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

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

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 section 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*):

Healthy Connections - Long Term Care Waiver

C. Type of Request: new

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**

☑ **New to replace waiver**

Replacing Waiver Number: SC.0186, SC.0405, SC.40181

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)*

Draft ID: **SC.037.00.00**

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

Regular Waiver

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

07/01/27

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so

that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☑ **Hospital**

Select applicable level of care

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

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

Hospital level of care will be limited to the subcategory of individuals 18 years and older with a diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS).

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 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 section 1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under section 1915(b) of the Act.**

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

1915(b) amendment is being submitted concurrently with 1915(c) application.

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

☑ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Healthy Connections Long Term Care (HC-LTC) Waiver combines the Mechanical Ventilator Dependent waiver, the HIV/AIDS waiver, and the Community Choices waiver into one comprehensive program. The SMA is designing this consolidated waiver using utilization and outcome data, as well as extensive input from providers, participants, and community partners. By integrating the strongest components of each existing waiver, the SMA aims to create a more flexible, equitable, and streamlined program that better supports individuals with complex needs statewide. Consolidation will simplify access to HCBS, reduce administrative complexity, and ensure consistent, equitable services across all populations. Integrating the consolidated waiver into managed care will further strengthen coordinated, whole-person care and enhance the ability of Medicaid Managed Care Plans to support participants across all care settings.

The goals of waiver consolidation include establishing uniform eligibility and service standards, reducing administrative burden and duplication, improving quality through consistent monitoring, strengthening care coordination within managed care, expanding access to community-based social supports, and advancing whole-person care across medical, behavioral, functional, and social domains.

The HC-LTC population includes individuals who meet the nursing facility or hospital level of care and receive case management along with at least one additional waiver service. Eligible groups include adults age 65 and older, adults age 18-64 with physical disabilities (including those dependent on mechanical ventilation), and individuals diagnosed with HIV/AIDS.

All HC-LTC participants will be required to enroll in Healthy Connections Medicaid. The SMA will determine waiver eligibility. Medicaid Managed Care Plans will provide assessment information annually using the State-approved assessment tool and will continue conducting outreach to ensure participants respond to requests for information needed for annual redeterminations.

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 section 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 section 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 section 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 section 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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:

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

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

7. Contact Person(s)

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

Last Name: Alewine

First Name: Margaret

Title: Program Manager III, Bureau of Policy

Agency: South Carolina Department of Health and Human Services

Address: 1801 Main Street

Address 2: Post Office Box 8206

City: Columbia

State: **South Carolina**

Zip: 29202-8206

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

Fax: (803) 255-8209

E-mail: Margaret.Alewine@scdhhs.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **South Carolina**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 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:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Medina

First Name: Eunice

Title: 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: 29201

Phone:

(803) 898-0212 **Ext:** ☐ **TTY**

Fax:

(803) 255-8235

E-mail:

Eunice.Medina@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:

1. Overview of Transition Approach
SCDHHS will transition the Community Choices, HIV/AIDS and Mechanical Ventilator Dependent waivers into a single consolidated HCBS waiver, Healthy Connections - Long Term Care (HC-LTC). All individuals currently served under the three waivers will transition without interruption, and no participant will lose waiver eligibility solely due to consolidation. HC-LTC eligibility criteria are intentionally structured to include all participants enrolled in the legacy waivers.

2. Participant Eligibility Transition
Financial Eligibility:
SCDHHS will continue to determine Medicaid financial eligibility. Participants who are financially eligible at HC-LTC implementation will not undergo additional or new financial reviews. New applicants will follow standard financial eligibility processes.

Level of Care Eligibility:
Participants clinically eligible under the current waivers will not require a new level-of-care assessment at implementation. Individuals applying for HC-LTC after launch will receive a level-of-care assessment as part of initial eligibility determination.

3. Waitlist Consolidation and Management
Existing waitlists for the three waivers will be merged into a single HC-LTC waitlist. Placement will be based on the original application date; when multiple applications exist, the earliest date will be used. Reserved capacity categories will be aligned across the waivers and incorporated into the HC-LTC structure. SCDHHS will continue to manage slot releases, reserved capacity approvals and ongoing review of the waitlist. Total slot capacity under HC-LTC will reflect the combined slot capacity of the three waivers. Additional slots will be released as funding becomes available.

4. Service Transition and Alignment
The majority of services offered under the three waivers will remain available in HC-LTC, including all self-directed service options. Certain services will change as part of consolidation and managed care integration:
-Telemonitoring: Discontinued as a waiver service; equivalent support will be provided through chronic disease management offered by the Medicaid Managed Care Plans.
-Private Duty Nursing: Expanded to all HC-LTC participants who meet medical necessity criteria for continuous skilled nursing.
-Case Management: Provided through Medicaid Managed Care Plans, which will contract with existing case management providers for at least one year to ensure continuity.

Participants will also gain access to managed-care value-added benefits such as integrated care coordination, chronic disease management and institutional transition supports.

5. Managed Care Integration of HCBS
HCBS will be carved into the managed care delivery system at HC-LTC implementation. Medicaid Managed Care Plans must:
-Honor all existing service authorizations at launch.
-Reimburse authorized services regardless of provider network status.
-Contract with active HCBS providers for at least one year.

A 90-day continuity-of-care period beginning July 1, 2027, will be used if needed to ensure uninterrupted access to care for participants and providers.

6. Participant and Provider Communication
SCDHHS will conduct advance outreach at least six months before implementation, informing participants of what is changing, what remains the same and how services will continue. Managed Care Plans will conduct direct follow-up outreach-welcome calls, care coordinator introductions and confirmation of services and providers-to support continuity and address questions. Outreach will prioritize HCBS participants with complex needs, dually eligible individuals and participants who self-direct services. Information will be delivered through mail, telephone, digital platforms (as applicable) and community partners. Plans will document outreach and report issues to SCDHHS for timely resolution.

7. Assurance of Continuity and Participant Protection
SCDHHS will ensure:
-No current participant loses waiver eligibility solely due to consolidation.
-All existing services remain available under HC-LTC, except where replaced by equivalent managed-care supports.
-Self-directed service options remain available.
-All existing authorizations are honored during transition.

This transition plan ensures continuity of care, preserves participant protections and supports a smooth migration to a unified, streamlined HCBS waiver structure.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Health Programs

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

- (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

  The State Medicaid Agency (SMA) contracts with a Quality Improvement Organization (QIO) for the provision of reviewing and approving participant's annual level of care re-evaluations adhering to approval criteria no more restrictive than SMA policies. The QIO serves as an independent, external reviewer to ensure compliance with federal and state requirements for the Healthy Connections Long Term Care Waiver program. Their primary responsibility in the reevaluation process is to review documentation.
  The QIO examines all submitted re-evaluation materials, including assessments, care plans, and supporting documentation, to verify that the individual continues to meet the program's medical and functional eligibility criteria. After completing the review, the QIO issues an official decision to the SMA to approve or deny the re-evaluation request.

  The SMA contracts with Medicaid Managed Care Plans (MCOs) to provide all waiver services through their provider networks. MCOs will be responsible for delivering services congruent with the long-term care needs of enrollees and supporting these services with an appropriate provider and customer service framework.
  Specific functions will include:
  • Operate member services hotline
  • Create and distribute enrollee and provider materials (handbooks, directory, forms, policies and procedures)
  • Quality improvement
  • Utilization review
  • Community outreach
  • Provider services including contracting and reimbursement
  • Provider training materials
  • Monitoring and compliance information
  • Case management
  • Care planning
  • Enrollee complaint hotline
  • Provider and enrollee dispute resolution

- ( ) **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:

The SMA monitors the QIO's adherence to the terms of its contract, including performance standards, timelines, and reporting requirements.

The SMA monitors and assesses the performance of MCOs.

Appendix A: Waiver Administration and Operation

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

The State monitors all waiver operational and administrative functions identified in Appendix A-7 through a structured oversight system that includes direct State review and monitoring of contracted entities, including the QIO. Oversight activities encompass record reviews, desk audits, onsite visits and performance reporting. The frequency of monitoring can vary from quarterly to annually. The SMA receives a monthly report of deliverables from the QIO. Delegated responsibilities for the QIO will be added to this report of deliverables.

The SMA reviews QIO activities to ensure that re-evaluation decisions are accurate, timely, and consistent with federal and state guidelines. This includes auditing cases and analyzing performance metrics. If deficiencies or non-compliance are identified, the SMA will issue a Corrective Action Plan (CAP) requiring the QIO to address root causes and implement process improvements.

The contract with MCOs requires plans to submit monthly, quarterly and annual reports on various aspects of program operations through which the State exerts control over program operations and assesses the performance of managed care plans.

MCO's compliance with contract requirements is monitored by the SMA. This monitoring process assesses each contract requirement through desk reviews of a sample number of plan enrollees. At the conclusion of the monitoring process, any deficiencies are noted and plans are required to correct them within specified time frames.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care waiver eligibility 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	☑	☐

Function	Medicaid Agency	Contracted Entity
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Percentage of service plans for waiver participants meeting established MCO contract requirements N: Total number of LTC member service plans for waiver participants completed in accordance with MCO contract D: Total number of waiver service plans required.

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

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

		Interval = 95 %
☑ **Other** Specify: MCOs	☐ **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:
Percentage of quarterly reports submitted to SCDHHS by Medicaid MCOs within the required time period. Numerator: Number of quarterly reports received within the

required time period. Denominator: Number of quarterly reports due.

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

MCOs are contractually required to submit reports consistent with all technical specifications and reporting requirements. The State Medicaid Agency (SMA) promptly reviews these reports to ensure accuracy, compliance with contractual performance standards and timely submission.

To address individual problems as they are discovered, the SMA uses a three-step compliance process:
-Collection and review of MCO policies and procedures to confirm alignment with program requirements.
-Onsite reviews to observe operational practices and validate implementation.
-System demonstrations and verification to confirm that MCOs are tracking required data and applying policies correctly.

During this process, MCOs must show the applicable policy, demonstrate how the associated data is tracked in their system and describe any remediation activities already undertaken.

When deficiencies are identified, the SMA requires corrective action through a corrective action plan, liquidated damages or other contractually defined remedies. The SMA issues written notice of non-compliance and monitors remediation activities through completion. If an MCO fails to correct deficiencies within required timeframes, the SMA may implement escalating corrective actions, based on severity and program impact. The SMA may also issue additional policy guidance or pursue contractual amendments to strengthen expectations and prevent recurrence. Systemic issues identified through trend analysis may result in the development of Performance Improvement Projects (PIPs).

All activities-including findings, corrective actions, follow-up reviews and remediation outcomes-are documented and retained by the SMA. Documentation is maintained in accordance with state requirements and is used to inform ongoing quality monitoring and compliance oversight.

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**

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
☑ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☑	**HIV/AIDS**	18		☑
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

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

Specify:

There is no transition procedure for the disabled population aged 18 to 64. This age range reflects the Social Security disability designation, and individuals who meet disability criteria will continue to participate in the waiver. Because the waiver has no maximum age limit, participants may remain enrolled without interruption.

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	24004
Year 2	23636
Year 3	23636
Year 4	23636
Year 5	23636

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).

Purpose(s) the state reserves capacity for:

Purposes
Transition from Institutional Placement
Medically Complex Children's (MCC) Waiver Transition
Transitions of individuals with serious mental illness who live in community residential care facilities.
Serious and Imminent Harm Risk

Appendix B: Participant Access and Eligibility

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

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

Transition from Institutional Placement

Purpose *(describe):*

This includes individuals being discharged from institutional placement who need transition into Waiver services.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on previous numbers reserved in the waivers being consolidated. These numbers were based on previous utilization.

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

Waiver Year	Capacity Reserved
Year 1	37
Year 2	37
Year 3	37
Year 4	37
Year 5	37

Appendix B: Participant Access and Eligibility

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

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

Medically Complex Children's (MCC) Waiver Transition

Purpose *(describe):*

Transition of individuals aging out of the MCC waiver program in need of continued LTC waiver services.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on previous numbers reserved in the waivers being consolidated. These numbers were based on previous utilization.

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

Waiver Year	Capacity Reserved
Year 1	127
Year 2	127
Year 3	127
Year 4	127
Year 5	127

Appendix B: Participant Access and Eligibility

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

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

Transitions of individuals with serious mental illness who live in community residential care facilities.

Purpose *(describe):*

Individuals with serious mental illness who live in community residential care facilities who wish to transition to alternative community-based settings and are in need of Waiver services.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on previous numbers reserved in the waivers being consolidated. These numbers were based on previous utilization.

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

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

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

Serious and Imminent Harm Risk

Purpose *(describe):*

Individuals requiring a service through the waiver, which, if not provided, will likely result in serious and imminent harm AND who have an immediate need for direct care or supervision which directly relates to their disability.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on previous numbers reserved in the waivers being consolidated. These numbers were based on previous utilization.

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

Waiver Year	Capacity Reserved
Year 1	97
Year 2	97
Year 3	97
Year 4	97
Year 5	97

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 applicants are required to be South Carolina Medicaid eligible or have proof on Medical Assistance Only (MAO). Reserved capacity criteria will be used to prioritize entrance to the waiver. When slots are available outside of reserved capacity, individuals will be admitted to the waiver on a first-come, first-served basis by date of application.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- ( ) **No**
- (●) **Yes**

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

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

- [x] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [x] **Pregnant Women (42 CFR § 435.116)**
- [x] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage: [ ]

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

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage: [ ]

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

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**
- [ ] **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42**

CFR § 435.320, § 435.322 and § 435.324)

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

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

Select one:

◉ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

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

Specify:

1. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.
2. Dentures. A one-time expense not to exceed $651.00 per plate or $1320.00 for one full pair of dentures. A licensed dental practitioner must certify necessity. An expense for more than one pair of dentures must be prior approved by State DHHS.
3. Denture Repair. Justified as necessary by a licensed dental practitioner. Not to exceed $77.00 per occurrence.
4. Hearing Aids. A one-time expense. Not to exceed $1000.00 for one or $2000.00 for both. Necessity must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by State DHHS.
5. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69 per visit.
6. Other non-covered medical expenses that are recognized by State law but not covered by Medicaid. These non-covered medical expenses must be prescribed by a licensed practitioner and prior approved by State DHHS.
7. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 or 42 CFR § 435.735:

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

Select one:

- ○ **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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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:

The State requires the provision of waiver services at least monthly with one exception. The State allows up to 60 days for a new enrollee to receive his/her first service. Thereafter, the State requires the provision of waiver services at least monthly.

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

Initial evaluations are completed by the SMA. Re-evaluations will be submitted by the MCOs and validated by the QIO. The SMA retains oversight and final authority for level-of-care evaluation. An entity under contract with the SMA (QIO) will perform administrative functions for level of care re-evaluations to include implementation of the state's approved standardized level of care evaluation tools in the performance of assessments.

- ○ **Other**

Specify:

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

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

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

Nursing Facility Level of Care:
The South Carolina Nursing Home Level of Care Criteria are used to determine medical eligibility for the waiver. Assessors use a standardized instrument to gather assessment information necessary for level of care determinations. The same level of care criteria and assessment instrument are used for both nursing facility placement and waiver enrollment. Program staff apply established intake criteria to all waiver applicants.

An applicant qualifies for waiver services through the NF LOC assessment in the following ways:
1. The applicant is totally dependent in all activities of daily living (ADL).
2. The applicant requires at least one skilled medical service and has at least one functional deficit in ADL.
3. The applicant has at least two functional deficits in ADL.
4. The applicant has at least one functional deficit in ADL and at least one of the following service needs, or, specifically for the purpose of gaining entry to the HASCI Waiver, the applicant has at least two of the following service needs:
a. Daily monitoring of a significant medical condition requiring overall care planning in order to maintain optimum health.
b. Supervision of moderate/severe memory issues, either long or short term, manifested by disorientation, bewilderment, and forgetfulness, which requires significant intervention in care planning.
c. Supervision of moderately impaired cognitive skills manifested by decisions which may reasonably be expected to affect an individual's safety.
d. Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior.

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

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

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

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

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

Nursing Facility Level of Care:
The same level of care criteria and assessment instrument are used for both nursing facility placement and waiver enrollment.

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

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

The same process is used; the same instrument and level of care are utilized. MCO case management and nursing staff may conduct assessment interviews and gather documentation for LOC re-evaluations. An entity under contract with the SMA (QIO) will perform administrative functions for level of care re-evaluations to include validation of assessments. The SMA retains final authority for all level of care evaluations and re-evaluations.

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

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

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

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

Master's degree in social work, nursing, rehabilitation, psychology or related health and human services area, and who have documented experience with the assigned Member population.

Or

Bachelor's Degree from an accredited university or college in nursing, psychology, social work, early childhood education, child development or a related field, and who have documented experience with the assigned member population

Or

Bachelor's degree in another field and has a minimum of 45 documented training hours related to long term care service delivery.

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):*

MCOs receive a waiver participant roster report from the SMA that identifies the level of care date. The plans use this report to track level of care dates and prompt case managers to request level of care reevaluations. This system ensures that reevaluations take place in a timely manner.

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:

Documentation of all evaluations and reevaluations are maintained by the SMA. In addition, the MCOs also maintain electronic copies of records.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percentage of participants who received an initial LOC determination prior to enrollment. N: The number of participants who received a LOC determination prior to enrollment. D: The total number of participants enrolled.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of LOC redeterminations conducted at least annually. N: number of LOC redeterminations conducted at least annually. D: Total number of LOC redeterminations conducted.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: 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:
Percentage of all LOC determinations completed using the appropriate instruments required by the SMA. N: Number of determinations completed using the appropriate instruments. D: Total number of determinations.

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

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

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **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**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

MCOs are contractually required to ensure participants have a current level of care based on the state approved assessment tool and must provide information about level of care through regular reporting. The State Medicaid Agency (SMA) promptly reviews these reports to ensure accuracy, compliance with contractual performance standards and timely submission.

To address individual problems as they are discovered, the SMA uses a three-step compliance process:
-Collection and review of MCO policies and procedures to confirm alignment with program requirements.
-Onsite reviews to observe operational practices and validate implementation.
-System demonstrations and verification to confirm that MCOs are tracking required data and applying policies correctly.

During this process, MCOs must show the applicable policy, demonstrate how the associated data is tracked in their system and describe any remediation activities already undertaken.

When deficiencies are identified, the SMA requires corrective action through a corrective action plan, liquidated damages or other contractually defined remedies. The SMA issues written notice of non-compliance and monitors remediation activities through completion. If an MCO fails to correct deficiencies within required timeframes, the SMA may implement escalating corrective actions, based on severity and program impact. The SMA may also issue additional policy guidance or pursue contractual amendments to strengthen expectations and prevent recurrence. Systemic issues identified through trend analysis may result in the development of Performance Improvement Projects (PIPs).

All activities-including findings, corrective actions, follow-up reviews and remediation outcomes-are documented and retained by the SMA. Documentation is maintained in accordance with state requirements and is used to inform ongoing quality monitoring and compliance oversight.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Medicaid Agency (SMA) ensures that all individuals applying for HCBS waiver services, or their legal representatives, are informed of feasible service alternatives-including institutional care-and are afforded full freedom of choice between institutional services and HCBS.

Waiver pre-enrollment activities are conducted by SMA Area Offices, which are staffed with administrators, case managers, nurse consultants and social workers. During the initial assessment and level-of-care determination, licensed SMA nurse consultants or social workers review available HCBS options with the individual and obtain the signed Freedom of Choice form, documenting that the individual was informed of alternatives and voluntarily chose HCBS. This form is retained in the participant's case record and is available to CMS upon request.

As part of HC-LTC enrollment, the State's enrollment broker informs prospective participants of their Medicaid Managed Care Plan options, including provider networks and available benefits. After the participant selects a plan, the broker notifies the Medicaid Managed Care Plan, which assigns a case manager and schedules a visit for service plan development. During this visit, the case manager obtains the participant's signed Service Choice form, which documents the participant's decision to receive HCBS or institutional care.

Case managers then work with participants to develop the person-centered service plan, confirm understanding of available HCBS services and ensure the participant is aware of additional managed-care benefits. The service plan documents that it was reviewed with and agreed to by the participant (or representative), and that the participant retains the right to request an appeal or Fair Hearing if services are denied, reduced, or if choice of qualified providers is limited.

Service information and plan comparisons are posted on the SMA website, and the enrollment broker provides counseling by phone, in writing and in person when requested. Case managers also review HCBS options during person-centered planning to ensure participants can make informed choices.

All Freedom of Choice forms are maintained by the SMA and are available to CMS upon request.

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.

Freedom of Choice forms are maintained by the SMA as part of the participant's official record.

Appendix B: Participant Access and Eligibility

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

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

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

Managed care plans are required to develop and make available appropriate foreign language versions of all materials available to recipients. The plans are required to provide interpreter services in person where practical, but otherwise by telephone, for recipients whose primary language is a foreign language. Foreign language versions of materials that are critical to obtaining services must be available in the prevalent non-English languages. Materials critical to obtaining services include but are not limited to Member handbooks, Appeal and Grievance notices, and denial and termination notices.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health Care		
Statutory Service	In-home Respite		
Statutory Service	Institutional Respite		
Extended State Plan Service	Personal Care Services		
Extended State Plan Service	Private Duty Nursing		
Other Service	Companion		
Other Service	Environmental Modifications		
Other Service	Home Delivered Meals		
Other Service	Personal Emergency Response System, Installation		
Other Service	Personal Emergency Response System, Monitoring		
Other Service	Pest Control		
Other Service	Self-directed Attendant Care		
Other Service	Self-directed Companion		
Other Service	Specialized Medical Equipment & 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:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
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 generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult day health care includes nutritional meals when the participant is at the center during mealtimes. Adult day health care provides medical screening emphasizing prevention and continuity of care. Nursing services which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene are also a component of the service.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

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

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Adult Day Health Provider

Provider Qualifications

License *(specify):*

SC Code of Laws §44-7-260 et. seq.; SC Code R. 61-75

Certificate *(specify):*

Other Standard *(specify):*

Adult Day Care license in accordance with the State Certification of Need Health Facility Licensure Act, Section 44-7-10 et seq. and Regulation 60-75, Standards for Licensing Day Care Facilities for Adults. Providers must also meet and maintain HCB settings requirements per 42. CFR 441.301(c)

Verification of Provider Qualifications

Entity Responsible for Verification:

SC Department of Public Health, SMA or its designee

Frequency of Verification:

Upon enrollment;
Every 3 years or more frequently as needed

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):

In-home Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
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.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Personal Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In-home Respite

Provider Category:

Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

In-home care provider license as outlined in SC Code of Laws §44-70-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

In-home care provider license as outlined in SC Code of Laws §44-70-10 et seq. enrolled with SMA to provide Personal Care services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health; SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

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):

Institutional Respite

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09011 respite, out-of-home
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. Services do not include 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.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

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

☑ **Provider managed**

☐ **Remote/via Telehealth**

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 Hospital
Agency	Licensed Nursing Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Institutional Respite

Provider Category:

Agency

Provider Type:

Licensed Hospital

Provider Qualifications

License *(specify):*

Hospital licensed in accordance with SC Code of Laws §44-7-260, R. 61-16, equivalent for NC & GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, Department of Public Health

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Institutional Respite

Provider Category:

Agency

Provider Type:

Licensed Nursing Facility

Provider Qualifications

License *(specify):*

Nursing Facility licensed in accordance with SC Code of Laws §44-7-250; R.61-17, equivalent for NC & GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, Department of Public Health

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

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:

Extended State Plan Service

Service Title:

Personal Care Services

HCBS Taxonomy:

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

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 are provided when personal care services furnished under the approved state plan limits are exhausted. The scope and nature of these services do not otherwise differ from Children's personal care services except by age of service recipient. All medically necessary services for children under age 21 are covered under state plan pursuant to the EPSDT benefit.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

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

☑ **Provider managed**

☐ **Remote/via Telehealth**

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	Personal Care Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Personal Care Services

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

In-home care provider license as outlined in SC Code of Laws §44-70-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

In-home care provider license as outlined in SC Code of Laws §44-70-10 et seq.

The provider must provide all of the following staff members; supervisory nurses may be provided through subcontracting arrangements:
A registered nurse(s) (RN) or licensed practical nurse(s) (LPN) who meets the following requirements:
Currently licensed by the S.C. State Board of Nursing; capable of evaluating the aide's competency in terms of their ability to carry out assigned duties and their ability to relate to the participant; and able to assume responsibility for in-service training for aides by individual instruction, group meetings or workshops.
Aides who meet the following minimum qualifications:
Capable of assisting with the activities of daily living
Capable of following a care plan with minimal supervision.
The provider must ensure the employee's license is valid while transporting any participants by verifying the official highway department driving record of the employed individual initially and every two years during employment.
Have passed competency testing or successfully completed a competency training and evaluation program performed by a RN or LPN prior to providing services to Home and Community-Based waiver participants. The competency evaluation must contain all elements of the personal care services. The competency training should also include training on appropriate record keeping and ethics and interpersonal relationships.
Have a minimum of ten (10) hours relevant in-service training per calendar year.

Aides must complete a training program in the following areas:
Confidentiality, accountability and prevention of abuse and neglect
Fire safety/disaster preparedness related to the specific location of services
First aid for emergencies, monitoring medications, and basic recognition of medical problems
Documentation and record keeping
Ethics and interpersonal relationships
Orientation to disabilities
Training in lifting and transfers
A SC Law Enforcement Division (SLED) criminal background check is required for all employees prior to hire and at least every two years thereafter. Providers are required to check the CNA registry and the Office of Inspector General (OIG) exclusions lists for all staff prior to hire, then at least every two years thereafter.
The provider agency shall acquire and maintain liability insurance and worker's compensation insurance.
The provider must comply with safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health; SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

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:

Extended State Plan Service

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1: 05 Nursing

Sub-Category 1: 05010 private duty nursing

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 are provided when the limits of private duty nursing furnished under the the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from private duty nursing services except by age of service recipient. All medically necessary services for children under age 21 are covered under state plan pursuant to the EPSDT benefit.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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 Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Nursing Provider

Provider Qualifications

License *(specify):*

In-home care provider license as outlined in SC Code of Laws §44-70-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

In-home care provider license as outlined in SC Code of Laws §44-70-10 et seq.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health; SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Companion

HCBS Taxonomy:

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

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):*

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Companion Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion

Provider Category:

Agency

Provider Type:

Companion Provider

Provider Qualifications

License *(specify):*

Providers of Companion services maintain a current in-home care provider license as outlined in SC Code of Laws §44-70-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

In-home care provider license as outlined in SC Code of Laws §44-70-10 et seq.
Must be 18 years or older and complete four hours of relevant in-service training per calendar year in the following areas:
i. Maintaining a safe, clean environment and utilizing proper infection control techniques;
ii. Following written instructions;
iii. Ethics and interpersonal relationships;
iv. Documenting services provided; and
v. Other areas of training as appropriate.

A South Carolina Law Enforcement Division (SLED) criminal background check is required for all employees prior to hire and at least every two years thereafter to include employees who will provide direct care to waiver participants and all administrative/office employees (office employees required to have SLED background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions). Providers are required to check the CNA registry, and the Office of the Inspector General (OIG) exclusions lists for all staff prior to hire then at least every two years thereafter. The Provider shall acquire and maintain liability insurance and workers' compensation insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health, SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

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:

Environmental Modifications

HCBS Taxonomy:

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

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, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. 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 except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Environmental modifications is limited to $7,500 per year.

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

This service is limited to $7500 per participant per waiver year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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
Individual	Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Licensed Business

Provider Qualifications

License *(specify):*

South Carolina Business License

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SCLLR; SMA or its designee

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Building Contractor

Provider Qualifications

License *(specify):*

Building Contractor licensed according to SC Code of Laws 40-59-5.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

South Carolina Department of Labor, Licensing, and Regulation (SCLLR); SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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):*

One to two nutritionally sound meals per day provided to participants who are otherwise unable to care for their nutritional needs. Nutritional risk and inability to prepare or obtain meals must be clearly documented. Each meal should provide one-third of the current recommended dietary allowance but not comprising a full nutritional regimen. These can be hot, shelf-stable, refrigerator-fresh, or blast-frozen meals. Meals should be medically tailored if needed by the participant. Meals cannot duplicate meals provided through another service for the same meal period. This includes meals provided as part of the ADHC service.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals

Provider Qualifications

License *(specify):*

A food retail permit issued by the South Carolina Department of Agriculture.

Certificate *(specify):*

Other Standard *(specify):*

A food retail permit issued by the South Carolina Department of Agriculture.

Agencies desiring to be a provider of Home Delivered Meals (HDM) Services must have the following:

- A Registered Dietitian
- Six (6) week menu cycle approved by the Registered Dietitian.
- At least one (1) year of demonstrated experience in food service meal planning and preparation

Each provider must offer: one (1) hot meal per day, five (5) or more days each week, and any additional authorized meals may be hot or cold. Shelf stable meal requests may be provided if authorized by the Case Manager and the participant or authorized representative. A hot meal, for the purposes of this program, is one in which the main food item is hot at the time of serving. A blast-frozen meal, if authorized, meets the hot meal requirement for this standard. (If the participant or responsible party agrees and/or requests shelf stable meals, we will allow this option in lieu of hot or frozen meals.) The facility at which the meals are prepared and/or packaged, as well as the manner of handling, transporting, serving and delivery of these meals must meet all applicable health, fire safety and sanitation regulations. Only single service covered aluminum foil or Styrofoam divided containers can be used for hot food. Each tray compartment must be large enough to contain the required portions without spillover.

Unless providing a blast frozen meal or shelf stable meal, hot and cold food shall be portioned and packed separately to ensure retention of heat or cold and shall be transported in approved insulated carriers which will maintain the required hot (135 degrees Fahrenheit or above) and cold (41 degrees Fahrenheit or below) temperatures until the time of delivery to the participant. Blast frozen meals must be transported in approved insulated carriers which will maintain the meals in a frozen state until the time of delivery to the participant.
Delivery routes must be clearly established. No more than three (3) hours shall elapse between the time of packaging and the time of delivery of the last hot meal on the route. Delivery of a cold meal beyond the three (3) hour limit for a participant who lives too far away may be made upon written approval of the SMA. The provider shall give initial and on-going training in the proper service, handling, and delivery of food to all staff, both volunteer and paid.

The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

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, Installation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

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):*

This service involves installation of the Personal Emergency Response System (PERS) for a waiver participant who lives alone or is alone for significant parts of the day. The waiver participant must be able to effectively utilize the equipment.

The unit must have three components:
a. A small radio transmitter (a help button carried or worn by the user)
b. A console when emergency help (medical, fire, or police) is needed
c. Emergency Response Center to determine the nature of the calls

The service includes installation, participant instruction and maintenance of devices/systems

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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, Installation

Provider Category:

Agency

Provider Type:

Emergency Response Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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.
The unit must have three components:
a. A small radio transmitter (a help button carried or worn by the user)
b. A console when emergency help (medical, fire, or police) is needed
c. Emergency Response Center to determine the nature of the calls

The Provider shall provide the PERS service seven (7) days per week for all authorized time periods.
The Response center staff must be able to monitor the PERS unit twenty-four (24) hours a day, seven (7) days a week.
Response center staff must be trained to perform duties related to monitoring the PERS unit.
Response center staff must be able to test the PERS unit in the home monthly.
Technicians that install equipment must meet the following requirements:
a. Qualified as a technician to install PERS equipment.
b. Capable of evaluating whether or not the equipment is functioning properly.
c. Able to assume responsibility for training Participants and/or caregivers in the use of PERS equipment.

A SLED criminal background check is required for all potential employees including technicians, response center staff and administrative/office employees. The provider shall acquire and maintain liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA or its designee

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System, Monitoring

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
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):*

The monitoring of an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, twenty-four hours per day, seven days per week.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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, Monitoring

Provider Category:

Agency

Provider Type:

Emergency Response Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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.
The unit must have three components:
a. A small radio transmitter (a help button carried or worn by the user)
b. A console when emergency help (medical, fire, or police) is needed
c. Emergency Response Center to determine the nature of the calls

The Provider shall provide the PERS service seven (7) days per week for all authorized time periods.
The Response center staff must be able to monitor the PERS unit twenty-four (24) hours a day, seven (7) days a week.
Response center staff must be trained to perform duties related to monitoring the PERS unit.
Response center staff must be able to test the PERS unit in the home monthly.
Technicians that install equipment must meet the following requirements:
a. Qualified as a technician to install PERS equipment.
b. Capable of evaluating whether or not the equipment is functioning properly.
c. Able to assume responsibility for training Participants and/or caregivers in the use of PERS equipment.

A SLED criminal background check is required for all potential employees including technicians, response center staff and administrative/office employees. The provider shall acquire and maintain liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control

HCBS Taxonomy:

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

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, such as cockroaches, from participant's residence. Services are provided based on demonstrated need to ensure participant's health, safety and welfare. Providers inspect participant's residence, confirm existent pests, and treat the residence (interior and exterior) to eliminate infestation. A maximum of six treatments can be authorized per 12 month period with a maximum frequency of every other month. Pest Control services must not be covered through other resources such as a lease agreement.

Pest Control services may also aid in maintaining an environment free of bedbugs to promote safety, sanitation, and cleanliness of the participant's residence. Once the existence of bedbugs is established as existent within the home, providers treat the residence to eliminate infestation. The provider must return to the home and provide retreatment as necessary within a one-year warranty time frame from the authorization of initial treatment. Bed bug extermination services must not be covered through other resources such as a lease agreement.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate

duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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):*

Providers must have an SC Pesticide Business License in accordance with SC Code of Laws 46-13-10 et. seq

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Clemson University Department of Pesticide Regulation; SMA or its designee

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Self-directed Attendant Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08050 homemaker
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08060 chore
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 or nursing care to the extent permitted by state law. Limited housekeeping activities, which are incidental to the performance of care, may also be furnished as part of this activity.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

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

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Attendant designated by waiver participant or authorized representative

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self-directed Attendant Care

Provider Category:

Individual

Provider Type:

Attendant designated by waiver participant or authorized representative

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Self-directed attendants must complete A SLED criminal background check and certify completion of the following: CPR, first aid, and medical training specific for medical condition(s). In addition, Self Directed attendant must meet the following minimum qualifications:
1. Demonstrate an ability to read, write and communicate effectively with the waiver participant/responsible party;
2. Fully ambulatory;
3. Capable of performing all attendant care duties;
4. Capable of following a care plan with participant and/or representative supervision;
5. Be at least 18 years of age;
6. Capable of following billing procedures and completing required paperwork;
7. No known conviction of abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Ann. Title 63, Chapter 7);
8. No known conviction for any crime against another person;
9. No known felony conviction of any kind;
10. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);
11. No record of exclusion or suspension from the Medicare or Medicaid Programs;
12. All Attendants shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Medicaid enrollment date.
13. The attendant must adhere to basic infection control procedures at all times when providing services.

Verification of Provider Qualifications

Entity Responsible for Verification:

MCO/Contracted FMS vendor

Frequency of Verification:

Upon enrollment;

Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Self-directed Companion

HCBS Taxonomy:

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

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):*

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-directed Companion

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self-directed Companion

Provider Category:

Individual

Provider Type:

Self-directed Companion

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Self-directed companions must complete A SLED criminal background check and certify completion of the following: CPR, first aid, and medical training specific for medical condition(s). In addition, the Self-Directed companion must meet the following minimum qualifications:
1. Demonstrate an ability to read, write and communicate effectively with the waiver participant/responsible party;
2. Fully ambulatory;
3. Capable of performing all companion duties;
4. Capable of following a care plan with participant and/or representative supervision;
5. Be at least 18 years of age;
6. Capable of following billing procedures and completing required paperwork;
7. No known conviction of abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Ann. Title 63, Chapter 7);
8. No known conviction for any crime against another person;
9. No known felony conviction of any kind;
10. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);
11. No record of exclusion or suspension from the Medicare or Medicaid Programs;

12. All companions shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Medicaid enrollment date.
13. The companion must adhere to basic infection control procedures at all times when providing services.

Verification of Provider Qualifications

Entity Responsible for Verification:

MCO/Contracted FMS vendor

Frequency of Verification:

Upon enrollment;
Annually or more frequently as needed

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 & Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
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: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that

enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items have to meet applicable standards of manufacture, design and installation.

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

It is the State's intention that the managed care plans have the maximum flexibility needed to ensure each individual receives the services necessary to maintain health, safety, and welfare, and to remain in a community setting. The State will require that plans provide management and oversight of services, and the State will monitor plan performance to ensure this occurs. Incentives have been established to encourage plans to manage the program efficiently and to prevent inappropriate duplication of services.

All managed care plans will be paid a monthly capitated payment and will be responsible for ensuring that each recipient receives appropriate services consistent with the approved plan of care. The State will analyze encounter data to identify aberrant billing practices or unusual spending patterns and will require plans to explain any such anomalies or face penalties.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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 & Supplies

Provider Category:

Agency

Provider Type:

Licensed Business

Provider Qualifications

License *(specify):*

Business license as required by the providers' location in South Carolina.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA or its designee

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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 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.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The waiver operates through a managed care service delivery model. MCO employees or other case management providers enrolled in the plan's provider network assess each member's care needs, develop the care plan to address the identified care needs with the assistance of the member or his or her designated representative.

MCO employees will minimally receive LTC training in the following areas: Case management responsibilities & procedures, SCDHHS-specified comprehensive state assessment training, SCDHHS-specified person-centered care planning training, freedom of choice, full continuum of LTC services (e.g., service settings), provider network, MCO service utilization tools, MCO chronic disease programs, other MCO case manager trainings for specific population types (e.g. SMI), member safety and fall prevention, self-directed services, community options/resources outside of Medicaid to promote independence and community integration, neurological degenerative diseases (e.g., Alzheimer's), general medical information, abuse neglect and exploitation. Annual refreshers are required and must include policy updates.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

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):

South Carolina law requires Nursing Homes, Community Residential Care Facilities, Home Health Agencies, Adult Day Health Care agencies, and Personal Care agencies to conduct background checks on all direct care staff. Personal Care agencies must also complete background checks on all employees. These checks are state-level investigations performed by the South Carolina Law Enforcement Division (SLED). The Department of Public Health verifies compliance during licensure inspections.

Providers must check the CNA Registry and the Office of Inspector General (OIG) Exclusions List before hiring and at least every two years thereafter. Search results must be kept in each employee's personnel file. Individuals appearing on either registry may not provide services to waiver participants or work in any SMA-funded program.

A SLED criminal background check is required for all employees-direct care and administrative-before hire and every two years thereafter. Administrative staff requiring checks include administrators, office managers, nurse supervisors, and other management personnel. SLED checks must cover at least ten years of statewide data, including South Carolina and any other states where the individual has lived in the prior ten years.

Individuals with felony convictions within the past ten years may not work with SMA or OIDD participants in any capacity. Individuals with non-violent felonies older than ten years may provide services only if the participant or responsible party is notified of the conviction and signs a written acknowledgment, which is kept in the participant's record. Administrative staff with non-violent felonies older than ten years may be employed at the provider's discretion.

Self-directed workers must meet the same background check requirements as all other direct care staff. Medicaid Managed Care Plans are responsible for monitoring and verifying compliance with these requirements as part of their contractual obligations.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Certified Nursing Aides (CNAs) must be screened for inclusion on the State's CNA abuse registry, which is maintained by a contracted vendor. Service providers are responsible for completing these screenings for all prospective employees. The SMA and Medicaid Managed Care Plans verify completion of these checks during compliance reviews.

Providers must conduct background screenings on all prospective employees-both administrative and direct care-before hire and at least every two years thereafter. A copy of each search result must be kept in the employee's personnel file. The SMA and Medicaid Managed Care Plans confirm compliance with these requirements during periodic reviews.

If a staff member is identified on the CNA abuse registry, the provider must immediately remove the individual from all service delivery. The provider must notify the participant's case manager within 24 hours, and must assign a qualified replacement worker without delay. If the provider cannot furnish a replacement, the case manager works with the participant to secure another qualified provider from the waiver network to ensure uninterrupted services. The SMA requires that replacement services be arranged within 14 days to protect the participant's health and welfare.

The case manager verifies that replacement services have begun by confirming directly with the participant or authorized representative and by confirming service initiation with the new provider. All continuity-of-care steps and outcomes must be documented in the Medicaid Managed Care Plan's electronic case management system.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

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

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

  Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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 self-directed services may be made to certain family members who meet SMA provider qualifications. Agency staff may be related to participants within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:
a. A parent of a minor Medicaid participant;
b. A stepparent of a minor Medicaid participant;
c. A foster parent of a minor Medicaid participant;
d. Person who has the legal responsibility of utilizing their own assets for the care of the Medicaid participant

Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:
a. The spouse of a Medicaid participant (including married but separated).
b. A parent of a minor Medicaid participant
c. A stepparent of a minor Medicaid participant
d. A foster parent of a minor Medicaid participant
e. Any other legally responsible guardian of a Medicaid participant

All other qualified family members may be reimbursed for their provision of waiver services

The SMA requires that all relatives and legal guardians serving as paid service providers meet the same provider qualifications, training requirements, and performance expectations as non-related providers. When a relative or legal guardian has legal decision-making authority, the SMA has established procedures to ensure substituted judgment is applied appropriately.

Case managers are required to evaluate and document that service decisions reflect the participant's known preferences, goals, and values. This includes review of the participant's person-centered service plan, consultation with the participant (to the extent possible), and ongoing monitoring to ensure that the services remain aligned with the participant's best interests. Additionally, the Medicaid Managed Care plan conducts periodic oversight and quality assurance reviews to verify that services delivered by relatives or legal guardians adhere to waiver requirements, are free from conflict of interest, and support the participant's health, safety, and autonomy. Any concerns identified through monitoring trigger corrective action, technical assistance, or other remedies as appropriate.

The state does not impose any limitations on the amount, frequency or duration of waiver services that may be furnished by relatives or legal guardians. Services must be medically necessary and congruent with assessment of need. Case managers monitor participant service plans through monthly phone calls and quarterly face to face visits.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Potential providers are given the opportunity to enroll/contract with the SMA. Potential providers are made aware of the requirements for enrollment through: (1) The agency's website and, (2) contacting the SMA directly. Potential providers are directed to SMA website to complete an online application.

MCOs are responsible for developing and maintaining a comprehensive provider network to serve waiver participants in compliance with 42 CFR Part 438. MCOs must develop and maintain a Network Development and Management Plan demonstrating adequate provider capacity to meet the needs of each waiver participant. For the first year of the waiver, MCOs are contractually required to contract with all willing HCBS providers.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - [ ] **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☐ **The HCBS must be identified in the individual's person-centered service plan; and**

☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Licensed/Certified providers only: Percentage of newly enrolled licensed and/or certified providers that meet SMA contractual requirements prior to furnishing waiver services. N: The number of all newly enrolled licensed and/or certified providers who meet contractual standards prior to furnishing waiver services. D: All newly enrolled licensed and/or certified providers

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
Non-licensed/Non-certified providers only: Percentage of newly enrolled providers who complete SMA enrollment validation processes prior to furnishing waiver services. N: The number of newly enrolled providers who complete SMA enrollment validation processes prior to furnishing waiver services. D: The number of newly enrolled waiver service providers.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

MCOs are required to ensure that providers remain in good standing with the SMA and to maintain documentation of this in their credentialing and re-credentialing files. MCOs receive a daily provider file from the SMA that includes each provider's SMA ID, enrollment type or specialty, location details, enrollment spans, and corresponding payment status indicators. The SMA's Quality Assurance Division will continue to follow its monitoring protocols to ensure provider compliance with all requirements. The SMA notifies MCOs when a provider is terminated from Medicaid or when other relevant actions occur. The SMA will also require MCOs to remove a provider from their network if necessary.

MCOs are required to notify affected participants in an appropriate formal communication, and via the case manager. The MCOs must then work with the affected participant to find an alternate provider and develop a transition plan as appropriate. The enrollee retains all of the rights described in this response and throughout the waiver application during the transition process.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The MCOs evaluate their licensed service providers, by type, within the plan provider network to ensure they meet provider qualifications prior to delivering services and on an ongoing basis. Any deficiencies found must be corrected within time frames based upon participant health and safety risks. The MCOs are required to submit at least quarterly provider network lists detailing new service providers. The MCOs are responsible for enrolling qualified service providers. If the State's review determines an MCO's service providers are unqualified, the MCO must correct the deficiency.

The MCOs evaluate their non-licensed/non-certified service providers, by type, within the plan provider network to ensure they meet provider qualifications prior to delivering services and continuously. Any deficiencies found must be corrected within time frames based upon participant health and safety risks. The MCOs are required to submit at least quarterly provider network lists detailing new service providers. The MCOs are responsible for enrolling qualified service providers. If the State's review determines an MCO's service providers are unqualified, the MCO must correct the deficiency.

The MCOs verify service providers with staff mandated to report abuse, neglect, and exploitation have received appropriate training. During an annual review, the Agency reviews the MCO reports for compliance with staff training requirements. The MCOs found with staff training deficiencies must ensure the staff receives appropriate training within 45 days.

The MCOs are required to provide case management services through case managers employed by the MCO or their subcontractors. The monitoring staff reviews case management training files as part of their desk review to ensure that all case managers receive contractually required trainings. The MCOs found with staff training deficiencies must ensure the staff receives appropriate training.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

HCBS are received in provider-controlled and participant-controlled settings. Participant-controlled settings are defined as homes or apartments owned or leased by an HCBS participant or by one of their family members. Provider-controlled settings are settings where a participant receives services from an agency provider who provides HCBS services the majority of the day. All DPH licensed Adult Day Health Care settings are considered provider-controlled settings.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Settings presumed to be institutional, but where services are truly individualized, person centered and integrated into the broader community can be determined compliant only by SCDHHS and/or its designee(s). No HCBS provider should assume a setting presumed to be institutional is determined to be compliant without written confirmation from SCDHHS or its designee(s). All Providers who believe a setting presumed to be institutional is compliant must contact MedicaidWaiver@scdhhs.gov about the setting to receive written confirmation.

Providers who provide HCBS in ADHCs that meet Category 1, Category 2 and Category 3, as defined below, must be assessed by SCDHHS and/or its designee(s) to determine compliance with the regulation. The agency will require that the settings in which Medicaid HCBS waiver services may be delivered demonstrate, before receiving Medicaid reimbursement for HCBS waiver services, that the setting is free from program design, operation characteristics, and programmatic practices that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Category 1: Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment

Category 2: Any setting in a building on the grounds of, or immediately adjacent to, a public institution, with public institution defined as an inpatient facility that is financed and operated by a county, state, municipality, or other unit of government

Category 3: Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Settings may, if compliance is demonstrated, be certified by the state as HCBS waiver compliant and be allowed to seek Medicaid reimbursement for services rendered. Ongoing compliance will be monitored through the SCDHHS and Medicaid MCO's established systems of quality assurance.

New providers and new settings will be reviewed on a site visit to ensure 100% compliance with these requirements prior to enrollment. After the initial enrollment, compliance monitoring will ensure continued compliance with these requirements. Any non-compliance with these requirements will result in remediation and possible sanctions up to termination of the provider with SCDHHS for non-compliance. Providers deemed compliant must maintain compliance with the HCBS Settings regulation in order to receive reimbursement for HCBS waiver services. There is an established compliance system in place at SCDHHS and the Medicaid MCOs that monitors providers and their services to ensure they are compliant in providing the waiver services as stated in their contracts/enrollment agreements which are congruent with the approved waiver applications. HCBS settings reviews will be incorporated into onsite visits and settings found not to be in compliance will be subject to remediation and possible sanctions up to termination of the provider or the setting with SCDHHS for non-compliance.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☑ **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. ***(see Appendix D-1-d-ii)***

☑ **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.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

◉ **No, the waiver does not include provider-owned or controlled settings.**

○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance doors.**
- ☐ **Individuals sharing units have a choice of roommates in that setting.**
- ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

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

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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:

Minimum qualifications of case managers are as follows:
Master's degree in social work, nursing, rehabilitation, psychology or related health and human services area, and who have documented experience with the assigned Member population.

Or

Bachelor's Degree from an accredited university or college in nursing, psychology, social work, early childhood education, child development or a related field, and who have documented experience with the assigned Member population

or

Bachelor's degree in another field and has a minimum of 45 documented training hours related to Long term care service delivery.

☐ **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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the

potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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.

Services and supports included in the service plan are determined by the Medicaid Managed Care Plan based on the initial assessment and in consultation with the participant or the participant's representative. The service plan addresses all health and social support needs identified through the assessment.

Medicaid Managed Care Plans must ensure that the service plan is reviewed at least quarterly through face-to-face contact with the participant to confirm that services remain appropriate and sufficient. During each review, the plan must work with the participant or representative to evaluate whether the services provided align with the participant's needs. Any revisions to the service plan must involve the participant, and when applicable, the caregiver and primary care provider.

Participants have the authority to choose who is involved in developing, reviewing, and revising their service plan, including representatives, family members, caregivers, and physicians. The person-centered service plan reflects agreements among these parties regarding the supports to be provided. Case managers assist participants in identifying desired outcomes, personal goals, and needed supports, and collaborate with the participant to design the person-centered service plan. Case managers must review the service plan at least quarterly with the participant, family or guardian, or primary caregiver to ensure goals, needs, and supports remain accurate and up-to-date.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

Each participant will have one person-centered service plan. The Medicaid Managed Care Plan must create an individualized, service plan within seven business days of enrollment, with any exceptions documented. The plan is based on a comprehensive assessment of the participant's physical, functional, psychosocial, and environmental needs, personal goals, and preferences. Participants direct the planning process and may include family, representatives, friends, caregivers, or physicians as they choose.

Participants receive information on waiver benefits and services through enrollment materials and Medicaid Managed Care Plan member resources. Plans must ensure participants understand available services during development of the service plan. Case managers complete the service plan utilizing the SMA assessment tool along with any plan-specific tools, evaluating service needs, personal goals, and the urgency of supports. Case managers maintain ongoing contact-monthly by phone and face-to-face at least quarterly-to review and update the service plan, revising it whenever the participant's health or functional status changes. They also authorize services, help participants access providers and appointments, arrange transportation, and coordinate care across all payor sources. Adjustments to the service plan are made as needed to reflect changes in goals, needs, or circumstances.

Throughout the year, State quality assurance staff review a representative sample of participant files to confirm that Medicaid Managed Care Plans meet service planning requirements and maintain proper documentation. Plans must correct deficiencies within fifteen business days and submit a corrective action plan outlining steps to prevent future issues, including evidence-based practices and ongoing improvement data.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **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.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☑ **A specific and individualized assessed need for the modification.**
- ☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☑ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☑ **Informed consent of the individual.**
- ☑ **An assurance that interventions and supports will cause no harm to the individual.**

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.

As part of person-centered service planning, the participant, their chosen supports, the primary care provider, and the case manager work together to create a back-up plan that complements the participant's primary service plan. Risk-mitigation services, such as nutritional assessments and home-delivered meals, are available through the waiver. While participants may decline involvement in developing a mitigation plan, the Medicaid Managed Care Plan must still maintain overall emergency back-up procedures, and the case manager must inform participants of any identified risks and invite them to participate in creating a mitigation strategy. Certain elements, such as alternate contacts for emergencies or disasters, are automatically built into the participant's service plan and communicated through both the case manager and the Medicaid Managed Care Plan's written materials, regardless of participant engagement. The service planning process also outlines procedures to follow if providers are unavailable or emergent situations occur.

A risk assessment is completed as part of the comprehensive assessment used to develop the service plan. The case manager evaluates potential risks related to the participant's physical and mental health, living environment, caregiver capacity, and other factors, and recommends services or supports to reduce those risks. The participant selects the provider for any agreed-upon services or supports

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.

Each Medicaid Managed Care Plan must maintain printed and online provider network directories to help participants choose qualified waiver providers. These directories are also available to the enrollment broker. Plans make trained staff available to assist participants in locating providers, and case managers are trained to offer unbiased information on all qualified waiver providers in the network. Participants may select any provider included in the Medicaid Managed Care Plan's network. Before implementation, each plan's network sufficiency will be evaluated to ensure an adequate number of waiver providers are available.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Agency will monitor Medicaid Managed Care Plans through annual desk reviews. These reviews assess the accuracy of required reports and verify that each plan is meeting contractual obligations and State performance measures outlined in the waiver. The Agency will require corrective action for any issues identified and may impose penalties or sanctions when appropriate.

Medicaid Managed Care Plans must ensure service plans are created and updated on time. The Agency is responsible for conducting case reviews and confirming that a representative number of cases are examined each year and that any needed remediation is completed.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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**
- [x] **Other**

Specify:

Medicaid Managed Care Plans must have secure centralized, electronic case management systems that are the repository for all information about participants.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The SMA will monitor Medicaid Managed Care Plans through annual desk reviews. These reviews verify the accuracy of required reports and confirm that each plan is meeting contractual obligations and State performance measures outlined in the waiver. The SMA will require corrective action for any issues identified and may impose penalties or sanctions when appropriate.

Medicaid Managed Care Plans must ensure service plans are developed and updated on time. The SMA is responsible for completing case reviews, ensuring that a representative number of cases are examined each year, and confirming that necessary remediation is addressed.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Percentage of participants whose personal goals were addressed in their service plans. N: Number of participants reviewed whose personal goals were addressed in their service plans. D: Total number of participants reviewed who identified personal goals.

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

MCO Member files

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of participants with service plans that address needs identified during assessment N: Participants reviewed with service plans that address needs identified during assessment D: Number of participants reviewed whose assessments identified needs that should be addressed on the service plan.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

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:

Percentage of participants with service plans updated/revised annually. N: the number of participants reviewed with service plans updated/revised annually. D: number of participants reviewed with service plans.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: 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:
Percentage of participants who received services in accordance with their service plans. N: Number of participants reviewed who received services in accordance within their service plans. D: Total number of participants reviewed with service plans.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **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: MCOs	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***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:
Percentage of participants afforded choice of all qualified waiver service providers.
N: number of participants reviewed who were afforded choice of all qualified waiver service providers, as signified by their initials/signature D: total number of participants reviewed.

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

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **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: MCOs	☐ **Annually**
	☐ **Continuously and Ongoing**

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

Performance Measure:
Percentage of participants informed of their right to choose waiver services, from those that are available, that will best meet their needs as documented by an attestation form. N: Number of participants reviewed that were informed of their right to choose waiver services D: Total number of participants reviewed.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Percentage of new participants with freedom of choice forms indicating choice between waiver services and institutional care in their case records N: Number of new enrollees reviewed with freedom of choice forms indicating choice between waiver services and institutional care in their case records D: Number of case records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
State Waiver Enrollment Management System; MCO member files

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of all new waiver participants with signatures on the care plan indicating a choice of services and service providers N: Number of all new enrollees reviewed with signatures on the care plan indicating choice of services and service providers D: Number of records reviewed

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

By contract, approved service plans must address all assessed needs, including identified risk factors. MCOs must use an integrated service-planning process that encourages participants to set personal goals and pursue community interests. During quarterly desk reviews, service plans are examined to ensure participant goals and community interests are included. If an MCO is out of compliance, it must provide documentation showing a personal goal is included in the service plan. If a

personal goal is not present, the case manager must meet with the participant to develop one and submit a revised service plan. The MCO must also submit a signed attestation confirming the case manager received training on the importance of personal goal planning.

Service plans must be signed by participants to verify their involvement in developing the plan. Quarterly desk reviews include checking for participant (or representative) signatures. If the MCO is out of compliance, the case manager must receive training on the importance of obtaining signatures. The MCO must submit evidence of remediation and provide both a signed-and-dated attestation of training completion and a signed-and-dated copy of the service plan.

By contract, MCOs must review participant service plans after a report of significant change. During quarterly desk reviews, case files are reviewed to ensure these reviews occurred. If an MCO has not completed a required review, the case manager must conduct an immediate face-to-face meeting with the participant. The MCO must confirm the meeting occurred and provide a signed attestation that the case manager was trained on performing service-plan reviews more frequently when participant needs change.

Approved service plans must be updated at least annually. Quarterly desk reviews verify this requirement. If a service plan has not been updated, the case manager must meet with the participant to complete an updated plan. The MCO must submit evidence of remediation and an attestation confirming the case manager was trained on annual update requirements.

Case managers must review the service plan face-to-face with the participant at least quarterly. Quarterly desk reviews examine compliance. If the review has not occurred, the case manager must meet with the participant to complete it. The MCO must submit evidence of remediation and a signed attestation confirming training on the quarterly review requirement.

Quarterly desk reviews also verify that participants receive services according to the service plan. If an MCO is out of compliance, the SMA will require an explanation for differences in service type, amount, frequency, duration, or scope. Updated service authorizations matching the service plan must be submitted.

Enrollment packets must include signed freedom-of-choice forms indicating whether the participant chooses waiver services or institutional care. Quarterly desk reviews verify the forms are present. If a signed form is missing, the case manager must assist the participant with completion. The MCO must submit evidence of remediation and a signed-and-dated attestation confirming the training occurred.

Quarterly desk reviews also confirm service plans contain participant or representative signatures and dates. If the MCO is out of compliance, the case manager must receive training on obtaining signatures. The MCO must submit evidence of remediation, a signed attestation confirming the training, and a signed-and-dated service plan.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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.

Participant direction is available to participants who have an eligible service included in their authorized service plan. Participants who wish to use participant direction but cannot manage the responsibilities themselves may appoint a representative to act on their behalf. Information about the participant direction is provided during enrollment and again during service plan development.

Participant direction is available for self-directed attendant care and self-directed companion. Medicaid Managed Care Plans must contract with a State approved Financial Management Service (FMS) vendor who will provide all training and process payroll and state and federal taxes for participants and their direct service workers.

Participants may choose a representative to manage participant-direction responsibilities. To prevent conflicts of interest, representatives may not serve as paid caregivers for the participant they represent. Participant direction is optional, and participants may discontinue it at any time; the case manager will assist with a seamless transition to provider-managed services. In limited circumstances, such as when a required representative is unavailable or when health or safety concerns arise, a participant may be involuntarily disenrolled from participant direction. In such cases, the case manager ensures the participant transitions to provider-managed services without interruption.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

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

If a participant does not meet criteria to self-direct services, they are allowed to appoint a representative to manage the self-directed service. If no one appropriate is available to serve as a representative, and the service is still desired, the participant will be offered the agency-managed service as an alternative.

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.

Information about participant direction opportunities, including the benefits, responsibilities, and potential liabilities of participant-direction, will be provided to enrollees at various times.

For both individuals gaining eligibility for HCBS at the same time as Medicaid and those already Medicaid eligible, this information will be presented by the case manager during the service planning process.

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 appoint a representative to direct their waiver services. To serve in this role, the representative must be willing to assume the rights, responsibilities, and risks involved in directing services. A representative may be a legal guardian, family member, friend, or other trusted individual. The representative must be at least 18 years old, demonstrate a strong commitment to the participant, and understand the participant's preferences and medical needs. Representatives must be able to review and approve weekly service logs and observe services monthly. Representatives are not paid for these responsibilities and may not provide additional waiver services to the participant.

Once a participant identifies a representative, the case manager completes an initial screening to confirm the representative can act in the participant's best interest. The representative must also acknowledge awareness 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
Self-directed Companion	☑	☐

Waiver Service	Employer Authority	Budget Authority
Self-directed 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:

Medicaid Managed Care plans will contract with a qualified state-approved FMS vendor.

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

Medicaid Managed Care Plans will compensate the FMS vendor for the activities they perform.

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:

Pre-employment screening and training.

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 SMA conducts monitoring of each Medicaid Managed Care Plan annually, or more frequently if needed. Plans must submit encounter data to the SMA that detail the use of participant-directed services and fiscal management services. Each Medicaid Managed Care Plan is responsible for overseeing the subcontracted fiscal management vendor to ensure the accuracy and integrity of all financial transactions.

Through EVV, retrospective reviews of service plans and paid timesheet records, the SMA verifies that service plans are developed in accordance with policy and that fiscal management and participant-directed services are delivered as authorized in the participant's service plan.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Delivered Meals	☐
Self-directed Companion	☐
Self-directed Attendant Care	☐
Specialized Medical Equipment & Supplies	☐
Adult Day Health Care	☐
Institutional Respite	☐
In-home Respite	☐
Pest Control	☐
Personal Emergency Response System, Monitoring	☐
Personal Emergency Response System, Installation	☐
Personal Care Services	☐
Private Duty Nursing	☐
Environmental Modifications	☐
Companion	☐

☑ **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:

Case managers through the Medicaid Managed Care Plans help participants access needed waiver, State plan, and other medical, social, or educational services, regardless of funding source. They ensure services are coordinated and integrated by monitoring delivery of supports as outlined in the participant's service plan. Case managers are responsible for discussing what is involved in participant direction.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (•) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participants may elect to voluntarily discontinue participant direction at any time and may choose agency-driven options. Participant health and welfare is assured during the transition period of a voluntary termination of service direction. The termination of participant directed services and authorization of agency driven services are coordinated to assure continuity of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Participants may be involuntarily terminated from the use of participant directed services when they are unable to direct their own care and have no representative willing and/or able to do so. Participants who are involuntarily terminated from participant directed services are given the option of receiving agency directed services. If a participant is involuntarily terminated from participant directed services, the termination of participant directed services, and the authorization of agency directed services are coordinated to assure continuity of services. These safeguards exist to assure participant health and welfare during the transition period of an involuntary termination of service direction.

Participants who are involuntarily terminated are given written appeal rights.

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	3050	
Year 2	3050	
Year 3	3050	
Year 4	3050	
Year 5	3050	

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

☐ **Recruit staff**

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

☑ **Select staff from worker registry**

☑ **Hire staff common law employer**

☐ **Verify staff qualifications**

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

Specify how the costs of such investigations are compensated:

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

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

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

☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☑ **Schedule staff**

☑ **Orient and instruct staff in duties**

☑ **Supervise staff**

☑ **Evaluate staff performance**

☑ **Verify time worked by staff and approve time sheets**

☑ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

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

The SMA provides Fair Hearings in accordance with 42 CFR Part 431 Subpart E, 42 CFR 438.400(a)(1), and 42 CFR 438.404. Participants are informed of their Fair Hearing rights whenever an action is taken regarding Medicaid eligibility or when services are denied, terminated, reduced, or suspended.

Under 42 CFR 438.402, Medicaid Managed Care Plans must maintain an internal grievance and appeal system related to Fair Hearing rights. Participants may request a Fair Hearing at any time after completing the plan's appeal process. Parties to the hearing include the Medicaid Managed Care Plan, the participant, and the participant's representative, or the representative of a deceased participant's estate.

Managed Care Plans are required to notify participants of any adverse decisions and explain the Fair Hearing process, including the continuation of services during an appeal. Plans must also issue written adverse action notices and provide Fair Hearing information, with copies maintained in the participant's case file. All grievances submitted to the plan must be reported to the SMA monthly. Fair Hearings may be requested verbally or in writing, and no specific form is required.

During the initial visit, the case manager reviews the participant's rights and responsibilities, including the right to a fair hearing, and explains how to file an appeal. When an adverse decision is made, individuals are notified verbally and in writing by SMA staff or Medicaid Managed Care Plan, and receive an Appeals Notice with instructions for submitting an appeal. Appeal information is also included in other SMA correspondence, such as the Level of Care Certification Letter and the participant's Rights and Responsibilities form. The SMA Division of Appeals and Hearings maintains a public-facing website (www.scdhhs.gov/appeals) with guidance and an online portal for filing appeals. Appeals may also be submitted through written correspondence sent via the U.S. Postal Service to the SMA Central Office.

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**

• **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.

Do not complete this item.

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**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The SMA operates the grievance/complaint system.

• **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 can submit a complaint through the SMA's member call center as well as through their respective MCO. They are also provided grievance and appeal information including the SMA fair hearing rights as part of their MCO member enrollment packet and from their waiver case manager at the initial and annual visits.

Complaints may address any concern related to waiver services, including provider conduct, service reductions or terminations, unmet needs, or issues related to waitlist processing. The complaint system may also be used to report concerns involving abuse, neglect, or exploitation; however, formal critical incident reporting must follow the separate SMA procedures outlined in Appendix G.

The SMA also receives complaints through its public-facing website, which routes submissions to the appropriate division. Timely responses to these complaints are required.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

The South Carolina Omnibus Adult Protection Act, SC Code of Laws §43-35-5 et. seq, guides the SMA in its incident reporting requirements for vulnerable adults. Among other guidance offered, this Act defines reportable incidents as well as mandates reporting from certain persons.

Pursuant to Code of Federal Regulations § 441.302(a)(6)(i)(A), a Critical Incident is defined as, at a minimum, verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect. Critical events or incidents must be reported by phone to the appropriate investigative entity and entered in the incident management system within twenty-four (24) hours or within the next business day of when the reporter becomes aware of the allegation or of witnessing the event.

In addition to the preceding incident types, SCDHHS has identified categories of critical incidents that providers of 1915(c) Waiver Services are required to report to SCDHHS, law enforcement, or other reporting entity. SCDHHS has implemented Critical Incident processes to ensure that providers are following the requirements as outlined in the HCBS Provider Manual and Medicaid MCO Contracts.

Definitions
Administrative Review
A review conducted by the provider or SCDHHS after the report of a critical incident to ensure that all required policies and procedures were followed and the critical incident has been reported correctly.

Behavioral Health Crisis
An event or situation that causes the person to experience extreme disorganization of thought, hopelessness, sadness, confusion, panic, or other emotional distress. The event includes action(s) by a person that poses a danger to themselves or others and is unable to be mitigated without the assistance of law enforcement, mental health, or medical services. If the incident involves a suicide attempt, it should be reported in that category in all cases.

Choking
When food or other items become lodged in the back of the throat and impact the person's ability to breathe. Choking incidents are reportable when they require interventions such as back blows, abdominal thrusts and/or the Heimlich maneuver. If the choking incident results from the failure to appropriately supervise or prepare the correct food texture, an allegation of neglect must be reported.

Corrective Action Plan
Plan written by the provider to outline how they will ensure that any policies and procedures found not to be followed during an administrative review will not occur again in the future.

Death Expected Death (Natural Causes): Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. For example, a person who has been diagnosed with cancer and is receiving Hospice services or when a Do Not Resuscitate (DNR) order is in place.

Unanticipated Death: An unanticipated death is primarily attributed to an external unanticipated force acting upon the person. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unanticipated.

Unexplained Death:
A death in which the cause of death noted on a person's death certificate is not supported by documentation found in the person's medical history and other documentation.

Elopement
Any time a person is missing from their designated location for a period of more than one (1) hour beyond their documented need for supervision. Based on a person's history, safety skills, and familiarity with the area, a person may be considered in jeopardy before one (1) hour elapses. In addition, when police are contacted about a missing person or the police independently find and return a person, this is reportable regardless of the amount of time a person has been missing.

Exploitation (SC Code Section 43-35-10(3))
Causing or requiring a participant to engage in activity or labor that is improper, unlawful, or against the reasonable and rational wishes of the participant; Exploitation does not include requiring a vulnerable adult to participate in an activity or labor which is a part of a written plan of care, or which is prescribed or authorized by a licensed physician attending the patient
An improper, unlawful, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a participant by an individual for the profit or advantage of that individual or another individual; or Causing a participant to purchase goods or services for the profit or advantage of the seller or another individual through undue influence, harassment, duress, force, coercion, or swindling by overreaching, cheating, or defrauding the participant through cunning arts or devices that delude the participant and cause him or her to lose money or other property.

Falls
Any fall resulting in death, injury requiring hospitalization, or injury that will result in permanent loss of function.

Fire
A situation that requires the active involvement of fire or other safety personnel such as extinguishing a fire, clearing smoke from the premises, checking for carbon monoxide at the site etc. In addition, fires that are extinguished by staff are reportable.

Fire with Property Damage: The fire causes property damage that may or may not make the premises uninhabitable. Fire without Property Damage: The fire does not cause property damage and may or may not result in the premises being uninhabitable.

Carbon Monoxide Detector
Any situation for which the carbon monoxide detector indicates the presence of carbon monoxide gas.

Initial Reporter
The person who witnesses and/or first becomes aware of the allegations of a critical incident.

Injuries
Any injury that requires treatment beyond first aid. This includes injuries that receive assessment and/or treatment at an Emergency Room, Urgent Care Center, Primary Care Physician Office etc. or that require a hospitalization. Serious injuries that are treated by a medical professional (i.e., doctor, nurse etc. that is used by the organization) on-site are reportable.

Law Enforcement Activity
Law enforcement action that occurs during the provision of service or for which a person is the subject of a law enforcement investigation that may lead to criminal charges against the person. This includes law enforcement responding to a possible crime when a person is in the community or in a vehicle.

Mandatory Reporter
Persons required in accordance S.C. Code Ann. §63-7-3 et. seq. and the Omnibus Adult Protection Act of 1993, S.C. Code Ann. § 43-35-5 and 43-35-10, et. Seq to include but not limited to healthcare professionals and social or public assistance workers, to report any abuse, neglect, or exploitation as defined in those state statutes.

Medication Error
A medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death.

Neglect (SC Code Section 43-35-10(6))
The failure or omission of a direct care staff member or direct care volunteer to provide the care, goods, or services necessary to maintain the health or safety of a participant including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Failure to provide adequate supervision resulting in harm to participants, including altercations or acts of assault between participants, may constitute neglect. Neglect may be repeated conduct or a single incident that has produced or could result in physical or psychological harm or substantial risk of death. Noncompliance

with regulatory standards alone does not constitute neglect. Neglect includes the inability of a vulnerable adult, in the absence of a caretaker, to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death.

Peer to Peer
Incidents Acts of aggression and/or assault between service recipients are to be reported as a Critical Incident whenever injuries requiring medical attention occur.

Physical Abuse (SC Code Section 43-35-10(8)
The act of intentionally inflicting or allowing to be inflicted physical injury on a participant by an act or failure to act. Physical Abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery, use of medication outside the standards of reasonable medical practice for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment except that a therapeutic procedure prescribed by a licensed physician or other Authorized Healthcare Provider or that is part of a written plan of care by a physician or other Authorized Healthcare Provider is not considered physical abuse. Physical abuse does not include altercations or acts of assault between participants.

Psychological Abuse (SC Code Section 43-35-10(10)
Deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

Seclusion, Unauthorized Restrictive Intervention or Restraint Seclusion:
The involuntary confinement of a person. Verbal instruction or any explicit or implicit intimidation that indicates to a person that they may not leave is also considered seclusion, regardless of whether the person has the ability to physically remove himself or herself from the situation.

Unauthorized Restrictive Procedure: Any restrictive procedure (other than a restraint) that does not follow guidelines related to restrictive procedures or is prohibited by policy. Restrictive procedures limit a person's movement, activity or function, interfere with the person's ability to acquire positive reinforcement, result in the loss of objects or activities that a person values or require a person to engage in a behavior in which, given the freedom of choice, the person would not engage.

Chemical Restraint: The use of a medication for the specific and exclusive purpose of controlling acute or episodic aggressive behavior.

Mechanical Restraint: A device that involuntarily restricts the freedom of movement or voluntary functioning of a limb or part of a person's body as a means to control their physical movements and normal access to their body.

Physical Restraint: A physical hands-on method, excluding health protections, that restricts, immobilizes, or reduces a person's ability to move his or her arms, legs, head, or other body parts freely. A physical restraint may only be used in the case of an emergency to prevent a person from immediate physical harm to herself/himself or others.

Rights Violation
An unauthorized act which improperly restricts or denies the human or civil rights of a person including those rights which are specifically mandated under applicable law, regulation, policy, or plan. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

Serious Illness
A physical illness, disease, or period of sickness that requires an emergency room visit, urgent care, or hospitalization. This does not include visits to these locations that are used in lieu of the ability to secure an appointment with a primary care physician or other medical professional.

Sexual Abuse
Any nonconsensual attempted or completed sexual acts. The acts may be physical or non-physical. Any act or attempted act that is sexual in nature between a paid service provider staff and a Medicaid beneficiary is considered a crime, regardless of consent on the part of the beneficiary.

Suicide Attempt
The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats or ideation. If medical treatment was sought after a suicide attempt, it should be reported under suicide attempt as a primary category in all cases, and not as serious injury, or illness.

Verbal Abuse
Using words to threaten, coerce, intimidate, degrade, demean, harass or humiliate an individual. Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to Medicaid beneficiaries or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

Vulnerable Adult
A person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection.

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.

Medicaid Managed Care Plans must report all critical incidents involving participants-including allegations of abuse, neglect, or exploitation-to the SMA. Plans and their subcontractors must also provide educational materials explaining the types of abuse and how to report concerns. This may include instructions for contacting South Carolina's toll-free abuse reporting hotline operated by the Department of Social Services. Plans and subcontractors must ensure direct care staff are trained to recognize and report abuse, neglect, and exploitation. Participant training is provided as often as needed based on the participant's situation and support needs.

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.

Critical incidents involving waiver participants may require involvement from multiple state agencies, depending on the nature and location of the event. The Medicaid MCO and case manager play a central role in documenting incidents and ensuring required follow-up, while the SMA monitors all reports for compliance with policy and statute. Waiver providers who witness or become aware of a critical incident must report it to the appropriate authorities as required by law and notify the participant's case manager within 24 hours or the next business day. The case manager must then enter the incident into the Critical Incident System and track it through resolution.

During routine contact and service coordination, case managers must address any changes in the participant's needs. If new concerns arise, they must document a new critical incident in the system within 24 hours or the next business day. Any incident requiring external reporting must be submitted within statutory timeframes. For participants with an active incident, case managers must document each contact within three business days and follow up at least monthly until involved agencies confirm resolution. If case managers cannot obtain required information from external agencies, they seek assistance from designated SMA staff; unresolved issues are then escalated to SMA central office staff until information is received.

Once an incident is submitted, SMA staff review documentation to confirm all statutory and policy requirements have been met. If not, SMA staff request corrections through the Critical Incident System or email. When documentation is complete, SMA staff acknowledge the incident and continue oversight until closure. The SMA maintains the full incident record.

Multiple state agencies investigate critical incidents as required by South Carolina law. Each agency has specific jurisdiction and timeframes:

• Department of Social Services / Adult Protective Services (SC Code §43-35-5): Investigates abuse, neglect, and exploitation of vulnerable adults in community settings. Timeframes vary from immediate response for emergencies to 72 hours for self-neglect. Cases involving possible criminal activity are referred to law enforcement or SLED within one working day.

• Office of the State Long-Term Care Ombudsman (SC Code §43-35-25): Investigates non-criminal allegations in licensed facilities. Reviews begin within two working days, with required referrals to law enforcement or SLED within one working day after review.

• South Carolina Law Enforcement Division (SC Code §43-35-15): Through the Vulnerable Adults Investigations Unit, investigates abuse, neglect, and exploitation occurring in facilities operated or contracted by the Department of Mental Health or the Department of Disabilities and Special Needs. The unit operates a 24/7 toll-free reporting line and investigates or refers cases with reasonable suspicion of criminal conduct.

• Attorney General (SC Code §43-35-80): May take action against individuals or facilities that fail to exercise reasonable care in hiring, training, or supervising staff, resulting in abuse, neglect, or exploitation.

Mandated reporters must follow state law when abuse, neglect, or exploitation is suspected in any home or community setting. Each agency follows its own procedures for notifying participants and other relevant parties of investigation results. The SMA ensures compliance with notification requirements through its administrative review process, confirming that incidents were reported properly and that all procedures were followed. Incident results and documentation are maintained in the SMA's critical incident record.

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

The SMA is renewing its Memorandum of Agreement with DSS to support information sharing and coordinated responses to alleged abuse, neglect, and exploitation involving vulnerable adults receiving SMA services. The agreement identifies SMA-operated or contracted programs required to report these incidents to DSS and establishes collaboration for training and technical assistance.

The SMA oversees the reporting and follow-up of all critical incidents. Reportable incident data are continuously monitored and reviewed for quality improvement, accountability, public reporting, and to support participant health and safety. The SMA also holds quarterly meetings with internal subject matter experts to review trends and address reports requiring additional follow-up.

Appendix G: Participant Safeguards

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

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

- (●) **The state does not permit or prohibits the use of restraints**

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

  The South Carolina Department of Social Services (SCDSS) and the Long-Term Care Ombudsman are responsible for monitoring the use of restrictive interventions, including restraints and seclusion. South Carolina Department of Public Health (SCDPH) is responsible for all facility licensing.

  Per DPH regulations, any incidents involving seclusions, restraints or restrictive interventions must be reported to DPH by facility staff. Staff at DPH 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:

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on*

restraints.)

- (●) **The state does not permit or prohibits the use of seclusion**

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

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

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

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

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

- ( ) **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

- **Medication Management and Follow-Up**

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

This section applies only to waiver participants residing in licensed Community Residential Care Facilities (CRCFs). Under state licensing requirements, a licensed CRCF is responsible for administering and monitoring participants' medication regimen. SCDPH oversees the scope of medication monitoring, focusing on certain types of medications and medication usage patterns assessed during on-site compliance visits.

SCDPH completes medication monitoring routinely to include: a substance that has therapeutic effects, including, but not limited to, legend, non-legend, herbal products, over-the counter, nonprescription, vitamins, and nutritional supplements. SCDPH additionally reviews medication storage, administration, receiving orders, security, interactions, and adverse reactions. Facilities are required to maintain a Medication Administration Record report. After a medication administration issue is identified SCDPH issues a citation. The facility cited then must respond with a plan of correction within 15 days. The plan of correction must outline a specific time frame in which the problem was corrected or will be corrected, describe how problems were addressed, and indicate how the issue will be prevented in the future.

Reports are provided to the SMA indicating problems noted with medication administration outcomes. If the facility under review has a history of compliance issues, SCDPH monitors the facility more frequently. When there is a recurrence of a violation (Classes I-III) cited under the same section of the regulation as previously noted, SCDPH conducts an onsite monitoring visit to the facility every 30-60 days.

The SMA does not conduct second-line monitoring for behavior modifying medications under this waiver.

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

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

Do not complete the rest of this section

- **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).

- **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:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

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:
Percentage of critical incidents wherein follow-up action was taken as required. N: Number of critical incidents reviewed where follow-up action was taken as required. D: Number of critical incidents requiring follow-up action.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCO member files	☐ **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:
Percentage of abuse, neglect, exploitation, and unexplained death reports with documentation of appropriate referrals to authorities. N: The number of abuse, neglect, exploitation, and unexplained death reports reviewed with documentation of appropriate referrals to authorities. D: The number of abuse, neglect, exploitation, and unexplained death reports reviewed.

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

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

		Review
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **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:
Percentage of caregivers who experienced moderate to severe stress with caregiving and have appropriate interventions identified on the service plan. N: The number of caregivers reviewed who experienced moderate to severe stress with caregiving and have appropriate interventions. D: Total number of caregivers with moderate to severe stress reviewed.

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

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

		Sample Confidence Interval = 95 %
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☑ **Other** Specify: MCO Member files	☐ **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:
Percentage of reported incidents in the IMS that are monitored until appropriate resolution. N: the number of reported incidents reviewed that are monitored until appropriate resolution. D: total number of reported incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Management 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 = 95 %
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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:
Percentage of substantiated complaints reported in the IMS associated with restrictive interventions that were remediated. N: Number of substantiated complaints reviewed that were associated with restrictive interventions that were remediated. D: Number of substantiated complaints reviewed that were associated with restrictive interventions.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 %
☐ **Other**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

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:
Percentage of participants indicating their health care needs are being addressed. N: Number and percent of participants reviewed indicating their current health care needs are being addressed. D: Number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS CAHPS 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** Confidence Interval = 95 %
☑ **Other** Specify: HCBS CAHPS Survey	☑ **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: HCBS CAHPS Survey	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

During required training, case managers and other MCO staff are informed of their responsibilities as mandated reporters of abuse, neglect, exploitation, and other events outlined in SC Code of Laws §43-35-25. They are trained to report these incidents to the appropriate entities whenever necessary. The training also explains both the statutory and administrative consequences that may occur if a case manager fails to report a required incident.

Additional information and on-demand training materials are available for waiver providers, case managers, and SMA staff. Case managers receive instruction on the correct processes for recording Adult Protective Services (APS) involvement and other reportable incidents, including how to enter, update, and track incidents within the Incident Management System. Case managers must document monthly follow-up in the participant's record until all involved entities have resolved the incident.

The SMA has procedures and agreements in place to resolve communication issues that may arise with external agencies during investigations, service coordination, and remediation of reportable events. If SMA supervisory staff cannot resolve an issue, SMA Central Office staff become involved until adequate feedback is obtained and documented.

SMA staff, both in the Central Office and regional locations, also receive training in reporting and tracking APS involvement and other reportable incidents in the Incident Management System, as well as instruction on the statutory requirements related to their roles.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The SMA is responsible for overseeing the reporting and monitoring processes associated with waiver participants who experience abuse, neglect, exploitation, or other reportable incidents. When issues are identified with the progress, accuracy, or timeliness of critical incident reporting or monitoring, the SMA will contact the managed care plan to inform them that follow-up is needed or to address any reporting issues identified. The managed care plan is expected to remediate the issue. If repeated issues occur, case managers will be required to complete refresher training in critical incident reporting. Depending on the severity or persistence of deficiencies, the SMA may also impose corrective action plans, penalties, liquidated damages, or other applicable sanctions.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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.

TThe SMA is responsible for oversight of all critical incident reporting and monitoring involving waiver participants who experience abuse, neglect, exploitation, or other reportable incidents. The Quality Bureau coordinates quarterly reviews of incident reporting and monitoring data to identify trends, system-wide issues, and best practices. When concerns arise-such as delays, inaccuracies, or missing reports-the SMA will notify the managed care plan to initiate follow-up. The plan must promptly remediate the issue. If problems reoccur, case managers may be required to complete refresher training in critical incident reporting. In alignment with Appendix H-1 a i's mandate for continuous system improvement, the SMA uses these findings to drive quality improvement activities and may impose corrective action plans, penalties, liquidated damages, or other sanctions based on the severity or persistence of deficiencies. Any revisions, additions, or deletions to performance measures listed in the waiver appendices will be submitted to CMS for approval through the waiver amendment process, and all performance measures will be reported in the evidentiary report as required by CMS.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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 Quality Improvement Team reviews performance measure results to determine whether a policy change or program adjustment has resolved the identified issue. If updated policies or program improvements-such as new forms, staff training or process revisions-do not lead to measurable improvement within six months to one year, the team develops recommendations to address performance in the problem area. The team evaluates expected performance rates against actual LTC plan results, and when performance falls below expectations, it prepares recommendations for SMA management to consider. Once approved, new program performance standards are implemented according to the prioritized improvement schedule. SMA monitors program results and communicates changes to performance measures or program policies to enrolled LTC providers through program memorandums and the contract amendment process. Any revisions, additions or deletions to performance measures listed in the waiver appendices will be submitted to CMS for approval through the waiver amendment process. Changes to the Quality Improvement Strategy (QIS) will also be reported in the annual CMS-372 report, which is posted on the SMA website.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Performance measure results are reviewed periodically to determine whether program or plan performance indicates a need for improvement. Survey parameters are set at a 95% confidence level, a 5% margin of error and 50% response distribution to ensure a representative program-level sample. When needed, the random sample is proportionally allocated across Medicaid Managed Care plans to match each plan's share of the population, ensuring all plans are represented and minimizing bias. Quality Improvement Strategy re-evaluation meetings are held as necessary, with SMA participating, and meeting minutes maintained by SMA.

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).*

Financial accountability is assured through the South Carolina Enterprise Information System (SCEIS), in following the Accounting Polices and Procedures issued through the South Carolina Office of the Comptroller General, and in adhering to all federal reporting requirements. Capitated MCO plans are paid a monthly capitation rate, which is paid prospectively beginning on or around the first Friday of each month. All enrollee, provider, and service utilization/payment data will be available through the federally certified South Carolina's Medicaid Management Information System (MMIS) that is operated by Clemson University. The South Carolina's State Auditor is responsible for performing the periodic independent audits of the state's Medicaid program under the provisions of the Single Audit Act.

Medical Loss Ratios are calculated in accordance with 42 CFR 438.8, the White House, Office of Management and Budget, Compliance Supplement (Part 4, Department of Health and Human Services), and Actuarial Standards of Practice. The Medical Loss Ratio (MLR) for each MCO is calculated annually using the instructions and templates with attestation developed by our consulting actuaries Milliman. The MCO MLRs are monitored quarterly through the NAIC quarterly and annual filing submitted by each MCO. Additionally, MCOs are required to send SCDHHS a copy of the independently audited statutory basis financial report filed with the South Carolina Department of Insurance under regulation 69-70. The MCOs are required in the MCO Contract to include a footnote or supplemental schedule specific to the Medicaid Managed Care line of business. SCDHHS's provider agreement establishes a minimum MLR of 86.0% for the Medicaid managed care population. Financial consequences of the minimum MLR requirements are specified in the provider agreement. However, in general, the MCO will be required to repay any revenue amounts below the 86.0% minimum threshold.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

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:
Percentage of approved monthly capitation payments made in a quarter to MCO for qualified recipients N: Number of approved monthly capitation payments made in the quarter to MCO for qualified recipients D: Number of monthly capitations made in the quarter

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Percentage of monthly capitation payments made in the quarter to MCOs for services rendered N: Number of monthly capitation payments made in the quarter for services rendered D: Number of monthly capitation payments made in the quarter

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

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

☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☑ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

South Carolina's certified Medicaid Management Information System verifies all MCO plan and recipient enrollment eligibility criteria before approving a recipient's enrollment and generating a capitation premium payment to the MCOs. These eligibility-based edits map the approval of a capitation premium payment to both the plan and rate cell levels prior to payment being made, preventing payments made on behalf of ineligible enrollees at the point the file is generated.

SCDHHS and Milliman monitor MCO performance via a review of Medical Loss Ratios (MLR). MLRs are calculated in accordance with 42 CFR 438.8, the White House, Office of Management and Budget, Compliance Supplement (Part 4, Department of Health and Human Services), and Actuarial Standards of Practice. The Medical Loss Ratio (MLR) for each MCO is calculated annually using the instructions and templates with attestation developed by our consulting actuaries Milliman. The MCO MLRs are monitored quarterly through the NAIC quarterly and annual filing submitted by each MCO. Additionally, MCOs are required to send SCDHHS a copy of the independently audited statutory basis financial report filed with the South Carolina Department of Insurance under regulation 69-70. The MCOs are required in the MCO Contract to include a footnote or supplemental schedule specific to the Medicaid Managed Care line of business. SCDHHS's provider agreement establishes a minimum MLR of 86.0% for the Medicaid managed care population. Financial consequences of the minimum MLR requirements are specified in the provider agreement. However, in general, the MCO will be required to repay any revenue amounts below the 86.0% minimum threshold.

The Agency's Medicaid Program Integrity (MPI) continuously monitors billing data to identify indicators of potential fraud, waste, and abuse. MPI conducts targeted reviews and audits when data analysis or other sources suggest irregular or errant billing practices.

MPI works closely with the Managed Care Organizations' Special Investigation Units (SIUs) to combat fraud, waste, and abuse and provides oversight to ensure SIU compliance with contractual requirements. When MPI identifies suspected fraudulent activity, the Agency refers those cases to the Medicaid Fraud Control Unit (MFCU) within the South Carolina Attorney General's Office for further investigation.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Clemson University operates South Carolina's MMIS system, which contains the program for all MCO plan and recipient eligibility as well as the capitation premium rates for each rate cell. In the event that capitation payments are made to an MCO for ineligible enrollees, the system error is researched, reconciled, with any necessary coding changes made to the system in a timely fashion. MCOs who receive these mispayments are notified that the payment will be recouped against at the earliest opportunity.

If incorrect rates are paid to an MCO for their eligible population, the payments are researched. Based upon the findings related to the error, affected plans will be notified and the payments will be reconciled, with both underpayments and overpayments addressed through the recoupment or supplemental payments made through the agency's gross-level adjustment 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***

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

c. 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).*

MCO Capitation Rate Range Development

The South Carolina Department of Health and Human Services (SCDHHS) contracted with Milliman, Inc. (Milliman) to develop actuarially sound capitation rate ranges for its Medicaid Managed Care program effective July 1, 2027 through June 30, 2028.

Capitation rate development begins in January as Milliman selects the base experience data and receives an administrative expense and rate survey from the MCOs. During the rate setting process, SCDHHS provides several opportunities for discussion, clarification, and commentary from the MCOs. A rate development methodology meeting with the MCOs and their actuaries is held in March, and draft rates are shared with the plans in advance of in-person meetings in May to provide the plans with an opportunity to research and address any concerns that need to be accounted for in the base data used to develop rates.

In these on-site meetings between SCDHHS, the MCOs, and Milliman, Inc., all considerations across rate cells inclusive of those classified as the "Standard Population" and the "Dual/LTSS Population." The Standard Population includes Medicaid beneficiaries enrolled in managed care who are not dually eligible and who are not eligible for LTSS, whereas the Dual/LTSS population includes those who are 18 and over and either dually eligible for Medicare or non-dual populations eligible for LTSS. The case mix amongst these populations is determined by Milliman, Inc., after factoring any applicable considerations from SCDHHS and the MCOs by using encounter data, assistance category assignments, and indicators for recipients of a special program (RSP) from MMIS.

Factoring all applicable considerations and feedback provided by SCDHHS and the MCOs, Milliman, Inc., presents the estimated aggregate annual expenditures under the managed care program based on projected membership and calculates certified capitation rates by rate cell.

These actuarially sound capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b) - 438.7 and provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and populations covered under the terms of the contract.

Medicaid Managed Care composite capitation rates are available on SCDHHS's website at the following link: SFY 2027 Medicaid Managed Care Certification.pdf.

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:*

MMIS has recipient eligibility and provider information. The recipient information is updated as part of the eligibility redetermination process. When a recipient is enrolled in the managed care program, this will be reflected on his/her eligibility file. Provider information is established upon enrollment of each MCO plan. Capitated payments flow directly to capitated MCO plans from SCEIS based upon data file generated by MMIS. For each recipient enrolled with an MCO, a monthly payment is generated. Capitated MCOs are responsible for paying provider claims and submitting encounters to the state. Edits in MMIS are designed to ensure that claims for enrollees for services covered by a capitated MCO will be denied.

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:*

MMIS has edits to ensure that prior to generating a payment to an MCO, the enrollee is eligible for the Medicaid Managed Care program and is enrolled with the appropriate MCO.

MCOs are required to monitor service delivery to ensure services are rendered in accordance with the plan of care. [Insert Contract Language Here]

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

● ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

MCOs receive monthly capitation payments for caring for their enrollees from SCEIS based upon a data file generated by MMIS. Service authorizations are sent to service providers to obtain the necessary waiver services for enrollees. After service providers deliver the waiver service, the provider submits a bill to the MCO for reimbursement per their subcontract.

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:

☑ ***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.

N/A

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:

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:

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

- ***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.

The payment to capitated MCOs is not reduced or returned in part to the state[JD6.1] unless a portion is later reduced as a part of minimum MLR requirement recoupments.

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 section 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 section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ***This waiver is a part of a concurrent section 1915(b)/section 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 section 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 section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☑ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

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:*

Limited services may be furnished in residential settings other than the participant's personal home, such as CRCFs; however, payments are made solely for the specific waiver service provided and do not include room and board. Services cannot duplicate the services required as part of the payment for CRCF services. Only authorized waiver services are reimbursed, and no payments are made directly to the residential provider for housing or related costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, 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	22397.45	8160.14	30557.59	70699.22	4472.35	75171.57	44613.98
2	23526.11	8445.75	31971.86	73173.69	4628.88	77802.57	45830.71
3	24713.40	8741.35	33454.75	75734.77	4790.90	80525.67	47070.92
4	25957.43	9047.30	35004.73	78385.48	4958.58	83344.06	48339.33
5	27268.10	9363.95	36632.05	81128.98	5132.13	86261.11	49629.06

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:	Level of Care:
		Hospital	Nursing Facility
Year 1	24004	23579	425
Year 2	23636	23211	425
Year 3	23636	23211	425
Year 4	23636	23211	425
Year 5	23636	23211	425

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) has been projected based on actual experience from April 2025 through March 2026 enrollment data for the Community Choices (CC), HIV/AIDS (HIVA), and Mechanical Ventilator Dependent (VENT) waivers. For the first waiver year, the ALOS was calculated by multiplying the total member months during the experience period by 30 days per month and dividing by the unduplicated participant count during the same period. The State Medicaid Agency (SMA) assumes that the resulting ALOS will remain consistent over the course of the 5-year waiver period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D for the waiver period was projected based on April 2025 through March 2026 data and review of emerging experience, as follows:
o Because the consolidated waiver combines the current CC, HIVA, and VENT waivers into a single waiver, historical experience from the originating waivers was used where applicable to develop service-level projections.
o The base number of users was calculated by determining the percentage of unduplicated CC, HIVA, and VENT waiver members who used a waiver service in April 2025 - March 2026, multiplied by the unduplicated waiver members for the appropriate waiver year. The projected number of users for the first waiver year reflects projected experience for current members adjusted for the change in unduplicated participant count. Changes from the first to the fifth waiver years applies the same methodology. For waiver services with no experience during April 2025 - March 2026, the number of users estimated in the first waiver year (SFY 2028) is based on projections consistent with the currently approved CC, HIVA, or VENT waiver as applicable.
o The baseline average units per user was calculated by dividing the utilization for each service by the number of users of that service during April 2025 - March 2026. To project waiver year 1, the baseline average units per user was trended by 6.0% annually to reflect sustained year-over-year utilization growth observed in emerging experience. Because waiver services are anticipated to be carved into managed care effective July 1, 2027 (waiver year 1), a 1.8% reduction in units per user was applied to Companion, Personal Care Services, Self-Directed Attendant Care, and Self Directed Companion to reflect anticipated managed care efficiencies. This efficiency adjustment was estimated by identifying members with utilization above expected levels for these services and assuming that approximately 20% of the utilization above those levels would be reduced under managed care. For this purpose, utilization above expected levels was identified as more than 25 combined hours per week of Personal Care Services, Self-Directed Attendant Care, and Self Directed Companion for members not receiving Adult Day Health Care in that week, and more than 15 combined hours per week of those services for members who did. For waiver services with no experience during April 2025 - March 2026, the average number of units per user estimated in the first waiver year (SFY 2028) is based on projections consistent with the currently approved CC, HIVA, or VENT waiver as applicable. Average units per user were trended by 3.0% in waiver years 2 through 5 to reflect more moderate utilization growth going forward. Combined with the 2.0% unit cost trend discussed below, this produces a composite annual trend of 5.1%.
o Unit costs for waiver year 1 reflect current fee schedules. Waiver years 2 through 5 reflect a 2.0% annual trend for all services, which is supported by historical South Carolina waiver service cost trends, and by national HCBS trend expectations for comparable service categories. In cases where a rate for a service is not available on the current fee schedule, we utilized information from the currently approved CC, HIVA, or VENT waiver as applicable and/or April 2025 - March 2026 experience.

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

Factor D' expenditures were developed based on the state plan services identified in historical expenditures, excluding expenditures for services included in the waiver. Factor D' was trended by 3.5% per year, which is supported by historical South Carolina state plan service spending for the waiver population and by national trend expectations for comparable Medicaid service categories.

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

Factor G derivations were developed using April 2025 - March 2026 experience and a blend of the following proxy populations:
o Nursing facility claims for members that had a nursing facility claim for every month in which they had Medicaid eligibility, and who are not enrolled in the CC, HIVA, or VENT waivers
o Hospital claims for members diagnosed with HIV and/or AIDS who had a hospital claim during April 2025 - March 2026 and who are not enrolled in the CC, HIVA, or VENT waivers.
The factors were blended using the unduplicated participant counts by level of care. Factor G was trended by 3.5% per year, consistent with the trend expectations for nursing facility services, which comprise the majority of care expenses for these members.

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

Factor G' expenditures were developed based on all other April 2025 - March 2026 expenditures excluding Nursing Facility claims for nursing facility members and excluding hospital claims for HIV/AIDS diagnosed members. Factor G' was trended by 3.5% per year, which is supported by historical South Carolina spending for the services that comprise the majority of care expenses for these members and by national trend expectations.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Health Care	
In-home Respite	
Institutional Respite	
Personal Care Services	
Private Duty Nursing	
Companion	
Environmental Modifications	
Home Delivered Meals	
Personal Emergency Response System, Installation	
Personal Emergency Response System, Monitoring	
Pest Control	
Self-directed Attendant Care	
Self-directed Companion	
Specialized Medical Equipment & Supplies	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health							*29533728.00*

GRAND TOTAL: ***537628452.48***

Total: Services included in capitation: *537628452.48*

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: ***24004***

Factor D (Divide total by number of participants): ***22397.45***

Services included in capitation: *22397.45*

Services not included in capitation:

Average Length of Stay on the Waiver: *330*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Total:							
Adult Day Health Care	☑	Day	2130	173.32	80.00	**29533728.00**	
In-home Respite Total:							**172800.00**
In-home Respite	☑	Hour	18	384.00	25.00	**172800.00**	
Institutional Respite Total:							**108400.97**
Institutional Respite	☑	Day	38	12.14	234.98	**108400.97**	
Personal Care Services Total:							**396699126.75**
Personal Care Services	☑	Hour	18657	850.51	25.00	**396699126.75**	
Private Duty Nursing Total:							**462106.82**
Private Duty Nursing	☑	Hour	7	1404.58	47.00	**462106.82**	
Companion Total:							**13821669.12**
Companion	☑	Hour	3264	292.04	14.50	**13821669.12**	
Environmental Modifications Total:							**6427553.38**
Environmental Modifications	☑	Event	2371	1.40	1936.36	**6427553.38**	
Home Delivered Meals Total:							**40212386.03**
Home Delivered Meals	☑	Unit	13954	389.43	7.40	**40212386.03**	
Personal Emergency Response System, Installation Total:							**30120.00**
Personal Emergency Response System, Installation	☑	Unit	1004	1.00	30.00	**30120.00**	
Personal Emergency Response System, Monitoring Total:							**3068640.00**
Personal Emergency Response	☑	Month	8524	12.00	30.00	**3068640.00**	

GRAND TOTAL: **537628452.48**

Total: Services included in capitation: 537628452.48

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **24004**

Factor D (Divide total by number of participants): **22397.45**

Services included in capitation: 22397.45

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
System, Monitoring							
Pest Control Total:							**2784645.44**
Pest Control	☑	Treatment	7553	5.12	66.50	**2571645.44**	
Pest Control - Bed Bugs	☑	Treatment	213	1.00	1000.00	**213000.00**	
Self-directed Attendant Care Total:							**38880641.52**
Self-directed Attendant Care	☑	Hour	2499	960.40	16.20	**38880641.52**	
Self-directed Companion Total:							**2560058.37**
Self-directed Companion	☑	Hour	574	348.44	12.80	**2560058.37**	
Specialized Medical Equipment & Supplies Total:							**2866576.08**
Specialized Medical Equipment	☑	Unit	449	1.00	48.94	**21974.06**	
Specialized Medical Supplies	☑	Unit	3699	18.38	41.84	**2844602.02**	

GRAND TOTAL: **537628452.48**
Total: Services included in capitation: 537628452.48
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: **24004**
Factor D (Divide total by number of participants): **22397.45**
Services included in capitation: 22397.45
Services not included in capitation:
Average Length of Stay on the Waiver: 330

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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
Adult Day Health Care Total:							**30547485.50**
Adult Day Health Care	☑	Day	2097	178.52	81.60	**30547485.50**	
In-home Respite Total:							**171457.92**
In-home Respite	☑	Hour	17	395.52	25.50	**171457.92**	
Institutional Respite Total:							**110852.00**
Institutional Respite	☑	Day	37	12.50	239.68	**110852.00**	
Personal Care Services Total:							**410385451.81**
Personal Care Services	☑	Hour	18371	876.03	25.50	**410385451.82**	
Private Duty Nursing Total:							**485490.30**
Private Duty Nursing	☑	Hour	7	1446.72	47.94	**485490.30**	
Companion Total:							**14298546.05**
Companion	☑	Hour	3214	300.80	14.79	**14298546.05**	
Environmental Modifications Total:							**6641042.62**
Environmental Modifications	☑	Event	2335	1.44	1975.09	**6641042.62**	
Home Delivered Meals Total:							**41609948.07**
Home Delivered Meals	☑	Unit	13740	401.11	7.55	**41609948.07**	
Personal Emergency Response System, Installation Total:							**30232.80**
Personal Emergency Response System, Installation	☑	Unit	988	1.00	30.60	**30232.80**	
Personal Emergency Response System, Monitoring Total:							**3082276.80**
Personal Emergency	☑	Month	8394	12.00	30.60	**3082276.80**	

GRAND TOTAL: 556063230.17

Total: Services included in capitation: 556063230.17

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 23636

Factor D (Divide total by number of participants): 23526.11

Services included in capitation: 23526.11

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System, Monitoring							
Pest Control Total:							**2868460.51**
Pest Control	☑	Treatment	7437	5.27	67.83	**2658460.51**	
Pest Control - Bed Bugs	☑	Treatment	210	1.00	1000.00	**210000.00**	
Self-directed Attendant Care Total:							**40217044.78**
Self-directed Attendant Care	☑	Hour	2461	989.21	16.52	**40217044.78**	
Self-directed Companion Total:							**2648213.42**
Self-directed Companion	☑	Hour	565	358.89	13.06	**2648213.42**	
Specialized Medical Equipment & Supplies Total:							**2966727.59**
Specialized Medical Equipment	☑	Unit	442	1.03	49.95	**22740.24**	
Specialized Medical Supplies	☑	Unit	3643	18.93	42.69	**2943987.35**	

GRAND TOTAL: **556063230.17**

Total: Services included in capitation: 556063230.17

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **23636**

Factor D (Divide total by number of participants): **23526.11**

Services included in capitation: 23526.11

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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
Adult Day Health Care Total:							**32093185.04**
Adult Day Health Care	☑	Day	2097	183.88	83.23	**32093185.04**	
In-home Respite Total:							**180135.64**
In-home Respite	☑	Hour	17	407.39	26.01	**180135.64**	
Institutional Respite Total:							**116504.62**
Institutional Respite	☑	Day	37	12.88	244.47	**116504.62**	
Personal Care Services Total:							**431150525.63**
Personal Care Services	☑	Hour	18371	902.31	26.01	**431150525.63**	
Private Duty Nursing Total:							**510068.08**
Private Duty Nursing	☑	Hour	7	1490.12	48.90	**510068.08**	
Companion Total:							**15026525.73**
Companion	☑	Hour	3214	309.83	15.09	**15026525.73**	
Environmental Modifications Total:							**7009060.80**
Environmental Modifications	☑	Event	2335	1.49	2014.59	**7009060.80**	
Home Delivered Meals Total:							**43710443.70**
Home Delivered Meals	☑	Unit	13740	413.15	7.70	**43710443.70**	
Personal Emergency Response System, Installation Total:							**30835.48**
Personal Emergency Response System, Installation	☑	Unit	988	1.00	31.21	**30835.48**	
Personal Emergency Response System, Monitoring Total:							**3143720.88**
Personal Emergency	☑	Month	8394	12.00	31.21	**3143720.88**	

GRAND TOTAL: **584125861.82**

Total: Services included in capitation: 584125861.82

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **23636**

Factor D (Divide total by number of participants): **24713.40**

Services included in capitation: 24713.40

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System, Monitoring							
Pest Control Total:							**3004093.54**
Pest Control	☑	Treatment	7437	5.43	69.19	**2794093.54**	
Pest Control - Bed Bugs	☑	Treatment	210	1.00	1000.00	**210000.00**	
Self-directed Attendant Care Total:							**42251177.69**
Self-directed Attendant Care	☑	Hour	2461	1018.89	16.85	**42251177.69**	
Self-directed Companion Total:							**2781987.23**
Self-directed Companion	☑	Hour	565	369.66	13.32	**2781987.23**	
Specialized Medical Equipment & Supplies Total:							**3117597.77**
Specialized Medical Equipment	☑	Unit	442	1.06	50.95	**23871.09**	
Specialized Medical Supplies	☑	Unit	3643	19.50	43.55	**3093726.68**	

GRAND TOTAL: **584125861.82**

Total: Services included in capitation: 584125861.82

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **23636**

Factor D (Divide total by number of participants): **24713.40**

Services included in capitation: 24713.40

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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
Adult Day Health Care Total:							**33718105.47**
Adult Day Health Care	☑	Day	2097	189.39	84.90	**33718105.47**	
In-home Respite Total:							**189248.31**
In-home Respite	☑	Hour	17	419.61	26.53	**189248.31**	
Institutional Respite Total:							**122433.27**
Institutional Respite	☑	Day	37	13.27	249.36	**122433.27**	
Personal Care Services Total:							**452963668.67**
Personal Care Services	☑	Hour	18371	929.38	26.53	**452963668.67**	
Private Duty Nursing Total:							**535897.75**
Private Duty Nursing	☑	Hour	7	1534.82	49.88	**535897.75**	
Companion Total:							**15784779.36**
Companion	☑	Hour	3214	319.12	15.39	**15784779.36**	
Environmental Modifications Total:							**7341161.54**
Environmental Modifications	☑	Event	2335	1.53	2054.88	**7341161.54**	
Home Delivered Meals Total:							**45898318.86**
Home Delivered Meals	☑	Unit	13740	425.54	7.85	**45898318.86**	
Personal Emergency Response System, Installation Total:							**31457.92**
Personal Emergency Response System, Installation	☑	Unit	988	1.00	31.84	**31457.92**	
Personal Emergency Response System, Monitoring Total:							**3207179.52**
Personal Emergency	☑	Month	8394	12.00	31.84	**3207179.52**	

GRAND TOTAL: **613529712.23**

Total: Services included in capitation: 613529712.23

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **23636**

Factor D (Divide total by number of participants): **25957.43**

Services included in capitation: 25957.43

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System, Monitoring							
Pest Control Total:							**3143794.61**
Pest Control	☑	Treatment	7437	5.59	70.57	**2933794.61**	
Pest Control - Bed Bugs	☑	Treatment	210	1.00	1000.00	**210000.00**	
Self-directed Attendant Care Total:							**44396975.02**
Self-directed Attendant Care	☑	Hour	2461	1049.46	17.19	**44396975.02**	
Self-directed Companion Total:							**2921380.52**
Self-directed Companion	☑	Hour	565	380.75	13.58	**2921380.52**	
Specialized Medical Equipment & Supplies Total:							**3275311.41**
Specialized Medical Equipment	☑	Unit	442	1.09	51.97	**25038.11**	
Specialized Medical Supplies	☑	Unit	3643	20.09	44.41	**3250273.31**	

GRAND TOTAL: 613529712.23

Total: Services included in capitation: 613529712.23

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 23636

Factor D (Divide total by number of participants): 25957.43

Services included in capitation: 25957.43

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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
Adult Day Health Care Total:							**35420660.40**
Adult Day Health Care	☑	Day	2097	195.07	86.59	**35420660.40**	
In-home Respite Total:							**198820.64**
In-home Respite	☑	Hour	17	432.20	27.06	**198820.64**	
Institutional Respite Total:							**128553.58**
Institutional Respite	☑	Day	37	13.66	254.35	**128553.58**	
Personal Care Services Total:							**475872382.83**
Personal Care Services	☑	Hour	18371	957.26	27.06	**475872382.83**	
Private Duty Nursing Total:							**562932.00**
Private Duty Nursing	☑	Hour	7	1580.87	50.87	**562932.00**	
Companion Total:							**16585631.66**
Companion	☑	Hour	3214	328.69	15.70	**16585631.66**	
Environmental Modifications Total:							**7732699.01**
Environmental Modifications	☑	Event	2335	1.58	2095.98	**7732699.01**	
Home Delivered Meals Total:							**48239258.99**
Home Delivered Meals	☑	Unit	13740	438.31	8.01	**48239258.99**	
Personal Emergency Response System, Installation Total:							**32080.36**
Personal Emergency Response System, Installation	☑	Unit	988	1.00	32.47	**32080.36**	
Personal Emergency Response System, Monitoring Total:							**3270638.16**
Personal Emergency	☑	Month	8394	12.00	32.47	**3270638.16**	

GRAND TOTAL: 644508807.40

Total: Services included in capitation: 644508807.40

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 23636

Factor D (Divide total by number of participants): 27268.10

Services included in capitation: 27268.10

Services not included in capitation:

Average Length of Stay on the Waiver: 330

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System, Monitoring							
Pest Control Total:							**3293415.90**
Pest Control	☑	Treatment	7437	5.76	71.98	**3083415.90**	
Pest Control - Bed Bugs	☑	Treatment	210	1.00	1000.00	**210000.00**	
Self-directed Attendant Care Total:							**46659791.18**
Self-directed Attendant Care	☑	Hour	2461	1080.94	17.54	**46659791.18**	
Self-directed Companion Total:							**3071044.05**
Self-directed Companion	☑	Hour	565	392.17	13.86	**3071044.05**	
Specialized Medical Equipment & Supplies Total:							**3440898.63**
Specialized Medical Equipment	☑	Unit	442	1.13	53.00	**26471.38**	
Specialized Medical Supplies	☑	Unit	3643	20.69	45.30	**3414427.25**	

GRAND TOTAL: **644508807.40**

Total: Services included in capitation: 644508807.40

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **23636**

Factor D (Divide total by number of participants): **27268.10**

Services included in capitation: 27268.10

Services not included in capitation:

Average Length of Stay on the Waiver: 330