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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

## 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

In renewing the waiver, the state is seeking to make changes to strengthen the waiver program by:
- Addressing the CMS 1915 (i) State Plan HCBS, 5-year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice and 1915 (c) HCBS Waivers (Final Rule);
- Incorporating CMS' required Quality Improvement project;
- Clarifying the definition for Specialized Medical Equipment and Supplies;
- Clarifying the service package for Pest Control; as well as,
- Removing the limitations on the amount, duration and frequency of Private Duty Nursing. Nursing services will be authorized based on participant's assessed need.
- Removing the Extra Prescription Drugs benefit from this waiver. Effective July 1, 2017, the State plan will no longer limit the benefit for prescription medications to four (4) prescriptions per month, making this service redundant.

Although these are substantial changes, waiver participants will not be adversely impacted. The Extra Prescription Drugs benefit provided two (2) additional prescription drugs above the State Plan limits when the limits under the State Plan were exhausted. Effective July 1, 2017, the State Plan will no longer limit beneficiaries to four (4) prescriptions per month which allows for the two (2) additional prescriptions which have been covered under this waiver. In addition, Private Duty nursing will no longer be limited to 60 hours per week. Nursing services will be authorized based on the participant's assessed need.

# 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*):

Mechanical Ventilator Dependent Waiver

**C. Type of Request: renewal**

**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.40181**
**Waiver Number:SC.40181.R05.00**
**Draft ID: SC.006.05.00**

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

Regular Waiver

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

12/01/17

**Approved Effective Date: 12/01/17**

## 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:

## 1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☒ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

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

**H. Dual Eligiblity for Medicaid and Medicare.**
Check if applicable:

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

## 2. Brief Waiver Description

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

South Carolina is seeking to renew the Mechanical Ventilator waiver. This waiver will serve the frail elderly and persons with physical disabilities who require mechanical ventilation and meet the nursing facility level of care criteria. The direct administration comes through 13 SCDHHS offices around the state, each of which covers designated counties of South Carolina. Case managers working in these 13 offices are responsible for ensuring that participants are aware of his/her service options and can make informed choices as to which form of service delivery they prefer. The Mechanical Ventilator waiver provides participant directed options for supervision of services. This waiver offers a continuum of service options capable of meeting the needs of all waiver participants, both those who choose agency directed services and those who choose self-directed services.

This waiver involves the use of Phoenix, our automated web-based case management system; and an Electronic Visit Verification (EVV) System and a mobile application used by providers to record service provision. Phoenix has been demonstrated to other State agencies, at the request of Truven Health staff, and the EVV has been cited as a "Best Practice" by CMS.

Description of Phoenix and Electronic Visit Verification
Phoenix is South Carolina's automated web-based case management system. This includes all tools used by nurses and case managers to assess and manage care of waiver participants. Some components are:

- Demographic information
- Application for waivers and current status of applications
- All assessments conducted, including level of care determination
- Person-Centered Service Plans
- Service referrals/authorizations for waiver services
- Documentation of other community supports
- Home assessment component including documentation of bathroom safety, ramp and home modification needs
- Caregiver supports section indicating available supports and level of stress and burnout in support system
- Electronic Visit Verification summary information

Phoenix has a number of features included in the software to ensure compliance with federal requirements. Examples include:

- Does not allow assessments to be completed in Phoenix on any applicant that fails to meet intake criteria (e.g., not old enough to enroll in waiver, does not live in state and has not indicated intent to move, or who is not dependent upon life sustaining mechanical ventilation at least six hours per day)
- Prevent waiver enrollment to anyone whose level of care is greater than 30 days of waiver enrollment
- Prohibit any waiver service to be authorized that is not indicated in the service plan
- Flags and records all cases where any federal regulations or state policies are not being followed appropriately.

The Electronic Visit Verification System (EVVS) including mobile application is used by providers to record service provision. The EVV receives information from Phoenix, such as authorized services, schedule and frequency of authorizations, phone numbers of waiver participants and information about providers and provider workers.

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

Providers use the Phoenix system to produce reports regarding the provision of service. In addition, claims are now submitted to MMIS for payment by Phoenix daily (except Mondays). This results in a quick turnaround in payments to providers when claims are submitted with the correct procedure code, amount, etc. The Financial Management Service (FMS) provider no longer produces paper checks and mails them to attendants. All attendants must now use electronic funds transfer (EFT) to his/her banking institution or receive his/her funds on a debit card.

For participants enrolled in Healthy Connections Prime, EVV will automatically submit claims to the Coordinated Integrated Care Organizations (CICOs) also known as Medicaid-Medicare Plans (MMPs) for payment to providers for all properly documented and authorized services.

For participants enrolled in CICOs of the Healthy Connections Prime demonstration, the CICOs will play a more direct role in care planning and service authorization, along with contractual oversight of the network of waiver providers. The State will retain responsibility for provider compliance quality assurance monitoring functions.

## 3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

## 4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

## 5. Assurances

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

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

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

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

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

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

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

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

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

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

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

**F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

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

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

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

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

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

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

**G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

**I. Public Input.** Describe how the state secures public input into the development of the waiver:

This renewal including the revised transition plan was shared during the agency's monthly Indian Health Services conference call on June 28, 2017 and was presented to the Medical Care Advisory Committee (MCAC), which included Tribal Notification, on August 29, 2017.

Public Notice of intent to renew this waiver including the revised transition plan was e-mailed to the agency listserv of interested stakeholders and group distribution which included MCAC members and Indian Health Services on or before July 10, 2017.

Public Notice of intent to renew this waiver including the revised transition plan was posted to the agency website at https://www.scdhhs.gov/service/waiver-management-field-management on or before July 10,2017.

This waiver renewal including the revised transition plan was posted to the agency website at https://www.scdhhs.gov/service/waiver-management-field-management on or before July 10, 2017.

Hardcopies of the waiver renewal which included the revised transition plan were placed in the SCDHHS lobby and the 13 SCDHHS Offices around the State on or before July 10, 2017 for public review and comments.

Additionally, a live statewide webinar was held on Wednesday, August 9, 2017. A recording of the webinar was posted to the agency's website on August 14, 2017 at https://https://www.scdhhs.gov/internet/Vent%20Waiver%20Renewal-Webinar.mp4

Individuals were able to submit electronic comments to comments@scdhhs.gov and non-electronic comments to:
Community Long Term Care and Behavioral Health
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Attention: Lisa Ragland

Both methods of comment submission were noted in all public notices.

Appendix A

Summary of Public Comments for Mechanical Ventilator Dependent Waiver Renewal, and Waiver Specific Transition Plan

Webinar: August 9, 2017, Statewide

No questions/comments received.

Public Comment Period: July 10, 2017-August 29, 2017

Electronic Questions:

The State did not receive any electronic questions/comments.

Non-electronic Questions/comments:

The State finalized its nursing rates while the waiver was in its Public Comment Period. The rates for nursing are as follows:

RN: $32.50/hour
LPN: $24.60/hour

After the first year, subsequent rates are increased at an annual rate of 3.8% in line with the medical consumer price index (MCPI).

Appendix J was updated to reflect the new rates for nursing.

**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:** Mitchell Threatt

**First Name:** Nicole

**Title:** Director, Division of Community Long Term Care

**Agency:** South Carolina Department of Health and Human Services

**Address:** 1801 Main Street

**Address 2:** Post Office Box 8206

**City:** Columbia

**State:** **South Carolina**

**Zip:** 29202-8206

**Phone:** (803) 898-2689 **Ext:** ☐ **TTY**

**Fax:** (803) 255-8209

**E-mail:** mitcheln@scdhhs.gov

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **South Carolina**

**Zip:**

**Phone:**

**Ext:** ☐ **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

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

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

**Signature:** Joshua Baker

State Medicaid Director or Designee

**Submission Date:** Dec 14, 2017

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

**Last Name:** Baker

**First Name:** Joshua

**Title:** Interim Director

**Agency:**

South Carolina Department of Health and Human Services

**Address:**

1801 Main Street

**Address 2:**

Post Office Box 8206

**City:**

Columbia

**State:** **South Carolina**

**Zip:**

29202-8206

**Phone:**

(803) 898-2504 **Ext:** ☐ **TTY**

**Fax:**

(803) 255-8209

**E-mail:**

Joshua.Baker@scdhhs.gov

## Attachments

**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

Removing the limitations on the amount, duration and frequency of Private Duty Nursing. Nursing services will be authorized based on participant's assessed need.

Removing the Extra Prescription Drugs benefit from this waiver. Effective July 1, 2017, the State plan will no longer limit the benefit for prescription medications to four (4) prescriptions per month, making this service redundant.

Although these are substantial changes, waiver participants will not be adversely impacted. The Extra Prescription Drugs benefit provided two (2) additional prescription drugs above the State Plan limits when the limits under the State Plan were exhausted. Effective July 1, 2017, the State Plan will no longer limit participants to four (4) prescriptions per month which allows for the two (2) additional prescriptions which have been covered under this waiver. In addition, Private Duty nursing will no longer be limited to 60 hours per week. Nursing services will be authorized based on the participant's assessed need.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings

requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

South Carolina Department of Health and Human Services
Mechanical Ventilator Dependent (Vent) Waiver
Transition Plan
Revised: July 3, 2017

Introduction

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

CMS has listed the following as the requirements of home and community based settings. They must have the following qualities (per 42 CFR 441.301 (c)(4)):

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

For provider owned and/or controlled residential HCB settings, CMS has listed the following additional conditions that must be met (per 42 CFR 441.301(c) (4) (vi)):

- A legally enforceable agreement (lease, residency agreement, or other form of written agreement) is in place for each individual in the HCB home/setting within which he/she resides.
- Each individual has privacy in their sleeping or living unit.
- Units have lockable entrance doors with the individual and appropriate staff having keys to doors as needed.
- Individuals sharing units have a choice of roommates.
- Individuals can furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have freedom and support to control their schedules and activities.
- Individuals have access to appropriate food any time.
- Individuals may have visitors at any time.
- The setting is physically accessible to the individual.
- Any modification of the additional conditions for HCB residential settings listed above must be supported by a specific assessed need and justified in the person-centered service plan.

CMS has also listed the following as settings that are not home and community based (per 42 CFR 441.301 (c) (5)):

- A nursing facility
- An institution for mental diseases (IMD)
- An intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- A hospital
- Any other settings that have the qualities of an institutional setting. This includes:
  - Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment
  - Any setting in a building on the grounds of, or immediately adjacent to, a public institution
  - Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

Any of the settings that have qualities of an institutional setting will be presumed to be institutional, and therefore HCB services cannot be provided in the setting, unless the Secretary of the US Department of Health and Human Services determines through heightened scrutiny that the setting does have the qualities of home and community-based settings and services can still be provided in that setting.

The South Carolina Department of Health and Human Services (SCDHHS) has branded this effort for HCBS with the tagline: Independent·Integrated·Individual. This tagline was developed because home and community-based services help our members be independent, be integrated in the community, and are based on what is best for the individual.

1.1 Waiver Specific Transition Plan Development

CMS required that each state submit a “Transition Plan” for each waiver renewal or amendment. The Transition Plan outlines how the state will come into conformance and compliance with the HCBS Rule settings requirements. States must come into full compliance with HCBS Rule requirements by March 17, 2022.

SCDHHS formed a workgroup to address and solicit input on how the state could come into compliance with the HCBS rule. This group is composed of members from:

- SC Department of Health and Human Services (34%)
- SC Department of Mental Health (1%)
- SC Department of Disabilities and Special Needs (9%)
- SC Vocational Rehabilitation Department (3%)
- Other governmental partners (4%)
- Advocacy groups (18%):
  - AARP South Carolina
  - Family Connections of South Carolina
  - Protection & Advocacy for People with Disabilities, Inc.
  - Able South Carolina
- Providers (26%):
  - Local Disabilities and Special Needs Boards
  - Housing providers for the mentally ill population
  - Adult Day Health Care Providers
  - Private providers of Medicaid and HCBS services
- Beneficiaries and family members (5%)

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

Per CMS requirements, the first draft of this Vent Waiver Transition Plan (April 2015) was made available for the public to read and comment on before being submitted to CMS for review. This plan may change as the state goes through the process of coming into compliance with the HCBS Rule. Since its initial submission, the Vent Waiver Transition Plan has been revised three (3) times as noted in the chart below. Anytime this plan undergoes any substantive changes after submission to CMS, the state will make it available again for public comment and input.

Revisions to Mechanical Ventilator Transition Plan

| Date of Revision | Reason |
|---|---|
| April 2015 | CMS first review of Mechanical Ventilator Transition plan requiring revisions |
| September 2015 | The Mechanical Ventilator Dependent Waiver was amended. Mechanical Ventilator Transition plan revised due to substantive changes made in the Statewide Transition Plan (STP) |
| April 2016 | The Mechanical Ventilator Dependent Waiver was amended. The Mechanical Ventilator Transition plan revised to include substantive changes made to the STP |
| July 2017 | Mechanical Ventilator Dependent waiver was renewed. Revised Mechanical Ventilator Transition plan due to substantive changes made to the STP and public comments made regarding the STP. |

2. Communications and Outreach-Public Notice Process

SCDHHS used multiple methods of public notice and input for the Mechanical Ventilator Waiver amendment and Transition Plan that was submitted to CMS in April 2015.

- The Medical Care Advisory Committee (MCAC) was provided advisories on the HCBS Rule and the Vent Transition plan on September 10, 2014 and November 12, 2014
- Per 42 CFR 441.304 (f)(4), Tribal Notification was provided on September 10, 2014 and November 12, 2014. A Tribal Notification conference call for the transition plan was held October 29, 2014.
- Public notice for comment on the Vent Waiver Transition plan was posted on the SCDHHS website on November 10, 2014.
- Public notice for comment on the Vent Waiver Transition plan was sent out via the SCDHHS listserv on November 10, 2014.

• Four public meetings were held to discuss the Vent Waiver amendment and Vent Waiver Transition plan, as well as the HCBS Rule and what it means for South Carolina beneficiaries. These meetings were held in November and December 2014 in the following cities:
o Florence, SC Nov. 13, 2014
o Greenville, SC Nov. 18, 2014
o Charleston, SC Dec. 2, 2014
o Columbia, SC Dec. 4, 2014
• Public notice on the Vent revised waiver transition plan, including the revised waiver transition plan document, was posted on the following website on March 20, 2015:
o SCDHHS website (scdhhs.gov)
• Public notice on the Vent revised waiver transition plan was sent out via the SCDHHS listserv on March 20, 2015.
• Public notice on the Vent revised waiver transition plan was sent out via e-mail to pertinent organizations, including MCAC and Tribal Notification on March 20, 2015
• Printed public notice on the Vent revised waiver transition plan was posted at SCDHHS Jefferson Square/Headquarters Lobby on March 20, 2015.
• Printed copy of the Vent revised waiver transition plan document were made available for public view and comment at SCDHHS Jefferson Square/Headquarters Lobby on March 20, 2015.
• Printed copies of public notice on the Vent revised waiver transition plan, including a printed copy of the revised waiver transition plan document, were provided in all Community Long Term Care Area Offices and satellite offices on March 20, 2015.
• Public comments were gathered from the public meetings listed above, from electronic communications sent to SCDHHS and from communications mailed to SCDHHS.
• SCDHHS reviewed the comments and incorporated any appropriate changes to the Vent Transition Plan. A summary of the public comments was included with the Vent Transition Plan submitted to CMS in April 2015.
South Carolina's revised HCBS Mechanical Ventilator Transition Plan, as submitted to CMS, is posted in the following location:

scdhhs.gov/public-notices

2.2 Communication during the Implementation of the Mechanical Ventilator Transition Plan
SCDHHS continues to hold monthly HCBS workgroup meetings and/or communicate to the workgroup monthly via email. This communication keeps stakeholders informed of the progress made during the implementation of the Mechanical Ventilator Transition Plan. Additionally, SCDHHS will publish on its main website and its HCBS website an annual update on transition plan activities. This update will also be made available in the CLTC Regional Offices and shared with interested stakeholders.

These communication efforts should allow for ongoing transparency and input from stakeholders on the Mechanical Ventilator Transition Plan.

As noted in the guidance and Questions and Answers documents provided by CMS, any substantive changes in an approved Statewide Transition Plan will require the state to go through the public notice and comment process again. This applies to the Mechanical Ventilator Transition Plan as well.

2.3 Update April 2016. The Statewide Transition plan was revised three times since its original submission to CMS on February 26, 2015.
• September 25, 2015
• February 3, 2016
• February 23, 2016
The version of the STP dated February 23, 2016 required substantive changes; thus requiring the Mechanical Ventilator Transition plan to be revised to ensure compliance. Therefore, the Mechanical Ventilator Transition plan was revised April 2016 and made available through the following methods:
• Public Notice of intent was emailed to the agency listserv of interested agency stakeholders and group distribution which included MCAC members and Indian Health Services on or before April 25, 2016.
• Public Notice of intent was posted to the agency website on or before April 25, 2016.
• This Transition plan was posted to the agency HCBS website and Healthy Connections Prime website on or before April 25, 2016.
• Hard copies were placed in the SCDHHS lobby and the 13 SCDHHS offices around the state on or before April 25, 2016 for public review and comment.
• Additionally, a public meeting was held on May 3, 2016, to address proposed Vent Transition plan.
• A live webinar was held on Wednesday, May 11, 2016.
• Individuals were able to submit electronic comments to comments@scdhhs.gov and non-electronic comments to :

Division of Community Long Term Care
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Attention: Lisa Ragland
Both methods of comments submission were noted in the Public Notice.

2.4 Update July 2017
As the Mechanical Ventilator Dependent Waiver is going through the renewal process, the Vent Transition Plan is also being updated to match the most recent version of the Statewide Transition Plan dated November 3, 2016, to ensure compliance. The Vent Transition Plan was made available through the following methods:

- This renewal to include the Vent Waiver Transition Plan was shared during the agency's monthly Indian Health Services conference call on June 28, 2017 and presented to the Medical Care Advisory Committee (MCAC), which included Tribal Notification, on August 29, 2017.
- Public Notice of intent was emailed to the agency listserv of interested agency stakeholders and group distribution which included MCAC members and Indian Health Services on July 10, 2017.
- Public Notice of intent was posted to the agency website on July 10, 2017.
- This Transition plan was posted to the agency HCBS website on July 10, 2017.
- Hard copies were placed in the SCDHHS lobby and the 13 SCDHHS CLTC Regional offices around the state on July 10, 2017 for public review and comment.
- A live webinar was held on August 9, 2017.
- Individuals were able to submit electronic comments to comments@scdhhs.gov and non-electronic comments to :

Division of Community Long Term Care
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Attention: Lisa Ragland
Both methods of comments submission were noted in the Public Notice.

3. Assessment of System-Wide Regulations, Policies, Licensing Standards, and Other Provider Requirements

3.1 Process of System-Wide Review
SCDHHS compiled a list of the laws, regulations, policies, standards, and directives that directly impact home and community based settings. This includes any settings in the Mechanical Ventilator Dependent waiver. The list was vetted through the appropriate leadership at SCDHHS, the South Carolina Department of Disabilities and Special Needs (SCDDSN), and other stakeholders to ensure that it was complete.

The list of laws, regulations, etc., was separated according to HCB setting. They were read and reviewed to determine that the law, regulations, etc. is not a barrier to the settings standards outlined in the HCBS rule. This review took place between October 2014 and January 2015. Any changes to any of the following laws, regulations, policies, standards, and directives after that time period have not been reviewed but will be subject to the ongoing compliance process. The settings for Mechanical Ventilator waiver are divided as follows:

- All of the Mechanical Ventilator Dependent Waiver participants reside and receive services in their own homes.

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

3.2 Outcomes of System-Wide Review
Based on feedback from CMS, SCDHHS reformatted the below information. The information and results have not changed, but the full analysis is now included indicating where our system complies with or conflicts with the HCB setting requirements, remediation needed, and the timeframe within which the remediation occurred or will occur.

3.2.1 Identified Laws/Regulations/Policies Found Not Compliant. With the first draft of the Mechanical Ventilator Dependent Transition Plan, SCDHHS identified the following areas as not being fully compliant with the Federal settings regulations. Since that draft, SCDHHS has sought specific action to come into compliance with the HCBS regulations to remediate or ameliorate the below areas of concern.

1. SCDHHS Policy: Leave of Absence from the State/CLTC Region of a Waiver Participant:"[…] "Individuals enrolled in Medicaid home and community-based waivers who travel out of state may retain a waiver slot under the following conditions: the trip out-of-state is a planned, temporary stay, not to exceed 90 consecutive days which is authorized prior to departure; the individual continues to receive a waiver service; waivered services are limited to the frequency of services currently approved in the participant's plan of service; waivered services must be rendered by South Carolina Medicaid providers; the individual must remain Medicaid eligible in the State of South Carolina."

a. This policy does not specifically touch on any of the home and community-based settings requirements, but it may be an unnecessary restriction on waiver participants if they wanted to travel longer than 90 consecutive days. These policies may need further review.

b. The policy was reviewed and determined that it was an administrative requirement. Therefore, changes will not be sought to this policy.

3.3 Actions to Bring System into Compliance

For those policies, procedures, standards and directives that need modification as indicated in the previous section, SCDHHS will work with the appropriate internal staff and external agencies to make necessary changes. Small teams of key personnel began meeting in the fall of 2015 to review those policies and procedures to determine where changes needed to be made to bring the waiver policies and procedures in line with HCBS requirements.

Community Long Term Care staff are reviewing waiver documents and related policies and procedures for areas that can be revised. CLTC at SCDHHS operates the Mechanical Ventilator Dependent Waiver. This waiver had an amendment submitted to CMS on May 31, 2016 and was approved on August 17, 2016. Changes to this waiver document to meet the HCBS standards were included and since approved, the appropriate changes were made to corresponding waiver policies and procedures.

3.4 Ongoing Compliance of System

Once system policies, procedures, standards and directives have been updated to reflect the new HCBS requirements, ongoing compliance of the system will be monitored per the updated policies.

SCDHHS serves as the Administrative and Operating Authority for the Mechanical Ventilator Dependent waiver. The CLTC division of SCDHHS has waiver review as part of the overall CLTC Quality Assurance (QA) Plan. SCDHHS Central Office has a QA Task Force committee to review all data accumulated. The QA Task Force meets bi-monthly throughout the year to identify and pursue action plans for making improvements in the waiver programs, including any issues related to HCBS settings requirements, as well as in the quality management framework and strategy. This process allows a thorough assessment of areas needing improvement and areas of best practice. Systems improvement for statewide problems can be addressed through different measures, including revision of policy and procedures, thereby allowing SCDHHS to ensure compliance with the new HCBS standards.

Additionally, staff members of CLTC have received and will continue to participate in in-depth training from CMS on HCBS requirements. Any new employees will receive training from knowledgeable staff members on the HCBS requirements.

It is through these established systems of quality assurance review that ongoing compliance of HCBS standards will be monitored after the transition period ends on March 17, 2019.

4. Assessment of Settings

4.1 Setting Types

All of Mechanical Ventilator Dependent waiver participants reside and receive services in their own homes.

4.2 Assessment of Individual Private Homes. Individuals not living in provider-owned or controlled homes deserve the same access and integration to their community as individuals not receiving HCB services. To ensure that these individuals are not isolated in their communities in which they choose to live, SCDHHS must confirm that individual private homes were not established or purchased in a manner that isolates them from their community. The CLTC Division of SCDHHS will explore appropriate ways to gather this information through the regular case manager face-to-face visits or annual re-evaluation assessments of the waiver participant. After policy and process revisions and any staff and/or provider training, a process will be determined and implemented.

4.3 Ongoing compliance

Ongoing compliance of the settings will be monitored through the updated SCDHHS policies and procedures as stated above. SCDHHS serves as the Administrative and the Operating Authority for the Mechanical Ventilator waiver.

The CLTC division of SCDHHS has waiver review as part of the overall CLTC Quality Assurance (QA) plan. Information is gathered and compiled from many data sources including Provider Compliance Reports from SCDHHS staff; APS/critical incident reports; and provider reviews conducted at least every 18 months by SCDHHS.

As part of the CLTC QA Plan, information gathered from the sources previously mentioned is taken to the Quality Improvement Task Force, which is scheduled to meet bi-monthly. Data is reviewed and discussed for discovery of non-compliance and strategies for remediation. Reports and trends are shared with area offices and providers as appropriate. Anything requiring corrective action generates a report and request for corrective action plan to the area office administrator. All reports, corrective action plans, appeals and dispositions are brought to the Quality Improvement Task Force to review outcomes. Outcomes would assist in determining necessary policy or system changes. This process allows a thorough assessment of areas needing improvement and areas of best practice. It is through this established system of quality assurance review that ongoing compliance of HCBS standards will be monitored.

South Carolina assures that the setting transition plan included in this waiver renewal will be subject to any provisions or requirements included in the South Carolina's approved Statewide Transition Plan. South Carolina will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Appendix A

Summary of Public Comments for Mechanical Ventilator Dependent Waiver Renewal, and Waiver Specific Transition Plan

Webinar: August 9, 2017, Statewide

No questions/comments received.

Public Comment Period: July 10, 2017-August 29, 2017

Electronic Questions:

The State did not receive any electronic questions/comments.

Non-electronic Questions/comments:

The State finalized its nursing rates while the waiver was in its Public Comment Period. The rates for nursing are as follows:

RN: $32.50/hour
LPN: $24.60/hour

After the first year, subsequent rates are increased at an annual rate of 3.8% in line with the medical consumer price index (MCPI).

Appendix J was updated to reflect the new rates for nursing.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Post Eligibility Treatment of Income (Appendix B-5): The personal needs allowance amount under a capitated system is up to $2,199. If a participant exceeds this amount, the State develops a method to carve out/identify the costs of home and community based waiver services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of home and community based waiver services. South Carolina Department of Health and Human Services Division of Eligibility determines existent excess costs through a carve out methodology and then forwards this information (via the DHHS 3229 ME form) to the Division of Accounting. Via internal processes, the Division of Accounting is then responsible for assuring that the excess income is only applied to waiver services.

I-2a:
Reimbursement Methodology and Policy uses the following rate modeling/construction procedures to ensure the appropriateness and adequacy of rate changes:
1)Annual salary data specific to the direct service provider description is researched and accumulated. Source is focused to ensure salary data is geographically or regionally relevant as well as appropriate to service provider (i.e. governmental and/or private entities). Fringe benefits are factored in using the State of South Carolina’s employee’s fringe rate, which is inclusive of the basic benefits package available to a state employee in a full time equivalent position.
2)Associated direct operational costs are added. These costs may include:
a)training and travel to maintain certification/licensure requirements (but not to obtain initial certification or licensure),
b)materials and supply costs that are required for direct services to patients (examples: curriculum, minor equipment, incidental medical supplies that are commonly used in provision of care),
c)travel required for service provision,
d)supervision of direct staff, if required by the service description.

3)Indirect costs, for provider support. Indirect costs (those supporting costs that cannot be directly attributed to the service but rather apportioned over all benefitting programs/services of the provider) are recognized by the application of a 10% indirect costs rate as applied to modified total direct costs. This is in accordance with 2 CFR 200, Subpart E, 200.414 (f).

4)Productivity standards to account for non-billable time, i.e. leave, administrative, and training, are applied to annual available hours to determine maximum number of billable hours.

Finally, the summation of items 1 through 3 above is divided by the maximum number of billable hours to determine an hourly billing rate. The hourly billing rate may be subdivided as needed to provide a billable service rate (i.e. 15 or 30 minutes).

## Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the state Medicaid agency.**

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Division of Community Long Term Care

   *(Do not complete item A-2)*

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

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

   *(Complete item A-2-a).*

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

   Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

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

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

## Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Participants not enrolled in Healthy Connections Prime will continue to have all functions performed by the State.

The State and CMS contract with health plans, Coordinated and Integrated Care Organizations (CICOs) also known as Medicare-Medicaid Plans (MMPs), for the provision of coordinated and integrated health care services under a federal financial alignment demonstration. This program is known as Healthy Connections Prime. Waiver participants who meet eligibility criteria may enroll in Healthy Connections Prime. Healthy Connections Prime CICOs that have passed the necessary benchmark reviews and qualified to do so will conduct re-evaluation assessments for aspects other than participant levels of care.

Healthy Connections Prime CICO contracted waiver case managers will consult with the participant and/or primary contact during the development of the service plan to ensure person-centeredness. Healthy Connections Prime has incorporated assurances within the three way contract to ensure the CICOs contract with waiver provider case managers. These provider case managers are approved by the state Medicaid agency and must be independent of service delivery. Additionally, case managers must meet all requirements as indicated in the state Medicaid agency's conflict free modality. This is constantly monitored by the state Medicaid agency to ensure compliance. Non- compliance with this requirement will result in termination of the waiver case manager's contract.

The CICOs that have passed the necessary benchmark reviews and qualified to do so will prior authorize waiver services for his/her participants enrolled in Healthy Connections Prime, adhering to approval criteria that are no more restrictive than the State's policies for participants who are not enrolled in Healthy Connections Prime.

The State Medicaid Agency will formally review all service plans and may object to CICOs proposed changes. Healthy Connections Prime participants also have access to an arbitration process in the event of dispute.

CICOs that have passed the necessary benchmark reviews and are qualified to do so will be able to establish rates for waiver services providers serving participants in Healthy Connections Prime. However, all rates must be at least equal to the rate the State pays providers for members who are not enrolled in Healthy Connections Prime. Any exceptions will only be made with the approval of the state, based upon a justification from the CICO assuring that quality will not be affected.

Benchmark reviews will be conducted by SCDHHS staff and its agent (a third party contractor). Failure to adequately address the benchmark standards could preclude the CICO from moving forward to the next phase of the Home and Community Based Services (HCBS) transition and may impact a CICO's eligibility for future passive enrollment.

CICO's that have successfully completed the first HCBS Benchmark Review will assume contractual authority for case management services and most HCBS, in addition to the full continuum of Medicare and Medicaid covered services it is already providing. If the CICO fails to adequately meet the benchmark standards, a corrective action plan, including specific dates, must be submitted to the review team. The benchmark review will evaluate the following:

- Case Management and RN assessor staffing competencies in conducting reassessments
- Network capacity for HCBS Case Management and other non-case management HCBS with the exception of self-directed services. CICOs must have providers in each geographic area sufficient to meet the needs of the target population and to guarantee members have a meaningful choice of providers for each service. Since the volume of and need for services differ, the number of providers will vary by specific services. CICOs will use a standard Scope of Service provided by SCDHHS to ensure consistent continuity of care standards are put into place.
- CICO ability to fully manage and integrate the full continuum of Medicare and Medicaid services as evidenced by the following:
  - o HCBS care coordination infrastructure
  - o Integration of HCBS into multidisciplinary team; and
  - o Policies in support of these integrated functions

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

## Appendix A: Waiver Administration and Operation

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

   ◉ **Not applicable**

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

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

Participants not enrolled in Healthy Connections Prime will continue to have all functions performed by the State.

For participants in the Healthy Connections Prime program, the State Medicaid Agency will assess the performance of contracted CICOs(MMPs).

## Appendix A: Waiver Administration and Operation

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

Contracted entities will only perform waiver operational and administrative functions for participants in Healthy Connections Prime. On an ongoing basis, the CICOs (MMPs) performance will be assessed in the following areas:

- Review of timeliness of all activities related to service plan development
- Review of timeliness on prior authorizations
- Review of service plans to determine if level of authorization is comparable to waiver fee-for-service participants; and
- Review of case managers' service level request versus CICO approval levels.

## Appendix A: Waiver Administration and Operation

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

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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

***Where possible, include numerator/denominator.***

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

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

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The state retains full operational and administrative authority of this waiver for participants not enrolled in Healthy Connections Prime. SCDHHS will continue its oversight of all cases and intervene where there are concerns or disputes about services and authorization levels. The Healthy Connection Prime Advocate is available to resolve disputes between the state and CICOs (MMPs) concerning services and authorization levels. Members will also have access to a state fair hearing to formally dispute authorization levels and/or level of care determinations. The Healthy Connections Prime Advocate can provide support to members throughout the state fair hearing process.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix B: Participant Access and Eligibility

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

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

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☐ **Aged or Disabled, or Both - General** | | | | | |
| | ☐ | **Aged** | | | ☐ |
| | ☐ | **Disabled (Physical)** | | | |
| | ☐ | **Disabled (Other)** | | | |
| ☒ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☒ | **Technology Dependent** | 21 | | ☒ |
| ☐ **Intellectual Disability or Developmental Disability, or Both** | | | | | |
| | ☐ | **Autism** | | | ☐ |
| | ☐ | **Developmental Disability** | | | ☐ |
| | ☐ | **Intellectual Disability** | | | ☐ |
| ☐ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | ☐ |
| | ☐ | **Serious Emotional Disturbance** | | | |

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

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

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

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    *Specify:*

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

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    **The dollar amount** *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

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

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

☐ **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:

## 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** | 70 |
| **Year 2** | 70 |
| **Year 3** | 70 |
| **Year 4** | 70 |
| **Year 5** | 70 |

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

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

# Appendix B: Participant Access and Eligibility

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

**e. Allocation of Waiver Capacity.**

*Select one*:

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

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

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

All individuals may enroll in the waiver as soon as all financial and level of care determinations have been done. There is no waiting list for this waiver. In addition, the agency has adopted policies which serve to prioritize enrollment into the waiver.

Healthy Connections Prime participants who meet the level of care criteria for this waiver will have access to HCBS under the demonstration without regard to a waiting list.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

**2. Miller Trust State.**

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

- ( ) **No**
- (●) **Yes**

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

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

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

  *Select one*:

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

    Specify percentage:

- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  *Specify:*

  Other caretaker relatives specified at 42 CFR §435.110; pregnant women specified at 42 CFR §435.116.

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

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

  *Select one and complete Appendix B-5.*

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

    *Check each that applies*:

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

*Select one*:

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

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

  Specify dollar amount: [ ]

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

  *Select one*:

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

    Specify percentage amount: [ ]

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

  *Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- [x] **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
  *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

(●) **The following standard included under the state plan**

*Select one*:

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

(*select one*):

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

Specify the percentage: [ ]

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

Specify dollar amount: [ ]

( ) **A percentage of the Federal poverty level**

Specify percentage: [ ]

( ) **Other standard included under the state Plan**

*Specify:*

[ ]

( ) **The following dollar amount**

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

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

*Specify:*

○ **Other**

*Specify:*

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

◉ **Not Applicable**

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

*Specify:*

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

*Specify:*

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

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

*Specify:*

○ **Other**

*Specify:*

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

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

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

◉ **The state establishes the following reasonable limits**

*Specify:*

1. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.

2. Dentures. A one-time expense not to exceed $651.00 per plate or $1320.00 for one full pair of dentures. A licensed dental practitioner must certify necessity. An expense for more than one pair of dentures must be prior approved by State DHHS.

3. Denture Repair. Justified as necessary by a licensed dental practitioner. Not to exceed $77.00 per occurrence.

4. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69 per visit.

5. Hearing Aids. A one-time expense. Not to exceed $1000.00 for one or $2000.00 for both. Necessity must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by State DHHS.

6. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

7. Other non-covered medical expenses that are recognized by State law but not covered by Medicaid, not to exceed $20 per item/service. These non-covered medical expenses must be prescribed by a licensed practitioner and prior approved by State DHHS.

## Appendix B: Participant Access and Eligibility

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

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

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

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

# Appendix B: Participant Access and Eligibility

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

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

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

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

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

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

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

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

  *Specify formula:*
- ○ **Other**

  *Specify:*

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

*Explanation of difference:*

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

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

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

◉ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

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

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

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

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

# Appendix B: Participant Access and Eligibility

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

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

*Specify the entity:*

- ( ) **Other**

*Specify:*

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

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

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

The South Carolina Nursing Home Level of Care criteria are used to determine medical eligibility for the waiver. A standardized instrument is utilized to gather assessment information necessary for level of care determinations. The same level of care criteria and assessment instrument are used for nursing facility placement and waiver enrollment.

Program staff apply established intake criteria to all waiver applicants. Applicants meeting the waiver intake criteria, are assigned to a state nurse consultant for initial assessment completion within waiver policy and procedure timeframes.

Initial level of care assessments are completed and team staffed by state nurse consultants. Individuals who meet waiver requirements may enroll in the waiver. The state nurse consultant verifies financial eligibility, level of care and participants' choice to participate in the waiver prior to enrollment. Re-evaluations are completed by SCDHHS case managers and by contracted case management providers and team staffed with designated SCDHHS employees or CICOs, also known as Medicare-Medicaid Plans, as applicable.

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

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

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

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

The same process, instrument and level of criteria are used for those participants not participating in Healthy Connections Prime.

Re-evaluations for Healthy Connections Prime participants will be completed by CICOs (MMPs) waiver case management providers and team staffed with a designated CICO staff member. The CICOs will use the same instrument and level of care criteria as established by the State. The State Medicaid Agency retains final authority for all level of care evaluations and re-evaluations.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

*Specify the other schedule:*

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

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

*Specify the qualifications:*

Individuals may be:
- Social Workers licensed by the state of South Carolina
- Individuals with a bachelor's degree or master's degree with at least two (2) years of assessment and care planning experience.
- Registered nurses currently licensed by the state of South Carolina or by a state that participates in the Nursing Compact
- Licensed Practical Nurse working under the auspices of a Registered Nurse

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

An automated tickler system produced by the States Phoenix System is used to ensure timely reevaluations.

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are housed electronically through the Phoenix system which is operated by the Medicaid Agency.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**The number and percent of all applicants who received a Level of Care determination. N: The number of applicants who received a Level of Care determination. D: Total number of applicants.**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**Phoenix Data System**

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

**Data Aggregation and Analysis:**

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

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**
**The number and percent of all Level of Care determinations completed using the appropriate forms/instruments as required by the State Medicaid Agency. N: Total number of Level of Care determinations completed using the appropriate forms/instruments as required by the State Medicaid Agency. D: Total number of Level of Care determinations completed**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**Phoenix Data System**

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**
**The number and percent of waiver applicants who enter the waiver with a Level of Care completed within the 30 days prior to waiver enrollment. N: Number of waiver applicants who enter the waiver with a Level of Care completed within the 30 days prior to waiver enrollment. D: Total number of waiver applicants**

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

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

| | | |
|---|---|---|
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**The number and percent of Level of Care determinations which differ from the Phoenix system recommended Level of Care that are verified for accuracy by a third team member. N: The number of Level of Care determinations which contain a third signature. D: The number of Level of Care determinations which differ from the Phoenix recommended Level of Care**

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

| **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: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

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

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

Waiver functions are performed by 13 SCDHHS offices throughout the state. Each office has state employees. Initial assessments and level of care determinations are performed by state nurse consultants. On-going case management services are performed by contracted case management providers and a limited number of state case managers. Services provided by contracted case management providers are monitored by SCDHHS office state staff throughout the state. Services provided by state employees are monitored by area administrators, lead team staff, and central office staff.

Phoenix tracks all participants on the processing list to ensure all eligible applicants requesting evaluations are assessed timely.

Phoenix ensures that 100% of waiver applicants/participants are assessed using the standardized assessment instrument. Phoenix recommends a level of care based on the assessment data entered which is coded against the state's level of care criteria. If the level of care recommended by Phoenix differs from the level of care determined by the team staffing, a review by the SCDHHS office lead team nurse consultant, lead team case manager or area administrator is required. If the office staff is unable to determine the appropriate level of care, the case may be referred to the central office for further review or medical consultation. If the level of care is determined to be medically ineligible, input is sought from the applicant/participant's primary care provider. If the primary care provider indicates the applicant/participant's medical condition is unstable or the applicant/participant has skilled needs or requires skilled services without a required functional deficit, the case is referred to the central office for final level of care review by the department's medical consultant.

Through Phoenix, management staff has the capability to run reports to determine if any level of care evaluations and/or reevaluation determinations were not completed timely.

Waiver participation (at entry or reevaluation) and level of care determination is not possible without completions of all modules of the assessment tool in Phoenix. The Phoenix system will not allow entry into the waiver if the initial assessment is over 30 days old. The State pulls a 100% sample size report for designated review periods to assure Phoenix performed as programmed. Any errors found in the sample size report would be addressed immediately.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Phoenix does not allow entry into the waiver outside of a 30 day level of care determination. In the event of a system failure, a problem would be reported in the Phoenix system. Problems are logged and tracked in the Phoenix system and reported to the Phoenix technical support group for follow-up. The Phoenix technical support group would determine and correct any issue allowing inappropriate waiver entry.

Central office or SCDHHS office supervisory staff across the state reviews Phoenix data (narrative, checklist, EVV, etc.) to discover any late level of care reevaluation problems. Once a problem has been identified by SCDHHS staff, the information is forwarded (via complaint log format in Phoenix) to the compliance department for review, resolution and/or recoupment.

The SCDHHS office staff and/or central office staff notifies the case manager and his/her agency through the electronic mail system requesting remediation in order to bring the level of care current and any other corrective action that may be deemed necessary. Corrective action plans are forwarded to Central office using the agency electronic mail system. SCDHHS offices across the state can monitor and follow-up with case manager on data generated through Phoenix quality assurance system for effectiveness of corrective action plans. Actions or activities not meeting goals stated in the corrective action plan will be reported to central office for further remediation. This may involve further training, suspension of new referrals/cases, reduction of caseloads, recoupments of payments, and termination.

The case manager will reassess a participant if it appears that he/she requires a different level of care. If it is determined that the level of care has changed, the service plan is adjusted and a Notification Form is sent to the participant. The participant is afforded full access to the Medicaid appeals process, which is administered by the SCDHHS Office of Legal Counsel, Regulations and Fair Hearings.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

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

The state nurse consultant and/or case manager discusses long term care options with potentially eligible individuals (or his/her representatives) during the assessment and subsequent visits.

The state nurse consultant secures a freedom of choice form (CLTC Service Choice Form) designating choice between home and community based services or institutional care from each waiver participant to ensure the participant is involved in planning his/her long term care. This choice will remain in effect until such time as the participant changes his/her mind or participant's situation changes. If the participant lacks the physical or mental ability required to make a written choice regarding his/her care, the representative may sign the Service Choice form.

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

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

## Appendix B: Participant Access and Eligibility

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

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

SCDHHS is in compliance with Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons by contracting with an outside entity for a telephone interpreter service line. Each SCDHHS office across the state has this equipment available for use by nurses and case managers during home visits. The agency also has a contract with an outside entity for a written material translation service and sign language capability.

For participant's in Healthy Connections Prime, the CICO, also known as Medicare-Medicaid Plans, standards for language interpretation services meets and/or exceeds those of the state. Based upon the three-way contract between CICOs, CMS and the state, the CICOs must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. Interpreter services must be available for members who are not proficient in English, free of charge. The CICOs must also have a process to measure the time from which the telephone is answered to the point at which an individual reaches a member service representative capable of responding to the member's question in the member's primary language or another mode of communication in a manner that is sensitive to the member's cultural needs.

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

## Appendix C: Participant Services

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

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

| Service Type | Service | | |
|---|---|---|---|
| **Statutory Service** | **Case Management** | | |
| **Statutory Service** | **Personal Care I and Personal Care II** | | |
| **Statutory Service** | **Respite** | | |
| **Other Service** | **Attendant Care** | | |
| **Other Service** | **Home Accessibility Adaptations** | | |
| **Other Service** | **Home Delivered Meals** | | |
| **Other Service** | **Personal Emergency Response System** | | |
| **Other Service** | **Pest Control** | | |
| **Other Service** | **Private Duty Nursing** | | |
| **Other Service** | **Specialized Medical Equipment and Supplies** | | |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

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

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

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

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Services that assist participants in gaining access to needed waivered services and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for ongoing monitoring and the coordination of the provision of services included in the participant's person centered service plan.

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

Case management is an ongoing service that is billed in monthly increments.

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

Case management agencies are not allowed to provide other direct waiver services or other services (e.g. Hospice) that are part of a participant's person centered service plan to ensure independence. Case managers are not allowed to receive any gifts or anything else of value from providers of waiver services. Also, during case management orientation, case managers are informed of conflict of interest requirements and must sign a disclosure form.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Medicaid Agency |

| Provider Category | Provider Type Title |
|---|---|
| Agency | Case Management Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Medicaid Agency

**Provider Qualifications**

**License** *(specify):*

Registered Nurse or Licensed Social Worker. Code of laws 40-33-10 et seq.

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon employment and at least once every 24 months

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Case Management Agency

**Provider Qualifications**

**License** *(specify):*

Licensed to do business in the state of South Carolina

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

Effective September 1, 2016, SCDHHS revised the case management service. Routine case management will be provided by a contracted case management agency with four (4) or more employees, two (2) of which must be a licensed Social Worker, or have a bachelor's degree or master's degree with at least two years of assessment and care planning experience with clients. Case management providers contracted prior to September 1, 2016, may continue to provide case management activities to participants served under this waiver.

Providers contracted prior to September 1, 2016 must have demonstrated experience in the field of case management/social work. Presently, a provider must show experience providing case management in a health and human services setting, and a demonstrated knowledge of the SC long-term care continuum and community resources. Case managers employed through agencies are required to have a bachelor's or master's degree and a minimum of two years of assessment and care planning experience in a home and community based setting. The provider must be licensed to operate a business in the state of South Carolina and be in good standing with the state and counties served. On an ongoing basis, providers attend meetings to ensure they understand waiver requirements, and policies and procedures for service delivery. Provider supervisors are required to attend training sessions to stay updated on changes and clarifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon enrollment and annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Personal Care I and Personal Care II

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |

| Category 2: | Sub-Category 2: |
|---|---|
| | |

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

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

A service designed to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (performing a task for the person) or cuing to prompt the participant to perform a task. Such assistance may include assistance in activities of daily living (bathing, dressing, toileting, transferring, maintaining continence, etc.). These services in activities of daily living are referred to as Personal Care II services. This service may also include assistance with instrumental activities of daily living (light housework, laundry, meal preparation, grocery shopping, and using the telephone). These services are referred to as Personal Care I. South Carolina has established different rates for these two components of personal care. Personal care services may be provided on an episodic or on a continuing basis. Personal care services may be furnished outside the home, and/or to assist a person to function in the work place or as an adjunct to the provision of employment services, based on the determination of its need by case managers.

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

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Licensed Personal Care Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Personal Care I and Personal Care II**

**Provider Category:**
Agency

**Provider Type:**

Licensed Personal Care Agency

**Provider Qualifications**

**License** *(specify):*

Providers of personal care services must meet the Standards for Licensing In-Home Care Providers as outlined in SC Code of Laws, Section 44-70-10 et.seq.

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

Contract
Scope of Services

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency
South Carolina Department of Health and Environmental Control

**Frequency of Verification:**

Upon enrollment and at least once annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

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

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

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

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

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

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

This service is limited to no more than 28 days of respite per year outside of the home. In home respite may be provided for a period not to exceed 14 days per state fiscal 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 | Nursing Agency - In Home Respite |
| Agency | Hospital |
| Agency | Nursing Facility |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Nursing Agency - In Home Respite

**Provider Qualifications**

**License** *(specify):*

RN, LPN

Nurse Practice Act and S.C. Code of Laws, Regulations, chapter 91, State Board of Nursing

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon Enrollment and at least every 18 months

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Hospital

**Provider Qualifications**

**License** *(specify):*

Yes, SC Code, Sec. 44-7-260 Reg. #61-16, Equivalent for NC & GA

**Certificate** *(specify):*

There are no certification requirements

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Health and Environmental Control;
Medicaid Agency

**Frequency of Verification:**

Upon Enrollment; Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Nursing Facility

**Provider Qualifications**

**License** *(specify):*

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

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Health and Environmental Control
Medicaid Agency

**Frequency of Verification:**

Upon Enrollment;Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Attendant Care

**HCBS Taxonomy:**

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Hands-on care of both a supportive and health related nature. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled service activities to the extent permitted by state law. Housekeeping activities, which are incidental to the performance of care, may also be furnished as part of this activity.

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

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual Attendant chosen by Waiver Participant |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Attendant Care**

**Provider Category:**

Individual

**Provider Type:**

Individual Attendant chosen by Waiver Participant

**Provider Qualifications**

**License** *(specify):*

There are no licensing requirements.

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

Attendants will be at least 18 years of age, capable of following a plan of service with minimal supervision, be free from communicable diseases, and be able to demonstrate a competency in caring for the participant.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Licensed nurse employed by a contracted entity

**Frequency of Verification:**

Upon Enrollment; Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Home Accessibility Adaptations

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
| --- | --- |
| | |
| **Category 2:** | **Sub-Category 2:** |

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

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, heating and air units, and the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations are prior authorized. Experimental or prohibited treatments are not covered.

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

There is a lifetime limit on home adaptations in the amount of $7,500 per participant.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Building Contractor |
| Agency | Licensed Business |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Home Accessibility Adaptations**

**Provider Category:**

Agency

**Provider Type:**

Building Contractor

**Provider Qualifications**

**License** *(specify):*

Code of laws, 1976 as amended 40-59-15 et seq

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency
Labor, Licensing, and Regulation (LLR)

**Frequency of Verification:**

Upon Enrollment and at least annually

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Home Accessibility Adaptations**

**Provider Category:**

Agency

**Provider Type:**

Licensed Business

**Provider Qualifications**

**License** *(specify):*

Code of laws for businesses in the state of South Carolina, 1976 as amended 40-59-15 et seq.

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon Enrollment; Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Home Delivered Meals

**HCBS Taxonomy:**

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Meals delivered to the participant’s residence providing a minimum of one-third of the current recommended dietary allowance. These can be hot, shelf-stable, refrigerator fresh or blast frozen meals.

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Meals Provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**

Agency

**Provider Type:**

Meals Provider

**Provider Qualifications**

**License** *(specify):*

There are no licensing requirements.

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

Contract
Scope of Services
Agencies desiring to be a provider of Home Delivered Meals (HDM) Services must have demonstrated experience. Experience must include no less than one year in food service, meal planning and preparation. All meals must meet 1/3 RDA requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon enrollment and at least once every 24 months

# Appendix C: Participant Services

## C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response System

**HCBS Taxonomy:**

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is programmed to signal a response center once a “help” button is activated. The service includes installation, participant instruction and maintenance of devices/systems. The response center is staffed by trained professionals.

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

**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 | Emergency Response Provider |

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Emergency Response Provider

**Provider Qualifications**

**License** *(specify):*

There are no licensing requirements.

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid agency

**Frequency of Verification:**

Upon enrollment

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Pest Control

**HCBS Taxonomy:**

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Pest Control includes services to remove pests (e.g., roaches) from participant's residence. Services are provided based on need to ensure participant's health, safety and welfare. Not only does removal of pests ensure the health, safety and welfare of participants, it enhances the ability to find willing providers of other in home services. The need for this service must also be noted in the Home Assessment section of Phoenix and service is delivered as specified in the participant's service plan.

Enhanced pest control is the treatment of bed bug infestation.

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

Pest control will be provided on a bi-monthly basis with any exceptions needing prior approval from Central Office.

Enhanced Pest can only be authorized once in a lifetime with any exceptions needing approval from Central Office.

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

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

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

- ☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Licensed Business |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Pest Control**

**Provider Category:**

Agency

**Provider Type:**

Licensed Business

**Provider Qualifications**

**License** *(specify):*

South Carolina Business License

**Certificate** *(specify):*

Certification by Clemson Extension Services

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon enrollment

## Appendix C: Participant Services

### C-1/C-3: 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:**

Private Duty Nursing

**HCBS Taxonomy:**

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to a participant at home.

The unit of service is one (1) hour of direct nursing care provided to the participant in the participant's place of residence. Services are not allowable when the participant is in an institutional setting. The amount of time authorized does not include travel time.

Nursing service providers will provide skilled nursing services as ordered by the physician performed by a registered nurse (RN) or licensed practical nurse (LPN) in accordance with SC Code 40-33-20 (47) and SC Code 40-33-20 (48). Duties include but are not limited to:

- Collecting health care data to assist in care planning of participants
- Assessing and analyzing health status of participants
- Administering and delivering medications and treatments prescribed by an authorized licensed provider
- Basic teaching for health promotion

In addition, providers will assist with/perform ADL's as needed

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

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

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

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Nursing Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Private Duty Nursing**

**Provider Category:**

Agency

**Provider Type:**

Nursing Agency

**Provider Qualifications**

**License** *(specify):*

Yes, Code of laws 40-33-10 et seq

Holds appropriate business licenses as required by state, county or municipal law.

**Certificate** *(specify):*

There are no certification requirements.

**Other Standard** *(specify):*

Contract
Scope of Services

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon Enrollment and at least every 18 months

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

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

**Service Title:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:**

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Specialized medical equipment and supplies include bath safety equipment (transfer benches, shower chairs, raised toilet seats, hand held shower heads), nutritional supplements, and other durable medical equipment and/or supplies may be authorized if the equipment or supplies cannot be reimbursed under Medicare, Medicaid State Plan, or third party insurance and the provider is a Medicaid enrolled DME provider. The services under this waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

Nutritional Supplements: Up to two cases per month based on State defined medical necessity criteria.

Medical Necessity Criteria-Nutritional Supplements:
The SCDHHS Physician's Order Form must be completed by the participant's physician in order for this service to be authorized. The physician must indicate the need for the supplement, recommend the quantity and indicate at least one of the qualifying conditions:

1. Wasting (loss of ten percent (10%)) body mass in the last sixty (60) days.
2. Severe dental or gum problems that prevent the participant from chewing.
3. Has a condition that requires a protein supplement .
4. Has a swallowing problem that prevents the participant from achieving adequate weight.
5. Due to a medical condition, the participant cannot maintain adequate weight.

Nutritional supplements should not be authorized for those with adequate weight unless the participant has dental or swallowing problems.

In addition, the Physician's Order requests information regarding the participant's height and weight, an indication of medically necessity and the number of cans needed per day (up to 48 cans/month). The physician may indicate if the participant needs diabetic supplements.

If the participant is receiving tube feedings, nutritional supplements may not be authorized. Tube feeding supplies should be obtained through the Medicaid State Health plan.

Any exceptions to this must be approved by Central Office.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Licensed Business |

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Licensed Business

**Provider Qualifications**

**License** *(specify):*

Licensed to do business in the state of South Carolina

**Certificate** *(specify):*

There are no certification requirements

**Other Standard** *(specify):*

Criteria established in Community Long Term Care provider manual.

Licensed business is the provider type of this service. Providers must be licensed to do business in the state of South Carolina. Providers must fill orders from his/her own inventory or contract with other companies for the purchase of items necessary to fill the order. Providers must notify participants of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicaid-covered items that are under warranty. In addition, providers must have adequate staff to coordinate service delivery; package products according to service authorization; as well as handle complaints and grievances received from participants.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Medicaid Agency

**Frequency of Verification:**

Upon Enrollment

## Appendix C: Participant Services

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

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

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

*Check each that applies:*

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

## Appendix C: Participant Services

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

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

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

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

Nursing Homes and Personal care agencies are all required by law to have background checks done on direct care staff (personal care agencies must also conduct background checks on all staff). These are state level investigations performed by South Carolina Law Enforcement (SLED checks) for each of the agencies above that hire and recruit direct care staff. The State Department of Health and Environmental Control performs licensure inspections incorporating the requirement that all direct care staff of these agencies have the required background check.

For the services attendant and case management, the contract or enrollment agreement signed by the provider requires state level background checks for administrative and direct care personnel. In all cases, SCDHHS has a staff member devoted to reviewing waiver service providers' records to ensure that background checks have been performed by the agencies.

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

- ◉ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

## Appendix C: Participant Services

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

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

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

## Appendix C: Participant Services

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

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

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

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

  ☐ **Self-directed**

  ☐ **Agency-operated**

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

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

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

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

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

- ◉ **Other policy.**

  Specify:

Reimbursement for services may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members may not be reimbursed: the spouse of a Medicaid participant; a parent of a minor Medicaid participant; a step-parent of a minor Medicaid participant; a foster parent of a minor Medicaid participant; and, any other legally responsible guardian of a Medicaid participant. All other qualified family members may be reimbursed for his/her 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/contract with the South Carolina Medicaid agency (SCDHHS). Potential providers are made aware of the requirements for enrollment through: (1) The agency's website and, (2) contacting the Medicaid agency directly. Potential providers are directed to SCDHHS website to complete an online application. Some services specified in this waiver require a pre-contractual review and signed contract for enrollment as a provider. Once a potential provider has signed a contract and/or an enrollment application, enrollment with DHHS occurs.

The timeframe established for providers when enrolling for Medicaid is 45 to 60 days after an accurately completed online application is submitted.

In order to serve waiver participants who are members of CICOs,also known as Medicare-Medicaid Plans, providers of waiver services other than self- directed attendant care will also contract with each CICO. Self-directed attendant care providers will continue to enroll only with the state Medicaid agency. Waiver services providers who do not contract with any CICO may continue to serve waiver participants who are not enrolled in Healthy Connections Prime.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of waiver providers (Personal Care, EMODs, Pest Control, Respite) who meet initial application criteria (e.g., liability, workers compensation**

**insurance, documentation of financial stability, nursing licenses, DHEC licensures). N: Number of providers who meet initial application criteria. D: Total number of providers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider records or provider sign-in sheets**

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

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |

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

**Performance Measure:**
**Number and percent of providers who scored less than 100 as a result of onsite reviews by waiver staff. N: Number of providers who scored less than 100 on an onsite review. D: Total number of providers reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider Compliance 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>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 provider complaints and the percentage of those complaints that were resolved and logged in the state's case management system, Phoenix, which is utilized to document complaints. N: The number of provider complaints resolved that were logged into Phoenix. D: Total number of provider complaints received.**

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

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

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

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

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

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

**Performance Measure:**
**Number and percent of non-licensed/non-certified provider applicants, by provider type, who meet initial waiver provider qualifications. N: Number of non-licensed/non-certified providers who meet initial qualifications. D: Total number of non-licensed/non-certified providers.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider records or Provider sign-in sheets**

| **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**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**For applicable providers, the number and percent of non-licensed/non-certified providers, by provider type (case management, HDMs, Attendants), that continue to meet waiver provider qualifications. N: Number of non-licensed/non-certified**

**providers that continue to meet waiver provider qualifications. D: Total number of non-licensed/non-certified providers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider Compliance 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |

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

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

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

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

**Performance Measure:**
**The number and percent of enrolled PCA and nursing provider employees who meet the annual in-service training hours, as specified in the approved waiver. N: number and percent of enrolled PCA and nursing provider employees who meet the annual in-service training hour requirement. D: Total number of enrolled PCA and nursing provider employees.**

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

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

| | | Review |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>A minimum of 20 staff reviews are conducted for each provider. Providers with fewer than 20 employees receive 100% review of staff. |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |

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

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

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

SCDHHS has a dedicated position to review Medicaid provider records every 18 months at a minimum, or more often as needed, to ensure that proper service authorizations are on file, provider personnel meet standards required in provider contracts, and ongoing compliance with 1915(i) State Plan HCBS 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice and 1915 (c) HCBS Waivers (Final Rule) regulations. Additionally, all providers are required to complete training with SCDHHS before his/her enrollment with South Carolina Medicaid.

A provider score of 0 indicates no deficiencies. A score between 1-99 indicates that a provider is meeting scope requirements with minor deficiencies, resulting in a corrective-action plan. A score between 100-199 results in a 30-day suspension of service provision. A score between 200-299 results in a 60-day suspension of service provision. A score between 300-399 results in a 90-day suspension of service provision. A score of 400+ results in termination of service provision.

The on-site review consists of three (3) components: administrative review, service review, and staffing review. The administrative review determines that all agency administrative requirements (e.g. liability insurance, organizational chart, policy and procedure manuals) have been met. The service review verifies that all requirements relating to the actual conduct of service have been met. The staffing review samples staff members at different levels to ensure they meet the requirements as outlined in the contract.

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

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based

on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

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

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

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

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

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

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

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

See Waiver Specific Transition Plan in Attachment #2.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Person Centered Service Plan

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

☒ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
*Specify qualifications:*

☐ **Social Worker**
*Specify qualifications:*

☐ **Other**
*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

SCDHHS currently operates under a participant-centered philosophy in all stages of program design in which participants maintain a high level of choice and control. Each participant is involved in the service planning and implementation process and may also include any other person(s) of his/her choice in this process.

The nurse consultant/case manager discusses with the participant and/or the participant's designee(s), his/her choices between home care and institutional services. When home and community based services are chosen, the nurse consultant/case manager informs the participant of available waivered services and waivered service providers. An integral part of the person-centered process is the partnership between the agency and the participant and/or his/her designee(s). The Rights and Responsibilities document, which is signed by the participant, and/or his/her designee(s), and the case manager provides meaningful information to let the participant know that he/she can participate in the service plan development. This meaningful information that is shared in the Participant's Rights and Responsibilities is denoted below:

- To participate fully in the assessment and in developing the person-centered service plan
- To be able to choose or change services and/or providers
- To participate in and have control over his/her services
- To assume risk and be willing to assume responsibility for the consequences of that risk
- To complain about the services rendered

Another method of providing meaningful information is when the person-centered service plan is reviewed with the participant and/or the participant's designee(s) during each contact by the case manager. This gives the participant and/or his/her designee(s) the opportunity to present any changes they would like to make to his/her person-centered service plan.

In addition, the Service Plan agreement form provides another method of meaningful information. This form is signed by the participant and/or his/her designee(s) at the first visit after entry into the waiver and the first visit after the annual re-evaluation. This signature confirms his/her participation in the development of the person-centered service plan as well as the right to choose providers that best meets his/her needs.

Throughout the person-centered planning process, the nurse consultant/case manager supports the participant and/or his/her designee(s) and connects them to necessary resources to address his/her needs. If the participant/designee(s) is not satisfied with the case manager's performance, he/she can contact the lead team case manager in his/her SCDHHS office.

For all participants, the State retains final authority for care plan development. For participants in Healthy Connections Prime HCBS transition, the CICOs, also known as Medicare-Medicaid Plans, will review and approve service plans under State Medicaid Agency oversight with an arbitration process for disputes through the independent ombudsman program. This will ensure that optimal levels of home and community based services are provided to persons enrolled in Healthy Connections Prime.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Completion, implementation, and monitoring of the service plan is a function of the case manager. During the initial person centered service plan development, the case manager and nurse consultant meet to discuss the assessment information for service plan development and to enter the participant into community case management. After the team conference with the nurse consultant, the case manager contacts the participant and/or his/her designee(s) and arranges a time for service plan completion. Thereafter, person-centered service plan development for re-evaluations are developed by SCDHHS case managers and/or provider case managers with the participant and/or his/her designee(s). Active participation and planning with the participant and/or his/her designee(s) regarding participant's long-term care is an integral part of the CLTC program. Development of a realistic and thorough service plan and its implementation in the community involves numerous contacts with the participant and/or his/her designee(s) as well as other agencies providing services to the participant for extensive planning and coordination.

Using the assessment tool that encompasses a comprehensive review of the participant's needs, preferences, goals, health status and strengths, a realistic and thorough person-centered service plan is developed and implemented. The service planning process allows for participation of the participant and/or his/her designee(s), physician, service providers, CLTC Case management team, any other identified person(s) at the participant request and CICO representative(s) for participants enrolled in Prime.

Service planning provides the involved person(s) with information necessary to make an informed choice regarding location of care and services to be utilized. The case manager confers with the participant and/or his/her designee(s) or other permitted caregiver supports concerning needs and to provide information that will assist them in making sound long term care decisions. The service counseling process includes educating the participant and/or his/her designee(s) with the long term care options available to them and ensuring the participant's right to be involved in planning his/her care. The various service options and his/her expected outcomes are clearly explored with the participant and/or his/her designee(s). In addition, service coordination with other involved agencies, e.g., home health, case management hierarchy agencies etc. to ensure all services are considered part of the service planning process.

Each service plan is individualized for a particular participant and completed so that a service professional unfamiliar with the participant can have, by reading the plan, a clear picture of what is being requested by the participant. Service planning must address strengths, needs, preferences, personal goals and health status identified through the assessment process as well as viable solutions. It must include resources currently utilized by the participant, both waiver and non-waiver supports, which may be available to meet the participant's needs. All payment sources, where appropriate, should be considered prior to using Medicaid services (including waiver services) in the service plan.

The service plan addresses all areas in which the participant requires at least limited assistance. These needs are identified in the assessment, home assessment, caregiver supports, and personal goals. Each need has corresponding goals and interventions that the participant and/or his/her designee(s), SCDHHS staff, provider case managers, and CICO (if applicable) work together to meet. When the case manager identifies needs that cannot be met through the waiver services or community resources, they are included in the person-centered service plan as unmet needs.

To evaluate the effectiveness of a service plan, the expected outcome or goal for an intervention must be identified. A goal may be rehabilitative, maintenance, participant or caregiver oriented, as appropriate. A goal is developed as a joint effort between the participant and/or his/her designee(s), physician, and the case management team. Each identified need has a related goal.

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

Once a goal has been established, interventions are discussed and developed toward accomplishing the goal.

Service coordination is a vital component of case management. The case manager works with the participant and/or his/her designee(s), other permitted caregiver supports and other agencies involved in the participant's care to ensure services:

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

Ensuring the person-centered service plan's effectiveness and accuracy is an on-going process. Phoenix assures waiver services cannot be authorized without a completed service plan. Service planning must address needs and goals identified by the participant and/or his/her designee(s) through the assessment process as well as viable solutions. The plan must include resources currently utilized by the participant including both waiver and non-waiver services. Service planning is always a team effort. Staffing for levels of care and service plan reviews at enrollment and reevaluation must be done with SCDHHS staff and/or CICO staff.

The case manager monitors the service plan for each waiver participant at least monthly. Monitoring should be accomplished through contacts with the participant and/or his/her designee(s). Also, case managers should contact waiver providers and non-waiver services as often as the need arises. SCDHHS regional staff as well as Central Office staff monitor to ensure that services are being provided per policy.

At a minimum a new person-centered service plan is required upon re-evaluation, but can be updated as the participant's needs and goals change. Through monthly monitoring, the case manager consistently strives to meet the needs of the participant through the exploration of all waiver services and non-waiver supports. As the case manager becomes aware of significant changes in the participant's health, safety, welfare, or personal goals, updates to the service plan are made accordingly. All new service plans must be staffed with and approved by SCDHHS staff (or CICO staff when applicable).

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Participants are designated for being at-risk for a missed provider visit and being at-risk during a natural disaster. These are identified, addressed and updated as part of the assessment and service planning process. Interventions are included in the service plan to address identified risks.

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The participant is given a list of available providers with phone numbers. This list is randomly ordered to ensure that choice is not related to name or position on the list. For many services a brochure is also given with suggestions as to what to consider in choosing a provider. In all cases, participants are encouraged to call the providers, talk to friends and use any other information they can obtain to make an informed choice. The participant gives an ordered list of chosen providers to the case manager who notifies the first provider through Phoenix. If the provider declines the referral, the second choice is notified. Once a provider accepts a referral, an authorization is created. Participants are informed at the beginning to notify the case manager if not satisfied with the service delivery or provider. At any time, a participant may choose a new provider or request a new worker in the case of in-home services.

At least monthly, the case manager will contact the participant and inquire as to how services are going and remind the participant of his/her right to choose a new provider if they are dissatisfied. Prior to this contact, the case manager will have reviewed Phoenix for claims indicating when services were provided, any missed visits and any flags (e.g., service not at desired time of day, delivery of less than authorized levels of service, delivery from an unauthorized location, etc.). Any indication of problems with these should guide the conversation with the participant to probe for problems with service delivery.

## 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):

SCDHHS designated staff throughout the state oversee waiver operations in a specific geographic area of the state and is charged with overview and approval of all service plans as appropriate. Services cannot be authorized until the service plan is approved by the designated SCDHHS staff throughout the state. Phoenix requires the signature of both parties (the case manager and designated SCDHHS staff) prior to service plan implementation.

The CICOs (MMPs) will review and approve service plans under State Medicaid Agency oversight with an arbitration process for disputes through the independent ombudsman program.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

*Specify the other schedule:*

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

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

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

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

Waiver and non-waiver services are identified in the service plan. No service can be authorized unless specified in the service plan. The case manager monitors service plan implementation monthly through phone contacts or face to face visits with the participant and/or his/her designee(s), to ensure that services are furnished in accordance with the person-centered service plan; the participant has access to waiver services; the participant has choice of providers and that services are meeting his/her needs. Additionally, the case manager monitors the participant's health and welfare and make necessary referrals and provide service coordination with waiver and non-waiver entities. Any identified problems are addressed by the case manager and actions are documented in the narrative. State Quality Assurance staff monitor case management activities through monthly ad hoc reports compiled from Phoenix data.

Providers of nursing and personal care services are required to have a written back up service provision plan for each participant. This plan includes a detailed description of how they will ensure services are provided. Compliance reviews on these providers pull a random sample of waiver participants and determine whether or not such a plan exists and, if the plan has been used, how effective it was. Participants that self-direct his/her hands on care are required to develop and maintain back-up plans. Assistance with this is provided by the case manager who facilitates the self-directed services.

For participants enrolled in Healthy Connections Prime, the CICOs (MMPs) must have waiver service providers in each county sufficient to meet the needs of the target population and to guarantee members have meaningful choice of providers for each service. Additionally, the mandatory utilization of Phoenix, the state's waiver case management system, ensures all members are able to exercise free choice by creating a randomized listing of the CICO's network provider for the member to select.

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

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

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the

participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

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

***The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.***

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of participants' whose identified needs (medical, caregiver supports and home environment) were addressed in the service plan N: Number of assessed participants D: Total number of participants**

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

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

| | | |
|---|---|---|
| | | Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**The number and percent of participants with whom personal goals were discussed**

**during the service planning process N: The number of participants with whom personal goals were discussed D: Total number of participants**

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

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

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |

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

**Performance Measure:**
**The number and percent of participants whose personal goals are addressed in the service plan N: Number of participants whose personal goals are addressed D: Total number of participants who have identified a personal goal**

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

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

| | | |
|---|---|---|
| | | |
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**The number and percent of service plans developed that involved participants and/or caregivers in the development process N: Number of service plans that involved participants and/or caregivers D: Total number of service plans**

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

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

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**
**The number and percent of service plans revised on or before the annual review date**
**N: Number of service plans revised on or before the annual review date D: Total number of service plans**

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

| **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: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

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

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

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

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

**Performance Measure:**
**The number and percent of participants who received services as designated in the service plan N: Number of participants who received services as designated in the service plan D: Total number of participants**

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

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

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

**Performance Measure:**
**The number and percent of participants afforded choice of all qualified waiver service providers N: Number of participants afforded choice of all qualified waiver service providers D: Total number of participants**

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

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

**Performance Measure:**
**The number and percent of participants informed of his/her right to choose waiver services, from those that are available, that will best meet his/her needs as documented by a signed CLTC Rights and Responsibilities form N: Number of participants informed of his/her right to choose waiver services D: Total number of participants**

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

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

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

Service plan updates and annual revisions are performed by case managers and monitored by SCDHHS designated staff throughout the state and central office staff. The Phoenix data system supplies reports to assist with monitoring and assurance that a service plan has been completed annually and within required time frames. All service plans are team staffed and signed in Phoenix by state SCDHHS staff or CICO staff. The service plan is not considered complete without the signature of a state SCDHHS staff or CICO staff.

All statewide data are aggregated in Phoenix and can be filtered as needed.

The Phoenix system links needs (including caregiver supports, home environment, personal goals and other needs) identified in the assessment to the service plan. Any errors discovered by state SCDHHS staff during assessment team staffing are remediated prior to service plan development. Phoenix will not allow service plan completion until all needs identified in the assessment are addressed.

Phoenix captures all waiver services as identified in the service plan. Phoenix will not allow authorization of services that are not identified. Authorization levels are prior approved by SCDHHS staff or the CICO staff for those participants enrolled in Healthy Connections Prime.

If the need for a new service is identified, the Phoenix data system will only allow authorizations if the service plan is updated to include an intervention for the service.

Phoenix generates a list of qualified providers upon request. The list is generated in random order so as to not bias choice. Selections are recorded in Phoenix by the case manager who generates a referral to the chosen provider. If the first choice declines the referral, Phoenix automatically sends a referral to the next chosen provider(s).

All authorizations are monitored to ensure services are received. The EVV is an automated system whose real time data allows for monitoring and verification of the providers delivering services. The toll-free number allows providers to document service delivery. Services not delivered in accordance with the authorization are identified.

For Healthy Connections Prime participants, the CICO staff can record significant changes in the participant's condition using Phoenix and make recommendations about changes to the service plan or make changes to the service plan and service authorizations as part of the demonstration's fully coordinated and integrated model of care.

For providers of in-home services, the Phoenix data system utilizes Care Call electronic visit verification to document time of providers starting and ending services. This entry is compared against authorized limits. Phoenix then creates a claim for the service delivery that will bill what is documented or whatever is authorized, whichever amount is lower. For providers of other services, Phoenix provides a web-entry system to document service delivery. Case managers are required to monitor claims monthly in Phoenix to address any exceptions in service provision.

The Medicaid agency's Phoenix/Care Call system documents the delivery of services by providers and compares the claims to authorizations to ensure appropriate service provision. Further, nurse consultants/provider case managers must receive prior approval from State workers before authorizing services for participants. This ensures needed services are appropriately authorized based on type, amount, and frequency. Also, during monthly case management activities with participants, nurse consultants/provider case managers review the appropriateness and delivery of all services. The outcome of this review is documented on a Phoenix generated narrative checklist. This checklist requires case managers to document whether formal/informal providers delivered services as agreed. Phoenix system-generated reports show the number of prior-approved services that have corresponding authorizations and the number of narrative checklists that accurately address the appropriateness of participant services.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Once a problem has been discovered, designated SCDHHS staff will review the problem with the case manager and notify the provider agency. Problems that can be corrected are considered pending until amended. If the problems are not amended timely, SCDHHS staff can take further designated action. If they cannot be corrected they are sent to provider compliance for sanctioning (e.g., recoupment).
All case management provider agencies are expected to file corrective action plans with his/her appropriate SCDHHS offices throughout the state regarding case manager non-compliance. SCDHHS offices are expected to monitor and report back to Central Office on progress. If the problem is with a state staff it is remediated by the supervisor, reported to Central Office and monitored for improvement. Further actions are taken as necessary.

Phoenix has an algorithm that links needs identified in the assessment to the service plan. The service plan cannot be completed and services authorized until all needs are addressed. If during team staffing or case review it is discovered that a need identified in the assessment was not included in the service plan, the service plan is immediately updated by the provider case manager. If during review it is discovered that a need should have been linked to the service plan but was not, Phoenix programmers are notified for immediate correction.

If during review it is discovered that a participant is not afforded choice of all qualified waiver service providers, the participant will receive a complete provider choice list and be offered the opportunity to change providers. Appropriate action will be taken with the provider case management entity.

**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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix E: Participant Direction of Services

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

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

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

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

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

The waiver offers the opportunity for participants to self-direct personal assistance services. This is done through the attendant care services which provides assistance with ADL's and IADL's. Participants choose who will be providing these services, negotiate a weekly schedule and may terminate the service provider if dissatisfied with the care being received. Participants must demonstrate that they are capable of acting as employer of record. This includes being able to negotiate a schedule, assess the work being done, and determine that needs are being met. If unable to do so, a representative of the participant may assume the responsibilities of employer of record.

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

SCDHHS staff and/or case managers introduce and provide more detailed information concerning the benefits and responsibilities of the option. Case managers assist each participant to identify individual needs, develop a person-centered service plan, and determine the level of participant direction he/she wants to exercise. When participants express an interest in self-direction, nurses employed with a contracted entity make a visit and provide extensive information about the risks, responsibilities and liabilities of the option. For attendant care, observation of care is done by licensed nurses to determine provider's ability to give acceptable care and provide teaching. Information about the role of the Financial Management Service (FMS) is given, as well as suggestions about the hiring, management and firing of workers. In addition, employment packets are completed and forwarded to the FMS.

A Financial Management Service (FMS) is coupled with a self-directed service. This is treated as an administrative function for this waiver. Payments are transferred from MMIS to the FMS, who is then responsible for processing payroll, withholding, filing and payment of applicable employment-related taxes and insurances. These services are provided for each participant with employer authority over his/her care.

Once a participant has chosen participant direction and is receiving services, case managers continue to monitor service delivery and the status of the participant's health and safety. Phoenix reports are monitored monthly for service delivery, and monthly contacts ensure that care is being provided and that the participant is receiving appropriate care. Quarterly visits are also made to ensure that the appropriate services are being provided.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

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

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

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

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

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

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

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

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

*Specify the criteria*

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

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

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

Waiver participants are given a brochure that provides an overview of all waiver services, including the participant directed services of attendant care, at the initial visit by the case manager for completion of the person centered service plan. Participants expressing an interest in self-directed services are given additional information about self- direction and the benefits and responsibilities of self-directed services. Participants who wish to receive this service after getting this information are visited by a licensed nurse, employed by a contracted entity, who gives detailed information about the service.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant may choose to have waiver services directed by a representative and he/she may choose anyone willing to understand and assume the risks, rights and responsibilities of directing the participant's care. A representative may be a legal guardian, family member, or a friend of the participant. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant's preferences and medical condition(s), be at least 18 years of age, and must sign off on service logs weekly and observe care given on at least a monthly basis. An individual chosen by the participant to serve as his/her representative will not be paid and cannot provide waiver services to that participant.

The case manager completes an initial screening assessment of the representative to ensure the representative is capable of functioning in the best interest of the participant. Additionally, the representative is required to sign a Rights and Responsibilities form which indicates that he/she is knowledgeable of the participant's needs.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Attendant Care | ☒ | ☐ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

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

**Provide the following information**

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

South Carolina contracts for Electronic Visit Verification services through award of a bid submitted in response to a Request for Proposals (RFP) by the State. The provision of FMS is included as a component of this contract.

The State provides FMS as an administrative function. These are included in the State's EVV RFP bid. The entity that provides Electronic Visit Verification (EVV) functions also is responsible (through sub-contract) for all FMS functions. This allows the state to leverage its electronic system to facilitate claims submission and other functions of FMS.

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

A monthly per participant fee is charged for financial management services.

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

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

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

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

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

☐ **Other**

*Specify:*

Supports furnished when the participant exercises budget authority:

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

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

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

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

☐ **Other services and supports**

*Specify:*

Additional functions/activities:

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

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

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

☐ **Other**

*Specify:*

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

The SCDHHS' EVV/Phoenix system documents the delivery of services by providers and compares the claims to authorizations to ensure appropriate service provision. SCDHHS receives files on a regular basis indicating payments that have been made to individuals providing self-directed services. These are compared with claims reports indicating money paid to the provider of FMS. In addition, the EVV vendor which currently sub-contracts for FMS, receives the same data and conducts periodic audits to determine payments are made appropriately . SCDHHS has one staff position charged with ensuring that provider payments are done timely and accurately. Any discrepancies or other issues are discussed with the vendor and resolved as appropriate. SCDHHS can request a complete financial audit at any time.

The system transfers data and submits claims to MMIS six times a week for the amount of service provided. Weekly payments are transmitted from MMIS to the FMS, including a detailed breakdown of each worker's payment. FMS makes payments bi-weekly.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

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

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

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

A case manager visits the participant and discusses what is involved in participant direction. The case manager helps the participant list individual needs, decide how to get needs met and develop a service plan.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3

(check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Case Management** | ☒ |
| **Pest Control** | ☐ |
| **Home Accessibility Adaptations** | ☐ |
| **Personal Emergency Response System** | ☐ |
| **Home Delivered Meals** | ☐ |
| **Attendant Care** | ☐ |
| **Personal Care I and Personal Care II** | ☐ |
| **Specialized Medical Equipment and Supplies** | ☐ |
| **Respite** | ☐ |
| **Private Duty Nursing** | ☐ |

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one).*

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

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

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

Case managers monitor participant directed services on a monthly basis or more often if needed. If there is any indication that services are not meeting participant needs, the case manager will work with the participant to determine what, if any, problems exist. If problems cannot be corrected so as to ensure that the participant's needs are being met, participant directed services will be terminated. If a participant is involuntarily terminated from participant directed services, the termination of participant directed services and the authorization of agency directed services are coordinated to assure continuity of services.

In all cases participants have the right to appeal any termination of services. Participants are notified of this right both verbally and in writing.

Participants in Healthy Connections Prime have additional resources available to help in his/her appeal, including his/her care coordinator and access to the independent ombudsman’s arbitration process

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

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

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | 14 | |
| **Year 2** | 14 | |
| **Year 3** | 14 | |
| **Year 4** | 14 | |
| **Year 5** | 14 | |

## Appendix E: Participant Direction of Services

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

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

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

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer

(managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

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

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

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

☒ **Recruit staff**

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

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

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

Specify how the costs of such investigations are compensated:

Prospective employees must provide acceptable background checks to be employed. Prospective employees pay for these background checks.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

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

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

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

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

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

# Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

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

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

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

# Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

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

# Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not

given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

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

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

Participants are notified in writing as to how to file an appeal by using an appeals notice. This notice is included with any CLTC Notification Form related to a termination, denial, reduction or suspension of any service or service request. These notices are sent when an applicant/ participant is determined to be medically ineligible for the waiver or is being involuntarily terminated from the waiver or when a service is being involuntarily suspended, terminated, denied or reduced for any reason. SCDHHS Division of Appeals and Hearings has a public website (www.scdhhs.gov/appeals) which houses information related to how to file an appeal and allows an applicant or participant to file an appeal online if desired.

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

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

Once an appeal has been filed, the appeals examiner may elect to order a pre-hearing conference in an attempt to resolve issues being appealed outside of a hearing. The appeals examiner will notify the participant or his/her designee(s) by certified mail of the deadline for the conference to be held and the deadline for a summary of the conference to be sent to the appeal examiner. If the issues being appealed are resolved to the participant's or his/her designee(s)'s satisfaction (as evidenced by the participant's/ designee(s)'s written summary) during the pre-hearing conference, the appeal will be dismissed. If there are outstanding issues which the participant/ designee(s) wish to appeal, the appeals examiner will notify the participant and the applicable SCDHHS office throughout the state and/or the Central Office of the date, time, and location of the hearing via certified letter. The letter also contains a toll free number to call for assistance.

All participants have access to the State-operated appeals and Fair Hearing process. Participants in Healthy Connections Prime also have access to the demonstration's ombudsman for disputes related to service authorizations and service levels to ensure that optimal community based services are provided in the best interest of each participant. The arbitration process is not a pre-requisite or substitution for a fair hearing.

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

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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

All participants will use the State-operated appeals and Fair Hearing process. Participants in Healthy Connections Prime have access to an additional independent ombudsman representative to assist in the arbitration process.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

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

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

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

The State Medicaid agency operates the Complaint/Grievance System.

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

Participants may make complaints at the SCDHHS offices throughout the state, central office and state agency level, in person, in writing and by phone. Participants are notified of his/her right to complain/grieve through a Participant's Rights and Responsibilities statement reviewed at the initial visit, the re-evaluation visit and other times as needed; and signed at the initial visit after waiver entry. Phone numbers and addresses are supplied to participants as a part of the initial visit information packet. When a participant elects to file a grievance or make a complaint, the participant is informed that doing so is not a pre-requisite or substitute for a Fair Hearing.

Types of complaints taken include complaints against providers including case management providers; complaints about reduction or termination of services; complaints regarding unmet needs; complaints regarding the processing list; allegations of abuse, neglect, and exploitation; and any other complaint about services received under the waiver.

The SCDHHS worker receiving the complaint fills out an electronic complaint form located in Phoenix, initiates action to address the complaint and tries to reach resolution. Complaint forms are sent electronically to the quality assurance (QA) and provider compliance departments. The expectation is the appropriate personnel will acknowledge and resolve the complaint as soon as possible. Pending actions and complaint data are tracked and documented via the Phoenix system.

Actions taken to resolve complaints may include contact with providers, referrals to supervisors and/or referral to adult protective agencies. In addition to the above, SCDHHS has a mechanism for receiving complaints through his/her website. These complaints are filtered to the correct division for resolution. Responses must be submitted to appropriate agency personnel within seven (7) days of receipt of the complaint.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or

Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

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

Mandated reporters are required to report incidents verbally by telephone or in written form to the County Department of Social Services/Adult Protective Services Unit. Written or verbal telephone reports of incidents occurring in facilities are reported to the State's Long Term Care Ombudsman Office.

SCDHHS also monitors for other reportable incidents. These are defined as incidents involving death or serious harm to a beneficiary/participant. Reportable incidents include:

- Unexplained deaths
- Falls (resulting in death, injury requiring hospitalization, injury that will result in permanent loss of function);
- Traumatic injuries (including third degree burns over more than ten (10%) percent of the body) that result in death, require hospitalization, or result in a loss of function;
- Unauthorized restraints, both chemical and physical, use that results in death, hospitalization, or loss of function;
- Media-related events. Any report that presents a potential or harmful characterization of the State Medicaid Agency or any of its contracted entities.

For participants enrolled in Healthy Connection Prime, these incidents are known as serious reportable incidents (SREs).

In addition to the aforementioned incidents, CICOs, also known as Medicare-Medicaid Plans, will monitor for:

- Infectious disease outbreaks
- Pressure ulcers that are unstageable or staged III and IV;
- All elopements in which a beneficiary with a documented cognitive deficit is missing for twenty-four (24) hours or more

The State will oversee compliance with State and Federal requirements to ensure all reportable incidents/SREs are reported to the proper regulatory entity, when appropriate. This applies to all waiver participants including those participants enrolled in Healthy Connections Prime.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including

how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Upon waiver enrollment, participants and family members are provided written information about reporting abuse, neglect and exploitation of the elderly and other vulnerable adults. The material provided defines vulnerable adults, what is abuse, and providers' phone numbers of where to report suspected abuse cases if they occur. Case managers explain this information to participants during the initial visit, annually during the reevaluation, and additionally as needed.

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

Reports of incidents occurring in facilities are reported to the State's Long Term Care Ombudsman's office (43-3525). Incidents in other settings are reported to the Adult Protective Services Program and the county Department of Social Services. Reports can always be made to law enforcement. SCDSS initiates an investigation upon information alleging abuse, neglect or exploitation in all settings other than facilities. They contact law enforcement if criminal violation is suspected. They initiate protective measures either through Ex Parte order or Emergency Protective Custody. They conduct complete investigation. The Long Term Care Ombudsman initiates investigation of suspected abuse, neglect or exploitation occurring in facilities. They contact law enforcement if criminal violation is suspected. They conduct complete investigation and if substantiated, notification is sent to appropriate agencies. Law Enforcement contacts appropriate social service agency, completes reports, initiates emergency protective custody if required, investigates, and if substantiated, prosecutes or forwards for prosecution. SC Dept. of Disabilities and Special Needs, Attorney General, Protection and Advocacy, Dept. of Mental Health have specific policies and procedures to follow and regulatory actions that can be taken.

Depending on the nature and location of the incident, many agencies (i.e. Department of Social Services/Adult Protective Services, South Carolina Long Term Ombudsman, Department of Special Needs and Developmental Disabilities, Mental Health, Law Enforcement, and Attorney General) may be involved in the investigation of an incident. The time frames for agencies to begin investigations are specific and are noted below. The investigation processes, completion of investigations and notification policies for these agencies vary. However, to monitor the health and safety of participants' who may be involved in an incident, at a minimum case managers must conduct monthly follow up with participants and complete service coordination with provider agencies that provide any service to participants at least quarterly.

During contacts with participants/primary contacts and service coordination with provider agencies, case managers are required to discuss changes in participants' needs and services. Therefore, any new or on-going incident(s) would be discussed and monthly follow up with the appropriate agency is required. Monthly follow up is provided until the incident has been resolved by staff from all agencies involved. If a case manager is not successful at obtaining information from agency staff, he/she must seek assistance from SCDHHS supervisory staff. If SCDHHS supervisory intervention is not successful, SCDHHS management staff become involved until acceptable feedback is obtained. Time frames for agencies to begin investigations are noted below:

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

South Carolina Long Term Care Ombudsman Office:
Upon receiving a report, the Long Term Care Ombudsman promptly shall: initiate an investigation; or review the report within two working days for the purpose of reporting those cases that indicate reasonable suspicion of criminal conduct to local law enforcement or to the Vulnerable Adults Investigations Unit of the South Carolina Law Enforcement Division (SLED). A report to local law enforcement or SLED must be made within one working day of completing the review.

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

Attorney General:
The Attorney General, upon referral from the Long Term Care Ombudsman Program or the Vulnerable Adults Investigations Unit, may bring an action against a person who fails through pattern or practice to exercise reasonable care in hiring, training, or supervising facility personnel or in staffing or operating a facility, and this failure results in the commission of abuse, neglect, exploitation, or any other crime against a vulnerable adult in a facility. A person or facility

which verifies good standing of the employee with the appropriate licensure or accrediting entity is rebuttably presumed to have acted reasonably regarding the hiring.

The process and timeframes for informing the participant and other relevant parties of the investigation results is the responsibility of the investigative agency. The applicable agency is statutorily required to notify the participant of the outcome of his/her investigation.

Contracted Coordinated Care Organization also known as Medicare-Medicaid Plans:

The Contracted Coordinated Care Organization is required to conduct a thorough investigation of each incident and provide a detailed report documenting the resolution. In the case of Serious Reportable Events (SRE) involving a facility, the Contracted Coordinated Care Organization will conduct a quality of care investigation to determine if the SRE was related to quality of care. The Contracted Coordinated Care Organization will also report to the State if a quality of care issue leads to adverse action against the provider including, but not limited to non-payment, suspension or termination of contract.

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

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

SCDHHS is responsible for overseeing the reporting of and response to any Reportable Incidents. Reportable Incidents data will be reviewed for quality improvement activities, accountability, public reporting, and improving the overall health and welfare of beneficiaries/participants. At a minimum, the State will schedule bi-monthly meetings with internal subject matter experts to determine if additional follow up is needed.

## Appendix G: Participant Safeguards

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

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

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

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

Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Social Security Act.

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

Per DHEC regulations, any incidents involving seclusions, restraints or restrictive interventions must be reported to DHEC by facility staff. Staff at DHEC investigates reported incidents and notify appropriate SCDHHS staff. Facility staff are also required to notify appropriate SCDHHS staff of any incidents.

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

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

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

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

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

## Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restrictive interventions**

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

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

Per DHEC regulations, any incidents involving seclusions, restraints or restrictive interventions must be reported to DHEC by facility staff. Staff at DHEC investigates reported incidents and notify appropriate SCDHHS staff. Facility staff are also required to notify appropriate SCDHHS staff of any incidents.

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

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

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

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

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

## Appendix G: Participant Safeguards

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

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

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

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

Per DHEC regulations, any incidents involving seclusions, restraints or restrictive interventions must be reported to DHEC by facility staff. Staff at DHEC investigates reported incidents and notify appropriate SCDHHS staff. Facility staff are also required to notify appropriate SCDHHS staff of any incidents.

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

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

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

## Appendix G: Participant Safeguards

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

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

**a. Applicability.** Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

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

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

## Appendix G: Participant Safeguards

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

**c. Medication Administration by Waiver Providers**

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

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

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

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

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

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

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

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

  (c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

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

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*** *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a.** ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of participants (and/or family or guardian) who received information on how to report abuse, neglect, exploitation and other reportable incidents N: Number of participants documented to have received information/education on how to report abuse, neglect, exploitation and other reportable incidents D: Total number of participants**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**Phoenix Data System - Signed "Participant Rights and Responsibilities" Form**

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**
**Number and percent of participants who report knowing how to report abuse, neglect, exploitation or other reportable incidents N: Number of participants who reported knowing how to report abuse, neglect, exploitation or other reportable incidents D: Total number of participants in the sample**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Health, Safety and Welfare Survey**

| **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**<br>Confidence Interval =<br>95% confidence interval |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**The number of abuse, neglect and/or exploitation complaints reported in the Phoenix complaint system and the percentage of those complaints resulting in referrals to Adult Protective Services (APS) N: Number of abuse, neglect and/or exploitation complaints reported that resulted in referrals to APS D: Total number of abuse, neglect and/or exploitation complaints**

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

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

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

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of reported incidents that are monitored until appropriate resolution N: The number of reported incidents that are monitored until appropriate resolution D: Total number of reported incidents**

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

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

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of case managers who received training on their responsibilities as mandated reporters of abuse, neglect and exploitation N: Number of case manager**

**entity staff with documentation of training on abuse, neglect and exploitation and mandated reporter requirements. D: Total number of case management entity staff**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case Manager Orientation sign-in sheets or CLTC's E-Learning verification**

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

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |

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

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

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

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

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of direct care provider staff (personal care and attendants) that are informed about mandated reporting requirements N: Number of direct care provider staff with documentation of mandated reporting training for staff. D: Number of provider agencies**

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

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

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

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of unauthorized uses of restrictive interventions that were appropriately reported N: Number of incidents of unauthorized uses of restrictive interventions that were appropriately reported D: Total number of incidents of unauthorized uses of restrictive interventions that were reported**

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

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

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

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of participants who have been evaluated for Emergency Disaster preparedness. N: The number of participants who have an Emergency Disaster preparedness plan D: Total number of participants**

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

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

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

During training, case managers are informed of his/her responsibility as mandated reporters to make referrals to the appropriate entities as necessary. The consequences for failing to report any incident of abuse, neglect or exploitation or other reportable incidents is also discussed with the case managers during training. A power point presentation on Elder Abuse and Adult Protection Act has been developed and placed on the internal website for training purposes. In addition, case managers are trained on the appropriate process for recording APS referrals and other reportable incidents and the use of the instrument (Phoenix) to record, update and track APS referrals and/or reportable incidents. Also, SCDHHS central office and SCDHHS offices staff throughout the state have been trained on the process of reporting and tracking APS referrals and/or other reportable incidents in the SC Phoenix data system.

Monthly follow up is provided and documented in the participant's record until the incident has been resolved by staff from all agencies involved. If a case manager is not successful at obtaining information from agency staff, he/she must seek assistance from SCDHHS offices supervisory staff. If the SCDHHS office supervisory intervention is not successful, Central office staff become involved until acceptable feedback is obtained.

The Health, Safety, and Welfare Survey seeks in part to obtain baseline data indicating waiver participants' knowledge of safety precautions and protocol in the event that they experience a threat or change to their safety or well-being. Other aspects of health and welfare material to the survey are participants' social engagement, participants' thoughts about their own physical health, and to what extent participants engage in 'healthy' activities. This data source is used only to identify the number and percent of participants who report knowing how to report abuse, neglect, exploitation or other reportable incidents. It does not extend to the number and percent of participants (and/or family or guardian) who received information indicating how to report abuse, neglect exploitation and other reportable incidents, nor to the number of abuse, neglect and/or exploitation complaints reported in the Phoenix complaint system or the percentage of those complaints resulting in referrals to Adult Protective Services.

Presently, SCDHHS uses the complaint section existent within the Phoenix case management system to capture and monitor the number of abuse, neglect and/or exploitation complaints reported. However, SCDHHS is developing a critical incident management system within Phoenix to replace the complaint section as a means of improving this process.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

SCDHHS is responsible for overseeing the reporting of any referrals related to APS and/or reportable incidents. When problems are identified with the progress of APS referrals and/or reportable incidents, the appropriate person(s) (APS worker and/or case manager) are contacted for immediate follow up and updates. Difficult cases are discussed at Central office's scheduled bi-monthly meetings (or as needed) with internal subject matter experts to determine possible resolutions.

**ii. Remediation Data Aggregation**

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

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 3)

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

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

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Phoenix data system provides 100% reporting on specified performance measures (i.e. monthly contact/visit activities, including initial/re-evaluation assessments and LOC determinations; documentation of activities; service plan development; and EVV activity logs covered under each assurance for each case manager). Phoenix generates reports that can be parsed at whatever level of detail is required. This process allows a thorough assessment of areas needing improvement and areas of best practice.

Prioritizing and implementing system improvements are based on the severity of identified problem(s) and the frequency of duplicated errors. Waiver assurances that fall below 86% and issues that show a systemic problem are top priority and would result in immediate system improvement. Systems improvement for waiver assurances below 86% may involve the following: 1. Revisions to the training program. 2. Revision of policy and procedure for clarification. 3. Modification to enhance the Phoenix system.

Systemically, any areas needing improvement, even if not one of the six assurances, would become a top priority based on the prevalence of the problem. Systems improvement for statewide problems can be addressed through any of the following: 1. Revision to the training program. 2. Revision of policy and procedure for clarification. 3. Modification to enhance the Phoenix system.

Throughout the demonstration, efforts will be made to carefully monitor each CICO's, also known as Medicare-Medicaid Plans, performance as outlined in the three-way contract and its ability to fully assume responsibilities for care coordination and integration. Any early indicators of performance concerns will lead the State's contracted EQRO to design and implement a Quality Improvement Plan (QIP), including remediation if needed, for the affected CICO(s).

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☒ **Quality Improvement Committee** | ☐ **Annually** |
| ☐ **Other**<br>Specify: | ☒ **Other**<br>Specify:<br>On-going |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The following process is used for monitoring and analyzing system design and data: The Phoenix data system allows Central Office staff to gather, monitor, and analyze data from the SCDHHS offices throughout the state related to reports on assurances and related performance measures, case management, other waiver service providers, complaint reports and adult protective service referrals/reportable incidents. SCDHHS office supervisory staff identifies problems and inconsistencies (e.g.,failure to meet Policy and Procedure guidelines) and reports these issues to Central Office and contracted provider agencies as needed. Also, Central Office staff has developed and implemented a standardized tool to assist with quality assurance efforts for the supervisors. Provider compliance reports and APS/reportable incidents are submitted, via Phoenix, daily or as needed.

In addition, Central Office staff gathers and compiles information from the following data sources: Client Satisfaction Surveys conducted by a contracted entity ; case management provider compliance reports from SCDHHS staff; case manager reviews conducted by SCDHHS staff; other waiver service provider reviews conducted at least every 18 months by SCDHHS staff; participant appeals and dispositions; SCDHHS Offices' administrative reviews; quality assurance reviews on selected case managers and reports on case management agencies that are non-compliant with corrective action plans.

Information gathered from the aforementioned data sources is discussed during the Quality Improvement task force meeting, which is scheduled to meet bi-monthly. The task force will meet more frequently, as needed. This task force is comprised of members from various SCDHHS divisions. Reports and trends are shared with SCDHHS offices and providers as appropriate. The data are reviewed and discussed for discovery of noncompliance, corrective action and strategies for remediation. Remediation strategies include but are not limited to recoupment, suspension, or other corrective actions. If corrective action plans are not adhered to, further action such as case load reduction, suspensions, up to termination may result. Reports, corrective action plans, appeals and dispositions are brought to the Quality Improvement task force to review outcomes. Outcomes would assist in determining necessary policy or system changes. SCDHHS offices and providers are notified of changes through e-mail and Phoenix.

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

The process to evaluate the quality improvement strategy is discussed at regularly scheduled central office internal staff meetings as well as central office/SCDHHS offices supervisory staff meetings. Input and feedback are sought to determine if the process is working properly, and systems are functioning as designed. Input and feedback are also accepted from external stakeholders on an ongoing basis.

Additionally, there is the capability to report problems in the Phoenix system that allows issues discovered by users to be submitted to the Phoenix helpdesk for consideration or correction. This allows ongoing quality improvement within the Phoenix system.

All quality improvement strategies are discussed at the task force meetings.

Results of the QIS are communicated to waiver providers through Phoenix broadcast messages; SCDHHS website; Medicaid bulletins; annual conferences/meetings; emails; P&P directives as changes occur. Any agencies that are affected through changes are provided information at meetings; through Medicaid bulletins and via the SCDHHS website as changes occur. Inquiries for information from interested parties and the public are responded to immediately and they have access to Medicaid bulletins and changes posted on SCDHHS website.

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

## Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

## *Appendix I: Financial Accountability*

### *I-1: Financial Integrity and Accountability*

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

*The State (SCDHHS) employs the following methods to ensure the integrity of payments made for waiver services in different departments within the agency:*

*The State (SCDHHS) has a designated staff member charged with conducting on-site reviews of providers of personal care and nursing services at least once every eighteen (18) months. The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other requirements as outlined in the contract. The administrative review determines that all agency administrative requirements (e.g., liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review pulls a sample of participants' charts and verifies that all requirements relating to the actual conduct of service have been met such as task sheets verifying service delivery. If a discrepancy is found, claims can be reviewed through Phoenix to ensure providers are not inappropriately reimbursed. The participant review verifies that all requirements relating to the actual conduct of service have been met. The Compliance Officer reviews Phoenix reports and compares them to provider's documentation of service delivery to ensure financial integrity.*

*The State employs Environmental Modification Specialists who conduct on-site reviews of environmental modifications to ensure all building codes and regulations are followed. Onsite reviews prior to the work being done are conducted on all modifications except those involving only ramps and grab bars. Reviews after the work is completed are done if requested by the case manager or if there are issues with the particular provider. Spot check reviews are also done on a subset of the jobs performed. If deficiencies are found, providers are afforded an opportunity to remediate the identified deficiencies. If providers do not remedy the deficiencies, they are recouped or suspended depending on the severity of the deficiency.*

*Program Integrity:*
*The Division of Program Integrity at SCDHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to CLTC waiver 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 SCDHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged. In this capacity, the Division of Audits can conduct a compliance review of the Fiscal Management Service (FMS) used for participant directed care in the CLTC waiver program.*

*Provider research is conducted. Research of the provider may include one or more of the following: Identification of NPI and affiliations, Secretary of State, Background Checks, MMIS Provider Enrollment Information, Review of Contract and/or Provider Enrollment Records (this information should be both on the NPI and legacy number);*
- *The following steps should always be done:*
- *Develop and review Surveillance and Utilization Review data (SUR)*
- *Reviewer should schedule meetings with SUR staff and PI investigator to discuss details of provider billing, any complaints, referral, etc.*
- *Review applicable Program Policies.*
- *Determine what type of review will be conducted (i.e., onsite, desk review, self-audit, or focus review)*
- *Determine period of review and select sample of beneficiaries based on all information gathered*

o *Reviewer completes an onsite packet which includes the following:*
*Letter detailing purpose of review;*
*Enrollment information*
*Applicable policies and regulations regarding access to records;*
*Disclosure of Ownership request;*
*Request list of employees;*
*Provider Review Questionnaire which request, contact information, provider's address, all NPI, legacy and FEIN numbers*

*Upon receipt, records are reviewed by the Program Integrity Reviewer to ensure that the documentation clearly indicates the medical need for the services and have been billed and paid according to policy and procedures.*

*After the initial review is completed, a findings letter is generated and supported with pertinent data and analysis reports. The provider is given 10 days to respond and provided an opportunity to request an informal conference to discuss the review findings.*

*After the 10 day letter, and any meeting requested by the provider, a final determination letter is generated which includes*

*appeal rights, instructions for filing an appeal and the timeframe for which to file an appeal.*

*If there is an indication of fraudulent billing at any point during the review process, the case is referred to the SC Medicaid Fraud Control Unit (MFCU). Regularly scheduled communication and feedback will continue between PI and MFCU until a determination and/or convictions or fraud of civil action is final. In situations where a credible allegation of fraud exists, PI must suspend the provider's payments and issue appropriate notifications as established by Program Integrity Policies and Procedures.*

*If the provider fails to abide by the PI recoupment, the provider may be subject to Termination for Cause due to non-payment of a PI established recoupment.*

*A review may occur upon receipt of a valid complaint from any source, referral from program areas based on QA they've conducted, outside agencies and/or selection as a result of Surveillance Utilization Exception Reporting.*

*For all claims submitted through Phoenix, a pre-payment review is conducted. Phoenix only submits claims to MMIS or CICOs for services that were prior authorized by the case manager and are included in the participant's service plan. Phoenix compares services documented by providers to the amount, frequency, and duration prior authorized by the case manager. Only service claims that meet these conditions are submitted to MMIS or CICOs for payment. The structure of this system therefore ensures the accuracy of billing.*

*In regard to the State's other reviews, potential fraudulent billings are identified and duly reported to SCDHHS Program Integrity.*

*A review time-period is selected and a random sample is generated. In addition to the random sample selection, additional records may be selected from exceptions and deviations discovered on SUR reports.*

*Reviewer requests and review records. Program Integrity may conduct any one of the following types of review:*
*Desk Review - A Desk Review occurs when the Program Integrity Reviewer requests the provider records but does not conduct an on-site review at the provider's place of business.*
*Onsite – An onsite occurs whenever there are strong indicators for waste, fraud and abuse.*
*Provider Self Review – In a provider self-review the provider performs a self-review and notifies the Department of the results.*
*You-Owe-Us – Data profile and analysis that can be used for provider notification and recoupment. This type of review does not typically require evaluation of the medical record. The provider is provided the opportunity to conduct his/her own review and submit information that may result in revision of the original amount identified by Program Integrity.*

*A random sample of claims is selected. The generated number of claims for each review differs between providers. The State determines the number of claims to review with the use of a random number generator, which is an Excel add-in feature.*

*In general, the review entails the review of applicable program policy, review of paid and/or rejected claims information, and review of the medical record and associated documents in beneficiaries' file in support of the claim submission.*

*The State's Compliance Officer completes exit interviews with providers and final results are electronically mailed to the provider. Program Integrity communicates all finding through certified letter to the providers.*

*The State does require corrective action plans from providers. Providers receive follow up within the designated time frame communicated in the final results.*

*The Division of Audits conducts compliance reviews upon request. However, the FMS completes yearly audits internally and refunds the State for any over payments.*

*Public, Partnership, LLC (PPL) has a Program Accounting and Compliance Team which is responsible for the internal audit of programs. As part of the internal audit, PPL's Program Accounting and Compliance Team completes an annual reconciliation for SCDHHS. This is a reconciliation of service cash receipts to program expenditures.*

*The State's Auditor Office is the entity responsible for conducting the periodic audit of the waiver program under the provisions of the Single Audit Act.*

*The State does not require waiver providers to secure an independent audit of his/her financial statements.*

## *Appendix I: Financial Accountability*

### *Quality Improvement: Financial Accountability*

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

***a. Methods for Discovery: Financial Accountability Assurance:***

***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.*** *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

***i. Sub-Assurances:***

***a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

***Performance Measures***

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

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

***Performance Measure:***
***Number of waiver claims that were paid per requirements outlined in the waiver application. N: Number of waiver claims paid per requirement as outlined in the waiver. D: Total number of submitted claims.***

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***Medicaid Management 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:* | ☐ ***Annually*** |
| | ☒ ***Continuously and Ongoing*** |
| | ☐ ***Other*** *Specify:* |

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

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***Electronic Visit Verification 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***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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*** |

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

***Performance Measure:***
***The number and percent of waiver claims using the EVV to document service delivery N: Number of EVV claims submitted for payment D: Total number of waivered claims paid for EVV services***

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***Electronic Visit Verification (EVV) 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***<br>*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***<br>*Specify:* | ☐ ***Annually*** |
| | ☒ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***The number and percent of cases for non-EVV services where participants indicated the service was provided N: Number of times participants indicated services were performed and billed D: Total number of responses from participants***

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

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

| | | |
|---|---|---|
| ☐ ***Operating Agency*** | ☐ ***Monthly*** | ☐ ***Less than 100% Review*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** | ☐ ***Representative Sample***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☐ ***Annually*** |
| | ☒ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

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

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

***Performance Measures***

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

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

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

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***Automated telephone and billing system***

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

| | | |
|---|---|---|
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other*** *Specify:* |
| | ☐ ***Other*** *Specify:* | |

***Data Aggregation and Analysis:***

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

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

*The Phoenix automated case management system automatically ties the needs identified in the assessment to the service plan. This ensures that any services billed for a participant are identified as a need on the assessment.*

*Claims for waiver services are submitted to the State's Medicaid Management Information System (MMIS) for payment via Phoenix, with the exception of institutional respite claims. These claims are submitted using the CMS-1500 form or the State's electronic billing system. Providers of waiver services are required to utilize the Phoenix or the Electronic Visit Verification system to document service delivery. Phoenix compares service documents in both systems and only allows for billing up to the authorized service limits and if the service is provided in the required time period.*

*The state's Medicaid Management Information System (MMIS) ensures that claims submitted via Phoenix are for participants in a waiver program, that the service is paid at the appropriate rate and that the participant is Medicaid eligible.*

*All claims submitted for Healthy Connections Prime participants via the State's automated system, Phoenix, will be routed electronically to the CICOs, also known as Medicare-Medicaid Plans, for payment. The CICOs will ensure that each service is paid at the appropriate rate and that the participant is Medicaid eligible.*

***b. Methods for Remediation/Fixing Individual Problems***

***i.*** *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

*Individual problems may arise if either the Phoenix case management system and/or Medicaid Management Information System are not updated correctly. Any errors identified by workers utilizing the systems are notified and corrections are made and claims are reprocessed appropriately. Provider trainings are done on an as needed basis and biannually. SCDHHS staff training is also done on a periodic basis to ensure the latest methods are covered.*

*If it is discovered that payments were made when services were not delivered then the payment will be recouped. Providers will be notified of the amount being recouped and the reason.*

***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***<br>*Specify:* | ☐ ***Annually*** |
| | ☒ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***c. Timelines***

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

- (●) ***No***
- ( ) ***Yes***

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

## *Appendix I: Financial Accountability*

### *I-2: Rates, Billing and Claims (1 of 3)*

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

*The Department of Reimbursement Methodology, with assistance from the Department of Long Term Care Services, is responsible for the development of waiver service payment rates. Each department operates under the direction of the SC Department of Health and Human Services.*

*Requests for public input for rate determination methods are primarily communicated through the quarterly MCAC (Medical Care Advisory Committee) meetings as well as monthly IHS (Indian Health Services) conference calls. Further, waiver renewals and amendments are communicated to the public through public notices and subsequent public meetings and webinars. Comments are solicited through these communications. Waiver rates are available upon request for any waiver participant. The State does not routinely inform the participants of rates unless requested.*

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

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

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

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

*The current fee-for-service reimbursement rates for all services exists as a rate floor that may be adjusted annually according to the state's fee schedule. Reimbursement rates below the rate floor must have state approved methodology and should include a corresponding performance and/or quality incentive reflective of 100 percent of the fee-for-service rate (at a minimum); however, there have been no cases wherein the rates were lower than the floor to date.*

*A large majority of the waiver service rates were established based upon the projected costs of the service to be provided. These services would include Personal Care I and II, Medicaid Nursing and Home Delivered Meals.*

*Personal Care I and II: The State uses market research to set rates or to make adjustments to existing rates. The State's market research consists of an informal process whereby private providers are contacted to inquire about the private pay rate of the same service. The State takes this information into consideration when determining rates or adjustments to rates. The State also uses the provider cost survey information when determining rates. The State does not conduct a formal survey of providers. The cost survey is an informal process whereby private providers are contacted to inquire about the private pay rate for the same service. When establishing the rates, the State will do a sample survey of providers to determine the private pay rate before establishing a waiver rate. The State randomly selects a sample of large providers and small providers of the service to survey. This is completed any time a new rate is considered. Other states' rates are used for comparison. Provider cost surveys only request rate information from states in Region IV. North Carolina and Georgia are the states primarily consulted within this process. Region IV states are used to determine the adequacy of rates other than personal care, in circumstances wherein the State is seeking a rate increase. The State does not have documentation of the market survey used to develop rates.*

*Personal Care I does not include any hands-on care to the participant and is restricted to activities such as errands,*

*laundry, meal preparation and similar tasks. Personal Care II includes hands-on assistance with activities of daily living and requires a higher skill and training level of the aide.*

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

*Attendant services are paid at a fixed rate. This rate includes the hourly rate for the service plus the employee and employer share of taxes and other benefits. The current bill rate for Attendant care is $11.60 per hour and the actual rate is $10.52 per hour, a differential of $1.08 which is used to calculate the employer share of taxes. The employee share of taxes is deducted from the actual rate. The attendants receive W-2 forms at the end of the year.*

*Institutional Respite: Institutional respite conducted in a nursing facility is based upon the daily rate for that facility. Hospital based respite is calculated as the average daily nursing facility rate.*

*In Home Respite: The rate is designed to cover the cost for 24 hours of care provided by a licensed nurse and was modeled after the institutional respite rate.*

*All Home Accessibility waiver service rates for modifications with the exception of ramps are manually priced based upon the provider's cost estimate. Ramps are priced by the linear foot and participants choose a provider. The State regularly solicits input from providers on the appropriateness of the per foot rate and adjusts this rate based upon changes in lumber costs. There is no single rate for all ramps. Phoenix includes a spreadsheet which gathers data on such things as number of feet of ramp, number of decks, turns, etc. This automatically calculates the cost of the ramp. For all other modifications, the State utilizes a licensed contractor. This contractor inspects the Home Accessibility Adaptations/Specialized Medical Equipment and Supplies projects, submits projects for bids, reviews bidders' quotes, and selects the winning bid (based upon lowest cost).*

*The State does not establish rate minimums or maximums for non-rate based services (home accessibility adaptations, specialized medical equipment, and supplies).*

*The environmental modification specialist will review bid rates and ask for adjustments if there is no appropriate bid returned based upon the specifications of the job. Home modifications are done by bid. An employee of SCDHHS provides specifications for all modifications and, through Phoenix, puts them out for bid to all providers covering the geographical area. Providers submit a bid and a winning bid is declared. The case manager authorizes the service at the bid level and the provider uses EVV/Phoenix to bill. The paid amount cannot exceed the winning bid level.*

*Appliances such as air conditioners, fans and space heaters are based upon retail pricing.*

*Pest control services are based upon established private pay rates. The state rate was established by taking the average of the initial and follow up rates for private pay treatments.*

*Pest control enhanced service : Enhanced Pest Control is the treatment of bed bugs. The participant chooses from providers who cover the geographical area. The chosen provider then assesses the job and verifies that there are bed bugs and gives a bid. If this bid is within acceptable limits, it is approved. If not, the next chosen provider is asked to give a bid. This continues until a provider is chosen. The maximum rate cap of $1000 was calculated using market research data.*

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

*PERS Monitoring: This rate is based upon prevailing market rates in SC for persons receiving this service by private payment.*

*PERS Installation: This rate is based upon prevailing market rates in SC for persons receiving this service by private payment.*

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

*Case management service rates provided to waiver participants were calculated based upon payments made to SCDHHS employees providing case management. At one time all case management was done by SCDHHS employees. When this changed, cost analyses were conducted to determine the payment per participant and this rate was set for non-state case management entities. Provider case managers are paid by unit (i.e., monthly unit). SCDHHS case managers are state employees. The reimbursement for them includes salary, fringe and other operating costs. When the waiver was amended to change from a monthly rate to a 15 minute rate for case management, the State conducted ongoing analyses of the cost effect.*

*Years 2 through 5 of waiver rate estimates are estimated with an inflation rate of 2.7% per year as is indicated by a 5 year medical consumer price index (MCPI) average (September 2013-September 2017).*

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

*Various methods are used to determine rates based upon the specific service. As noted, institutional respite is based upon the daily rate of the nursing facility or the average daily rate when provided in a hospital. Market based rates are used for many services, such as PERS. SC also uses comparisons with other states (particularly in Region 4) for some services. In all cases, the guiding principle is that the rate should not be higher than that paid by other payment sources and must be adequate to ensure a sufficient number of qualified providers. The State will use cost based data for evaluating the need for rate increases where these data are reliable and available. The State has also considered rate increases which benefit the direct care workers. While less of a factor recently, the State also considers inflationary factors and, for some services, variations in gasoline prices.*

**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:*

*For many services, waiver providers use the EVV and Phoenix systems to document delivery of services. This is done through adding claims to the EVV or through web entry of claims in Phoenix. For services not using the EVV system, providers may bill either by use of a CMS 1500 form or by the State's electronic billing system.*

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

*Providers use the Phoenix/EVV system to bill for all services other than institutional respite. For this service, they use the regular Medicaid billing method (web tool to submit claims).*

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

*For Prime, Phoenix/EVV will do the same actions, but will route the claims to the appropriate plan. At present, Prime claims are being billed to Medicaid and an adjustment is made to the plan payments to cover those expenditures .*

*Providers of services to Healthy Connections Prime participants will be paid by the CICOs. For all waiver services, providers use the EVV and Phoenix systems to document delivery of services. This is done through adding claims to the EVV or web entry of claims in Phoenix. All complete claims will be submitted via EVV are transmitted to the CICOs daily for payment processing. CICOs then pay providers directly, as specified in the three-way contract between CMS, the State, and each CICO.*

## *Appendix I: Financial Accountability*

### *I-2: Rates, Billing and Claims (2 of 3)*

***c. Certifying Public Expenditures*** *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

***Select at least one:***

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## *Appendix I: Financial Accountability*

### *I-2: Rates, Billing and Claims (3 of 3)*

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

*Claims for waiver services are submitted to the State's Medicaid Management Information System for payment via Phoenix, with the exception of institutional respite claims. Institutional Respite claims are reviewed by Program Integrity's post payment reviews although they are authorized through Phoenix. Program Integrity completes post payment reviews and ensures services were provided as authorized. These claims are submitted using the CMS-1500 form or the State's electronic billing system. For all claims submitted through Phoenix, a pre-payment review is conducted. Phoenix only submits claims to MMIS or the CICOs for services that were prior authorized by the case manager and are included in the participant's service plan. Phoenix compares services documented by providers to the amount, frequency, and duration prior authorized by the case manager. Only service claims that meet these conditions are submitted to MMIS or the CICOs for payment.*

*Once the claim is submitted to MMIS or the CICOs, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is an indication in MMIS that the participant is enrolled in the waiver program.*

*The Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized. Whenever a recoupment is identified, the Division of Program Integrity notifies the Financial Department of SCDHHS who reimburses CMS utilizing the "CMS 64 Summary Sheet."*

***e. Billing and Claims Record Maintenance Requirement.*** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (1 of 7)*

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

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

*Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

*CLTC case management costs for services are allocated by taking the percentage of case management to total salary costs in the SCDHHS offices throughout the state. At present the cost is being allocated at 43.946%. These costs are then allocated to the case management service in the CLTC waivers. The office and administrative costs are captured using specific project codes on agency financial reports. These allocations are made based on financial expenditure reports, which are transcribed onto a spreadsheet for calculation using the aforementioned percentage for services and another calculation is made to spread office and administrative costs by waiver. The spreadsheet is included in our work papers, which is claimed for reimbursement on the CMS-64 and audited by CMS quarterly.*

*All waiver providers not participating in Healthy Connections Prime do receive payments directly from the Medicaid agency.*

*Each CICO receives a monthly capitation payment for its members who are also participating in one of the waiver programs. This payment is calculated using historical fee-for-service data minus a built in savings amount. These rates are reviewed and approved by CMS annually and posted on the SCDHHS website. CICOs also receive a separate payment from CMS for Medicare A/B and Part D services. The actual payment and payment processing is conducted via MMIS and ensures the maintenance of an audit trail.*

○ ***Payments for waiver services are not made through an approved MMIS.***

*Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds*

*expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

*Describe how payments are made to the managed care entity or entities:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (2 of 7)*

***b. Direct payment.*** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

*A financial management services entity is used to make payments for self-directed services (attendant). Weekly data and payments are transmitted from MMIS to the FMS, including a detailed breakdown of each worker's claims. From these transmittals, the FMS collects and processes the time worked for each worker, processes payroll, withholds, files and pays all applicable employment-related taxes and insurance. The FMS reimburses providers weekly and transmits this information to the Phoenix system. Daily, the monies received are reviewed and compared to the amount of monies being paid.*

*All providers for this waiver use Phoenix/EVV for his/her Medicaid billing. Depending upon the service, this is done either through electronic visit verification (EVV) or through web-based billing, with the exception of institutional respite claims. These claims are submitted using the CMS-1500 form or the State's electronic billing system.*

*Phoenix is South Carolina's automated system for assessment, care planning, service authorization, service monitoring and service billing. Providers receive referrals and authorizations through Phoenix for the provision of waiver services. When they accept these, they are able to use a Provider Portal to view authorizations, service plans and any special requirements of the authorization (e.g., the participant is a smoker, services should be provided only in the morning, etc.).*

*Providers using the EVV document through a phone line or a smart phone application when they commence services, what the service is, who the worker is, when they stop providing services, specifics of what they did while providing the service and any observations about the overall wellbeing of the participant (e.g., recent falls, Emergency Department visit, etc.). Phoenix then compares this with the authorization and, if the service is provided as authorized, submits a claim up to the authorized level.*

*Providers using the web for billing other services (e.g., home delivered meals, etc.) use the portal to indicate the date of service and the units provided. As with the EVV, this is compared with the authorized amount and billed to that limit. In both cases, Phoenix submits claims multiple times a week and providers are paid once weekly. There is also a resolution process for providers to use in case of worker error or problems with the system (e.g., worker forgets to check out, phone line is down).*

*Providers receive initial billing training prior to getting service authorizations. They can reference a manual online in Phoenix which describes how to bill and run reports so they can monitor his/her workers and the billings. There is also periodic training for any provider in need of a refresher. A helpdesk phone line is available and a group e-mail has been developed to assist providers. They can also submit a problem at any time from within Phoenix.*

*Audits are conducted through post-payment reviews by the Division of Audits, Division of Program Integrity, as well as the program area. The former focus on proper documentation of delivery of service in accordance with the established policies and procedures for documentation. Negative findings are likely to result in recoupment of payments. Program audits are more wide ranging and focus on a broader range of activities. While they can result in recoupments, they also are likely to result in other types of sanctions up to and including termination for non-compliance of the contract. Both types of audits would include corrective action plans.*

*The Division of Audits and Program Integrity conduct reviews based upon requests and at random. The program area conducts audits at least every other year, and more often if previous reviews identify deficiencies.*

*A fiscal agent is used for the self-directed attendant service. All documentation of service is done as with other EVV services. The payment goes to the fiscal agent who pulls out deductions and makes payment of the remainder to the attendant.*

*SCDHHS receives files on a regular basis indicating payments that have been made to individuals providing self-directed services. These are compared with claims reports indicating money paid to the provider of FMS. In addition, the vendor for EVV which sub-contracts for FMS, receives the same data and conducts periodic audits to determine payments are made appropriately. SCDHHS has one staff position charged with ensuring that provider payments are done timely and accurately. Any discrepancies or other issues are discussed with the vendor and resolved as appropriate. SCDHHS can request a complete financial audit at any time.*

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

*All services are included in the contract with managed care entities.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (3 of 7)*

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

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (4 of 7)*

***d. Payments to state or Local Government Providers.*** *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

*Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:*

*Some County Councils on Aging provide waiver services. They receive payments for the provision of personal care I and II and home delivered meals. The contractual process is the same for these as for all other providers of these services and reimbursement rates are the same as well.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (5 of 7)*

***e. Amount of Payment to State or Local Government Providers.***

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

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

*Describe the recoupment process:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (6 of 7)*

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

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

*This waiver includes both FFS and monthly capitated service payments. The monthly capitated payment is not reduced or returned to the State.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (7 of 7)*

***g. Additional Payment Arrangements***

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

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

*Specify the governmental agency (or agencies) to which reassignment may be made.*

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

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements***

***under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

***iii. Contracts with MCOs, PIHPs or PAHPs.***

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

◉ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

*The State and CMS contract with health plans, known as CICOs, for the provision of coordinated and integrated health care services under a federal financial alignment demonstration. This program is known as Healthy Connections Prime. Waiver participants who meet eligibility criteria may enroll in Healthy Connections Prime. CICOs are required to contract with the State's existing waiver providers. CICOs have assumed contractual authority of some HCBS non-case management services.*

*The State anticipates the CICOs operating state-wide, as long as they pass the required CMS network adequacy reviews.*

*The CICOs' capitated payment covers all waiver services, as well as all Medicaid and Medicare benefits, for Healthy Connections Prime participants.*

*Payment to the CICOs is made by an approved MMIS. Payments to CICOs will be made generally once a month based on each individual's capitation rate group assignment, which is communicated and verified between the State and the CICOs.*

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

## *Appendix I: Financial Accountability*

### *I-4: Non-Federal Matching Funds (1 of 3)*

***a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

☐ ***Other State Level Source(s) of Funds.***

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

## *Appendix I: Financial Accountability*

### *I-4: Non-Federal Matching Funds (2 of 3)*

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

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

*Check each that applies:*

☐ ***Appropriation of Local Government Revenues.***

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

☐ ***Other Local Government Level Source(s) of Funds.***

*Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly*

*expended by local government agencies as CPEs, as specified in Item I-2-c:*

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ○ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ◉ ***The following source(s) are used***

*Check each that applies:*

- ☒ ***Health care-related taxes or fees***
- ☐ ***Provider-related donations***
- ☐ ***Federal funds***

*For each source of funds indicated above, describe the source of the funds in detail:*

*The Community Long Term Care Waiver Services Program budget line receives an allocation of a hospital provider tax that was implemented in order to expand Medicaid eligibility. All South Carolina general hospitals are subject to the tax.*

## Appendix I: Financial Accountability

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

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

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

***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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

***Level(s) of Care: Nursing Facility***

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 42094.51 | 21624.00 | 63718.51 | 137982.88 | 10248.96 | 148231.84 | 84513.33 |
| 2 | 43332.08 | 22207.85 | 65539.93 | 141708.42 | 10525.68 | 152234.10 | 86694.17 |
| 3 | 44497.09 | 22807.46 | 67304.55 | 145534.55 | 10809.88 | 156344.43 | 89039.88 |
| 4 | 45701.55 | 23423.26 | 69124.81 | 149463.98 | 11101.74 | 160565.72 | 91440.91 |
| 5 | 46937.38 | 24055.69 | 70993.07 | 153499.51 | 11401.49 | 164901.00 | 93907.93 |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (1 of 9)*

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

***Table: J-2-a: Unduplicated Participants***

| *Waiver Year* | *Total Unduplicated Number of Participants (from Item B-3-a)* | *Distribution of Unduplicated Participants by Level of Care (if applicable)* |
|---|---|---|
| | | *Level of Care:* |
| | | *Nursing Facility* |
| *Year 1* | *70* | *70* |
| *Year 2* | *70* | *70* |
| *Year 3* | *70* | *70* |
| *Year 4* | *70* | *70* |
| *Year 5* | *70* | *70* |

## *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 CMS 372 report for the most recent three years of the current waiver has been used to estimate the average length of stay for waiver participants served under this waiver. The three years together show almost exactly the same length of stay for each year (about nine months).*

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (3 of 9)*

***c. Derivation of Estimates for Each Factor.*** *Provide a narrative description for the derivation of the estimates of the following factors.*

***i. Factor D Derivation.*** *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

*The CMS 372 report for the most recent three years of the current waiver has been used to derive estimates for Factor D. The most recent of the three years has not yet been submitted to CMS. South Carolina produces this report six months after the conclusion of the waiver year and then reruns the report for the 18 month lag period. We do this for internal planning and development. Our experience has been that there are only very insignificant changes between the six month run and the 18 month run.*
*The three years together show almost exactly the same length of stay for each year (about nine months) and similar patterns of use of services. There has also been only slight growth in the number of waiver participants. South Carolina has no waiting list for this waiver but the demand is limited.*
*Rates from the current waiver are inflated for the first year of the renewal only when there are specific plans in place to increase these rates. This is the case for case management and nursing services (RN and LPN). Years 2 through 5 are estimated with an inflation rate of 2.7% per year as is indicated by a 5 year medical consumer price index (MCPI) average (September 2013-September 2017).*

*Utilization is based upon historic data and is not expected to vary significantly, either in the percentage of waiver participants receiving a service or the units per person of the service, with the exception of in-home respite. This service is expected to grow from its current very low utilization level, both in units per participant and percentage of participants receiving the service.*

*The State uses claims data as recorded on the CMS 372 report. As stated, the last three years were analyzed for trends. In-home respite has been used by one waiver participant in the last two years and none the year before. The projection is based upon increased interest in the service by case managers and families.*

*Some of the waiver participants will also be in Healthy Connections Prime. At this time, there are no data available to suggest that service utilization and costs will vary for those waiver participants. This is being closely monitored to look for any savings or additional costs associated with the dual eligible initiative. Until such data demonstrate a difference, South Carolina assumes that the projections in the waiver apply for both subgroups of waiver participants. If the State makes any changes which would substantially increase the number of people in the waiver program under capitation, the State intends to amend this waiver to reflect those changes.*

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

*Factor D' estimates are also based upon the three most recent program years of the current waiver. The most recent year with data available is Year 4 of the waiver. As noted, South Carolina has produced a 372 report containing data on D and D' but has not yet submitted that, since it is not yet due. Years 2 through 5 are estimated with an inflation rate of 2.7% per year as is indicated by a 5 year medical consumer price index (MCPI) average (September 2013-September 2017).*

**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:*

*Nursing facilities in South Carolina may, upon meeting all qualifications, provide what is known as complex care to residents with special medical needs. One of these needs is being reliant on mechanical ventilation. In estimating Factor G, the State has identified 20 residents who are ventilator dependent and who received nursing facility care for at least three months during the time period of July 1, 2015 through June 30, 2016. The standard rate of care for this population is $530 per day. However, since some residents pay part of that amount themselves, the actual daily rate paid by Medicaid is slightly lower. The average daily rate for those 20 individuals was calculated and is used as the basis of estimates in Year 1 of the waiver. Since waiver cost effectiveness is based upon comparison to this institutional population, Factor G was based upon an estimated length of stay equal to the waiver population, about nine months.The State used existing claims data from those 20 individuals. $530 per day is the rate that facilities can receive for participants requiring mechanical ventilation. The actual amount that Medicaid pays the facility depends upon recurring income amounts, which vary by individual. Therefore, $530 is the maximum daily Medicaid payment rate. We have adjusted Factor G to reflect this increase. Our figure is slightly lower to account for the recurring income Medicaid beneficiaries contribute to the total rate.*

*Only D and D' values are calculated on an annual basis. The comparison figures are those from the approved waiver. The State sought to use the most recent available data rather than figures that were estimates done several years ago. Estimates were based upon individual level claims data for persons in a facility that provides care for persons on mechanical ventilation.*

*Years 2 through 5 are estimated with an inflation rate of 2.7% per year as is indicated by a 5 year MCPI average (September 2013-September 2017).*

***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:*

*G' is based upon an examination of all Medicaid claims other than nursing facility claims for the 20 residents identified in the Factor G description. Claims were pulled only for dates of institutionalization. An average daily cost was obtained and then applied to an average length of stay of about nine months, to be consistent with the waiver population. As expected, G' estimates are lower than those for D'. Years 2 through 5 are estimated with an inflation rate of 2.7% per year as is indicated by a 5 year medical consumer price index (MCPI) average (September 2013-September 2017).*

*The 372 report does not include actual G' data each year. Instead, it compares actual D and D' figures with the most recent approved waiver estimates. By using actual data we are able to get better and more recent estimates for G'.*

## *Appendix J: Cost Neutrality Demonstration*

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

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

| *Waiver Services* | |
|---|---|
| *Case Management* | |
| *Personal Care I and Personal Care II* | |
| *Respite* | |
| *Attendant Care* | |
| *Home Accessibility Adaptations* | |
| *Home Delivered Meals* | |
| *Personal Emergency Response System* | |
| *Pest Control* | |
| *Private Duty Nursing* | |
| *Specialized Medical Equipment and Supplies* | |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

***ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

**Waiver Year: Year 1**

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | | **45360.00** |
| Case Management | ☐ | Month | 70 | 9.00 | 72.00 | **45360.00** | |
| **Personal Care I and Personal Care II Total:** | | | | | | | **352720.00** |
| Personal Care I | ☐ | Hour | 23 | 200.00 | 14.00 | **64400.00** | |
| Personal Care II | ☐ | Hour | 32 | 530.00 | 17.00 | **288320.00** | |
| **Respite Total:** | | | | | | | **16800.00** |
| Respite-In Home | ☐ | Day | 3 | 7.00 | 500.00 | **10500.00** | |
| Respite-Institutional | ☐ | Day | 2 | 7.00 | 450.00 | **6300.00** | |
| **Attendant Care Total:** | | | | | | | **278460.00** |
| Attendant Care | ☐ | Hour | 14 | 1700.00 | 11.70 | **278460.00** | |
| **Home Accessibility Adaptations Total:** | | | | | | | **14634.00** |
| Home Adaptations | ☐ | Event | 9 | 1.00 | 1626.00 | **14634.00** | |
| **Home Delivered Meals Total:** | | | | | | | **42833.70** |
| Home | ☐ | | | | | **42833.70** | |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | **2946615.70** |
| Total: Services included in capitation: | | |
| Total: Services not included in capitation: | | 2946615.70 |
| **Total Estimated Unduplicated Participants:** | | **70** |
| **Factor D (Divide total by number of participants):** | | **42094.51** |
| Services included in capitation: | | |
| Services not included in capitation: | | 42094.51 |
| **Average Length of Stay on the Waiver:** | 272 | |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| Delivered Meals | | Meal | 21 | 390.00 | 5.23 | | |
| **Personal Emergency Response System Total:** | | | | | | | **5820.00** |
| Installation | ☐ | Event | 5 | 1.00 | 30.00 | **150.00** | |
| Monitoring | ☐ | Month | 21 | 9.00 | 30.00 | **5670.00** | |
| **Pest Control Total:** | | | | | | | **6395.00** |
| Pest Control | ☐ | Event | 30 | 4.00 | 45.00 | **5400.00** | |
| Enhanced Pest Control | ☐ | Event | 1 | 1.00 | 995.00 | **995.00** | |
| **Private Duty Nursing Total:** | | | | | | | **2164050.00** |
| Private Duty Nursing LPN | ☐ | Hour | 35 | 1800.00 | 24.60 | **1549800.00** | |
| Private Duty Nursing RN | ☐ | Hour | 21 | 900.00 | 32.50 | **614250.00** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | | **19543.00** |
| Bathroom Safety Equipment | ☐ | Unit | 7 | 1.00 | 200.00 | **1400.00** | |
| Other Necessary Supplies and Equipment | ☐ | Unit | 10 | 1.00 | 1250.00 | **12500.00** | |
| Nutritional Supplements | ☐ | Case | 10 | 18.00 | 31.35 | **5643.00** | |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | **2946615.70** |
| Total: Services included in capitation: | | |
| Total: Services not included in capitation: | | 2946615.70 |
| **Total Estimated Unduplicated Participants:** | | **70** |
| **Factor D (Divide total by number of participants):** | | **42094.51** |
| Services included in capitation: | | |
| Services not included in capitation: | | 42094.51 |
| **Average Length of Stay on the Waiver:** | 272 | |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (6 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 2***

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | | **46582.20** |
| Case Management | ☐ | Month | 70 | 9.00 | 73.94 | **46582.20** | |
| **Personal Care I and Personal Care II Total:** | | | | | | | **362269.60** |
| Personal Care I | ☐ | Hour | 23 | 200.00 | 14.38 | **66148.00** | |
| Personal Care II | ☐ | Hour | 32 | 530.00 | 17.46 | **296121.60** | |
| **Respite Total:** | | | | | | | **17499.44** |
| Respite-In Home | ☐ | Day | 3 | 7.00 | 513.50 | **10783.50** | |
| Respite-Institutional | ☐ | Day | 2 | 7.00 | 479.71 | **6715.94** | |
| **Attendant Care Total:** | | | | | | | **286076.00** |
| Attendant Care | ☐ | Hour | 14 | 1700.00 | 12.02 | **286076.00** | |
| **Home Accessibility Adaptations Total:** | | | | | | | **15029.10** |
| Home Adaptations | ☐ | Event | 9 | 1.00 | 1669.90 | **15029.10** | |
| **Home Delivered Meals Total:** | | | | | | | **43980.30** |
| Home Delivered Meals | ☐ | Meal | 21 | 390.00 | 5.37 | **43980.30** | |
| **Personal Emergency Response System Total:** | | | | | | | **5977.14** |

| | | |
|---|---|---|
| | ***GRAND TOTAL:*** | ***3033245.35*** |
| | *Total: Services included in capitation:* | |
| | *Total: Services not included in capitation:* | *3033245.35* |
| | ***Total Estimated Unduplicated Participants:*** | ***70*** |
| | ***Factor D (Divide total by number of participants):*** | ***43332.08*** |
| | *Services included in capitation:* | |
| | *Services not included in capitation:* | *43332.08* |
| | ***Average Length of Stay on the Waiver:*** | *272* |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| Installation | ☐ | Event | 5 | 1.00 | 30.81 | 154.05 | |
| Monitoring | ☐ | Month | 21 | 9.00 | 30.81 | 5823.09 | |
| **Pest Control Total:** | | | | | | | 6568.27 |
| Pest Control | ☐ | Event | 30 | 4.00 | 46.22 | 5546.40 | |
| Enhanced Pest Control | ☐ | Event | 1 | 1.00 | 1021.87 | 1021.87 | |
| **Private Duty Nursing Total:** | | | | | | | 2229192.00 |
| Private Duty Nursing LPN | ☐ | Hour | 35 | 1800.00 | 25.37 | 1598310.00 | |
| Private Duty Nursing RN | ☐ | Hour | 21 | 900.00 | 33.38 | 630882.00 | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | | 20071.30 |
| Bathroom Safety Equipment | ☐ | Unit | 7 | 1.00 | 205.40 | 1437.80 | |
| Other Necessary Supplies and Equipment | ☐ | Unit | 10 | 1.00 | 1283.75 | 12837.50 | |
| Nutritional Supplements | ☐ | Case | 10 | 18.00 | 32.20 | 5796.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | 3033245.35 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 3033245.35 |
| **Total Estimated Unduplicated Participants:** | 70 |
| **Factor D (Divide total by number of participants):** | 43332.08 |
| Services included in capitation: | |
| Services not included in capitation: | 43332.08 |
| **Average Length of Stay on the Waiver:** | 272 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

***d. Estimate of Factor D.***

***ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 3***

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | | **47842.20** |
| Case Management | ☐ | Month | 70 | 9.00 | 75.94 | **47842.20** | |
| **Personal Care I and Personal Care II Total:** | | | | | | | **372034.80** |
| Personal Care I | ☐ | Hour | 23 | 200.00 | 14.77 | **67942.00** | |
| Personal Care II | ☐ | Hour | 32 | 530.00 | 17.93 | **304092.80** | |
| **Respite Total:** | | | | | | | **18045.72** |
| Respite-In Home | ☐ | Day | 3 | 7.00 | 527.36 | **11074.56** | |
| Respite-Institutional | ☐ | Day | 2 | 7.00 | 497.94 | **6971.16** | |
| **Attendant Care Total:** | | | | | | | **293692.00** |
| Attendant Care | ☐ | Hour | 14 | 1700.00 | 12.34 | **293692.00** | |
| **Home Accessibility Adaptations Total:** | | | | | | | **15434.91** |
| Home Adaptations | ☐ | Event | 9 | 1.00 | 1714.99 | **15434.91** | |
| **Home Delivered Meals Total:** | | | | | | | **45208.80** |
| Home Delivered Meals | ☐ | Meal | 21 | 390.00 | 5.52 | **45208.80** | |
| **Personal Emergency Response System Total:** | | | | | | | **6138.16** |
| Installation | ☐ | Event | 5 | 1.00 | 31.64 | **158.20** | |
| Monitoring | ☐ | Month | 21 | 9.00 | 31.64 | **5979.96** | |
| **Pest Control** | | | | | | | **6744.66** |

| | |
|---|---|
| **GRAND TOTAL:** | **3114796.60** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 3114796.60 |
| **Total Estimated Unduplicated Participants:** | **70** |
| **Factor D (Divide total by number of participants):** | **44497.09** |
| Services included in capitation: | |
| Services not included in capitation: | 44497.09 |
| **Average Length of Stay on the Waiver:** | 272 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Total:** | | | | | | | |
| Pest Control | ☐ | Event | 30 | 4.00 | 47.46 | **5695.20** | |
| Enhanced Pest Control | ☐ | Event | 1 | 1.00 | 1049.46 | **1049.46** | |
| **Private Duty Nursing Total:** | | | | | | | **2289042.00** |
| Private Duty Nursing LPN | ☐ | Hour | 35 | 1800.00 | 26.05 | **1641150.00** | |
| Private Duty Nursing RN | ☐ | Hour | 21 | 900.00 | 34.28 | **647892.00** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | | **20613.35** |
| Bathroom Safety Equipment | ☐ | Unit | 7 | 1.00 | 210.95 | **1476.65** | |
| Other Necessary Supplies and Equipment | ☐ | Unit | 10 | 1.00 | 1318.41 | **13184.10** | |
| Nutritional Supplements | ☐ | Case | 10 | 18.00 | 33.07 | **5952.60** | |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | **3114796.60** |
| Total: Services included in capitation: | | |
| Total: Services not included in capitation: | | 3114796.60 |
| **Total Estimated Unduplicated Participants:** | | **70** |
| **Factor D (Divide total by number of participants):** | | **44497.09** |
| Services included in capitation: | | |
| Services not included in capitation: | | 44497.09 |
| **Average Length of Stay on the Waiver:** | 272 | |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (8 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 4***

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | | **49133.70** |
| Case Management | ☐ | Monthly | 70 | 9.00 | 77.99 | **49133.70** | |
| **Personal Care I and Personal Care II Total:** | | | | | | | **381969.60** |
| Personal Care I | ☐ | Hour | 23 | 200.00 | 15.16 | **69736.00** | |
| Personal Care II | ☐ | Hour | 32 | 530.00 | 18.41 | **312233.60** | |
| **Respite Total:** | | | | | | | **18609.64** |
| Respite-In Home | ☐ | Day | 3 | 7.00 | 541.60 | **11373.60** | |
| Respite-Institutional | ☐ | Day | 2 | 7.00 | 516.86 | **7236.04** | |
| **Attendant Care Total:** | | | | | | | **301546.00** |
| Attendant Care | ☐ | Hour | 14 | 1700.00 | 12.67 | **301546.00** | |
| **Home Accessibility Adaptations Total:** | | | | | | | **15851.61** |
| Home Adaptations | ☐ | Event | 9 | 1.00 | 1761.29 | **15851.61** | |
| **Home Delivered Meals Total:** | | | | | | | **46437.30** |
| Home Delivered Meals | ☐ | Meal | 21 | 390.00 | 5.67 | **46437.30** | |
| **Personal Emergency Response System Total:** | | | | | | | **6305.00** |
| Installation | ☐ | Event | 5 | 1.00 | 32.50 | **162.50** | |
| Monitoring | ☐ | Month | 21 | 9.00 | 32.50 | **6142.50** | |
| **Pest Control Total:** | | | | | | | **6926.59** |

| | |
|---|---|
| **GRAND TOTAL:** | **3199108.82** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 3199108.82 |
| **Total Estimated Unduplicated Participants:** | **70** |
| **Factor D (Divide total by number of participants):** | **45701.55** |
| Services included in capitation: | |
| Services not included in capitation: | 45701.55 |
| **Average Length of Stay on the Waiver:** | 272 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| Pest Control | ☐ | Event | 30 | 4.00 | 48.74 | 5848.80 | |
| Enhanced Pest Control | ☐ | Event | 1 | 1.00 | 1077.79 | 1077.79 | |
| **Private Duty Nursing Total:** | | | | | | | 2351160.00 |
| Private Duty Nursing LPN | ☐ | Hour | 35 | 1800.00 | 26.76 | 1685880.00 | |
| Private Duty Nursing RN | ☐ | Hour | 21 | 900.00 | 35.20 | 665280.00 | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | | 21169.38 |
| Bathroom Safety Equipment | ☐ | Unit | 7 | 1.00 | 216.64 | 1516.48 | |
| Other Necessary Supplies and Equipment | ☐ | Unit | 10 | 1.00 | 1354.01 | 13540.10 | |
| Nutritional Supplements | ☐ | Case | 10 | 18.00 | 33.96 | 6112.80 | |

| | |
|---|---|
| **GRAND TOTAL:** | 3199108.82 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 3199108.82 |
| **Total Estimated Unduplicated Participants:** | 70 |
| **Factor D (Divide total by number of participants):** | 45701.55 |
| Services included in capitation: | |
| Services not included in capitation: | 45701.55 |
| **Average Length of Stay on the Waiver:** | 272 |

# *Appendix J: Cost Neutrality Demonstration*

## *J-2: Derivation of Estimates (9 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 5***

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | | **50463.00** |
| Case Management | ☐ | Month | 70 | 9.00 | 80.10 | **50463.00** | |
| **Personal Care I and Personal Care II Total:** | | | | | | | **392335.60** |
| Personal Care I | ☐ | Hour | 23 | 200.00 | 15.57 | **71622.00** | |
| Personal Care II | ☐ | Hour | 32 | 530.00 | 18.91 | **320713.60** | |
| **Respite Total:** | | | | | | | **19191.83** |
| Respite-In Home | ☐ | Day | 3 | 7.00 | 556.23 | **11680.83** | |
| Respite-Institutional | ☐ | Day | 2 | 7.00 | 536.50 | **7511.00** | |
| **Attendant Care Total:** | | | | | | | **309876.00** |
| Attendant Care | ☐ | Hour | 14 | 1700.00 | 13.02 | **309876.00** | |
| **Home Accessibility Adaptations Total:** | | | | | | | **16279.65** |
| Home Adaptations | ☐ | Event | 9 | 1.00 | 1808.85 | **16279.65** | |
| **Home Delivered Meals Total:** | | | | | | | **47665.80** |
| Home Delivered Meals | ☐ | Meal | 21 | 390.00 | 5.82 | **47665.80** | |
| **Personal Emergency Response System Total:** | | | | | | | **6473.78** |
| Installation | ☐ | Event | 5 | 1.00 | 33.37 | **166.85** | |
| Monitoring | ☐ | Month | 21 | 9.00 | 33.37 | **6306.93** | |
| **Pest Control Total:** | | | | | | | **7114.09** |

| | | |
|---|---|---|
| | ***GRAND TOTAL:*** | ***3285616.28*** |
| | *Total: Services included in capitation:* | |
| | *Total: Services not included in capitation:* | *3285616.28* |
| | ***Total Estimated Unduplicated Participants:*** | ***70*** |
| | ***Factor D (Divide total by number of participants):*** | ***46937.38*** |
| | *Services included in capitation:* | |
| | *Services not included in capitation:* | *46937.38* |
| | ***Average Length of Stay on the Waiver:*** | *272* |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| Pest Control | ☐ | Event | 30 | 4.00 | 50.06 | 6007.20 | |
| Enhanced Pest Control | ☐ | Event | 1 | 1.00 | 1106.89 | 1106.89 | |
| **Private Duty Nursing Total:** | | | | | | | 2414475.00 |
| Private Duty Nursing LPN | ☐ | Hour | 35 | 1800.00 | 27.48 | 1731240.00 | |
| Private Duty Nursing RN | ☐ | Hour | 21 | 900.00 | 36.15 | 683235.00 | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | | 21741.53 |
| Bathroom Safety Equipment | ☐ | Unit | 7 | 1.00 | 222.49 | 1557.43 | |
| Other Necessary Supplies and Equipment | ☐ | Unit | 10 | 1.00 | 1390.57 | 13905.70 | |
| Nutritional Supplements | ☐ | Case | 10 | 18.00 | 34.88 | 6278.40 | |

| | |
|---|---|
| **GRAND TOTAL:** | 3285616.28 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 3285616.28 |
| **Total Estimated Unduplicated Participants:** | 70 |
| **Factor D (Divide total by number of participants):** | 46937.38 |
| Services included in capitation: | |
| Services not included in capitation: | 46937.38 |
| **Average Length of Stay on the Waiver:** | 272 |