are referred to/investigated by DSS/APS.

Reports of providers using unauthorized seclusion on vulnerable adults placed in community residential care facilities or assisted living facilities are filed with the Long Term Care Ombudsman and DSS/APS. Per DHEC regulations, any unauthorized use of seclusion must be reported to DHEC by facility staff. Staff at DHEC investigate reported incidents and notify appropriate SMA staff. Facility staff are also required to notify appropriate SMA staff of any unauthorized use of seclusion incidents occurring.

As is outlined in G-2a, APCC provides additional oversight for detection and advocacy of issues involving vulnerable adults residing in South Carolina, inclusive of issues arising from unauthorized use of seclusion.

○ **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.

This section applies only to waiver participants residing in licensed community residential care facilities (CRCFs).

Under state licensing requirements, a licensed CRCF is responsible for administering and monitoring participants' medication regimen. SCDHEC oversees the scope of medication monitoring, focusing on certain types of medications and medication usage patterns assessed during on-site compliance visits. SCDHEC completes medication monitoring routinely to include: a substance that has therapeutic effects, including, but not limited to, legend, non-legend, herbal products, over-the counter, nonprescription, vitamins, and nutritional supplements. SCDHEC additionally reviews medication storage, administration, receiving orders, security, interactions, and adverse reactions. Facilities are required to maintain a Medication Administration Record report.

After a medication administration issue is identified SCDHEC issues a citation. The facility cited then must respond with a plan of correction within 15 days. The plan of correction must outline a specific time frame in which the problem was corrected or will be corrected, describe how problems were addressed, and indicate how the issue will be prevented in the future. Reports are provided to the SMA indicating problems noted with medication administration outcomes.

If the facility under review has a history of compliance issues, SCDHEC monitors the facility more frequently. When there is a recurrence of a violation (Classes I-III) cited under the same section of the regulation as previously cited, SCDHEC conducts an onsite monitoring visit to the facility every 30-60 days.

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.

Case managers monitor health status, at a minimum, on a monthly basis during required contact. One component of this monitoring is to determine if waiver participants are taking their medications as prescribed. However, case managers are not required to have a medical background and are not qualified to assess all aspects of medication management. If a case manager notes that a participant is unable to manage medications as prescribed, the case manager is directed to follow-up with DHEC while consulting with regional/central entities of the SMA as needed.

As is described in G-3-b-i, DHEC is the State Health Agency that oversees licensure and inspections of CRCFs and is responsible for issuing corrective action when violations are discovered.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

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

Do not complete the rest of this section

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 States quality improvement strategy, provide information in the following fields to detail the States 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 and percent of critical incidents wherein follow-up action was taken as required. N: Number of critical incidents where follow-up action was taken as required. D: Number of critical incidents requiring follow-up action.

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:

Performance Measure:
The number and percent of abuse, neglect, exploitation, and unexplained death reports in Phoenix with documentation of appropriate referrals to authorities. N: The number of abuse, neglect, exploitation, and unexplained death reports in Phoenix with documentation of appropriate referrals to authorities. D: The number of abuse, neglect, exploitation, and unexplained death reports in Phoenix.

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**

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

Performance Measure:
The number and percent of participants/authorized representatives who received information on how to report abuse, neglect, exploitation and other reportable incidents. N: The number of participants/authorized representatives who received information on how to report abuse, neglect, exploitation and other reportable incidents. D: The number of participants.

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:

Performance Measure:
The number and percent of caregivers who experienced moderate to severe stress with caregiving and have appropriate interventions identified on the service plan. N: The number of caregivers who experienced moderate to severe stress with caregiving and have appropriate interventions. D: Total number of caregivers with moderate to severe stress.

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:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of case managers with documentation of training in their responsibilities as mandated reporters of abuse, neglect and exploitation as required by SMA policy. N: Number and percent of case managers with documentation of training in their responsibilities as mandated reporters of abuse, neglect and exploitation as required by SMA policy. D: Total number of case managers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case manager orientation sign-in sheets and CLTC's E-learning verification

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 reported incidents in Phoenix that are monitored until appropriate resolution. N: the number of reported incidents that are monitored until appropriate resolution. D: total number of reported incidents.

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of substantiated complaints reported to the SMA associated with restrictive interventions that were remediated. N: Number of substantiated complaints reported to the SMA associated with restrictive interventions that were remediated. D: Number of substantiated complaints associated with restrictive interventions.

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:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants indicating their health care needs are being addressed. N: Number and percent of participants indicating their current health care needs are being addressed. D: Number of participants sampled.

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 = 95/5/50
☐ **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.

During required training, case managers are informed of their responsibility as mandated reporters of abuse, neglect, exploitation, and other events outlined in SC Code of Laws §43-35-25 to make reports to appropriate entities as necessary. Both the statutory and administrative consequences that can occur as a failure to report a required incident are discussed during this training. Additional information and training materials are available via Phoenix for on-demand use by waiver providers, case managers, and SMA staff.

Case managers are also trained in using appropriate processes for recording APS/other reportable incident involvement, including the use of Phoenix to record, update and track. Case managers are required to document monthly follow up in the participant's record until the incident has been resolved by staff from all entities involved. The SMA has processes and agreements in place to escalate and resolve any communication issues that may occur with other agencies during investigation, service coordination, and remediation of reportable events. If SMA supervisory staff intervention is not successful, staff located in SMA Central Office become involved until acceptable feedback is obtained and documented.

Similarly, SMA staff both central and regionally-based receive training in reporting/tracking APS involvement and/or other reportable incidents in Phoenix, as well as statutory requirements associated with staff roles.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 SMA is responsible for overseeing the reporting/monitoring process associated with waiver participants subjected to abuse/neglect/exploitation/other reportable incidents.

When issues are identified with the progress of critical incident reporting/monitoring, SMA staff contact involved individuals (APS worker and/or case manager) directly to request action. Issues which prove difficult to resolve/monitor are discussed during SMA bimonthly quality assurance meetings with internal subject matter experts to invite collaboration and to inform of any developing trends.

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 3)

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; and
- 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 3)

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.

Phoenix provides 100% reporting for specified performance measures (monthly contact/visit activities, including initial/re-evaluation assessments, LOC determinations, documentation of activities completed, service plan development, and EVV activity logs covered under each assurance specific to case managers). Parameters of Phoenix reporting can be modified to facilitate analysis at varied levels of detail. This process promotes a thorough assessment of program areas and reveals those needing improvement as well as those of best practice.

The process of prioritizing and implementing system improvements is based on the assessed severity of identified problem(s) as well as the noted frequency of duplicated errors. Waiver assurances falling below 86% compliance and issues revealing systemic problems receive top priority in guiding SMA staff toward needed action and resolution, ultimately resulting in system improvements. System improvement strategies for waiver assurances falling below 86% compliance involve the following measures: 1. Evaluation of relevant policy and procedure for potential revision and/or clarification. 2. Evaluation of training provided to relevant staff (SMA and/or provider), with revisions applied as suggested. 3. Modifications to enhance Phoenix user interaction.

While areas identified as needing systematic improvement related to assurances outlined in 42 CFR §441.301 and §441.302 receive top priority in quality improvement efforts, the SMA constantly evaluates need for quality improvement efforts based on the prevalence of the issue observed and its assessed impact on waiver participants. Such identified systematic issues are addressed utilizing the following measures: 1. Evaluation of relevant policy and procedure for potential revision and/or clarification. 2. Evaluation of training provided to relevant staff (SMA and/or provider), with revisions applied as suggested. 3. Modifications to enhance Phoenix user interaction.

In addition, the SMA engages in quality assurance reporting on a regular basis. A data analyst on staff with the SMA provides regular reporting (weekly/monthly) regarding aspects of waiver status. Such reporting includes information on unduplicated counts of participants, open critical incidents, and monthly service activities. This data serves to inform SMA quality assurance staff of the need for targeted areas of inquiry in compliance efforts. When a provider is under quality assurance review, they are provided documentation of findings and required action through both electronic mail and the US postal service.

The SMA also utilizes an annual survey of waiver participants in its quality improvement methodology. This survey, known as the Experience and Satisfaction survey, utilizes random sampling to establish a representative sample of waiver participants/primary contacts, who provide responses indicating their satisfaction (or lack thereof) in various forms of waiver interaction. These results are then disseminated within the SMA for utilization in quality improvement activities.

Throughout the MMP demonstration, the performance of each CICO is carefully monitored as outlined contractually, as are CICO's ability to fully assume responsibilities for care coordination and integration. Any indicators of performance concerns prompt the SMA-contracted external quality review organization to design and implement a quality improvement plan outlining needed remediation (if applicable) for involved CICOs.

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.

In monitoring and analyzing system design and data, several processes are utilized.

• Through collaboration with a contracted entity (Clemson University Youth Learning Institute, Office of Research and Organizational Development), SMA coordinates completion of an annual survey exploring waiver participant experience and satisfaction. The study instrument utilized includes items designed to gather data specific to participant experience in waiver performance measures including service planning, provider choice, and areas of health welfare such as abuse, neglect, and exploitation. Participants are also surveyed on their experience and satisfaction with services provided by case managers and personal care workers, additional providers, social health, quality of life, and general quality of care received through the waiver. This survey utilizes simple random sampling to select a sampling frame of approximately 10-15% of the waiver population. Final sample sizes and overall margin of error are calculated using the Raosoft sample size calculator, with an identified margin of error of +/-5% or lower. Samples from the waiver program generally mirror population demographics. Research materials, including a pre-survey letter, survey script, and debriefing materials, are generated annually to communicate with those who are selected in the sample. Selected participants are notified prior to survey administration of the request through written correspondence clearly identifying the purpose of the survey as well as the participant's right to decline participation without affecting waiver status or service provision. Data are collected telephonically by a team of interviewers trained in waiver policy/procedure, involved waiver populations, interviewing techniques, and survey protocols. Following data collection, data are analyzed using IBM SPSS, SAS, or Stata software. All data are summarized and reported back to SMA through comprehensive reporting with all study findings indicated. Implications of survey findings and program recommendations are provided within the report to assist SMA in applying gathered information.

• Phoenix allows SMA staff tasked with quality improvement responsibilities to gather, monitor, and analyze data from SMA regional offices related to reporting on assurances and related performance measures, performance of case management/other waiver service providers, complaint reports, and critical incident reports. Supervisory staff located in SMA regional offices assist through identifying areas of non-compliance noted (failure to meet policy and procedure guidelines) and reporting these issues to SMA Central Office, as well as contracted provider agencies, as needed. SMA has developed and implemented a standardized tool to assist SMA regional office staff with these quality assurance efforts. Relevant compliance reports, critical incidents, and other related data are submitted via Phoenix daily or as needed subsequently.

• Additionally, SMA Central Office staff gather and compile information from additional data sources, including case management provider compliance reports, case manager/case management agency quality assurance reviews completed by SMA staff, other waiver service provider reviews (conducted at time frames specified by policy/procedure) by SMA staff, participant appeals and resulting dispositions, and SMA regional office administrative reviews.

• Information gathered from aforementioned data sources is discussed during regularly scheduled quality improvement meetings, comprised of members from all SMA program areas/departments involved in waiver administration. Quality improvement meetings are conducted bimonthly, or more often as needed. During these meetings, reported data and noted trends are reviewed for discovery of noncompliance, determination of corrective action, and identification of remediation strategies. Remediation strategies which may result include but are not limited to recoupment of funds paid, requirement to attend supplemental training, suspension from accepting new participants for a defined time period, and termination as a waiver provider.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

While evaluation of QIS effectiveness is a regular process within the SMA, the effectiveness of QIS is specifically under scrutiny during annual evaluations of data intended to replicate the formal evidence reporting process required by CMS in advance of waiver renewal. This annual process provides specific guidance to involved entities regarding the success or failure of QIS. Results from this process can be used to track metrics associated with quality improvement in between annual evaluations.

Quality improvement meetings scheduled bimonthly, as detailed in H-1.b.i constitute another avenue of input in monitoring/assessing system design changes. These meetings serve as routine time points for quality improvement review.

Input from external stakeholders regarding system design changes is welcomed additionally on an ongoing basis through a variety of means, including during regularly scheduled meetings at SMA regional offices and through a variety of available staff at the SMA tasked with quality improvement duties. This input is collated for discussion during quality improvement meetings.

QIS results are communicated to waiver providers through Phoenix broadcast messages, notices posted on the SMA public-facing website, Medicaid bulletins, annual conferences/meetings, policy and procedure directives, and email correspondence. Any entities affected through QIS changes are provided this information through these same avenues of communication.

The QIS cited does not span more than one waiver and is addressed individually in each waiver application.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

As is described in H-1.b.1, through collaboration with a contracted entity (Clemson University Youth Learning Institute, Office of Research and Organizational Development), SMA coordinates completion of an annual survey exploring waiver participant experience and satisfaction. The study instrument utilized includes items designed to gather data specific to participant experience in waiver performance measures including service planning, provider choice, and areas of health welfare such as abuse, neglect, and exploitation. Participants are also surveyed on their experience and satisfaction with services provided by case managers and personal care workers, additional providers, social health, quality of life, and general quality of care received through the waiver.

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 SMA utilizes the following methods to ensure integrity of payments made for waiver services. The SMA does not require waiver providers to secure an independent audit of their financial statements.

Division of Audits
Services: All services performed by contracted providers
• The Division of Audits reviews SMA contracts with external entities in order to ensure that contract terms are met and only allowable costs are assessed. In this capacity, the Division of Audits can conduct a compliance review of the Fiscal Management Service (FMS) used for participant-directed care in the waiver program. The Division of Audits conducts compliance reviews upon request. However, the FMS completes yearly audits internally and refunds the SMA for any overpayments.

Provider Compliance Reviews
Services: Personal Care I, II, and Companion-Agency
• The SMA has designated staff to conduct compliance reviews of Personal Care I/II service providers, Companion Agency service providers, and Nursing service providers. These providers are reviewed within the first year of service and a sample of active providers are reviewed every 18 months. These reviews consist of three components: staffing review, administrative review, and participant review. The staffing review samples provider staff members to ensure they meet initial training and certification requirements, any pertinent background requirements, tuberculin skin test requirements, ongoing training documentation requirements, and any other requirements as outlined contractually. The administrative review determines whether or not agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been demonstrated. The participant review uses a sample of waiver participants' charts to verify that all requirements relating to the actual conduct of service have been met. If a discrepancy is found, claims can be reviewed through Phoenix to ensure providers are not inappropriately reimbursed. Designated staff review Phoenix reports and compare to provider's documentation of service delivery to ensure financial integrity.

Division of Program Integrity
Services: All waiver services
• The Division of Program Integrity (PI) within the SMA responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects/analyzes provider data in order to identify billing exceptions and deviations. In this capacity, PI may audit payments made to State Medicaid Agency waiver service providers. Issues involving fraudulent billing by providers are reported to the Medicaid Fraud Control Unit (MFCU) housed within the State Attorney General's Office. During a PI review, staff:
• Review Surveillance Utilization Review System (SURS) reporting, schedule meeting between related SURS staff and the PI investigator(s) to discuss details of provider billing. A review time-period is selected and a random sample is generated.
A sample of beneficiaries' records and/or claims data may be selected for review by various methods:
o Non-random/judgmental sampling
o Random sampling
o 100% review of all claims
• In addition to the random sample selection, additional records may be selected from exceptions and deviations discovered on SURS reports.
• Review applicable policies for associated program
• Determine what type of review will be conducted (onsite, desk review, self-audit, or focused review)
• Determine period of review and select sample of beneficiaries based on information gathered.
o Desk Review - a desk review occurs when PI requests provider records but does not conduct an on-site review at the provider's place of business.
o Onsite – An onsite review is prompted whenever there are strong indicators for waste, fraud and abuse.
o Provider Self Review – In a provider self-review the provider performs a guided review of documents and notifies PI of the results.
If review is onsite, complete an "onsite packet," including following information:
o Letter detailing purpose of review
o Applicable policies and regulations regarding records access
o Disclosure of Ownership request
o List of employees
o Provider Review Questionnaire establishing contact information, provider's address, and all NPI, legacy, and Federal Tax Identification Numbers (FEIN)

Upon their acquisition, records are reviewed by PI staff to ensure that documentation clearly establishes a medical need for services provided, and that claims submitted have been billed and paid according to policy and procedure. In general, the review entails the review of applicable program policy, review of paid and/or rejected claims information, and review of the

medical record and associated documents in beneficiaries' file in support of the claim submission. After an initial review is completed, a letter indicating findings is generated. These findings are supported in this correspondence with pertinent data and analysis reports as indicated. The provider under review is provided an opportunity to request an informal conference to
discuss the review findings, with ten days allowed in response time before findings are determined complete. After there are no pending meeting requests to discuss review results, and the time period associated with the findings letter has expired, a final determination letter is generated. This letter features an explanation of appeal rights as well as guidance in filing an appeal, including time frames associated. If there is an indication of fraudulent billing at any point during the review process, the case is referred to the SMA's Medicaid Fraud Control Unit (MFCU). Regularly scheduled communication is established between PI and MFCU until a final determination is made and/or convictions or fraud of civil action is final. In situations where a credible allegation of fraud has been established, PI must suspend the provider's payments and issue appropriate notifications as established by policy and procedure. If the provider fails to abide by the recoupment agreement, the provider may be subject to Termination for Cause.

A review may be prompted following quality assurance assessments from program areas within the SMA, as a result of SURS data analysis, and/or as a result of a complaint filed by any involved entity. In process, provider research may include one or more of the following courses of action: identification/review of National Provider Identifiers (NPI)/affiliations, examination of records filed with the Secretary of State, background Checks, review of Medicaid Management Information Service (MMIS) provider enrollment information, and review of SMA provider enrollment records.

Environmental Modification Specialist
Services: Environmental Modifications
• The SMA employs Environmental Modification Specialists who also conduct compliance reviews. Staff assess compliance with environmental modifications to ensure all building codes and regulations are followed. Staff also may review providers' work after environmental modifications are complete upon request, or if there are non-compliance issues previously identified with the provider involved. Spot-check reviews are also completed on a subset of the jobs performed. If deficiencies are identified, providers are afforded an opportunity to remediate. If providers do not remedy identified deficiencies, the agency proceeds to assess sanctions against the provider. Sanctions escalate from recoupment of funds paid to suspension as a provider, depending on the severity of non-compliance.

Single Audit Act: Office of the State Auditor
• As an additional entity providing payment integrity, the Office of the State Auditor is responsible for conducting periodic audits of the waiver program under the provisions of the Single Audit Act. Within this audit, the Auditor's Office is responsible for determining State Agencies' compliance with federal statutes, regulations, and the terms and conditions of federal awards applicable to its federal programs. This office conducts audits of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States; and the audit requirements of Uniform Guidance. An audit includes examining, on a test basis, evidence about the SMA's compliance with those requirements and performing such other procedures considered necessary circumstantially. The audit does not provide a legal determination of the SMA's compliance.

• The SMA currently demonstrates compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and will demonstrate compliance with home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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 monthly responses from participants indicating non-EVV services were provided. N: The number of monthly responses from participants indicating non-EVV services were provided D: Number of monthly responses from participants

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:*

Performance Measure:
The number and percent of waiver claims for in-home services documented by the EVV system. N: Number of waiver claims for in-home services documented by the EVV system D:Number of claims for in-home services

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:*

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

Performance Measure:
The number and percent of claims for waiver services submitted with the correct service code. N: The number of claims for waiver services submitted with the correct service code. D: The number of claims for waiver services

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:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
The number and percent of waiver claims with the correct rate methodology applied as specified in the waiver application. N: Number of waiver claims with the correct rate methodology applied as specified in the waiver application. D: Number of waiver claims.

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:*

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

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.*

Phoenix automatically populates needs identified in a waiver participant's assessment to their service plan. This ensures any services ultimately billed for a participant exist as a need on the assessment.

Providers of waiver services are required to utilize Phoenix or electronic visit verification system (EVV) to document service delivery. Claims for waiver services are submitted to the Medicaid Management Information System (MMIS) for payment via Phoenix. MMIS ensures that claims submitted via Phoenix are for individuals who are Medicaid eligible participants in a waiver program and that the service is paid at the identified rate. 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. An exception applies to Institutional Respite claims. These claims are submitted using a specified form or the State's electronic billing system.

Claims submitted for participants enrolled in the MMP demonstration via Phoenix will be routed electronically to CICOs for payment. CICOs receiving claims ensure that each service is paid at the appropriate rate and that the participant is Medicaid eligible.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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 Phoenix and/or MMIS are not updated correctly. Any errors identified by staff utilizing these systems are addressed as per policy. Corrections are established and claims are re-processed by staff as a result of identified errors.

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:*

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

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).*

With assistance from Health Programs, the Department of Reimbursement Methodology is responsible for the development of waiver service payment rates. Each department operates under the direction of the SMA.

Requests for public input for rate determination methods are primarily communicated through quarterly MCAC (Medical Care Advisory Committee) meetings on an as-needed basis as well as through monthly IHS (Indian Health Services) conference calls. Further, waiver renewals and amendments are communicated to the public through public notices and subsequent public meetings and webinars. Comments are solicited through these communications.

Waiver rates are available upon request for any waiver participant. The SMA does not routinely inform the participants of rates unless requested.

The SMA reviews rates on an ongoing basis. The frequency of rebasing rates is not on any specific schedule. It is subject to several factors, including provider requests for new rates, new data regarding the adequacy of rates, availability of funding, and, most importantly, whether the existing rate is sufficient to support an adequate network of providers.

Working collaboratively alongside the waiver provider associations and committees, SMA staff (Program and Reimbursement) continually monitor and gauge the effectiveness of reimbursement rates and methodologies. Historically, annual cost report filings, comparable Medicaid service rates, and surveys of other states' waiver rates were used to validate and substantiate the periodic provider group requests for updates to waiver rates. Due to changing trends in SMA rate development strategies and design as well as CMS guidance in recent years, the SMA has shifted from rate justifications based on cost report data to the construction (rate build-up) of rate models based on market salary data, associated direct operational costs and application of an indirect rate for support costs. When trend rates are applied to provider rates during the rate setting process, the trend factor used is normally the CMS Medicare Economic Index.

For the MMP demonstration, reimbursement is based upon the fee-for-service rate floor. Rates are mutually agreed upon between the provider and the CICO. If the CICO and the provider negotiate a rate that is less than the fee-for service (FFS) rate floor, it must be approved by the SMA. The purpose of this authorization process is to ensure quality is not sacrificed. This protection process is valid throughout the life of the program.

CICOs must comply with rate floors adjusted annually for each service that will set a minimum reimbursement level. These floors will also allow CICOs to create incentives for performance and quality. Rates that fall below 100 percent of the current FFS level should have a corresponding performance and/or quality incentive that should be reflective of 100 percent of the FFS rate (at a minimum).

Original rates were established during the implementation and development of the waiver dating back as early as 1983. The current rates reflected in Appendix J were established at different times ranging from 2011 to 2021. Generally, they were established based on budgeted or projected costs of services and utilization pattern or comparable Medicaid service rates.

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/II, Medicaid Nursing, and Home Delivered Meals.

For Personal Care I/II services, the SMA performs market analysis to determine what the private rate is for these services. This does not mean that the SMA will match the private pay market rate but it is used to determine the reasonableness of any services.

For Home Delivered Meals, the rate structure is determined by the cost of the meal, transportation to provide the service, and associated administrative costs.

Attendant and Individual Companion service rates are determined based upon the salaries of frontline workers of personal care agencies. Their salaries represent a slightly higher rate because there are no benefits provided. The SMA uses market analysis to determine what the private rate is for Attendant and Companion services. This research consists of an informal process whereby private providers are contacted to inquire about the private pay rate for the same service. The SMA takes this information into consideration when determining rates or adjustments to rates. As appropriate, the SMA will survey agencies for the salaries of front line workers. The SMA has, in the past, done a rate increase as a wage pass through. Attendant and Individual Companion services are paid at a fixed rate. This rate includes the hourly rate for the service plus the employee and employer share of taxes and other benefits.

Companion - Agency: The SMA utilizes market analysis to determine what the private rate is for these services. This does not mean that the SMA will match the private pay market rate but it is used to determine the reasonableness of any service. The SMA increased the rate from $8.00 to $9.00/hour following its most recent analysis. Within this process, the SMA utilized an informal process of contacting providers to determine what the private pay rate was for the same service.

Medicaid Nursing-LPN & RN: Private duty nursing rates were established based on the projected costs of the service. Cost reports submitted by providers are renewed on as-needed basis to ensure the appropriateness of the rates or to justify any proposed rate increase. RN and LPN rates build-up models have been used to substantiate prior rate increases. The July 2017 rate increase averaging 3.5% was implemented due to legislative budget priorities in the SFY 2017 session. Future rates and rebasing will be based on rate build-up models.

All Home Accessibility waiver service rates for modifications with the exception of ramps are manually priced based upon the provider's cost estimate. Ramps are priced by the linear foot and participants choose a provider. The State regularly solicits input from providers on the appropriateness of the per foot rate and adjusts this rate based upon changes in lumber costs. There is no single rate for all ramps. Phoenix includes a spreadsheet which gathers data on such things as number of feet of ramp, number of decks, turns, etc. This automatically calculates the cost of the ramp. For all other modifications, competitive bids are solicited and the lowest responsive bid is accepted. Cost is the evaluation criteria for all other modifications. The State does not establish rate minimums or maximums for other modifications. The environmental modification specialist will review bid rates and ask for adjustments if there is no appropriate bid returned based upon the specifications of the job. Home modifications are done by bid. An employee of the SMA provides specifications for all modifications and, through Phoenix, puts them out for bid to all providers covering the geographical area. Providers submit a bid and a winning bid is declared. The case manager authorizes the service at the bid level and the provider uses EVV/Phoenix to bill. The paid amount cannot exceed the winning bid level.

All CICO rates are loaded into Phoenix. The state will review and approve any rates lower than the fee for service floor.

Pest control services are based upon established private pay rates. The state rate was established by taking the average of the initial and follow up rates for private pay treatments. Appliances such as air conditioners and fans are based upon retail pricing.

Pest control enhanced service: Enhanced Pest Control is the treatment of bed bugs. The participant chooses from providers who cover the geographical area. The chosen provider then assesses the job and verifies that there are bed bugs and gives a bid. If this bid is within acceptable limits, it is approved. If not, the next chosen provider is asked to give a bid. This continues until a provider is chosen.

The rates for Specialized Medical Equipment and Supplies are based on the market value of private pay vendors as determined by our Environmental Modification Specialist. The Environmental Modification Specialist conducts surveys of the market to establish the value. These are done periodically to adjust rates as needed. Internet searches, provider surveys, and researching retail stores are the data sources used.

Case management service rates provided to waiver participants were calculated based upon payments made to SMA employees providing case management. At one time all case management was done by SMA 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. Provider case managers are paid by a monthly unit. SMA case managers are state employees. The reimbursement for SMA case managers includes salary, fringe and other operating costs.

Various methods are used to determine rates based upon the specific service. In all cases, the guiding principle is that the rate should not be higher than that paid by other payment sources and must be adequate to ensure a sufficient number of qualified providers. The SMA will use cost based data for evaluating the need for rate increases where these data are reliable and available. The SMA has also considered rate increases which benefit the direct care workers.

Funds from the ARP Act, Section 9817 will be temporarily utilized for activities approved in SCDHHS ARPA spending plan.

South Carolina did not include rate increases in the initial spending plan submitted on July 12, 2021. Ongoing

stakeholder engagement with providers and associations has included discussions about rate increases for various services offered through the 1915(c) waivers. As a result, South Carolina has included the addition of rate increases to the state's spending plan as an activity to support the recruitment and retention of a robust provider network. This revision was included in South Carolina's Quarterly Spending Plan submitted in October 2021. Use of the ARP enhanced funding to provide rate increases for HCBS services will support provider access in the near- and long-term future. SCDHHS anticipates utilizing ARP funds through March of 2024, unless section 9817 funds are fully expended and recurring funds have been secured prior to that date.

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:*

In-home services require the use of the EVV system to document service delivery. Claims are generated based on the EVV visit data. In cases of worker error or EVV system unavailability, providers may bill directly via Phoenix. All other services are billed through Phoenix. These two services are billed through the SMA's standard claim submission process.

Providers bill the SMA directly. For MMP participants, development is being done to bill the plans directly, but the process will be identical to billing Medicaid.

For providers of in-home services, EVV is used (either through a landline telephone or smart telephone application) to document time of starting and ending services. This is compared against authorized limits. Phoenix creates a claim for the service delivery that will bill what is documented or what is authorized, whichever amount is lower. For providers of other services, Phoenix provides a web entry system to document service delivery.

Claims for waiver participants also enrolled in the MMP demonstration are being billed to the SMA. An adjustment is made to plan payments to cover those expenditures. Providers of services to MMP participants are paid by CICOs, who then pay providers directly, as specified in the three-way contract between CMS, the SMA, and each enrolled CICO. For all waiver services, providers use EVV and the Phoenix system to document delivery of services. This documentation is completed through adding claims, either through EVV or web entry of claims in the Phoenix system. All complete claims submitted via EVV are transmitted to CICOs daily for payment processing.

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:*

Claims for waiver services are submitted to MMIS for payment via Phoenix. Program Integrity completes post-payment reviews ensuring services were provided as authorized. These claims are submitted using a specified form or the SMA's electronic billing system. 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. Whenever a recoupment is identified, the Division of Program Integrity notifies the Financial Department of the SMA who reimburses CMS utilizing the "CMS 64 Summary Sheet."

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:

Case management costs for services are allocated by assessing the percentage of case management costs as compared to costs of total salaries throughout the SMA. At present this cost is allocated at 33.616%. Once derived, these costs are then applied to the case management service in the waiver. Office and administrative costs are captured using specific project codes in 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. Another calculation is made to spread office and administrative costs across waivers. The spreadsheet is included in documentation used to claim reimbursement on the CMS-64 and is audited by CMS quarterly.

Waiver providers not participating in the MMP demonstration do receive payments directly from the SMA. Each CICO receives a monthly capitation payment for its members who are also participating in one of the waiver programs. This payment is calculated using historical fee-for-service data minus a built in savings amount. These rates are reviewed and approved by CMS annually. CICOs also receive a separate payment from CMS for Medicare A/B and Part D services. The actual payment and payment processing is conducted via MMIS and ensures the maintenance of an audit trail.

○ ***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 (FMS) is used to make payments for participant-directed services (Attendant Care and Companion-Individual). 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 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, funds received are reviewed and compared to the amount of funds paid.

All waiver providers use Phoenix and/or EVV interface for Medicaid billing. Depending upon the service, this is performed either through in-person visit verification at the participant's residence or through web-based billing. These claims are submitted using the CMS-1500 form or the SMA's electronic billing system. Providers using EVV do so through a telephone line or a smart telephone application when they commence and end services. This input communicates the service type, the worker's identity, specific content noting work completed while providing the service, and any observations about the overall well-being of the participant. Phoenix then compares this with the associated authorization and, if the service is provided as authorized, submits a claim up to the authorized level.

Providers using the EVV web-interface in billing other services use the portal to indicate the date of service and the number of units provided. As with EVV entry, this is compared with the authorized amount and billed to that limit. In both cases, Phoenix submits claims multiple times a week, while providers are paid once weekly. There is a resolution process for providers to use in case of user error or system failure.

Providers receive initial training in billing prior to any authorizations of service. In addition, providers have access to online guidance through Phoenix, which describes how to bill and run reports so providers can monitor staff and associated billing activity. There is also made available periodic training for any provider upon request. Additionally, a help desk is available for providers over the telephone as well as through "submitting a problem" via Phoenix.

Audits are conducted through post-payment reviews by the Division of Audits, Division of Program Integrity, as well as within the program area of the SMA. All audits require corrective action plans for noted non-compliance.

The Division of Audits & Division of Program Integrity focus on proper documentation of delivery of service in accordance with established documentation policies and procedures. Negative findings are likely to result in recoupment of payments. The Division of Audits and Program Integrity conduct reviews both randomly as well as following internal/external requests.

SMA program area audits are more wide-ranging in scope, as they focus on a range of activities broader than fiscal accountability. While program area audits can result in payment recoupments, they also are likely to result in other types of sanctions up to and including termination for noncompliance of the contract. The program area conducts audits at least every other year, and more often if prior reviews identify deficiencies.

The participant-directed Attendant service uses a fiscal agent. All documentation of service is completed following noted EVV service guidelines. Payments are applied to the fiscal agent, who makes indicated deductions then remits payment to the Attendant. The SMA receives files on a regular basis indicating payments applied for individuals providing participant-directed services. These are compared with claims reports indicating funds paid to the FMS provider. The SMA outlines staff responsibilities to ensure provider payments are timely and accurate.

☒ ***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 MMP 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 State County Councils on Aging are registered as waiver service providers. The Councils receive payments for services including Home Delivered Meals, Personal Care I/II, and Companion. The contractual process involved remains the same as for all other providers of these services. Reimbursement rates are the same as well.

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.

- ○ ***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 SMA and CMS contract with Coordinated Integrated Care Organizations (CICOs) for the provision of coordinated and integrated health care services under a federal financial alignment demonstration (MMP). Waiver participants who meet MMP eligibility criteria may choose to enroll. An additional route of access to waiver/MMP dual-enrollment exists through MMP members who become eligible for waiver participation. MMP membership is available in 44 of 46 state counties. The State anticipates offering MMP membership statewide by 2022.

  Initially during the demonstration, CICOs were required to contract with the SMA's existing waiver providers. During the current phase of the demonstration, CICOs assumed contractual authority of all HCBS non-case management services, except (participant-directed) Attendant care.

  A capitated payment to CICOs accommodates all authorized waiver services monthly for MMP-enrolled waiver participants, as well as all additional Medicaid and Medicare benefits utilized by the participant/member. Payments to CICOs are provided through MMIS and are based on each individual's capitation rate group assignment. This assignment is communicated and verified between the State and CICO.

- ○ ***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.***
- ○ ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:

☐ ***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:

CLTC 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 this 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 made only for authorized waiver services. No payments are made directly to CRCF providers. Participants must find alternative means for making room and board payments, primarily through the use of personal recurring income. Fee-for-service payments do not include an allowance for room and board. The only services available to participants residing in Community Residential Care Facilities are Case Management and Specialized Medical Equipment - Nutritional Supplements.

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: Hospital

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	5291.08	14300.78	19591.86	15450.84	12926.78	28377.62	8785.76
2	5887.32	14729.81	20617.13	15759.86	13314.59	29074.45	8457.32
3	6063.13	15171.70	21234.83	16075.05	13714.02	29789.07	8554.24

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)
4	6245.84	15626.85	21872.69	16396.56	14125.45	30522.01	8649.32
5	6432.72	16095.66	22528.38	16888.45	14549.21	31437.66	8909.28

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:
		Hospital
Year 1	889	889
Year 2	889	889
Year 3	889	889
Year 4	889	889
Year 5	889	889

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 average length of stay (ALOS) has been projected based on actual experience from state fiscal year 2020 (July 1, 2019 - June 30, 2020) enrollment data. The calculation of the ALOS estimate for the first fiscal year of the renewal period is based on the number of member months during fiscal year 2020 divided by the unduplicated participant count for fiscal year 2020. The SMA assumes the ALOS will remain consistent with data observed during fiscal year 2020 over the course of the 5-year renewal period.

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 and methodology for these estimates is as follows:*

Factor D for the waiver renewal period was projected based on state fiscal year (SFY) 2020 data, as follows:

• Base number of users was calculated by determining the percentage of unduplicated waiver members who used a waiver service in SFY 2020 multiplied by the unduplicated waiver members for the appropriate waiver year. The projected number of users for the first waiver year of the renewal period represents projected experience of the current members multiplied by the change in unduplicated participant count. Growth from the first to the fifth year of the renewal period applies the same methodology. For waiver services with no experience in SFY 2020, the number of users estimated in the first year of the waiver renewal period (SFY 2022) is based upon the number of projected users during SFY 2021.

• Baseline average units per user was calculated by dividing the utilization for a service by the number of users of the service for SFY 2020. The waiver renewal does not reflect a change in the average units per user during the renewal period. For waiver services with no experience in SFY 2020, the average number of units per user estimated in the first year of the waiver renewal period (SFY 2022) is based upon the average units per user during SFY 2021.

The unit cost for waiver year 2 was updated in J-2-d to reflect the new rates for Attendant Care, Home Delivered Meals, Personal Care I/II, Companion-Individual, Companion-Agency and Medicaid Nursing-RN and LPN. Unit costs for waiver years 3-5 were trended by 3% each year.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' expenditures were developed based on the state plan services identified in historical expenditures excluding any expenditures included in the HIV/AIDS waiver. The projected Factor D annual aggregate expenditure growth rate is approximately 3.0%, driven by annual projected unit cost increases of 3.0%, consistent with Factor D increases of 3% reflected in Appendix J-1, and constant projected unduplicated participants over the 5-year waiver period.

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:*

Factor G expenditures were developed based on SFY2020 hospital claims for members diagnosed with HIV and/or AIDS. Factor G was trended by 2.0% per year, consistent with the inpatient hospital trend applied in the development of CY2020 Prime capitation rates.

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:*

Factor G' expenditures were developed based on all other SFY2020 expenditures (excluding hospital claims) for HIV/AIDS diagnosed members. Factor G' was trended by 3.0% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Personal Care I	
Personal Care II	
Attendant Care Services	
Companion Care - Agency	
Companion Care - Individual	

Waiver Services	
Home Accessibility Adaptations - Environmental Modifications	
Home Delivered Meals	
Medicaid Nursing - LPN	
Medicaid Nursing - RN	
Pest Control	
Specialized Medical Equipment and Supplies	

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
Case Management Total:							707288.40
Case Management	☐	Month	889	11.05	72.00	707288.40	
Personal Care I Total:							912448.60
Personal Care I	☐	Hour	283	230.30	14.00	912448.60	
Personal Care II Total:							1385294.05
Personal Care II	☐	Hour	269	279.88	18.40	1385294.05	
Attendant Care Services Total:							266948.35
Attendant Care Services	☐	Hour	40	561.76	11.88	266948.35	
Companion Care - Agency Total:							77628.77
Companion Care - Agency	☐	Hour	37	220.85	9.50	77628.78	
Companion Care - Individual Total:							47200.50
Companion Care -	☐	Hour	18	308.50	8.50	47200.50	

GRAND TOTAL:		4703768.38
Total: Services included in capitation:		
Total: Services not included in capitation:		4703768.38
Total Estimated Unduplicated Participants:		889
Factor D (Divide total by number of participants):		5291.08
Services included in capitation:		
Services not included in capitation:		5291.08
Average Length of Stay on the Waiver:	340	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual							
Home Accessibility Adaptations - Environmental Modifications Total:							**34024.48**
Environmental Modification-Home Repair	☐	Event	85	1.12	357.40	**34024.48**	
Home Delivered Meals Total:							**929155.52**
Home Delivered Meals	☐	Unit	516	344.30	5.23	**929155.52**	
Medicaid Nursing - LPN Total:							**6466.55**
Medicaid Nursing - LPN	☐	Hour	1	228.50	28.30	**6466.55**	
Medicaid Nursing - RN Total:							**8545.90**
RN nursing	☐	Hour	1	228.50	37.40	**8545.90**	
Pest Control Total:							**85580.10**
Pest Control	☐	Treatment	360	4.67	42.75	**71871.30**	
Pest Control - Advanced	☐	Treatment	14	1.00	979.20	**13708.80**	
Specialized Medical Equipment and Supplies Total:							**243187.15**
Hand Held Shower	☐	Unit	22	1.00	47.50	**1045.00**	
Nutritional Supplements	☐	Unit	403	18.18	33.05	**242142.15**	

GRAND TOTAL:	**4703768.38**
Total: Services included in capitation:	
Total: Services not included in capitation:	4703768.38
Total Estimated Unduplicated Participants:	**889**
Factor D (Divide total by number of participants):	**5291.08**
Services included in capitation:	
Services not included in capitation:	5291.08
Average Length of Stay on the Waiver:	340

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 concurrent managed care authorities utilizing capitated payment arrangements. *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
Case Management Total:							**728507.05**
Case Management	☐	Month	889	11.05	74.16	**728507.05**	
Personal Care I Total:							**964588.52**
Personal Care I	☐	Hour	283	230.30	14.80	**964588.52**	
Personal Care II Total:							**1460581.77**
Personal Care II	☐	Hour	269	279.88	19.40	**1460581.77**	
Attendant Care Services Total:							**364020.48**
Attendant Care Services	☐	Hour	40	561.76	16.20	**364020.48**	
Companion Care - Agency Total:							**118486.02**
Companion Care - Agency	☐	Hour	37	220.85	14.50	**118486.02**	
Companion Care - Individual Total:							**71078.40**
Companion Care - Individual	☐	Hour	18	308.50	12.80	**71078.40**	
Home Accessibility Adaptations - Environmental Modifications Total:							**35045.02**
Environmental Modification-Home Repair	☐	Event	85	1.12	368.12	**35045.02**	
Home Delivered Meals Total:							**1137016.32**
Home Delivered Meals	☐	Event	516	344.30	6.40	**1137016.32**	
Medicaid Nursing - LPN Total:							**6809.30**
Medicaid Nursing - LPN	☐	Hour	1	228.50	29.80	**6809.30**	
Medicaid Nursing - RN Total:							**9002.90**

GRAND TOTAL:		**5233824.29**
Total: Services included in capitation:		
Total: Services not included in capitation:		5233824.29
Total Estimated Unduplicated Participants:		**889**
Factor D (Divide total by number of participants):		**5887.32**
Services included in capitation:		
Services not included in capitation:		5887.32
Average Length of Stay on the Waiver:	340	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
RN nursing	☐	Hour	1	228.50	39.40	9002.90	
Pest Control Total:							88143.36
Pest Control	☐	Treatment	360	4.67	44.03	74023.24	
Pest Control - Advanced	☐	Treatment	14	1.00	1008.58	14120.12	
Specialized Medical Equipment and Supplies Total:							250545.15
Hand Held Shower	☐	Unit	22	1.00	48.93	1076.46	
Nutritional Supplements	☐	Unit	403	18.18	34.05	249468.69	

GRAND TOTAL:	**5233824.29**
Total: Services included in capitation:	
Total: Services not included in capitation:	5233824.29
Total Estimated Unduplicated Participants:	**889**
Factor D (Divide total by number of participants):	**5887.32**
Services included in capitation:	
Services not included in capitation:	5887.32
Average Length of Stay on the Waiver:	340

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 concurrent managed care authorities utilizing capitated payment arrangements. *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
Case Management Total:							750315.11
Case Management	☐	Month	889	11.05	76.38	750315.11	
Personal Care I Total:							993265.48
Personal Care I	☐					993265.48	

GRAND TOTAL:	**5390120.26**
Total: Services included in capitation:	
Total: Services not included in capitation:	5390120.26
Total Estimated Unduplicated Participants:	**889**
Factor D (Divide total by number of participants):	**6063.13**
Services included in capitation:	
Services not included in capitation:	6063.13
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Hour	283	230.30	15.24		
Personal Care II Total:							**1504248.65**
Personal Care II	☐	Hour	269	279.88	19.98	**1504248.65**	
Attendant Care Services Total:							**375030.98**
Attendant Care Services	☐	Hour	40	561.76	16.69	**375030.98**	
Companion Care - Agency Total:							**122081.46**
Companion Care - Agency	☐	Hour	37	220.85	14.94	**122081.46**	
Companion Care - Individual Total:							**73188.54**
Companion Care - Individual	☐	Hour	18	308.50	13.18	**73188.54**	
Home Accessibility Adaptations - Environmental Modifications Total:							**36096.98**
Environmental Modification-Home Repair	☐	Event	85	1.12	379.17	**36096.98**	
Home Delivered Meals Total:							**1170771.49**
Home Delivered Meals	☐	Event	516	344.30	6.59	**1170771.49**	
Medicaid Nursing - LPN Total:							**7012.66**
Medicaid Nursing - LPN	☐	Hour	1	228.50	30.69	**7012.66**	
Medicaid Nursing - RN Total:							**9272.53**
RN nursing	☐	Hour	1	228.50	40.58	**9272.53**	
Pest Control Total:							**90786.04**
Pest Control	☐	Treatment	360	4.67	45.35	**76242.42**	
Pest Control - Advanced	☐	Treatment	14	1.00	1038.83	**14543.62**	
Specialized							**258050.34**

	GRAND TOTAL:	**5390120.26**
	Total: Services included in capitation:	
	Total: Services not included in capitation:	5390120.26
	Total Estimated Unduplicated Participants:	**889**
	Factor D (Divide total by number of participants):	**6063.13**
	Services included in capitation:	
	Services not included in capitation:	6063.13
	Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment and Supplies Total:							
Hand Held Shower	☐	Unit	22	1.00	50.39	**1108.58**	
Nutritional Supplements	☐	Unit	403	18.18	35.07	**256941.76**	
					GRAND TOTAL:		**5390120.26**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		5390120.26
					Total Estimated Unduplicated Participants:		**889**
					Factor D (Divide total by number of participants):		**6063.13**
					Services included in capitation:		
					Services not included in capitation:		6063.13
					Average Length of Stay on the Waiver:		340

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 concurrent managed care authorities utilizing capitated payment arrangements. *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
Case Management Total:							**772909.05**
Case Management	☐	Month	889	11.05	78.68	**772909.05**	
Personal Care I Total:							**1023245.93**
Personal Care I	☐	Hour	283	230.30	15.70	**1023245.93**	
Personal Care II Total:							**1549421.28**
Personal Care II	☐	Hour	269	279.88	20.58	**1549421.28**	
Attendant Care Services Total:							**386266.18**
Attendant Care Services	☐	Hour	40	561.76	17.19	**386266.18**	
					GRAND TOTAL:		**5552552.91**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		5552552.91
					Total Estimated Unduplicated Participants:		**889**
					Factor D (Divide total by number of participants):		**6245.84**
					Services included in capitation:		
					Services not included in capitation:		6245.84
					Average Length of Stay on the Waiver:		340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Companion Care - Agency Total:							**125758.62**
Companion Care - Agency	☐	Hour	37	220.85	15.39	**125758.62**	
Companion Care - Individual Total:							**75409.74**
Companion Care - Individual	☐	Hour	18	308.50	13.58	**75409.74**	
Home Accessibility Adaptations - Environmental Modifications Total:							**37179.41**
Environmental Modification-Home Repair	☐	Event	85	1.12	390.54	**37179.41**	
Home Delivered Meals Total:							**1206303.25**
Home Delivered Meals	☐	Unit	516	344.30	6.79	**1206303.25**	
Medicaid Nursing - LPN Total:							**7222.89**
Medicaid Nursing - LPN	☐	Hour	1	228.50	31.61	**7222.88**	
Medicaid Nursing - RN Total:							**9551.30**
RN nursing	☐	Hour	1	228.50	41.80	**9551.30**	
Pest Control Total:							**93508.85**
Pest Control	☐	Treatment	360	4.67	46.71	**78528.85**	
Pest Control - Advanced	☐	Treatment	14	1.00	1070.00	**14980.00**	
Specialized Medical Equipment and Supplies Total:							**265776.42**
Hand Held Shower	☐	Unit	22	1.00	51.90	**1141.80**	
Nutritional Supplements	☐	Unit	403	18.18	36.12	**264634.62**	

GRAND TOTAL:	**5552552.91**
Total: Services included in capitation:	
Total: Services not included in capitation:	5552552.91
Total Estimated Unduplicated Participants:	**889**
Factor D (Divide total by number of participants):	**6245.84**
Services included in capitation:	
Services not included in capitation:	6245.84
Average Length of Stay on the Waiver:	340

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 concurrent managed care authorities utilizing capitated payment arrangements. *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
Case Management Total:							**796092.39**
Case Management	☐	Month	889	11.05	81.04	**796092.39**	
Personal Care I Total:							**1053878.13**
Personal Care I	☐	Hour	283	230.30	16.17	**1053878.13**	
Personal Care II Total:							**1596099.66**
Personal Care II	☐	Hour	269	279.88	21.20	**1596099.66**	
Attendant Care Services Total:							**397950.78**
Attendant Care Services	☐	Hour	40	561.76	17.71	**397950.78**	
Companion Care - Agency Total:							**129517.48**
Companion Care - Agency	☐	Hour	37	220.85	15.85	**129517.48**	
Companion Care - Individual Total:							**77686.47**
Companion Care - Individual	☐	Hour	18	308.50	13.99	**77686.47**	
Home Accessibility Adaptations - Environmental Modifications Total:							**38295.15**
Environmental Modification-Home Repair	☐	event	85	1.12	402.26	**38295.15**	
Home Delivered Meals Total:							**1241835.01**

GRAND TOTAL:	**5718684.12**
Total: Services included in capitation:	
Total: Services not included in capitation:	5718684.12
Total Estimated Unduplicated Participants:	**889**
Factor D (Divide total by number of participants):	**6432.72**
Services included in capitation:	
Services not included in capitation:	6432.72
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals	☐	event	516	344.30	6.99	1241835.01	
Medicaid Nursing - LPN Total:							7439.96
Medicaid Nursing - LPN	☐	Hour	1	228.50	32.56	7439.96	
Medicaid Nursing - RN Total:							9836.92
RN nursing	☐	Hour	1	228.50	43.05	9836.92	
Pest Control Total:							96328.74
Pest Control	☐	Treatment	360	4.67	48.12	80899.34	
Pest Control - Advanced	☐	Treatment	14	1.00	1102.10	15429.40	
Specialized Medical Equipment and Supplies Total:							273723.41
Hand Held Shower	☐	Unit	22	1.00	53.46	1176.12	
Nutritional Supplements	☐	Unit	403	18.18	37.20	272547.29	

GRAND TOTAL:		**5718684.12**
Total: Services included in capitation:		
Total: Services not included in capitation:		5718684.12
Total Estimated Unduplicated Participants:		**889**
Factor D (Divide total by number of participants):		**6432.72**
Services included in capitation:		
Services not included in capitation:		6432.72
Average Length of Stay on the Waiver:	340	