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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Pervasive Developmental Disorder (PDD)

C. Waiver Number:SC.0456
Original Base Waiver Number: SC.0456.

D. Amendment Number:SC.0456.R01.03

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

03/01/14

Approved Effective Date: 03/01/14
Approved Effective Date of Waiver being Amended: 01/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The State is seeking to amend this waiver for the following reasons:
1) Add Waiver Case Management(WCM) as a service using a multi-year phase-in rate;
2) Revise references using "Mentally Retarded" or "MR" to "Intellectually Disability" and "ID".
3) Revise Quality Improvement sections as needed;
4) Update Appendices as needed; and
5) Enhance clarity of language as needed.

The requested effective date for this amendment is March 1, 2014 or the first day of the month after approval from CMS.

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	
☑ Appendix J – Cost-Neutrality Demonstration	

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:
  Quality Improvement updates.

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*):
Pervasive Developmental Disorder (PDD)

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.0456
Waiver Number:SC.0456.R01.03
Draft ID: SC.15.01.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/10
Approved Effective Date of Waiver being Amended: 01/01/10

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

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

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

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Not applicable (NA)

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 purpose of this waiver is to support Medicaid eligible children ages three through ten. The services in this waiver are Case Management and Early Intensive Behavioral Intervention (EIBI). The latter service is habilitative in nature and is not available to children through the Medicaid State Plan. Operations for this waiver will be conducted by SCDDSN.

•

EIBI providers of PDD Waiver services must not bill any entity (e.g. SCDDSN, SCDHHS or parents) for any EIBI services or EIBI related services that are provided in a public school, private school, home school or other setting where educational services are being simultaneously provided to the child during identified school hours.

•EIBI providers must not render PDD Waiver services in any educational setting (public school, private school, home school or other educational setting) where educational services are being provided.

3. Components of the Waiver Request

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

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

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

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

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

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

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
Notice to Tribal Governments was conducted by SCDHHS on August 21, 2013 and again on September 11, 2013. Public notice was conducted by SCDHHS at the SCDHHS Medical Care Advisory Committee Meetings (MCAC) on March 19, 2013 and September 17, 2013. Information was also submitted September 19, 2013, to the SCDHHS email

list-serve, and comments were solicited for two (2) weeks. The South Carolina Department of Disabilities and Special Needs (SCDDSN) announced the information about the waiver amendment as their September 19, 2013 Commission Meeting.

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

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

7. Contact Person(s)

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

Last Name:	Atwood
First Name:	Anita
Title:	Program Coordinator II
Agency:	South Carolina Department of Health and Human Services
Address:	P.O. Box 8206
Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29202
Phone:	(803) 898-4641 **Ext:** ☐ **TTY**
Fax:	(803) 255-8209
E-mail:	Atwood@scdhhs.gov

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

Last Name:	Davis
First Name:	Daniel
Title:	Director, Autism Division
Agency:	South Carolina Department of Disabilities and Special Needs
Address:	3440 Harden Street

Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29240
Phone:	(803) 898-9609 **Ext:** ☐ **TTY**
Fax:	(803) 898-9653
E-mail:	DDavis@ddsn.sc.gov

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:	Anthony Keck
	State Medicaid Director or Designee
Submission Date:	Jan 30, 2014

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

Last Name:	Keck
First Name:	Anthony
Title:	Director
Agency:	South Carolina Department of Health and Human Services
Address:	PO Box 8206
Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29202
Phone:	(803) 232-2504 **Ext:** ☐ **TTY**
Fax:	(803) 898-4515
E-mail:	keck@scdhhs.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

March 1, 2014 Amendment: The state expects that all current waiver participants receiving services coordination as a state plan service will continue to receive waiver case management (WCM) once it becomes a formal waiver service. The state does not anticipate any impact on access to care, but does expect to implement improved quality measures.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not Applicable

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

DHHS and DDSN have a Memorandum of Agreement (MOA) to ensure an understanding between agencies regarding the operation and administration of the waiver. The MOA delineates the waiver will be operated by DDSN under the oversight of DHHS. The MOA specifies the following waiver functions between both agencies:

- Agreement Period
- Purpose
- Scope of Service
- Fiscal Administration
- Terms and Conditions
- Appendices

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

DHHS and DDSN also have a service contract outlining the requirements and responsibilities for the provision of waiver services by the operating agency. This contract clarifies the following:

- Definition of Terms
- Scope of Services
- SCDDSN Responsibilities
- Conditions for reimbursement
- Audits and Records
- Termination of Contract
- Appeals Procedures
- Covenants and Conditions
- Appendices

The service contract is reviewed and updated every three to five years and amended as needed.

DHHS utilizes various quality assurance methods to evaluate the operating agency's compliance with the terms and conditions established in the MOA and service contract, with special focus on DDSN's performance of assigned waiver operational functions in accordance with waiver requirements. DHHS uses a Quality Improvement Organization (QIO), quality assurance staff, and other agency staff to continuously evaluate the operating agency's quality management processes to ensure compliance. The following describes the roles of each entity:

CMS Approved QIO: Conducts validation reviews of a representative sample of initial level of care determinations performed by DDSN. Reports are produced and shared with DDSN, who is responsible for remedial actions witin 30 days of the completion of reports in which concerns regarding the waiver are noted.

DHHS QA Staff: Conducts periodic quality assurance reviews. These reviews focus on the CMS quality assurance indicators and performance measures. A report of findings is provided to DDSN, who is required to develop and implement a remediation plan, if applicable witin 30 days of the completion of reports in which concerns regarding the waiver are noted.

DHHS QA staff utilizes other systems such as Medicaid Management Information Systems (MMIS) and

MedStat Advantage to monitor quality and compliance with waiver standards. The use and results of these discovery methods may require special focus reviews. In such instances, a report of findings is provided to DDSN for remediation purposes.
Other DHHS Staff: Conducts utilization reviews, investigate potential fraud, and other requested focused reviews of DDSN as warranted. The CMS approved QIO conducts monthly validation reviews and information is provided to DDSN on a quarterly basis.

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.:*
1. DHHS contracts with a CMS certified QIO to review a representative sample of ICF/IID level of care determinations determined by DDSN.

2. DHHS periodically contracts with Winthrop University to perform validation reviews, focus evaluations, and trend analysis.

3. DDSN contracts with a CMS certified QIO contractor for oversight and review of all waiver services and providers participating in the DDSN operated waivers.

4. DDSN contracts with the Jasper DSN Board to operate as the fiscal agent for self-directed line therapy program.

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

Appendix A: Waiver Administration and Operation

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

( ) **Not applicable**

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

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

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

DDSN contracts with local Disabilities and Special Needs (DSN) Board providers. Waiver Case Management and early intervention Staff at the local DSN Boards prepare the Plans of Service and complete reevaluation of ICF/IID levels of care (LOC).

DDSN contracts with the Jasper DSN Board to operate as the fiscal agent of the self-directed Adult Attendant Care Program.

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

Medicaid agency or the operating agency (if applicable).

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

DHHS and DDSN contracts with approved and qualified private providers for Waiver Case Management (WCM) and Early Intervention (EI) staff member's, who prepare the Plans of Service and complete Level of Care reevaluations.

DHHS contracts with approved and qualified Early Intensive Behavioral Intervention (EIBI) Providers for PDD waiver services to perform the following services: Annual EIBI Assessment, EIBI Training/Development, EIBI Plan Implementation, EIBI Lead Therapy, and EIBI Line Therapy.

Appendix A: Waiver Administration and Operation

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

-The Jasper DSN Board will operate as the fiscal agent for participant directed services.
-DDSN will contract with DSN Boards and other qualified/approved providers and assess these providers on a 12-18 month cycle.

-DHHS Quality Assurance (QA) staff will conduct reviews on an annual basis of the waiver operational functions performed by DDSN and/or any of its contracted local/regional non-state entities, in addition to assessing the performance of contracted entities in conducting administrative functions.

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

-DHHS Medicaid Program Integrity (MPI) conducts reviews upon requests.

Appendix A: Waiver Administration and Operation

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

DDSN will assess the performance of its contracted and local/regional non-state entities responsible for conducting waiver operational functions. DDSN will contract with a Quality Improvement Organization (QIO) to assess the local DSN boards and other qualified providers on a twelve to eighteen month cycle depending on the provider's past performance. The QIO will also conduct follow-up reviews as needed and will share the Report of Findings with DHHS within 45 days of completion of the report. DDSN will provide technical assistance to the local DSN Boards, and provide DHHS reports of such reviews upon completion.

Additionally, DDSN Internal Audit Division will conduct internal audit reviews of the local network of DSN Boards and other approved providers. The local DSN Boards are required to have a financial audit conducted annually by a CPA firm that is chosen by the Boards, and all results related to waiver participants will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will also conduct special request audits, investigate fraud cases, provide training and technical assistance, and review the audited financial statements of the local DSN Boards. All findings will be shared with DHHS.

DHHS will utilize:1) a Quality Improvement Organization (QIO) to conduct QA reviews of a representative sample of initial Level of Care Determinations performed by DDSN; 2) QA staff to conduct periodic quality assurance focus reviews on the CMS quality assurance indicators and performance measures. If applicable, DDSN is required to develop and implement a remediation plan within 45 days of completion of the report of findings provided by DHHS; 3) Other DHHS Staff to conduct utilization reviews of DDSN as warranted. DDSN is to take remedial actions within 45 days of the report of findings from DHHS.

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of desk/focus reviews, utilization reviews, and/or suspected fraud investigations whose results are specific to delegated operational waiver functions as outlined in the MOA. N=all reviews conducted/D=all reviews required by waiver policy.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Desk/Focus Review Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling is determined by evidence warranting a special review and/or investigation.
	☑ **Other** Specify: as warranted	

Data Aggregation and Analysis:

Responsible Party for data aggregation	**Frequency of data aggregation and**

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

Performance Measure:
Quarterly meetings between DHHS and DDSN waiver administrative staff are held to discuss significant waiver issues. N=number of meetings held/D=number of meetings required by MOA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS/DDSN Agendas/Meeting Summaries

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

Data Aggregation and Analysis:

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

Performance Measure:
All policy changes related to the PDD waiver are approved by DHHS prior to implementation by DDSN. N=number of policy changes approved by DHHS prior to implementation/D=all changes implemented.

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

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

	☑ **Other** Specify: As warranted	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHHS produces reports of findings based on reviews. For non-recoupable findings, the State advises that DDSN include the findings in district staff trainings. For recoupable issues, the State refers the report of findings to DHHS-Program Integrity, who conducts an independent audit of program records and submits a separate report of findings to DDSN. DDSN must make the necessary financial adjustments to recover Federal Financial Participaton (FFP). The State requires DDSN to include training on the recoupable issues in district staff trainings. DDSN must develop and implement remedial actions to prevent future occurrences of the issues.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
◉ **Intellectual Disability or Developmental Disability, or Both**					
	☑	**Autism**	3	10	☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			

	☐	**Serious Emotional Disturbance**			

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

1.Waiver participants will be terminated from the waiver after receiving either a total of three years of enrollment in the waiver program or upon reaching the eleventh birthday.
For individuals who have received a total of three years of enrollment in the waiver, whose enrollment will be terminated, will have a period of three months prior to termination to work with their case manager for transition planning. The case manager will review the individual's assessment, and provide the parents/legal guardians information about other available services and supports to meet the individual's needs. The case manager will coordinate the transition to other available services and resources (i.e. make contacts and referrals to other providers and agencies and forward any records and/or information when approved by the parents/legal guardians).

2.Children who have been diagnosed by age 8 with a Pervasive Developmental Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and who meet the ICF-IID level of care criteria.

3.Participants cannot receive EIBI services in any educational setting (public school, private school, home school or other educational setting) where educational services are being simultaneously provided to the child during identified school hours.

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:

The State's transition planning procedures will begin three months prior to the participant's eleventh birthday or 36 months in the waiver program whose enrollment will be terminated. Parents/legal guardians will be provided information about other services, supports, and appropriate referrals available (i.e., state plan services and other waiver alternatives). The case manager is responsible for coordinating the transition to other services.

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.

Although the cost limit of $50,000 per child per year was established by the South Carolina General Assembly, it is more than sufficient to assure the health and welfare of waiver participants. Numerous fact based, peer reviewed studies have been conducted that demonstrate the significant advancements of children participating in intensive ABA programs of at least 25-30 hours per week. The PDD waiver allows up to 40 hours per week and does not exceed the established cost limit.

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

◉ **The following dollar amount:**

Specify dollar amount: 50000

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:

Prior to a waiver slot being allocated, the case manager completes an assessment in an effort to identify individual needs and supports. A centralized approval process will ensure that entrance will be granted only when anticipated costs do not exceed the specified cost limit, and health and welfare can be reasonably assured. EIBI services can be provided up to 40 hours per week. If an individual requires the maximum amount of support, along with case management, the cost of waiver services will remain below the State cap of $50,000/per year.

If denied entry into the waiver, the applicant's parent/legal guardian will be notified in writing of the opportunity to request a fair hearing. The Appeals process is located in Appendix F-1 of the waiver document.

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:

If the participant’s condition changes the individual needs will be assessed and the participant’s parent/legal guardian will be informed about other available options. The waiver case manager (WCM) will coordinate this effort with the participant’s parent/legal guardian.

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	700
Year 2	770
Year 3	847
Year 4	932
Year 5	1025

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	600
Year 2	670
Year 3	747
Year 4	832
Year 5	925

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes	
Reserve Capacity of children who are receiving ABA therapy through BabyNet services	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Reserve Capacity of children who are receiving ABA therapy through BabyNet services

Purpose *(describe):*

Children who are receiving ABA therapy and aging out of BabyNet Program will be prioritized and awarded PDD waiver slots to continue receiving therapy services.

Describe how the amount of reserved capacity was determined:

In the initial General Appropriations Act pertaining to the PDD Waiver Program, the South Carolina General Assembly stated, "The project must target the youngest ages feasible for treatment effectiveness." In an effort to comply with this mandate, the State is requesting that we are allowed to award 150 PDD slots specifically for the children who are completing their ABA related service period through BabyNet.

Once these children have aged out of BabyNet, they will be immediately enrolled into the PDD Waiver Program to continue to receive therapy services from the same EIBI Provider without disruption, and to further create a seamless transition of stability and consistency for individuals with Autism Spectrum Disorder.

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

Waiver Year	Capacity Reserved
Year 1	
Year 2	
Year 3	150
Year 4 (renewal only)	150
Year 5 (renewal only)	150

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:

Waiver applicants will be admitted to the waiver after they meet all criteria for enrollment. If there are not sufficient slots for all applicants, applicants will be admitted based upon date of application.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

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

  Select one:

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

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **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:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and*

community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage: [ ]

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

Specify dollar amount: [ ]

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

Select one:

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

Specify percentage amount: [ ]

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

Specify:

[ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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

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

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

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

  - ○ **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete 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 4)

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller Trust.

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

Not Applicable (see instructions)
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:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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 4)

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).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

1. The Director of Consumer Assessments: Minimum qualifications are a Doctorate in Applied Psychology from a designated program in Psychology; or 60 semester hours post-graduate credit towards a Doctorate in Applied Psych and 3 years experience in the practice of Applied Psych subsequent to 1 year graduate work (30) hours in Psych; or Master's degree in Applied Psych and 5 years experience in practice subsequent to Master's degree, or possession of current license to practice Psychology in South Carolina.
2. Psychologist: Minimum qualifications are a Master's degree in psychology and 4 years of clinical experience subsequent to Master's degree or possession of a license to practice psychology in the State of South Carolina. If the years of experience are not met, the psychologist will receive direct supervision and all work is reviewed by a psychologist.

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

The South Carolina Level of Care criteria for Intermediate Care Facility for Persons with Intellectual Disability (ICF/ID) issued by SCDHHS states: Eligibility for Medicaid sponsored Intellectual Disability or a Related Disability (ID/RD) in South Carolina consists of meeting the following criteria:

A. The person has a confirmed diagnosis of intellectual disability, OR a related disability as defined by 42 CFR 435.1009 (as amended by 435.1010), and South Carolina Code Section 44-20-30. "Intellectual Disability" means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

B. "Related disability" is a severe, chronic condition found to be closely related to intellectual disability and must meet the four following conditions:
(1.) It is attributable to cerebral palsy, epilepsy, autism or any other condition other than mental illness found to be closely related to mental retardation because this condition results in impairment similar to that of persons with intellectual disability and requires treatment or services similar to those required for these persons.
(2.) It is manifested before 22 years of age.
(3.) It is likely to continue indefinitely.
(4.) It results in substantial functional limitations in 3 or more of the following areas of major life activities: self-care, understanding and use of language,learning, mobility, self-direction and capacity for independent living.

C. The person's needs are such that supervision is necessary due to impaired judgment, limited capabilities, behavior problems, abusiveness, assaultiveness or because of drug effects and medical monitoring.

D. The person is in need of services directed toward a) the acquisition of the behaviors necessary to function with as much self-determination and independence as possible; or b) the prevention or deceleration of regression or loss of current optimal functional status.

The above criteria are applied as a part of a comprehensive review conducted by an interdisciplinary team. The criteria describe the minimum services and functional deficits necessary to qualify for Medicaid sponsored ICF/ID.

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

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

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

Evaluation: a waiver case manager (WCM) collects documents and information regarding the applicant's condition, need for supervision, and need for services. The gathered information is reviewed by operating agency's Consumer Assessment Team (CAT) who determines if Level of Care (LOC)criteria is met.

Reevaluation: The reevaluation process is the same as the initial evaluation process. Once enrolled in the PDD waiver the LOC evaluations are valid for up to 365 calendar days. Each individual must be reevaluated at least 365 calendar days from current LOC effective date and certified to meet LOC in order to continue to receive services funded through the PDD waiver. CAT will be responsible for the reevaluations and certifications. The child's case manager must send CAT a request for annual LOC determination at least two months prior to expiration of the current certification.

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

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

Conducted at least annually (within every 365 days from the date of the previous LOC determination).

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

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

Specify the qualifications:

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

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

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

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

An automated system produced by DDSN tracks due dates and timing of reevaluations and alerts the WCM/EI and/or his/her supervisor to its impending due date. Additionally, if any level of care is found out of date, FFP is recouped from DDSN for any services that were billed when the level of care was not timely.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3

years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written and electronically retrievable documents are housed with the contracted providers of DDSN.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of new enrollees whose Level of Care completion date is not 30 days prior to waiver enrollment. N= new enrollees whose Level of Care was completed within 30 days prior to waiver/D=the total number of LoC determinations for the waiver.

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

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of participants whose Level of Care reevaluation does not occur prior to the 365th day of the previous Level of Care evaluation. N=participants whose LOC reevaluation that occur prior to 365 days of the previous LOC evaluation /D=the total number of LOC reevaluations completed.

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN CAT Log

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post review.	

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of Level of Care (LOC) determinations that were conducted using the appropriate criteria and instrument. N=LOC determinations that were conducted using inappropriate criteria and instrument/D=the total number of LOC determinations.

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DDSN's QIO identifies problems, the provider aency being reviewed is required to submit a plan of correction to address the issues discovered. The QIO conducts a follow-up review to determine if corrections have been made. Additionally, QIO reports are reviewed by DDSN Operations staff. As needed, technical assistance is provided to providers by the Operations staff. Documentation of all technical assistance is available. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are available to DHHS.

ii. Remediation Data Aggregation

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

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

☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

DDSN is the entity responsible for providing information about feasible alternatives and informing the individual's parent/legal guardian, about freedom of choice. Prior to enrollment, the waiver case manager (WCM) explains to the individual's parent/legal guardian what options are available (i.e. community based services or institutional care) and the services available through each option.

A written Freedom of Choice Form (FOC) is secured, signed/dated from each waiver participant's parent/legal guardian to ensure that the individual's parent/legal guardian is involved in the planning of their child's care. This choice will remain in effect until such time as the individual's parent/legal guardian changes their mind on options and services and a new FOC form will need to be secured. This form, which documents the preferred choice of location for service delivery, is provided by the WCM/EI and is maintained in the waiver record.

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

The Freedom of Choice Form is maintained in the participant's record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
DDSN's policy entitled "Compliance with Title VI of the Civil Rights Act of 1964, American Disabilities Act of 1990, Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 and Establishment of the Complaint Process" (700-02-DD) describes the methods DDSN utilizes. As specified in DDSN policy, when required, service coordination providers can access funds to pay for an interpreter to provide meaningful access to the waiver.

Additionally, the State contracts with the University of South Carolina (USC) for a telephone interpreter service line called the "Language Line", and for written materials translation services.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Waiver Case Management (WCM)**		
Other Service	**EIBI Assessment**		
Other Service	**EIBI Plan Implementation**		
Other Service	**EIBI Program Development and Training**		
Other Service	**Lead Therapy**		
Other Service	**Line Therapy**		
Other Service	**Self Directed Line Therapy**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):
Waiver Case Management (WCM)

Service Definition *(Scope):*
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, education and other services, regardless of the funding sources for the services to which access is gained. Waiver case managers are responsible for initiating and/or conducting the process to evaluate and/or re-evaluate the individual's level of care as specified in waiver policy. Waiver case managers are responsible for conducting assessments and service plans as specified in waiver policy. This includes the ongoing monitoring for the provision of services included in the participant's service plan. Waiver case managers are responsible for the ongoing monitoring of the participant's health and welfare, as specified in waiver policy.

For waiver participants utilizing participant/representative directed-care waiver services, waiver case managers must provide supports to participants/representatives about any options and/or obligations. Waiver case managers are responsible for documenting the choice between institutional care or home and community-based services using the approved Freedom of Choice document.

Pre-enrollment activities that directly facilitate waiver enrollment for individuals leaving the facility can be conducted for 120 days prior to enrollment as part of waiver case management. Billing for these activities may not occur until after the participant is enrolled.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Case Management Provider (WCM)

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Waiver Case Management Provider (WCM)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All waiver case managers must have the following education and/or experience:
-Bachelor's degree or higher in a Health or Human Services field plus one year of experience with services to people with disabilities and special needs and/or with case management services;

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Qualified waiver case managers must meet these standards prior to employment. The provider agency that employs the case manager is responsible for ensuring case manager qualifications. The waiver case management agency enrolls/contracts with SCDHHS.

Frequency of Verification:
Upon employment and annually per standards.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:
EIBI Assessment

Service Definition *(Scope):*
This service is to be provided only by the EIBI Consultant. The assessment is a completion of the adaptive assessments by the Consultant. EIBI providers utilize the adaptive assessment tools such as but not limited to the following: Assessment of Basic Language and Learning Skills Revised, Peabody Picture Vocabulary Test IV, Expressive Vocabulary Test II, and Vineland Adaptive Behavioral Skills II.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is only authorized annually.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid contracted EIBI providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: EIBI Assessment

Provider Category:
Agency
Provider Type:
Medicaid contracted EIBI providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Applied Behavior Analysis Consultant must be Board Certified Behavior Analyst (BCBA); or Board Certified Assistant Behavior Analyst (BCABA)
Other Standard *(specify):*
-ABA Consultant must have a master's degree in behavior analysis, education, psychology, special education, or related field; and current certification by the Behavior Analyst Certification Board (BACB) as a BCBA; and at least one year of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the Autism Division PDD interview team or;

-BCABA must have a Bachelor's degree in behavior analysis, education, psychology, special education, or related field; and current certification by the Behavior Analyst Certification Board (BACB) as a BCABA; and at least two years of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the Autism Division PDD interview team.

-Non-Board Certified (Tier 3) must have a Bachelor's degree in behavior analysis, education, psychology, special education, or related field; and at least five years of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a work sample that is reviewed and critiqued for competency by the DDSN Autism Division PDD interview team.

-General requirements for all employees of an EIBI Provider must have Background checks conducted by Federal Criminal Record Check, SC Department of Social Services Child Abuse and Neglect Central Registry, Sexual Offenders Registry, Search on CMS website for List of Excluded Individuals/entities; and written reference checks from previous employers. All employees must provide a copy of current and valid SC driver's license; and a PPD TB Test that the result is negative.

Verification of Provider Qualifications
Entity Responsible for Verification:
Contracted EIBI Provider; DHHS; DDSN
Frequency of Verification:
Upon enrollment, annual renewal and recertification every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

EIBI Plan Implementation

Service Definition *(Scope):*

This service is provided by the Consultant who provides implementation of the treatment plan; educates family members and caregivers to use evidenced based interventions as a means to enhance skill development and reduce interfering behaviors; analyzes data to monitor the effectivenss of the EIBI treatment plan; supervises the Lead and Line Therapists via monthly visits; modifies the EIBI treatment plan based on analysis of data; trains Lead and Line therapists, and family members regarding goals/objectives added to the plan; and completes the EIBI Program Exit Summary.

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	Medicaid contracted EIBI providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: EIBI Plan Implementation

Provider Category:

Agency

Provider Type:

Medicaid contracted EIBI providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Applied Behavior Analysis Consultant must be Board Certified Behavior Analyst (BCBA); or Board Certified Assistant Behavior Analyst (BCABA)

Other Standard *(specify):*

-ABA Consultant must have a master's degree in behavior analysis, education, psychology, special education, or related field; and current certification by the Behavior Analyst Certification Board

(BACB) as a BCBA; and at least one year of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the Autism Division PDD interview team or;

-BCABA must have a Bachelor's degree in behavior analysis, education, psychology, special education, or related field; and current certification by the Behavior Analyst Certification Board (BACB) as a BCABA; and at least two years of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the Autism Division PDD interview team.

-Non-Board Certified (Tier 3) must have a Bachelor's degree in behavior analysis, education, psychology, special education, or related field; and at least five years of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a work sample that is reviewed and critiqued for competency by the DDSN Autism Division PDD interview team.

-General requirements for all employees of an EIBI Provider must have Background checks conducted by Federal Criminal Record Check, SC Department of Social Services Child Abuse and Neglect Central Registry, Sexual Offenders Registry, Search on CMS website for List of Excluded Individuals/entities; and written reference checks from previous employers. All employees must provide a copy of current and valid SC driver's license; and a PPD TB Test that the result is negative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted EIBI Provider; DHHS; DDSN

Frequency of Verification:

Upon enrollment, annual renewal and recertification every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

EIBI Program Development and Training

Service Definition *(Scope):*

This service is provided by the EIBI Consultant who develops an EIBI Treatment Plan based on the assessment results; completes the Functional Behavior Assessment, completes a Behavioral Support Plan if challenging behaviors exist; trains family members, Lead Therapists, Line Therapists, and Family Members; and updates the initial assessment according to schedule.

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

This service may be conducted up to two times a year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid contracted EIBI providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: EIBI Program Development and Training

Provider Category:
Agency

Provider Type:
Medicaid contracted EIBI providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Applied Behavior Analysis Consultant must be Board Certified Behavior Analyst (BCBA); or Board Certified Assistant Behavior Analyst (BCABA)

Other Standard *(specify):*
-ABA Consultant must have a master's degree in behavior analysis, education, psychology, special education, or related field; and current certification by the Behavior Analyst Certification Board (BACB) as a BCBA; and at least one year of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the Autism Division PDD interview team or;

-BCABA must have a Bachelor's degree in behavior analysis, education, psychology, special education, or related field; and current certification by the Behavior Analyst Certification Board (BACB) as a BCABA; and at least two years of experience as an independent practitioner; successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the Autism Division PDD interview team or;

-Non Board Certified (Tier 3) must have a Bachelor's degree in behavior analysis, education, psychology, special education, or related field; and at least five years of experience as an independent practitioner;successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the Autism Division PDD interview team.

General requirements for all employees of an EIBI Provider must have Background checks conducted by Federal Criminal Record Check, SC Department of Social Services Child Abuse and Neglect Central Registry, Sexual Offenders Registry, Search on CMS website for List of Excluded Individuals/entities; and written reference checks from previous employers. All employees must provide a copy of current and valid SC driver's license; and a PPD TB Test that the result is negative.

Verification of Provider Qualifications

Entity Responsible for Verification:
Contracted EIBI Provider; DHHS; DDSN

Frequency of Verification:
Upon enrollment, annual renewal and recertification every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Lead Therapy

Service Definition *(Scope):*

The EIBI Lead Therapist provides the Lead Therapy who implements the EIBI treatment plan and behavior support plan as written; reviews all data to monitor the effectiveness of the EIBI treatment plan and Behavior Support Plan during scheduled weekly visits; reviewing all recorded data; provides guidance, support and supervision to the Line Therapists; receives family/caregiver feedback; and coordinates and faciltate communication and cooperation between all team members. This excludes educational settings (e.g. public school, home school and private school).

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid contracted EIBI providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Lead Therapy

Provider Category:

Agency

Provider Type:

Medicaid contracted EIBI providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Lead Therapist must have a Bachelor's degree in behavior analysis, education, psychology, or special education or related field; and at least 500 documented hours of supervised line therapy or supervised experience in implementing behaviorally based therapy programs consistent with best practices and research on effectiveness, for children with PDD to include Autism and Asperger's Disorder; current first aid certification; current CPR certification.

General requirements for all employees of an EIBI Provider must have Background checks conducted by Federal Criminal Record Check, SC Department of Social Services Child Abuse and Neglect Central Registry, Sexual Offenders Registry, Search on CMS website for List of Excluded Individuals/entities; and written reference checks from previous employers. All employees must provide a copy of current and valid SC driver's license; and a PPD TB Test that the result is negative.

Verification of Provider Qualifications

Entity Responsible for Verification:
Contracted EIBI Provider; DHHS; DDSN

Frequency of Verification:
Upon enrollment and yearly contract renewal.

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:
Line Therapy

Service Definition *(Scope):*
Line Therapy is provided by the EIBI Line Therapist who implements interventions designed in the EIBI Treatment Plan and the Behavior Support Plan, records data and therapy notes during shift and reports concerns and progress or lack thereof to the Lead Therapist and/or Program Consultant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
8 hours of service per day, the average amount will be below the maximum based upon the identified needs and other services of the participant.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title

Agency	Medicaid contracted EIBI providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Line Therapy

Provider Category:

Agency

Provider Type:

Medicaid contracted EIBI providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

There are two levels of Line Therapy. Line Therapist I is the existing and Line Therapist II is the new level created for this amendment.

-Line Therapist I must be age 18 years old and a high school graduate,be able to speak, read and write English, and complete designated requirements prior to providing EIBI services. The provider must document the following requirements to be completed prior to a person providing line therapy: current first aid certification; current CPR certification; twelve hours of training on confidentiality, accountability, prevention of abuse/neglect, SCDDSN PDD Waiver Policy and Procedures; Autism Spectrum Disorder, and ABA principles. Trainings must include a face- to- face component with validation of skills through demonstration and a post test.

-Line Therapy II must be age 18 years old and have at least an Associate Degree, two years post-secondary education, or two years of EIBI line therapy work experience, be able to speak, read and write English, and complete designated requirements prior to providing EIBI services. The provider must document the following requirements to be completed prior to a person providing line therapy: current first aid certification; current CPR certification; twelve hours of training on confidentiality, accountability, prevention of abuse/neglect, SCDDSN PDD Waiver Policy and Procedures; Autism Spectrum Disorder, and ABA principles. Trainings must include a face- to- face component with validation of skills through demonstration and a post test.

General requirements for all employees of EIBI Provider must have Background checks conducted by Federal Criminal Record Check, SC Department of Social Services Child Abuse and Neglect Central Registry, Sexual Offenders Registry, Search on CMS website for List of Excluded Individuals/entities; and written reference checks from previous employers. All employees must provide a copy of current and valid SC driver's license; and a PPD TB Test that the result is negative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted EIBI Provider; DHHS; DDSN

Frequency of Verification:

Upon enrollment and yearly contract renewal.

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:

Self Directed Line Therapy

Service Definition *(Scope):*

Self Directed Line Therapy I is provided by the EIBI Line Therapist who implements interventions designed in the EIBI Treatment Plan and the Behavior Support Plan, records data and therapy notes during shift and reports concerns and progress or lack thereof to the Lead Therapist and/or Program Consultant.

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

The self directed line therapy is up to 40 units in 7 days which is equivalent to 40 hours in a week.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Enrolled Provider with DDSN

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self Directed Line Therapy

Provider Category:

Individual

Provider Type:

Enrolled Provider with DDSN

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

There are two levels of Self Directed Line Therapy. Self Directed Line Therapist I is the existing and Line Therapist II is the new level created for this amendment.

-Self Directed Line Therapist I must be age 18 years old and have a high school education; be able to speak, read and write English, and complete designated requirements prior to providing EIBI services. The provider must document the following requirements to be completed prior to a person

providing line therapy: current first aid certification; current CPR certification; twelve hours of training on confidentiality, accountability, prevention of abuse/neglect, SCDDSN PDD Waiver Policy and Procedures; Autism Spectrum Disorder, and ABA principles. Trainings must include a face- to- face component with validation of skills through demonstration and a post test.

-Self Directed Line Therapist II must be age 18 years old and required to have an Associate Degree, two years post-secondary education, or two years of EIBI line therapy work experiences; be able to speak, read and write English, and complete designated requirements prior to providing EIBI services. The provider must document the following requirements to be completed prior to a person providing line therapy: current first aid certification; current CPR certification; twelve hours of training on confidentiality, accountability, prevention of abuse/neglect, SCDDSN PDD Waiver Policy and Procedures; Autism Spectrum Disorder, and ABA principles. Trainings must include a face- to- face component with validation of skills through demonstration and a post test.

-General requirements for all employees of EIBI Provider must have Background checks conducted by Federal Criminal Record Check, SC Department of Social Services Child Abuse and Neglect Central Registry, Sexual Offenders Registry, Search on CMS website for List of Excluded Individuals/entities; and written reference checks from previous employers. All employees must provide a copy of current and valid SC driver's license; and a PPD TB Test that the result is negative.

Verification of Provider Qualifications

Entity Responsible for Verification:
Responsible Party/ DDSN

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.*

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

Waiver case management (WCM) functions are conducted by entities that are governmental or non-governmental. If the participant/family declines the waiver case management (WCM) service, required waiver functions will be performed by an entity chosen by DDSN/DHHS.

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

All service providers in this waiver are required to have background checks completed on direct care staff and waiver case managers in accordance with State Law. DDSN's QIO and DHHS Provider Compliance ensures mandatory investigations are conducted.

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

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

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

The South Carolina Department of Social Services (DSS) maintains a Central Registry of persons convicted of abusing a child under the age of 18. All provider agency personnel must have a Central Registry check completed upon employment. Additionally, abuse registry screenings must be completed for all direct care staff of SCDDSN and contracted service providers. DDSN's policy, as indicated in Department Directive 406-04-DD, outlines the specific timelines that must be met. DDSN uses its QIO to monitor provider compliance with this policy.

Appendix C: Participant Services

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

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

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

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

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

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

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

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

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

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

- (●) **Other policy.**

Specify:

Reimbursement for services may be made to certain family members who meet SC Medicaid provider qualifications. The following family members may not be reimbursed:
1. A parent of a minor Medicaid participant;
2. A step-parent of a minor Medicaid participant;
3. A foster parent of a minor Medicaid participant; and,
4. Any other legally responsible guardian of a minor Medicaid participant or court appointed guardian of a minor Medicaid participant.
5. The spouse of a Medicaid participant.
All other qualified family members may be reimbursed for their provision of the services listed above. Should there be any question as to whether a paid caregiver falls in any of the categories listed above, SCDHHS legal counsel will make a determination.

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 or contract with South Carolina Medicaid (SCDHHS) and/or sub-contract with SCDDSN. Potential providers are made aware of the requirements for enrollment through either SCDDSN or SCDHHS by contacting them directly. DDSN validates that all standards and qualifications are met by subcontractors. DDSN utilizes its QIO to review subcontractors to assure they continue to meet standards and qualifications, and will share these review findings with DHHS. All potential providers are given a packet of information that is used in the enrollment process. The procedures utilized to qualify and the timeframes established are for qualifying enrolled providers. Additionally, potential providers can find information regarding enrollment requirements and timeframes at the following two websites:
http://www.scdhhs.gov
http://www.ddsn.sc.gov

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of new providers that meet required licensing, certification, and other state standards prior to the provision of waiver services.

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 100% prior within 18 months	

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of waiver providers that continue to meet required licensing, certification, and other state standards.

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

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

☑ **Other** Specify: DDSN QIO CONTRACTOR	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of non-licensed/non-certified providers that continue to meet waiver requirements.

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

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

	Ongoing	Specify:
	☑ **Other** Specify: 100% within 18 months	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider. Reports are available 45 days post review.	

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted.	

Data Aggregation and Analysis:

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

Performance Measure:

Proportion of new non-licensed/non-certified providers that meet waiver requirements.

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

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

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

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

		Representative Sample Confidence Interval =
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: QIO reviews are conducted every 12-18 months depending on past provider performance. Reports are available within 45 days post review.	

Data Aggregation and Analysis:

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

Performance Measure:
Waiver Case Manager meets required education and experience for employment. N=# of waiver case managers who meet the required education and experience /D = the # of waiver case managers reviewed.

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

DDSN QIO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

Data Aggregation and Analysis:

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

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of providers that meet training requirements by provider type as specified in the State's scope of service or other operational directive.

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

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

☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past provider performance. Reports are available 45 days post review.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk Review Reports

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted.	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Information about agencies that were reviewed, compliance issues uncovered, and corrections made will be maintained along with timeframes of correction. DDSN will share this information with DHHS on an on-going basis as reports are received from the QIO and/or the contracting agency.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in

Appendix C-3.

Applicable - The State imposes additional limits on the amount of waiver services.

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

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

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Service Plan

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

- **Registered nurse, licensed to practice in the State**
- **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- **Licensed physician (M.D. or D.O)**
- **Case Manager** (qualifications specified in Appendix C-1/C-3)
- **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

☐ **Social Worker.**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

-Service Plan is developed by the waiver case manager (WCM) /Early Interventionist (EI) provider. Each participant is offered the choice of WCM/EI providers initially and annually thereafter, and may freely change providers upon request throughout the year.

-Once a waiver case manager/EI provider is chosen, he/she is required to utilize a standardized tool for assessing the needs of all waiver participants. These tools must be supported by current professional reports. Once needs are identified, waiver case managers/EIs explain the service options available to meet the assessed needs. Each need identified in the assessment is discussed with the participant, family, his/her legal guardian and/or representative, caregivers, professional service providers, and others of the participant's choosing to provide input. The information obtained is used by the WCM/ EI provider in order to develop the Service Plan. Upon completion, a copy of the Service Plan is provided to the participant, family, legal guardian and/or representative.

-At the time of waiver enrollment and annually, participants are given a copy of the "Acknowledgement of Rights and Responsibilities" form. This form outlines the participant's right to be told about services, participate in the completion of an assessment and plan, and choose services from all qualified providers, contact available providers, change providers, and request reconsideration of decisions.

-DDSN's Quality Improvement Organization (QIO)reviews each entity providing waiver case management to assure waiver participants are offered choice, have been given "Acknowledgment of Rights" annually and assure that the services in the plan correspond to a documented assessed need. QIO review results are made available to DHHS through a secure, Web-based reporting portal within 30 days of the review. The QIO measures compliance approves all required plan of corrections and conducts a follow-up review to ensure successful remediation.

-In addition to the QIO reviews, SCDDSN also ensures that the service plans and Annual Assessments are reviewed through an internal random selection review process. Random review samples are selected by SCDDSN and the names of waiver participants selected are tracked in a database. Using this sample, DDSN staff review plans of those participants selected. Once a plan is reviewed, feedback is provided to the provider. It is the responsibility of the Supervisors to ensure that waiver case managers/ EIs providers complete indicated

corrections. SCDDSN tracks this quality assurance activity in detail and uses findings to direct its training and technical assistance efforts.

SCDDSN maintains an automated Consumer Data Support System (CDSS) in which the Annual Assessments and Support Plans are completed by WCM/EI. The system will not allow the user to complete the assessment until a response has been given for each question/ item. Once complete, a decision is required whether or not to formally address each need identified by the assessment. To "formally address" means that the need is included in the Support Plan and services/interventions in response to the need are authorized. The decision is made by the participant and those chosen by the participant to assist with planning.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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

During the planning process the participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The waiver case manager (WCM)/EI uses the information obtained in order to develop the Service Plan. The participant/legal guardian will receive a copy of the service plan upon completion. Copies will also be provided to other service providers of the participant's/legal guardian's choosing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Service Plan is developed by the waiver case manager/Early Interventionist (WCM/EI) and is based on the comprehensive assessment of the waiver participant's strengths, needs, and personal priorities (goals) and preferences. The participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing may provide input. Service plans are developed prior to the waiver enrollment and at least within 365 days.

Parent/legal guardians are informed in writing at the time of enrollment of the names and definitions of waiver services that can be funded through the waiver when the waiver case manager/early interventionist (WCM/EI) has identified the need for the service.

Participation in the planning process (assessment, plan development, implementation) by the parent/legal guardian, knowledgeable professionals and others of the parent/legal guardian's choosing, helps to assure that the participant's personal priorities and preferences are recognized and addressed by the Plan. All needs identified during the assessment process must be addressed. As part of the support plan development process, it is determined if the participant has health care needs that require consistent, coordinated care by a physician, therapist, or other health care professionals. The Waiver Case Manager/Early Interventionist (WCM/EI) must utilize information about the participant's strengths, priorities and preferences to determine how those needs (to include health care needs)will be addressed. The Plan will include a statement of the participant's need, indication of whether or not the need relates to a personal goal, the specific service to meet the need, the amount, frequency, duration of the service, and the type of provider who will furnish the service.

The Plan will include the roles and responsibilities of the case manager and the parent/legal guardian for each service included in the plan. The waiver case manager (WCM)/EI will have primarily responsibility for coordinating services but must rely on the parent /legal guardian to choose a service provider from among those available, avail him/herself for, and honor appointments scheduled with providers when needed for initial service implementation, and cooperate with coordination efforts.

Waiver Case managers (WCM)/EI are responsible for locating and coordinating other community or State Plan and/or Federal services. The objectives of case managment is to counsel, support and assist participants/families with all activities related to the PDD waiver program. Waiver Case managers (WCM)/EI must provide ongoing problem solving to address participant/family needs. They must coordinate community-based support, provide referrals to other agencies and participate in interagency case staff meetings as needed. These activities must be fully documented in the participant's waiver record.

At least every 6 months the Waiver Case Manager (WCM)/EI will review the entire service plan to determine if updates are needed. This review is conducted by the case manager in consultation with the participant, family, legal guardian and/or representative during which the effectiveness, usefulness, and benefits of the plan will be discussed in addition to the overall satisfaction with the services/providers.

Changes to the Plan will be made as needed by the waiver case manager (WCM)/EI when the results of monitoring or when information obtained from the participant, parent/legal guardian, and/or service providers indicates the need for a change to the Plan.

-Every calendar month the waiver case manager/early interventionist will contact the participant/family to conduct non face to face monitoring of the plan or waiver services/other services. Non face-face contacts are required during months in which a face-to-face contact is not conducted. Based on the results of the monitoring amendments may be needed to update the plan.

-On at least a quarterly basis there will be a review of the entire plan to determine if updates are needed. This will be conducted during a face to face contact with the participant/family during which the effectiveness, usefulness, and benefits of the plan will be discussed along with the participant's/family's satisfaction with the services/providers. During two (2) of four quarterly visits each plan year the WCM/EI will visit the participant in the home/natural environment to monitor the health and welfare of the participant's living arrangements as well as any changes in the family dynamics which might impact the needs of the participant.

Amendments to the plan will be made as needed by the WCM/EI based on the results of plan monitoring or when information obtained from the participant, his/her legal guardian, and/or service providers indicates the need for a change to the plan.

Changes to the plan will be made as needed by the WCM/EI when the results of monitoring or when information obtained from the participant, his/her guardian, and/or service providers indicates the need for a change to the plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Participants' needs, including potential risks associated with their situations, are assessed and considered during the annual plan process. The Plan includes a section for a description of the plan to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver/supporter.

A standardized assessment tool is used for all waiver participants. This tool assesses the person's current situation, risks, and his/her personal preferences. The plan of service document includes sections that outline the responsibilities of the waiver participant, family, legal guardian and/or representative, and the responsibilities of the waiver case manager/service coordinator. The WCM/EI provider agency also conducts training with staff annually to

review proper reporting procedures for abuse/neglect.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

WCM/EI's share information about available providers of needed services to help participants make an informed choice. Annually, upon request or as service needs change, participants are given a list of providers of specified waiver services for which a change is requested or needed in order to select a provider. This list includes phone numbers. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider.

Additionally, participants are supported in choosing providers by being encouraged to contact support and advocacy groups such as but not limited to the Arc of South Carolina, and the Brain Injury Alliance of South Carolina. Participants are encouraged to ask friends and peers about provider websites, and other resources of information to assist them in choosing a provider. Participants, families, legal guardians and/or representatives may request a list of providers of specified waiver services when service needs change, or when a change is requested, or when selection of another provider is needed. Participants can contact their WCM/EI with questions about available providers and/or check the DDSN's website for the most current listing.

The service directory provider list is available on SCDDSN website @ http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx

Participants may also access the SCDHHS Medicaid Provider Directory @ http://www1.scdhhs.gov/search4provider/Default.aspx

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The format and content of the questions for the service plan document, as well as, the intended planning process must be reviewed and approved by DHHS prior to implementation. Participant plans are available upon request. A sample of participant plans is reviewed by DDSN and results shared with the WCM/EI and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS in an annual report.

-DHHS QA periodically reviews service plans on an annual basis. The information included in the person-center plan contains specific documentation such as: the participant's name and demographic information; the plan outlines the participant's individual strengths/interests, goals and objectives, amount, frequency, duration of services, type of providers performing the services, and includes an emergency plan. The plan documents the evaluation of actual results and satisfaction of the services and supports the individual waiver participant is receiving.

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:

Updated at least annually (within every 365 days from the date of the previous Service Plan).

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☐ **Operating agency**

☑ **Case manager**

☑ **Other**

Specify:

Early Interventionist (EI)

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

WCMs/EIs are required to monitor the service plan with the participant/family by making monthly contacts. This monitoring is completed for all waiver and non-waiver services or interventions included in the service plan. The form used for monitoring specifically requires the WCM/EI to indicate if the service/intervention was furnished, if the service was effective, and if the participant was satisfied with the service and/or provider. The form also requires the WCM/EI to document the actions taken to follow-up and remediate identified problems. WCMs/EIs routinely monitor the participant's' emergency plan and health/welfare status. This monitoring is documented in the participant's' waiver record. Monthly contacts to service providers, review of progress notes/records, or visits to school professionals is also acceptable as long as the required monthly contact to the participant/family has been conducted to monitor the service plan and health and welfare.

On a quarterly basis the WCM/EI monitors the service plan with a face-to-face contact with the participant/family. This may be conducted more frequently as needed. Two (2) of the four (4) face-to-face visits each calendar year must be conducted in the participant's home/natural environment in order to more carefully assess and obtain information about the participant's health, safety and welfare in that location. Additionally, changes to the family dynamic should be assessed to determine any impact they may have on the needs of the participant.
At least every 365 days from the date of the previous plan, or more often if the participant's needs change, a new Plan will be developed by the Waiver Case Manager in consultation with the participant, family legal guardian and/or representative.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

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

Policy dictates the minimum frequency with which monitoring must occur and the elements (service effectiveness/usefulness, service providers, service delivery and participant/family satisfaction with services) that must be included. Annually or more often as concerns are noted, information about available providers of needed services including Waiver Case Management/Early Intervention is shared with participants/families. Waiver service monitoring is reviewed by the QIO.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of participants whose plans includes services and supports that are consistent with needs identified in the assessment in accordance with waiver policy. N=participants whose plans include services and supports that are inconsistent with needs identified in the assessment/D=total number of PDD waiver files reviewed.

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

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider. Reports are available 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk Review Reports

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of participants whose plans that include services and supports to address personal goals in accordance with waiver policy.N=participants whose plans do not include services and supports to address personal goals/D=total number of PDD waiver files reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of newly enrolled participants whose plans were updated to include the need for waiver services prior to authorization in accordance with waiver policy.N=newly enrolled participants whose plans were not updated to include the need for waiver services prior to authorization/D=total number of PDD waiver files reviewed.

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

DDSN QIO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider. Reports are available 45 days post review.	

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

DHHS Focus/Desk Review Reports

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of participants whose new support plans were developed at least annually and when warranted by a change in participant's needs. N=participants whose new support plans were not developed at least annually and when warranted/D=total number of PDD waiver files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider. Reports are available 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk Review Reports

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted	

Data Aggregation and Analysis:

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of participants who are receiving services and supports in the type, amount, frequency, and duration as specified in their plans in accordance to waiver policy.N=participants who are not receiving services and supports in the type, amount, frequency and duration as specified in their plans/D=total number of PDD waiver files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider. Reports are available 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk Review Reports

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

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
Waiver Case Manager must complete the required non face to face contact each month with the waiver participant/family per policy. N=# of required non face to face contacted / D= # of all completed contacts.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post-review.	

Data Aggregation and Analysis:

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

that applies):	
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DDSN QIO CONTRACTOR	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Waiver Case Manager must complete (4) four quarterly face to face visits with the participant/family during each plan year. N = # of quarterly face to face visits / D = # of all face to face visits.

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

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

	DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post-review.	

Data Aggregation and Analysis:

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

Performance Measure:
Waiver Case Manager must complete (2) two quarterly face to face visits with the participant/family in the home/natural environment during each plan year per policy. N = # of completed quarterly face to face visits in the home/natural environment / D = # of completed quarterly face to face visits.

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

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

		+/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post-review.	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of newly enrolled waiver participant records containing completed/signed FOC Form specifying choice was offered between HCBS or institutional care in accordance with waiver policy. N=newly enrolled waiver participant records did not contain a completed and signed FOC form that specifies choice was offered between HCBS or institutional care/D=total number of PDD waiver files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider. Reports are available 45 days post review.	

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

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

Performance Measure:
Proportion of waiver participants who were offered choice of qualified providers in accordance with waiver policy. N=waiver participants who were not offered choice of qualified providers/D=total number of waiver files reviewed

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

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

	DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider. Reports are available 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk Review Reports

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DDSN's QIO identifies problems, than the provider agency being reviewed is required to submit a plan of correction to address the issues discovered. The QIO conducts a follow-up review to determine if corrections have been made. Additionally, QIO reports are reviewed by DDSN Operations Staff. As needed, technical assistance is provided to providers by the Operations Staff. Documentation of all technical assistance is available. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are available to DHHS.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

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

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

Indicate whether Independence Plus designation is requested *(select one):*

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

This waiver offers participants the opportunity to direct their waivers services with employer authority. Since all participants in this waiver are children ages 3 through age 10, their parent/legal guardian can choose to direct the participant's care or designate another adult to direct the participant's care. The adult directing the participant's care must go through the screening process ensuring the lack of a communication or cognitive deficit that would interfere with their representation of the participant. This information will be documented in the participant's record.

Waiver case managers (WCM) will provide information to the parent/legal guardian about Participant Direction Services (PDS) include the associated benefits and responsibilities of this option. Waiver case managers will inform interested parent/legal guardian of related liabilities, role of the FMS and the intricacies of staff development and management. Upon request the waiver case manager will supply the necessary documents to be completed and submitted by the parent/legal guardian and selected line therapists. Waiver case managers will continue to monitor service delivery and program progress.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

-The participant or RP must have no communication or cognitive deficits that would interfere with participant or RP direction. The waiver case manager (WCM) will assess and determine if these criteria are met. Participants interested in self-directed care are prescreened to assure capability utilizing a standardized pre-screen form. If he/she is not capable a responsible party may direct care if he/she passes the pre-screen. The prescreening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare of the participant.

-The three principal areas screened during the assessment are communication, cognitive patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/responsible party to make them understood and the ability of others to understand the participant/responsible party. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the participant/responsible party.

-Finally the assessment tool reviews the mood and behavior patterns of the participant/responsible party to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the

participant/responsible party. If the participant/responsible party disagrees with the results they may appeal the decision. The RN match visit is completed prior to service authorization.

-Waiver case managers assess the cognitive and communication abilities of participants/family members who wish to direct some of their waiver services. This process is consistent for all participants meeting the ICF/ID Level of Care in the Head and Spinal Cord Injury waiver (HASCI), the Pervasive Developmental Disorder (PDD), and the ID/RD waiver.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time of enrollment, the waiver case manager (WCM) will introduce Participant Direction of Services as an option to the participant's parent,legal guardian/or responsible party.

If the participant's parent,legal guardian/or responsible party pursue this option, participant direction,the waiver case manager (WCM) will provide a handout entitled, PDD Waiver Program Responsible Party Enrollment Information. This handout outlines the program's benefits, liabilities and responsibilities. The waiver case manager (WCM) is required to document this action in the child's record. Once the child is awarded a slot in the PDD waiver program, the waiver case manager (WCM) will provide additional information about the role of the financial manager and also the hiring, management, and firing of workers. Independent consultation and assistance is available at no cost to participant's parent,legal guardian/or responsible party who have a need for additional support.

Once the parent, legal guardian/or responsible party has chosen to direct the child's EIBI services, the waiver case manager (WCM) will continue to provide information annually or as requested by the parent,legal guardian/or responsible party. The waiver case manager (WCM) will monitor service delivery and the status of the participant's health and safety.

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:

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.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Self Directed Line Therapy	☑	☐

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 C1/C3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

SCDDSN currently uses an FMS to provide these services to participants. This sole source is procurement with a governmental entity.

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

Payment will occur to the FMS through an administrative grant from SCDDSN. The payment does not come from the participant's budget.

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

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

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Verify the representative's verification of the worker's minimum qualifications to include all required background checks.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintains a separate account for each participant's participant-directed budget**
- [ ] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [ ] **Processes and pays 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:

- [ ] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

An annual independent audit is required to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing

their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

☐ **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
EIBI Plan Implementation	☐
Lead Therapy	☐
Line Therapy	☐
Self Directed Line Therapy	☐
Waiver Case Management (WCM)	☐
EIBI Assessment	☐
EIBI Program Development and Training	☐

☑ **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:

A sole source contractor provides the FMS supports, which is one of the operation agency's disabilities and special needs boards. SCDDSN will have a contract with the FMS to provide these supports. The supports include providing each participant with a checklist of responsibilities they have in hiring their workers, and verification of qualifications and requirements. SCDDSN will assess the performance of the FMS on a quarterly basis. The FMS is also required to have an independent financial audit every year.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The waiver case manager (WCM) will accommodate the participant by providing a list of qualified providers they can select from to maintain service delivery. The WCM and the operating agency will work together to ensure the participant's health and safety in this transition and will work to avoid any break in service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

If the participant's parent/legal representative becomes unable to fulfill all the responsibilities required by the PDS option, the WCM will transition services from participant direction to agency directed services. The authorization of agency directed services will be coordinated by the WCM. DDSN will use written criteria in making this determination. The participant's parent/legal representative will be informed of the opportunity and means of requesting a fair hearing, choosing an alternate provider, and the service plan will be revised.

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	14	
Year 2	15	
Year 3	17	
Year 4	19	
Year 5	21	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated*

in Item E-1-b:

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

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

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

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

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

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The FMS will reimburse the participant’s representative for the cost of the background check when presented with appropriate payment vouchers. FMS will not reimburse the cost of any extraneous expenses (e.g. postage, mileage, etc…).

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

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

-The Waiver Case Manager (WCM) will provide written notification and verbal explanation to the individual applicant or the legal guardian during a meeting concerning the SCDDSN Reconsideration and SCDHHS Appeal (Fair Hearing) prior to enrollment and when the individual applicant signs the Freedom of Choice (FOC) form.

The Waiver participant or the parents/legal guardian of the Waiver participant is informed in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of the SC Code Ann. §1-23-310 thru 1-23-400, (Supp 2007) and 27 SC Code Ann. Regs. 126-150 thru 126-158 (1976).

Whenever there is an adverse decision or action related to enrollment in the PDD Waiver or subsequent receipt of services, the Service Coordinator must provide written notification to the applicant or participant or the legal guardian, including reason for the adverse decision or action. Written information concerning SCDDSN Reconsideration and SCDHHS Appeal (Fair Hearing) must also be provided by their WCM. The waiver case manager will assist in filing a written reconsideration if necessary.

Copies of all notices of adverse action and Fair Hearing information are maintained in the participant's Service Coordination file.

The notice used to offer individuals the opportunity to request a Fair Hearing is called "SCDDSN Reconsideration Process and SCDHHS Medicaid Appeals Process".

The WCM must offer a participant or legal guardian assistance to request DDSN Reconsideration and/or SCDHHS Appeal (Fair Hearing). The participant or legal guardian may also seek assistance from other persons.

The notice states the following:
A request for reconsideration of an adverse decision must be sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representatives' request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision.

The participant is informed by the WCM that services will continue during the period that the participant's appeal is under consideration by written notification (letter) concerning the SCDDSN Reconsideration and SCDHHS Appeal (Fair Hearing) that is provided to the participant or legal guardian includes the following statement:
"In order for affected Waiver services to continue during the SCDDSN Reconsideration process and the SCDHHS Medicaid Appeal process, the consumer, legal guardian, or representative's request for SCDDSN Reconsideration must be submitted within ten (10) calendar days of receipt of written notification of the adverse decision/action. Continuation of affected Waiver services must be specifically requested in the request for SCDDSN Reconsideration. If the adverse decision/action is upheld, the consumer or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes."

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the

original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

SCDDSN operates the Complaint/Grievance System.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the

mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

-DDSN responds to grievances/ complaints, when the participate who receives services or their representative indicates their concerns have not been satisfied through informal or routine contact with staff directly associated with the service, support or program. Contact with a DDSN Staff outside of the situation provides an opportunity for objective and impartial review of the concern.

DDSN has a Department Directive 535-08-DD that establishes the procedures to assure concerns are handled appropriately and in a timely manner. The types of concerns handled through this process may include but are not limited to concerns about service planning, restrictions of personal rights and freedoms, program, support and placement decisions, access to files/records or ability to give informed consent. People are encouraged to seek remediation through their service provider first. If not resolved, the matter is referred to DDSN. Appropriate DDSN staff will contact the person expressing the concern, review/research the concern and attempt to mediate a resolution. Concerns involving the health, safety, or welfare of the person will receive immediate review and, as needed, necessary actions will be taken.

Additionally, contacts typically are made when the participate who receives services or their representative feel their concerns have not been satisfied through informal or routine contact with staff directly associated with the service, support or program. Contact with someone outside of the situation provides an opportunity for objective and impartial review of the concern.

All waiver case manager (WCM) providers have a procedure for participants who receive services and supports or representatives acting in their behalf that assures their right to voice concerns without actions being taken against them for doing so. The procedure is reflective of the values and principles of DDSN and clearly delineates all steps in the process. Participants who receive services and their representatives are provided with information about the process in a manner that is understandable to the individual. Supports are provided, if needed, to participants who wish to express a concern but need assistance in understanding or following the process.

-All efforts are made to resolve concerns at the most immediate staff level that can properly address the concern. Efforts are made to promote trust and open communication at the local service level whenever possible. Concerns involving health and safety of participants receiving services receive immediate review and necessary action is taken if the individual’s health or safety is at risk.

-Participants who receive services and/or their representatives expressing concerns are encouraged to seek remediation through their direct service provider’s policy regarding concerns. If the concern is unable to be resolved at this level, then the matter may be referred to the DDSN Office of Consumer Affairs.

-Follow-up to a concern includes contact with the participant or representative expressing the concern, review and research of the concern, efforts to mediate resolution, and documentation of all actions taken. Executive Directors/CEOs will be notified whenever a participant’s concern involves their service area.

-The WCM is responsible for communicating to the participant that their decision to file a grievance or make a complaint is not a pre-requisite for a fair hearing. The State has indicated in the application (F-3 b) that filing a grievance or making a complaint is not a pre-requisite or a substitute for a Fair Hearing. These are two totally separate processes as aforementioned.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The South Carolina Child Protection Reform Act requires the reporting and investigating of suspected abuse, neglect and exploitation (ANE) of a vulnerable child (under the age of eighteen) to the Department of Social Services (DSS)/Child Protective Services (CPS) and local/state law enforcement. The South Carolina Omnibus Adult Protection Act requires the reporting and investigating of suspected ANE of a vulnerable adult (age 18 and above) to the DSS/Adult Protective Services (APS) and local/state law enforcement. The appropriate reporting agency is determined by the age of the victim, suspected perpetrator, and the location of the alleged incident. These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing. These incidents are defined as physical abuse, or psychological abuse, threatened or sexual abuse, neglect, and exploitation. Mandatory reporters have a duty to report if they have information, facts or evidence that would lead a reasonable person to believe that a child or vulnerable adult has been or is at risk for ANE. Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected ANE to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the ANE. All DDSN staff are required to have annual training on mandated reporting responsibilities and reporting channels. This is outlined in DDSN Directive 543-02-DD. It is part of the agency's preservice and annual training requirements and is monitored throught the QIO process.

The reporting of Critical Incidents as defined by DDSN Directive(100-09-DD) must be followed. A critical incident is an “unusual, unfavorable occurrence that is: a) not consistent with routine operations; b) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and c) occurs in a DDSN Regional Center, DSN Board facility, other service provider facility, or during the direct provision of waiver case management (WCM) (e.g., if a child receiving service coordination services sustains a serious injury while the service coordinator is in the child’s home, then it should be reported as a critical incident; however if the service coordinator is not in the home when the injury occurred then it would not be reported)”. An example of a critical incident includes but is not limited to possession of firearms, weapons or explosives or consumer accidents which result in serious injury requiring hospitalization or medical treatment from injuries received. Reports of critical incidents are required to be made to the operating agency within 24 hours or the next business day of the event.

In addition, DDSN Directive 534-02-DD specifically addresses the procedures for preventing and responding to ANE. This directive sets the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers.

-In order to coordinate the process of reviewing all reports, DDSN has implemented a secure, Web-based Incident Management System (IMS) which contains three different modules: ANE reporting, Critical Incident reporting, and Death reporting. The applicable DDSN Directives govern the reporting process, but the IMS provides a mechanism for processing the reports. In some cases, a provider may make a verbal notification to the District Director, but a report on the IMS is required within 24 hours, or the next business day.

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

Waiver participant''s parent/legal guardians are provided written information about what constitutes abuse, neglect and exploitation how to report, and to whom to report. They are informed of their rights annually; this information is explained by their waiver case managers (WCM).

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.

The reporting of critical incidents should follow the procedures outlined in DDSN Directive 100-09-DD. DDSN Directive 534-02-DD specifically addresses the procedures for preventing and responding to Abuse, Neglect, and Exploitaion (ANE). This Directive sets forth the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE.

The directive also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers.

-DDSN Directives 100-09-DD and 534-02-DD require the service provider to make an initial report of the incident within 24 hours or the next business day. The providers must then complete an internal review of the incident within 10 working days. The internal review is submitted to DDSN for acceptance by the Statewide Incident Management Coordinator. DDSN policies require the provider, upon completion of the internal review, to notify the participant and/or responsible party of the outcome of the review. The Case Management Provider is also informed in order to ensure that any health and safety concerns are addressed.

When there is reason to believe that a child has been abused, neglected, or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. DSS is the mandated agency to investigate suspected ANE in these settings. DDSN and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN to assist contract provider agencies in resolving issues with DSS regarding intake referrals and investigations. DSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification is sent to appropriate agencies for personnel and other required actions to be taken. If the alleged perpetrator is also employed by DDSN a contract provider agency, or the family, and ANE is substantiated, the employee will be terminated.

When there is reason to believe that an adult has been abused, neglected or exploited, mandated reporters have a duty to make a report to DSS or local law enforcement. All alleged abuse and other critical events are also reported to DDSN within 24 hours. DDSN works closely with DSS and local law enforcement regarding applicable critical incidents and/or ANE allegations.

Incidents that do not meet the threshold for reporting under Directives 100-09-DD or 534-02-DD are captured under DDSN Directive 535-08-DD, Concerns of People Who Receive Services: Reporting and Resolution. All providers have a procedure for people who receive services and supports or representatives acting in their behalf that assures their right to voice concerns without actions being taken against them for doing so. The procedure delineates all steps in the process. Support may be provided, if needed to people who wish to express a concern but need assistance in understanding or following the process. All efforts are made to resolve concerns at the most immediate staff level that can properly address the concern. Concerns involving health and safety of people receiving services receive immediate review and necessary action is taken if the person’s health or safety is at risk.

On a regular basis, DDSN quality management staff review critical incidents and ANE reports, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. Statewide trend data is provided to DSN Boards and contracted service providers to enhance awareness activities as a prevention strategy.

Each regional center, DSN Board or contracted service provider will also utilize their respective risk managers and committees to regularly review all critical incidents for trends and to determine if the recommendations made in the final written reports were actually implemented and are in effect. Statewide trend data will be provided to DHHS on an annual basis.

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

The DDSN Critical Incident and ANE directives set forth the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive, 100-09-DD, also

identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers.

DSS Child Protective Services and local and state law enforcement are responsible for overseeing the reporting of and response to allegations of ANE. In addition to investigations by the State Ombudsman, DSS, and law enforcement, other agencies have jurisdiction to make inquiry into incidents of ANE and may conduct their own investigation. These agencies include 1.)SLED/Child Fatalities Review Office; 2.)Protection and Advocacy for People with Disabilities (P&A); and 3.)the Vulnerable Adult Fatalities Review.

1.)SLED/Child Fatalities Review Office:
The Child Fatalities Review Office of the State Law Enforcement Division will investigate all deaths involving abuse, physical and sexual trauma as well as suspicious and questionable deaths of children. The State Child Fatalities Review Office will also review the involvement that various agencies may have had with the child prior to death.

2.)Protection and Advocacy for People with Disabilities,Inc.:
Protection and Advocacy for People with Disabilities (P&A) has statutory authority to investigate abuse and neglect of people with disabilities.

3.)Vulnerable Adult Fatalities Review:
The Vulnerable Adult Fatalities (VAF) Review Office of the State Law Enforcement Division (SLED) will investigate all deaths involving abuse, physical and sexual trauma, as well as, suspicious and questionable deaths of vulnerable adults. The State Vunerable Adult Investigations Unit (VAIU) will also review the involvement that various agencies may have had with the person prior to death.

In addition, the DDSN Division of Quality Management maintains information on the incidence of ANE, including trend analyses to identify and respond to patterns of abuse, neglect, or exploitation. All data collected is considered confidential and is used in developing abuse prevention programs. All reports of ANE are reviewed for consistency and completeness to assure the victim is safe, and to take immediate personnel action. DDSN requires that all identified alleged perpetrators be placed on administrative leave without pay until the investigation is completed. Periodic audits of the abuse reporting system are conducted to ensure compliance with state law. All findings from trending analysis will be shared with DHHS on an annual basis.

Appendix G: Participant Safeguards

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

a. Use of Restraints or Seclusion. *(Select one)*:

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

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

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

In accordance with DDSN policy, restraints may be employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the person's needs. The following types of restraints may be used:

(1.) Planned restraint (mechanical or manual) when approved by the person his/her legal guardian, the program director/supervisor, an approved provder of behavior support services, the Human Rights Committee (HRC) of the Executive Director.
(2.) Mechanical restraints to allow healing of injury produced by an inappropriate behavior when approved by the person or his/her legal guardian, the program director/supervisor, an approved provider of behavior support services, the HRC, and the Executive Director.
(3.) Psychotropic medication when approved by the person or legal guardian, the program director/supervisor, an approved provider of behavior support services, the HRC, and the Executive Director.
The uses of the following are prohibited by DDSN policy:
(1.) Procedures, devices, or medication used for disciplinary purposes, for the convenience of the staff or as a substitute for necessary supports for the person;
(2.) Seclusion (defined as the placement of an individual alone in a locked room);
(3.) Enclosed cribs;
(4.) Programs that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
(5.) Having a service recipient discipline other people with disabilities;
(6.) Prone (i.e., face down on the floor with arms folded under the chest) basket-hold restraint;
(7.) Timeout rooms; and,
(8.) Aversive consequence (defined as the application of startling, unpleasant, or painful consequences) unless specifically approved by the State Director of DDSN or his/her designee.

The unauthorized or inappropriate use of restraints would be considered abuse by the State; therefore, the same methods used to detect abuse (e.g., staff supervision, identification of situations that may increase risk, etc.) are employed to detect restraints/seclusion.

The State''s policy requires that only curricula or systems for teaching and certifying staff to prevent and respond to disruptive and crisis situations that are validated and competency-based be employed. Any system employed must emphasize prevention and de-escalation techniques and be designed to utilize physical confrontation only as a last resort. Each system dictates its own specific certification and re-certification procedures. Systems approved by the State are MANDT Crisis Prevention Institute (CPI), and Professional Crisis Management (PCM).

Any individual program that involves restrictive procedures may only be implemented when less restrictive procedures are proven ineffective. Restrictions may only be implemented with the informed consent of the individual/ representative and with the approval of the Human Rights Committee (HRC). Restrictions must be monitored by staff; and the behavior supports provider, and the HRC.

Additionally, when planned restraints are employed, State policy requires that restraints may not be applied for more than one continuous hour and release must occur when the person is calm. Mechanical restraints must be applied under continuous observations.

DDSN utilizes a QIO to conduct contract compliance reviews which include direct observation of service provision and record reviews. The QIO reviews include, but not limited to, determining if staff are appropriately trained, that risk management and quality assurance systems are implemented consistent with policy, and that abuse and critical incidents are reported and responded to in accordance with policy.

Additionally, the QIO determines if individuals are provided the degree and type of supervision needed but not inappropriately restricted. Information collected by the QIO is shared with DHHS.

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

DDSN is responsible for oversight of the use of restraints. DDSN policies dictate the responsibilities of service providers and the HRC regarding monitoring programs that include restraint. DDSN monitors compliance with policies through its contract compliance reviews conducted by the QIO and through its licensing reviews.

Contract compliance review and licensing review reports are provided to SCDHHS per the requirements

of the MOA. Traditional survey methods including record reviews, staff interviews, and observations are implemented to detect unauthorized use, overuse, or inappropriate/ ineffective use of restraint procedures. Deficiencies noted must be addressed in a written plan of correction that provides individual and systemic remediation. DDSN provides technical assistance as needed based on findings. Follow-up reviews are conducted, as needed.

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

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

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

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

DDSN policy allows the use of:

(1.) Restrictive procedures (procedures that limit freedom or cause loss of personal property or rights excluding restraint) when approved by the person, his/her legal guardian, the program director/supervision, an approved behavior support provider, and the Human Rights Committee (HRC).

(2.) Adverse consequences which are defined as startling, unpleasant or painful consequences, consequences that have a potentially noxious effect, when approved by the person or his/her legal guardian, the physician, an approved provider of behavior support services, HRC, the Executive Director, and the State Director of DDSN. Such procedures may only be employed to protect the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the needs of the person.

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

DDSN is responsible for oversight of the use of the restrictive procedures. DDSN policies dictate the responsibilities of service providers and the HRC regarding monitoring programs that include restrictive procedures. DDSN monitors compliance with policies through its contract compliance reviews conducted by the QIO and through its licensing reviews. When adverse consequences are approved, in addition to monitoring through contractual compliance and licensing reviews, the procedures are monitored by a DDSN state office staff person.

DDSN Standards and Directives referenced include the following:
Behavior Support Plans 600-05-DD
Human Rights Committee 535-02-DD

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

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

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

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

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Number of incidents of abuse, neglect , or exploitation that are reported within required time frame.N=incidents of ANE that are not reported within the required time/D= the total number of PDD Waiver ANE reports.

Data Source (Select one):

Other
If 'Other' is selected, specify:
DDSN Reports

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

Data Aggregation and Analysis:

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

Performance Measure:

Number of incidents of abuse, neglect, or exploitation in which the internal review was completed within required timeframe.N=incidents of ANE in which the internal review was not completed within required timeframe/D= the total number of incidents reported.

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

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

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
Number and proportion of substantiated incidents of abuse, neglect, and exploitation.N=unsubstantiated incidents of ANE/D=the total number of incidents of ANE reported.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and proportion of participants who receive information yearly about how to report abuse, neglect and exploitation.N=participants who do not receive information yearly/D=the total number of participants.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = -/+ 5%
☑ **Other** Specify: DDSN QIO CONTRACTOR	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: QIO reviews are conducted every 12-18 months depending on past performance of the provider organization.	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

As abuse, neglect, and exploitation are identified, DDSN is taking action to protect the health and welfare of the participant by following state regulations and requirements. DDSN collects data and analyzes for trends to implement system strategies to prevent future occurrences. DDSN will provide this information to DHHS on an ongoing basis as reports are received from the QIO and/or contracting agency.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

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

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The objective of the DDSN''s Quality Management Systems (QMS) is to identify, both positive and negative trends allowing for necessary adjustments to enhance the overall performance of the system. DDSN''s system improvement activities are designed to ensure that they address all six (6) CMS assurances based on performance measures.

Timely discovery and remediation of aggregated data allows the state to take the necessary action to improve the system's performance, thereby learning how to improve meaningful outcomes for waiver participants.

DDSN is able to stratify information related to each approved waiver program and provider type. DDSN's Quality Management System has formal processes and activities in place for trending, prioritizing, and implementing system improvements. DDSN is continuously reviewing and updating its QMS processes to ensure it is responsive to the quality assurances. DDSN provides DHHS with the results of all quality assurance review activities throughout the year. This includes, but is not limited too, critical incident data, results of all QIO provider reviews.

The State maintains a MOA and a waiver service contract to outline the responsibilities for the operating agency and the administrating agency as they participate in joint quality improvement and trend analysis efforts.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: DDSN QIO CONTRACTOR	☑ **Other** Specify: DDSN QIO reviews are conducted 12-18 months per past provider performance.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DHHS and DDSN meet periodically to monitor and analyze the effectiveness of system design changes. Any

changes recommended to the overall system's design or any sub-systems are brought to the DHHS/DDSN Policy Committee.

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

DHHS and DDSN meet periodically to discuss the effectiveness of Quality Improvement initiatives implemented by both state agencies. Changes recommended to the overall quality system are brought to the DHHS/DDSN Policy Committee for review.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

DHHS and DDSN both use CMS-approved Quality Improvement Organizations for different aspects of quality management reviews, all of which contribute to financial integrity and accountability. The DDSN QIO provider reviews consist of three components: staffing reviews, administrative reviews and participant reviews. The staffing reviews sample staff members at different levels of the organization to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and all other specified requirements. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of waiver services have been met.

DDSN's Internal Audit Division conducts periodic reviews of the billing systems and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS. DDSN Internal Audit Division will also conduct special request audits, investigate fraud cases, provide training and technical assistance, and review the audited financial statements of the local DSN Boards. All findings will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will conduct a review of the contracted fiscal agent, and likewise, all findings related to waiver participants will be shared with DHHS within 30 days of completion. DHHS will review DDSN Internal Audit Division annual reports, special request audits, and fraudulent case investigations and request remedial action(s) as determined necessary.

Each DSN Board is required to perform a yearly audit of their financial position. These yearly audits are performed by independent CPA firms to determine if provider agencies are upholding general accepted accounting practices and are maintaining a sound financial position.

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Proportion of paid claims for waiver participants that are coded and paid in accordance with policies in the approved waiver.N=Waiver claims that paid correctly as determined through record reviews.D= All paid waiver claims for wavier participant record reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN/QIO Adjustment Logs

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

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

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

(check each that applies):	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Paid Claims in Medicaid Management Information System (MMIS).

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of participants with paid claims for wavier services in accordance with waiver policy for the service plans.N=Paid claims for approved waiver services on waiver participant's plan as determined through record reviews. D=All waiver paid claims during waiver participant's record reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Desk/Focus Review Reports

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling determined by evidence warranting a special review.
	☑ **Other** Specify: As warranted	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN/QIO Adjustment Logs

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of participants with paid claims for waiver services in accordance with waiver policy for Level of Care determinations.N=Paid claims rendered during a current and valid LOC determination. D=All waiver paid claims during a waiver participant's record review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Desk/Focus Review Reports

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

☑ **Other** Specify: As warranted

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN/QIO Adjustment Logs

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DDSN''s Internal Audit Division conducts periodic reviews of the billing systems and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS in a timely manner.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHHS financial policy requires DDSN to void/replace incorrect claims using the web-based system. DDSN reviews and amends its' financial policies and procedures upon review and approval by DHHS.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies

referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The SCDHHS Bureau of Reimbursement Methodology and Policy is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public meetings, or through meetings with association representatives.

-Effective October 1, 2012, waiver service fixed rates were established based upon the projected costs of the service to be provided. Projected costs used in the determination of the waiver rates effective October 1, 2012 were based on FY 2010 Medicaid waiver cost reports adjusted for a trend factor to closely approximate allowable Medicaid reimbursable costs for the services provided at October 1, 2012. Both SCDDSN and SCDHHS, Bureau of Reimbursement Methodology perform financial reviews to ensure that funding provided by the SC General Assembly was appropriately expended by providers of these services.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers maintain the option of billing directly to the SCDHHS or they may voluntarily reassign their right to direct payments to the SCDDSN. Providers billing Medicaid directly may bill either by use of a CMS 1500 form or by the State's electronic billing system/web-tool.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

○ **No. State or local government agencies do not certify expenditures for waiver services.**

◉ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☑ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

(a) – The South Carolina Department of Disabilities and Special Needs (SCDDSN). (b) – SCDDSN files annual cost reports that report the total costs incurred for both their institutional services (ie ICF/IDs) and all waiver services providers. (c) – The SCDDSN received $7.5 million in state appropriations for these services in SFY 2009/2010. The contract between SCDHHS and SCDDSN applicable to these services will require the following contract language:
"SCDDSN agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable, and necessary cost for the provision of services to be provided to Medicaid recipients under the contract prior to submitting claims under the contract." Additionally, the Internal Audit Division within the SCDHHS has included in its' audit plan planned audits of State Agency Medicaid contracts.

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance

with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

Claims for waiver services are submitted to MMIS through either the use of a CMS 1500 form or through the State's electronic billing system. Providers of waiver services are given a service authorization, which reflects the service identified on the service plan. This authorization is produced by the case manager and contains the frequency, date and type of service authorized along with a unique authorization number. Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is an indication in MMIS that the participant is enrolled in the waiver program. This is the case for all claims.

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

The SCDDSN internal audit division periodically conducts audits of SCDDSN's billing system to ensure billing is appropriate for the service provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☑ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A financial management services entity is used to make payments for in-home services delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed periodically.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

SCDDSN will receive payment for waiver services and will provide the following waiver services: EIBI Line Therapy and waiver case management.

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:

SCDDSN will submit annual cost reports that reflect the total costs incurred by SCDDSN and/or its local Boards of the services provided under this waiver. The SCDHHS will desk review the cost report and determine the average unit cost of the services provided under this waiver based upon costs and units of the total population served (i.e. both Medicaid and non-Medicaid recipients). The actual cost rate will then be compared against the

interim rate paid to determine an overpayment or underpayment. If an overpayment occurs, the SCDHHS will recoup the federal portion of the overpayment from the SCDDSN and return it to CMS via the quarterly expenditure report.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

SCDDSN

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

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) SCDDSN operates as an organized health care delivery system (OHCDS). This system of care is comprised of SCDDSN and the local DSN County Boards and together they form an OHCDS. The

OHCDS establishes contracts with other qualified providers to furnish home and community based services to people served in this waiver. (b) Providers of waiver services may direct bill their services to SCDHHS. (c) At a minimum, waiver participants are given a choice of providers, regardless of their affiliate with the OHCDS, annually or more frequent if requested or warranted (d) SCDDSN will assure that providers that furnish waiver services under contract with the OHCDS meet applicable provider qualifications through the state's procurement process. (e) SCDDSN assures that contracts with providers meet applicable requirements via QIO reviews of the provider, as well as, periodic record reviews. (f) SCDDSN requires its local DSN County Boards to perform annual financial audits.

Providers are not required to contract with an OHCDS in order to furnish services to waiver participants.-

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

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [ ] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The South Carolina Department of Disabilities and Special Needs (SCDDSN) received state appropriations to provide services under this waiver. A portion of these funds will be transferred to the South Carolina Department of Health and Human Services (SCDHHS) via an IGT for payments that will be made directly to private providers enrolled with the SCDHHS. For services provided by SCDDSN, these funds will be directly expended by SCDDSN as CPE.

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an

Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	29217.00	4913.00	34130.00	104190.00	2063.00	106253.00	72123.00
2	30012.69	5060.00	35072.69	107316.00	2125.00	109441.00	74368.31
3	22808.01	5212.00	28020.01	91000.00	2189.00	93189.00	65168.99
4	30963.97	5368.00	36331.97	93730.00	2255.00	95985.00	59653.03
5	34377.72	5529.00	39906.72	96542.00	2323.00	98865.00	58958.28

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	700	700
Year 2	770	770
Year 3	847	847
Year 4	932	932
Year 5	1025	1025

Appendix J: Cost Neutrality Demonstration

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

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

The estimate for the average length of stay is based on the current census for SCDDSN waiver participates. SCDDSN anticipates 10% attrition, or approximately 70 new recipients, will receive services during each new waiver year. The 70 new recipients are distributed evenly throughout each waiver year. This computes to a total expected number of 700 unduplicated participates, averaging 350 days/participant, which equates to 11.53 months of average length of stay per recipient for year one. This projected average length of stay remains approximately the same over the 5 waiver years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The derivation of the figures originates with the CMS 372 Report for Waiver #0456 for the year ending 12/31/2008 with an inflation factor of 3% per year. This waiver serves participants with the same level of care (ICF/IID).

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

The derivation of the figures originates with the CMS 372 Report for Waiver #0456 for the year ending 12/31/2008 with an inflation factor of 3% per year. This waiver serves participants with the same level of care (ICF/IID).

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:

2008 ICF/IID Cost Reports and the 2009 Preliminary Cost Reports.
The 2008 Cost Report is on file at SCDHHS.

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

The derivation of the figures originates with the CMS 372 Report for Waiver #0456 for year ending 12/31/2008 with an inflation factor of 3% per year. This waiver serves participants with the same level of care (ICF/IID).

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
Waiver Case Management (WCM)
EIBI Assessment

EIBI Plan Implementation
EIBI Program Development and Training
Lead Therapy
Line Therapy
Self Directed Line Therapy

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Case Management (WCM) Total:						**0.00**
Waiver Case Management - Face to Face Contact	0	0	0.00	0.01	**0.00**	
Waiver Case Management - Non Face To Face Contact	0	0	0.00	0.01	**0.00**	
EIBI Assessment Total:						**490000.00**
EIBI Assessment	Annual	700	1.00	700.00	**490000.00**	
EIBI Plan Implementation Total:						**2905560.00**
EIBI Plan Implementation	Hour	700	69.18	60.00	**2905560.00**	
EIBI Program Development and Training Total:						**980000.00**
EIBI Program Development and Training	Annual	700	1.00	1400.00	**980000.00**	
Lead Therapy Total:						**6300000.00**
Lead Therapy	Hour	700	300.00	30.00	**6300000.00**	
Line Therapy Total:						**9604000.00**
Line Therapy II	Hour	0	0.00	0.01	**0.00**	
Line Therapy	Hour	686	1000.00	14.00	**9604000.00**	
Self Directed Line Therapy Total:						**172200.00**
Self Directed Line Therapy II	Hour	0	0.00	0.01	**0.00**	
Self Directed Line Therapy	Hour	14	1000.00	12.30	**172200.00**	
				GRAND TOTAL:		**20451760.00**
				Total Estimated Unduplicated Participants:		**700**
				Factor D (Divide total by number of participants):		**29217.00**
				Average Length of Stay on the Waiver:		

	346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Case Management (WCM) Total:						**0.00**
Waiver Case Management - Face to Face Contact	0	0	0.00	0.01	**0.00**	
Waiver Case Management - Non Face To Face Contact	0	0	0.00	0.01	**0.00**	
EIBI Assessment Total:						**539000.00**
EIBI Assessment	Annual	770	1.00	700.00	**539000.00**	
EIBI Plan Implementation Total:						**3277723.68**
EIBI Plan Implementation	Hour	770	68.88	61.80	**3277723.68**	
EIBI Program Development and Training Total:						**1078000.00**
EIBI Program Development and Training	Annual	770	1.00	1400.00	**1078000.00**	
Lead Therapy Total:						**7137900.00**
Lead Therapy	Hour	770	300.00	30.90	**7137900.00**	
Line Therapy Total:						**10887100.00**
Line Therapy II	Hour	0	0.00	0.01	**0.00**	
Line Therapy	Hour	755	1000.00	14.42	**10887100.00**	
Self Directed Line Therapy Total:						**190050.00**
Self Directed Line Therapy II	Hour	0	0.00	0.01	**0.00**	
Self Directed Line Therapy	Hour	15	1000.00	12.67	**190050.00**	
				GRAND TOTAL:		**23109773.68**
				Total Estimated Unduplicated Participants:		**770**
				Factor D (Divide total by number of participants):		**30012.69**
				Average Length of Stay on the Waiver:		344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Case Management (WCM) Total:						**0.00**
Waiver Case Management - Face to Face Contact	0	0	0.00	0.01	**0.00**	
Waiver Case Management - Non Face To Face Contact	0	0	0.00	0.01	**0.00**	
EIBI Assessment Total:						**592900.00**
EIBI Assessment	Annual	847	1.00	700.00	**592900.00**	
EIBI Plan Implementation Total:						**3706958.18**
EIBI Plan Implementation	Hour	847	68.76	63.65	**3706958.18**	
EIBI Program Development and Training Total:						**1185800.00**
EIBI Program Development and Training	Annual	847	1.00	1400.00	**1185800.00**	
Lead Therapy Total:						**8088003.00**
Lead Therapy	Hour	847	300.00	31.83	**8088003.00**	
Line Therapy Total:						**5649280.00**
Line Therapy II	Hour	0	0.00	0.01	**0.00**	
Line Therapy	Hour	416	1000.00	13.58	**5649280.00**	
Self Directed Line Therapy Total:						**95440.00**
Self Directed Line Therapy II	Hour	0	0.00	0.01	**0.00**	
Self Directed Line Therapy	Hour	8	1000.00	11.93	**95440.00**	
				GRAND TOTAL:		**19318381.18**
				Total Estimated Unduplicated Participants:		**847**
				Factor D (Divide total by number of participants):		**22808.01**
				Average Length of Stay on the Waiver:		344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Case Management (WCM) Total:						**0.00**
Waiver Case Management - Face to Face Contact	0	0	0.00	0.01	**0.00**	
Waiver Case Management - Non Face To Face Contact	0	0	0.00	0.01	**0.00**	
EIBI Assessment Total:						**652400.00**
EIBI Assessment	Annual	932	1.00	700.00	**652400.00**	
EIBI Plan Implementation Total:						**4205034.13**
EIBI Plan Implementation	Hour	932	68.82	65.56	**4205034.13**	
EIBI Program Development and Training Total:						**1304800.00**
EIBI Program Development and Training	Annual	932	1.00	1400.00	**1304800.00**	
Lead Therapy Total:						**9165288.00**
Lead Therapy	Hour	932	300.00	32.78	**9165288.00**	
Line Therapy Total:						**13298700.00**
Line Therapy II	Hour	457	1000.00	15.52	**7092640.00**	
Line Therapy	Hour	457	1000.00	13.58	**6206060.00**	
Self Directed Line Therapy Total:						**232200.00**
Self Directed Line Therapy II	Hour	9	1000.00	13.87	**124830.00**	
Self Directed Line Therapy	Hour	9	1000.00	11.93	**107370.00**	
			GRAND TOTAL:			**28858422.13**
			Total Estimated Unduplicated Participants:			**932**
			Factor D (Divide total by number of participants):			**30963.97**
			Average Length of Stay on the Waiver:			344

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component	Total Cost

					Cost	
Waiver Case Management (WCM) Total:						**3058436.00**
Waiver Case Management - Face to Face Contact	15 minute	1025	19.00	38.06	**741218.50**	
Waiver Case Management - Non Face To Face Contact	15 minute	1025	65.00	34.78	**2317217.50**	
EIBI Assessment Total:						**717500.00**
EIBI Assessment	Annual	1025	1.00	700.00	**717500.00**	
EIBI Plan Implementation Total:						**4763599.96**
EIBI Plan Implementation	Hour	1025	68.82	67.53	**4763599.96**	
EIBI Program Development and Training Total:						**1435000.00**
EIBI Program Development and Training	Annual	1025	1.00	1400.00	**1435000.00**	
Lead Therapy Total:						**10381200.00**
Lead Therapy	Hour	1025	300.00	33.76	**10381200.00**	
Line Therapy Total:						**14637300.00**
Line Therapy II	Hour	503	1000.00	15.52	**7806560.00**	
Line Therapy	Hour	503	1000.00	13.58	**6830740.00**	
Self Directed Line Therapy Total:						**244130.00**
Self Directed Line Therapy II	Hour	9	1000.00	13.87	**124830.00**	
Self Directed Line Therapy	Hour	10	1000.00	11.93	**119300.00**	

GRAND TOTAL:	**35237165.97**
Total Estimated Unduplicated Participants:	**1025**
Factor D (Divide total by number of participants):	**34377.72**
Average Length of Stay on the Waiver:	344