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.

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

1. Request Information

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

B. Program Title:
Head and Spinal Cord Injury (HASCI) Waiver

C. Waiver Number:SC.0284
Original Base Waiver Number: SC.0284.

D. Amendment Number:SC.0284.R06.02

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

11/01/25

Approved Effective Date: 11/01/25
Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

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

1. Reserved capacity categories were updated to streamline/align with other waivers.

2. Revised unduplicated counts and removed point in time counts for number of participants served.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Main A
☐ **Appendix A - Waiver**	

Component of the Approved Waiver	Subsection(s)
Administration and Operation	
☒ Appendix B - Participant Access and Eligibility	B-3a, B-3c, B-3f
☒ Appendix C - Participant Services	C-5
☐ Appendix D - Participant Centered Service Planning and Delivery	
☐ Appendix E - Participant Direction of Services	
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☐ Appendix J - Cost-Neutrality Demonstration	

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☒ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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*):

Head and Spinal Cord Injury (HASCI) Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: SC.0284
Waiver Number:SC.0284.R06.02
Draft ID: SC.009.06.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23
Approved Effective Date of Waiver being Amended: 07/01/23

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:

○ **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:

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 Head and Spinal Cord Injury Waiver serves persons with traumatic brain injury, spinal cord injury, or both, or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to aging. The services offered in this waiver are meant to prevent and/or delay institutionalization in a nursing home or ICF/IID. All participants must meet either the Nursing Facility Level of Care or the ICF/IID Level of Care criteria.

The South Carolina Department of Health and Human Services (DHHS) has administrative authority over this waiver. The South Carolina Department of Disabilities and Special Needs (DDSN) operates the waiver under administrative and service contracts with DHHS. DDSN utilizes an organized health care delivery system that includes both county disability and special needs boards as well as private providers. Services in this waiver are provided at the local level mainly through a traditional service delivery system. This waiver also has a participant-directed attendant care service. DDSN is responsible for ensuring that waiver participants are aware of their options for receiving services both through this waiver and outside of it.

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:

On August 12, 2025, this amendment was presented to the SCDHHS Medical Advisory Committee (MAC), which includes tribal notification. In addition, the amendment was shared during the agency's Beneficiary Advisory Council and the monthly Indian Health Services via conference call on 07/29/2025 and 07/30/2025 respectively.

Public Notice of intent to amend this waiver was e-mailed to the agency listserv of interested stakeholders and group distribution, including MAC members and Indian Health Services on 08/18/2025.

Public Notice of intent to amend this waiver was posted to the agency website at https://www.scdhhs.gov/public-notices on 08/15/2025.

This waiver amendment was posted to the agency website at https://www.scdhhs.gov/service/waiver-management-field-management on 08/15/2025.

Hard copies of the waiver amendment were placed in the SMA Central Office lobby and the 13 SMA offices around the state on 08/15/2025, for public review and comments.

Additionally, two public webinars were held 09/04/2025 and 09/5/2025 respectively, to address the proposed waiver amendment. A recording of the 09/05/2025 webinar was posted to the agency's website at https://www.scdhhs.gov/service/waiver-management-field-management.

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

Questions/Comments/Responses from Online Submissions and 09/04/2025 and 09/05/2025 Webinars.

Will the state budget determine the number of waiver slots?
What will be the criteria for obtaining a waiver slot?
The point in time count and number of waiver slots are dependent on state appropriations through the legislature. There are no current changes being made to level of care for the waivers. SCDHHS will be utilizing the reserve capacity criteria to prioritize entrance into the waiver for available waiver slots.

How will the new “point-in-time count” reporting be used? Could it lead to caps or waiting list limits that restrict access for people who need services?
The point in time counts are being updated.
SCDHHS will specify a maximum number of unduplicated participants, and the state will also specify the maximum number of participants who are served at any point in time during the waiver year.
Specifying a maximum number will assist the state in managing waiver expenditures and will take into account participant turnover during the course of a waiver year. The updating of point in time count will allow the state to cap the waiver, resulting in limits for access to the services. SCDHHS is updating reserve capacity categories to prioritize entrance into the available waiver slots.

It appears that updating the point in time numbers for the waivers will greatly decrease the availability of waiver slots, resulting in longer, stagnant waiting list. What is the reasoning behind these changes and how will the adverse effects to people with disabilities be mitigated?
The point in time count and number of waiver slots are dependent on state appropriations through the legislature. There are no current changes being made to level of care. SCDHHS will be utilizing the reserve capacity criteria to prioritize entrance into the waiver for available waiver slots.

I have reviewed the Public Notice dated August 15 and have the following questions. I am seeking answers and clarification for the changes that will be happening within the above mentioned Programs. (Two separate submissions containing the same questions were submitted by a Case Management Company and a Home Care Provider) Questions from this submission are bulleted below:

- Who will determine "number of Participants served" per Program?

Changes to the number of participants served per program are included in the proposed 11/01/2025 waiver amendments and are determined by state appropriations.

- Appendix B-3: Added reserved capacity categories to streamline/align with other waivers... What are "reserved

capacity categories"? Who determines what "category" someone goes in?
Reserving waiver capacity means that some waiver openings (a.k.a., “slots”) are set aside for persons who will be admitted to the waiver on a priority basis. The 11/01/2025 waiver amendments outline these categories.
• Updated policies that apply to the selection of individuals for entrance to the waiver... Is the criteria for the Waiver Programs changing? If so, what are the changes to the criteria?
The criteria for waiver participation have not changed.
• When will training be held for current Case Management Providers/Home Care Providers?
Training on policy will be held after CMS approval of the amendments.
• Direct communication from SC DHHS to Case Managers would greatly improve the outcome of this transition. Unfortunately, this has not happened and left the majority of Case Management Companies/Home Care Companies/Owners/Employees in the dark about the future of these Programs. I know there are not enough Medicaid beds in SC to house all of the Participants that we manage on these Waiver Programs, so out of respect for the work that Case Managers do each month to manage these folks at home (saving Medicaid money), please make room and bring us to the table for changes to the Program(s) that directly affect our livelihood and that of our employees.
The state will take recommendations/suggestions under advisement.

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: Chief of Policy

Agency: SC Department of Health and Human Services

Address: PO Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29201

Phone:

(803) 898-0047 **Ext:** ☐ **TTY**

Fax:

(803) 255-8204

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:

Manos

First Name:

Lori

Title:

Associate State Director of Policy

Agency:

SC Department of Disabilities and Special Needs

Address:

PO Box 4706

Address 2:

Harden St. Ext.

City:

Columbia

State: **South Carolina**

Zip:

29203

Phone:

(803) 898-9715 **Ext:** ☐ **TTY**

Fax:

(803) 898-9653

E-mail:

LManos@ddsn.sc.gov

8. Authorizing Signature

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

Signature: Eunice Medina

State Medicaid Director or Designee

Submission Date: Oct 24, 2025

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: Agency Head

Agency: South Carolina Department of Health and Human Services

Address: 1801 Main Street

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29201

Phone: (803) 898-0212 **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:

Lowering the number of Factor C unduplicated participants to reflect the number of individuals currently enrolled plus reserved capacity amounts to allow for priority admissions. No individuals will lose waiver services.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Removed previous

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The South Carolina Department of Disabilities and Special Needs

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:

SCDHHS and SCDDSN have a service contract and an administrative agreement to ensure an understanding between agencies regarding the operation and administration of the HASCI waiver. The administrative agreement delineates the waiver will be operated by SCDDSN under the oversight of SCDHHS. The administrative contract specifies the following:
• Purpose
• Scope of Services
• Fiscal Administration
• Terms and Conditions
• The administrative contract is renewed at least every five (5) years and amended as needed.

SCDHHS and SCDDSN also have a waiver service contract to outline the requirements and responsibilities for the provision of waiver services by the operating agency. The waiver service contract is renewed at least every five (5) years and amended as needed. The waiver service contract includes the following:
• Definition of Terms
• Scope of Services
• SCDDSN Responsibilities
• Conditions for Reimbursement by SCDHHS
• Records and Audits
• Termination of Contract
• Appeals Procedures
• Covenants and Conditions
• SCDHHS utilizes various quality assurance methods to evaluate SCDDSN's compliance with the administrative contract and
Medicaid waiver policy.

SCDHHS uses a CMS approved Quality Improvement Organization (QIO), quality assurance staff, and other agency staff to continuously evaluate the SCDDSN's quality management processes to ensure compliance. A CMS Approved QIO conducts validation reviews of a representative sample of initial level of care determinations performed by SCDHHS for NF Level of Care and SCDDSN for ICF/IID Level of Care. Each entity is responsible for remedial actions as necessary within 45 days.

-SCDHHS QA staff: Conducts periodic quality assurance reviews. These reviews focus on the CMS quality assurance indicators and performance measures. A report of findings is provided to SCDDSN, who is required to develop and implement a remediation plan, if applicable, within 45 days.

-SCDHHS QA staff: Utilizes other systems such as Medicaid Management Information Systems (MMIS) and SAS Data Analytics to monitor quality and compliance with waiver standards. The use and results of these discovery methods may require special focus reviews. In such instances, a report of findings is provided to SCDDSN for remediation purposes.
-Other SCDHHS staff: Conducts utilization reviews, investigate potential fraud, and other requested focused reviews of the Operating Agency as warranted. A report of findings is produced and provided to SCDDSN for remedial action(s) as necessary. To ensure compliance of quality and general operating effectiveness, the State will conduct a review of the Operating Agency(SCDDSN) at least annually. More frequent reviews may be warranted as a result of consumer complaints or identification of non-compliance by other means.

The annual review of the Operating Agency will include, but is not limited to, the following:
- waiver performance measure results and outcomes of remediation
- contract deliverables
- delegated waiver operation functions as outlined in the approved waiver application
- incident management and investigation results
- findings of audits, plans of correction, sanctions and actions that are pertinent to waiver operation
- Financial Division annual reports, special request audits, and fraudulent case investigations
- Rules, policies, procedures and information development governing the waiver program
- Additional delegated operational functions as outlined in section A-7

There will also be an established quarterly schedule of meetings with SCDDSN based on identified topics including review of performance measure results, incident management and investigation,

incident management audits, mortality reviews, and quality assurance functions.

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.:*

USC School of Medicine: Performs quality assurance of University Affiliated Program (UAP) activities supporting self-directed or designated responsible party-directed attendant care services.

CMS-certified QIO: Performs quality assurance reviews of waiver services and providers.

FMS Provider: Verifies qualifications of and executes payment to self-directed attendant care and respite provider.

○ **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:

Local Disabilities and Special Needs (DSN) Boards: These are governmental and/or quasi-governmental entities typically based out of a particular county. They provide case management and direct services. They also complete level of care re-evaluations; develop plans of service; and, perform other administrative tasks.

Charles Lea Center: Operates as fiscal agent for the UAP Self-Directed Attendant Care Program and Respite.

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:

SCDDSN will assess the performance of its contracted local/regional non-state entities responsible for conducting waiver operational functions and services. SCDDSN contracts with DSN Boards and other qualified/approved private providers and the providers are assessed on a 24 month cycle. The current practice of QIO Reviews every 12-18 months will continue, based on the provider's prior performance. There is some lead time involved in the review scheduling, therefore, this 24-month time frame will account for scheduling adjustments.

SCDHHS QA staff will conduct quarterly reviews of the waiver operational functions performed by SCDDSN and any of its contracted local/regional non-state entities, in addition to assessing the performance of contracted entities in conducting waiver administrative functions.

SCDHHS Quality Assurance (QA) staff will conduct quarterly reviews of waiver administrative functions performed by the SCDHHS-contracted QIO.

Additionally, upon request, SCDHHS Medicaid Program Integrity also conducts provider reviews.

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 administrative contract sets forth the operational agency responsibility for QA and the administering agency oversight of the QA process.

SCDDSN will assess the performance of its contracted and local/regional non-state entities responsible for conducting waiver operational functions. SCDDSN will contract with a Quality Improvement Organization (QIO) to assess the local DSN Boards and other qualified providers on a twelve to eighteen month cycle depending on the provider's past performance. The QIO will also conduct follow-up reviews of the local DSN Boards and other approved providers. A comprehensive Report of Findings will be issued by the QIO to the local DSN Board provider/other approved providers and to SCDDSN. SCDDSN will provide technical assistance to the local Boards/other approved providers. Access to all reviews and the Report of Findings are shared with SCDHHS within 45 days of completion. When necessary, SCDDSN Central Office will also conduct reviews and provide technical assistance to the local DSN Boards, and provide SCDHHS reports of such reviews and technical assistance upon completion.

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

SCDHHS will utilize: 1) a Quality Improvement Organization (QIO) to conduct reviews of a representative sample of initial Level of Care Determinations performed by SCDDSN; 2) QA staff to conduct periodic quality assurance focus reviews on the CMS quality assurance indicators and performance measures; and 3) other SCDHHS Staff to conduct utilization reviews of SCDDSN/DSN Boards/qualified providers as warranted. SCDDSN is to take remedial actions within 45 days upon receipt of the report of findings from SCDHHS.

SCDHHS will review SCDDSN Financial Division annual reports, special request audits, and fraudulent case investigations and request remedial action(s) as determined necessary.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the

performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* 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	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☐	☐
Waiver enrollment managed against approved limits	☒	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☒	☐	☐
Level of care 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	☒	☒	☐	☐
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:
Based on SCDHHS QA review findings, number and percent of plans of correction (POC) received from the operating agency within the required timeframe. Numerator – Number of POC received from the operating agency within the required timeframe. Denominator – Number of POC requiring submission from the operating agency within the required timeframe.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Provider Compliance Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%,+-5 & 50/50
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Policy changes related to the HASCI waiver are approved by SCDHHS prior to implementation. N = The number of waiver policy changes approved by SCDHHS prior to implementation. D = The total number of changes implemented.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of quarterly Quality Management meetings between SCDHHS and SCDDSN where the SCDDSN's quality performance data was reviewed as specified in the waiver. N: Number of quarterly QM meetings between SCDHHS and SCDDSN where the SCDDSN's quality performance data was reviewed as specified in the waiver. D: Number of QM meetings between SCDHHS and SCDDSN.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly Quality Management Meeting Log

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

SCDHHS produces reports of findings based on reviews. These reports are shared with SCDDSN to address identified issues as warranted through a remediation plan, which may include training, policy corrections, or financial adjustments for Federal Financial Participation. The report of findings identifies issues such as untimely level of care re-evaluations, incomplete service plans, and/or incorrect billings to Medicaid. SCDDSN is responsible for developing and implementing remedial actions to prevent future occurrences of the same issues.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to 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**			☐
	☒	**Disabled (Physical)**	0	0	
	☒	**Disabled (Other)**	0	0	
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	0		☒
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Waiver services are limited to participants with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, disease, dementia, or a neurological disorder related to aging, regardless of the age of onset where the individual:

1. Has urgent circumstances affecting his/her health or functional status; and,
2. Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision in order to avoid institutionalization; and,
3. Needs services not otherwise available within existing community resources, including family, private means and other agencies/programs, or for whom current resources are inadequate to meet the basic needs of the individual, which would allow them to remain in the community.

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 maximum age limit for individuals enrolled into the HASCI waiver.

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	1407
Year 2	1407
Year 3	1114
Year 4	1051
Year 5	1025

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
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	
Individuals discharged from ICF/IIDs or nursing facilities.	
New Housing Participants	
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):*

Individuals discharged from ICF/IIDs or nursing facilities.

Purpose *(describe):*

Individuals discharged from ICF/IID or Nursing Facility directly into Waiver funding. This includes individuals who transition directly from ICF/IID or Nursing Facility into Home Again (Money Follow the Person) and then transition to Waiver funding.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on previous utilization for these purposes.

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	5
Year 4	5
Year 5	5

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):*

New Housing Participants

Purpose *(describe):*

Individuals admitted to community-based housing sponsored, licensed, or certified by the Office of Intellectual and Developmental Disabilities needing waiver services.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on previous utilization for these purposes.

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 utilization for these purposes.

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

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	5
Year 4	5
Year 5	5

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)

☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**

☐ **Pregnant Women (42 CFR § 435.116)**

☐ **Infants and Children under Age 19 (42 CFR § 435.118)**

☒ **SSI recipients**

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

☒ **Optional state supplement recipients**

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

Select one:

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

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

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in 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)**

☒ **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:

Other caretaker relatives specified at 42 CFR §435.110;
Pregnant women specified at 42 CFR §435.116,
and Children specified at 42 CFR §435.118

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 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:

The following is a listing of Medical expenses which are allowable deductions from the recipient's monthly recurring income:
• Eyeglasses not otherwise covered by the Medicaid Program, not to exceed a total of $108.00 per occurrence for lenses, frames and dispensing fee. The necessity for eyeglasses must be certified by a licensed practitioner of optometry or ophthalmology.
• Dentures - A one-time expense, not to exceed $651.00 per plate or $1320.00 for one full pair of new dentures. The necessity for dentures must be certified by a licensed dental practitioner. An expense for more than one pair of dentures must be approved by the staff of the South Carolina Department of Health and Human Services (SCDHHS).
• Denture repair which is justified as necessary by a licensed dental practitioner, not to exceed $77.00 per occurrence. • Physician and other medical practitioner visits above the 12 visit limit per fiscal year, not to exceed $77.00 per visit.
• Hearing Aids - A one time expense, not to exceed $1000.00 for one or $2000.00 for both. The necessity for a hearing aid must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by the staff of SCDHHS.
• The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.
• Reasonable and necessary medical and remedial care expenses not covered by Medicaid incurred in the 3 months prior to the month of application are allowable deductions. Expenses incurred prior to this three month period are not allowable deductions.

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: 2

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 (other than waiver case management). 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:

- ○ **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:

NF Level of Care:

Registered Nurses licensed by the state or Licensed Practical Nurses working under the auspices of a Registered Nurse.

ICF Level of Care:

The Director of the Eligibility Division: Minimum qualifications are a Bachelor's degree and extensive experience of the SCDDSN service delivery system; robust understanding of the technical and legal issues pertaining determining eligibility for SCDDSN services based on an Intellectual Disability (ID) and/or Related Disability (RD); Autism Spectrum Disorder (ASD); Traumatic Brain Injury (TBI); and/or Spinal Cord Injury (SCI); extensive management experience. The Director of Eligibility holds a supervisory role over the psychologist.

Psychologist: A master's degree in Applied Psychology and 4 years clinical experience subsequent to master's degree or possession of a license to practice Psychology in the state of SC; must have working knowledge/understanding of Intellectual Disability; Related Disability; Autism Spectrum Disorder; Traumatic Brian Injury and Spinal Cord Injury; developmental issues and sequence; and knowledge of medical issues/or diagnoses; knowledge of Medicaid processes. The psychologist completes the initial LOC evaluation.

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.

Initially, an applicant's situation is reviewed to determine if he/she is a member of the target population of the waiver. An applicant is a member of the target population when, at the time of determining eligibility, he/she has a severe chronic limitation that:

1. is attributed to a physical impairment including head injury, spinal cord injury, or both, or a similar disability, regardless of the age of onset not associated with the process of a progressive degenerative illness or disease, dementia, or a neurological disorder related to aging;

2. is likely to continue indefinitely without intervention;

3. results in substantial functional limitations in at least two of these life activities:
   a. self-care;
   b. receptive and expressive communication;
   c. learning;
   d. mobility;
   e. self-direction;
   f. capacity for independent living;
   g. economic self-sufficiency; and

4. reflects the person’s need for a combination and sequence of special interdisciplinary or generic care or treatment or other services, which are of lifelong or extended duration and are individually planned and coordinated.

After it is established that the applicant meets the target population for the waiver, either the NF Level of Care or ICF Level of Care (LOC) criteria are used to evaluate/reevaluate whether an individual qualifies for services through the waiver.

ICF Level of Care

Eligibility for Medicaid sponsored Intermediate Care Facility /Individuals with Intellectual Disabilities (ICF/IID) in South Carolina consists of meeting the following criteria:

1. The person has a confirmed diagnosis of intellectual disability, OR a related disability as defined by 42 CFR § 435.1010 and S.C. Code Ann. § Section 44-20-30.

“Intellectual Disability” means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which is defined as prior to the age of 22.

“Related disability” is a severe, chronic condition found to be closely related to intellectual disability and must meet the four following conditions:

• It is attributable to cerebral palsy, epilepsy, spectrum disorder or any other condition other than mental illness found to be closely related to intellectual disability because this condition results in impairment similar to that of persons with intellectual disabilities and requires treatment or services similar to those required for these persons.
• It is manifested before 22 years of age.
• It is likely to continue indefinitely.
• It results in substantial functional limitations in 3 or more of the following areas of major life activities: self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

AND

2. The person’s needs are such that supervision is necessary due to impaired judgment, limited capabilities, behavior problems, abusiveness, assaultiveness or because of drug effects/medical monitorship.

AND

3. The person is in need of services directed toward a) the acquisition of the behaviors necessary to function with as much

self-determination and independence as possible; or b) the prevention or deceleration of regression or loss of current optimal functional status.

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

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

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

NF Level of Care:

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.

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

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

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

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

LOC reevaluations are primarily completed by Waiver Case Management (WCM) providers. Final determination for LOC reevaluation is conducted by the SCDDSN. (SCDDSN is the Operating Agency specified in Appendix A). Internal policy dictates when this is necessary.

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

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

Specify the other schedule:

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

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

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

Specify the qualifications:

Possess a bachelor's degree from an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse,

And

Documentation of at least one year of experience working with people with intellectual disabilities and related disabilities, autism, traumatic brain injury and/or spinal cord injury and/or one year of case management experience. The degree must be from an institution accredited by a nationally recognized educational accrediting body.

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

An automated system tracks level of care (LOC) due dates for reevaluations and alerts the WCM provider and/or his/her supervisor to its impending due date. Additionally, if any LOC determination is found to be out of date, FFP is recouped for waiver services that were billed when the LOC was not timely.

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

Electronic documents are housed in a Waiver Case Management system maintained by SCDDSN and accessible by the State Medicaid Agency and qualified providers.

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:
HASCI waiver enrollees have an initial Level of Care determination (LOC) completed within 30 days prior to waiver enrollment. Numerator = Number of new HASCI waiver enrollees whose LOC determination was completed within 30 days prior to waiver enrollment; Denominator= total number of new enrollees in the HASCI waiver.

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

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

Performance Measures

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

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied***

appropriately and according to the approved description to determine participant level of care.

Performance Measures

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

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

Performance Measure:
Initial Level of Care (LOC) determinations are conducted using the appropriate instrument. Numerator = Number of HASCI waiver initial LOC determinations that were conducted using the appropriate instrument; Denominator= total number of HASCI waiver initial LOC determinations.

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

Performance Measure:
Initial LOC determinations conducted using appropriate criteria. Numerator = Number of HASCI waiver initial LOC determinations that were conducted using the appropriate criteria. Denominator = Total number of HASCI waiver initial LOC determinations.

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

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

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%,+-5 & 50/50
☒ **Other** Specify: SCDHHS QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Adverse LOC Determinations are reviewed by the SCDHHS QIO Contractor as required by SCDHHS. N = Number of Adverse LOC Determinations the Contractor agreed with and D = The total Number of Adverse LOC Determinations.

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

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

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: SCDHHS QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction 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.

On a monthly basis, the SCDHHS QIO randomly pulls a sample of all new LOC determinations and re-determinations for HASCI participants to verify accuracy. In addition, 100% of all initial adverse LOC determinations are reviewed.

On a quarterly basis, SCDDSN staff will review the SCDDSN Waiver Enrollment Report and SCDDSN LOC Report to ensure compliance. There are edits in the two systems to prevent Waiver Enrollment for individuals who do not have a current LOC determination. SCDDSN will develop a Plan of Correction, as needed, for any non-compliance.

ii. Remediation Data Aggregation

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

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

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

Prior to waiver enrollment, a signed Freedom of Choice (FOC) form is secured from each waiver applicant to ensure that the participant is involved in his/her long term care planning. This choice will remain in effect until the applicant/guardian changes his/her mind. If the applicant lacks the physical or mental ability required to make a written choice regarding care, a representative may sign the FOC form. If the FOC form is signed prior to the applicant's 18th birthday, the current form or a new form is signed again within 90 days following the applicant's 18th birthday.

The FOC form does not include language about the services available under the waiver. That information is on the waiver information sheet which is given to every waiver applicant, and contains language about all services available under the waiver. The FOC form is used to offer individuals or his/her guardian the choice between institutional services and home and community-based waiver services. This form, which documents the preferred choice of location for service delivery, is provided by the waiver case manager/early interventionist and is maintained in the waiver record.

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

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

Appendix B: Participant Access and Eligibility

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

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

The Operating agency policy entitled "Compliance with Title VI of the Civil Rights Act of 1964, American Disabilities Act of 1990, Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 and Establishment of the Complaint Process" (700-02-DD) describes the methods SCDDSN utilizes to provide meaningful access to the waiver services by persons with limited English proficiency. As specified in SCDDSN policy, when required, WCM providers can access funds to pay for an interpreter to provide meaningful access to the waiver. Additionally, the State utilizes telephone interpreter services and written materials translation services.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Attendant Care/Personal Assistance Services
Statutory Service	Career Preparation Services
Statutory Service	Day Activity
Statutory Service	Residential Habilitation
Statutory Service	Respite Care Services
Statutory Service	Waiver Case Management (WCM)
Extended State Plan Service	Incontinence Supplies
Extended State Plan Service	Nursing Services
Extended State Plan Service	Occupational Therapy
Extended State Plan Service	Physical Therapy
Extended State Plan Service	Speech and Hearing Services
Supports for Participant Direction	Peer Guidance for Participant-Directed Care
Other Service	Behavior Support Services
Other Service	Employment Services
Other Service	Environmental Modifications
Other Service	Health Education for Participant-Directed Care
Other Service	Independent Living Skills
Other Service	Personal Emergency Response Systems
Other Service	Pest Control Bed Bugs
Other Service	Pest Control Treatment
Other Service	Private Vehicle Assessment/Consultation
Other Service	Private Vehicle Modifications
Other Service	Psychological Services
Other Service	Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation
Other Service	Specialized Medical Equipment, Supplies and Assistive Technology

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care/Personal Assistance 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:**

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.

Transportation may be provided as a component of AC/PA when necessary for provision of personal care or performance of daily living activities. Cost of incidental transportation is included in the rate paid to the provider.

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

The limit for AC/PA is 49 hours per week, *with no daily cap.

AC/PA may be provided in the participant's home and/or other community settings only if attendant care or personal assistance is not already available in such settings. Supports provided during community access activities must directly relate to the participant's need for care and/or supervision.

Participants or the Responsible Party are offered the option to choose Self-Directed Attendant Care for all or part of their authorized Attendant Care/Personal Assistance. Supervision may be performed directly by the participant or a responsible party, when the participant or responsible party has been trained to perform this function, and when safety and efficacy of supervision provided by the participant or responsible party has been certified by a licensed nurse or otherwise as provided in State law. Certification must be based on direct observation of the participant or responsible party and the specific attendant care/personal assistance provider(s) during actual provision of care. Documentation of this certification will be maintained in the participant's Support Plan.

If a HASCI Waiver participant receives Waiver Nursing in addition to AC/PA, the total hours for the combination of nursing and AC/PA are limited to 10 hours per day or 70 hours per week.

The participant may use authorized hours flexibly during the week to best blend with the availability of other resources and

natural supports. Unused hours in a particular week do not transfer to later weeks.

Transportation may be provided as a component of AC/PA when necessary for provision of personal care or performance of daily living activities. Cost of incidental transportation is included in the rate paid to the provider.

The intensity and frequency of supervision of AC/PA personnel are specified in the participant's Support Plan.

- For agency providers enrolled with DHHS, nursing supervision requirements are determined by DHHS (as necessary, but minimum every 4 months; supervision must be by a licensed RN or by a licensed LPN who is supervised by a licensed RN)
- For DSN Board or other DDSN-contracted agencies, supervision requirements are the same as for providers enrolled with DHHS (as necessary, but minimum every 4 months; supervision must be by a licensed RN or by a licensed LPN who is supervised by a licensed RN)
- For Self-Directed Attendant Care, ongoing supervision is the responsibility of the participant or Responsible Party. The participant or responsible party is trained to perform this function, and when safety and efficacy of supervision provided by the participant or responsible party has been certified by a licensed nurse or otherwise as provided in State law. Certification must be based on direct observation of the participant or responsible party and the specific attendant care/personal assistance provider(s) during actual provision of care. Documentation of this certification will be maintained in the participant's Support Plan.

*The limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized.

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	Attendant Care Provider Agencies
Agency	DSN Board/contracted providers
Individual	Independent attendant care providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:

Agency

Provider Type:

Attendant Care Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Scope of Services

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Annually/Biannually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:

Agency

Provider Type:

DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DDSN Home Supports Caregiver Policy, Pre-service Training Requirements and Orientation (567- 01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers.

DSN Boards are single or multiple county entities authorized in state statute to provide services at the local level under contract with DDSN. They may provide waiver services for which they meet the relevant federal (including Medicaid), state, and DDSN requirements. DDSN also qualifies private organizations and individuals for specific services for which they meet the relevant federal (including Medicaid), state, and DDSN requirements. This allows HASCI Waiver participants to have options for choosing providers.

For Attendant Care/Personal Assistance, a DSN Board or qualified provider is required to ensure all AC/PA personnel meet minimum qualifications. SCDDSN's Home Supports Caregiver Certification must be completed for all AC/PA personnel. The DSN Board or qualified provider is responsible for ensuring that supervision of AC/PA personnel is provided by a nurse licensed in the state and according to SCDHHS standards for Attendant Care Services. The DSN Board or qualified provider is responsible to ensure that any specific skilled nursing procedures performed by AC/PA personnel are formally delegated by a licensed Registered Nurse.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Disabilities and Special Needs

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:

Individual

Provider Type:

Independent attendant care providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DDSN Home Supports Caregiver Policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN/UAP

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Career Preparation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Career Preparation Services are time-limited and aimed at engaging a participant in identifying a career direction and preparing individuals for competitive employment. These services can include experiences and exposure to careers and teach such concepts as attendance, task completion, problem solving, interpersonal relations and safety as outlined in the individual's person-centered plan. Services are designed to create a path to integrated community-based employment for which an individual is compensated at or above minimum wage. On site attendance at the licensed facility is not required to receive services that originate from the facility. The cost for transportation is included in the rate paid to the provider.

Transportation will be provided from the individual's residence to the habilitation site, or between Career Preparation sites, when the service start time is before 12:00 Noon. Transportation will be available from the individual's habilitation site to their residence when the service start time is after 12:00 Noon.

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

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Career Preparation Services

Provider Category:

Agency

Provider Type:

Career Preparation Provider

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs 88-105 thru 88-020 (1976)

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN Career Preparation Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Initially; Annually; SCDDSN QIO Reviews are conducted on a 24 month cycle depending on past provider performance.

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:

Day Habilitation

Alternate Service Title (if any):

Day Activity

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day Activity assists a HASCI Waiver participant to acquire, retain, or improve in self-help, adaptive, and socialization skills, as well as community inclusion. It focuses on enabling the participant to attain or maintain maximum functional levels. The service is provided in or originates from a licensed, non-residential setting.

Transportation will be provided from the individual’s residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the individual’s habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **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	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Activity

Provider Category:

Agency

Provider Type:

DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*

For Day Activity, a DSN Board or other contracted provider must operate a facility or program licensed by DDSN or its contracted QIO under SCDDSN Licensing Day Facility Standards. The DSN Board or qualified provider must comply with SCDDSN Day Services Standards and Day Activity Services Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted with Department of Disabilities and Special Needs

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:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Residential Habilitation is the care, supervision and skills training provided to a person in a non- institutional setting. The type, scope and frequency of care, supervision, and skills training to be furnished are described in the person's service plan and are based on his/her assessed needs and preferences. Services furnished as Residential Habilitation must support the person to live as independently as possible in the most integrated setting that is appropriate to his/her needs.

The care provided as part of Residential Habilitation may include but is not limited to assistance with personal care, medication administration, and other activities that support the person to reside in his/her chosen setting.

The type and level of supervision provided as part of Residential Habilitation must be proportionate to the specific needs and preferences of the person.

The skills training provided as part of Residential Habilitation may include but is not limited to the following: adaptive skill building, activities of daily living, community inclusion, access and use of transportation, educational supports, social and leisure skill development and other areas of interest /priorities chosen by the person.

Payments for Residential Habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents. Payment for Residential Habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Provider controlled, owned or leased facilities where Residential Habilitation services are furnished must be compliant with the Americans with Disabilities Act.

Transportation may be provided between the participant's place of residence and other locations as a component of Residential Services. The cost of this transportation is included in the rate paid to the residential provider.

Residential habilitation is transitioning to delivery of service based on the following service elements/activities and settings:

The 8 tiers for the daily residential habilitation service are as follows: 1. High Management (Intensive Support Residential Habilitation); 2. Tier 4 (Intensive Support Residential Habilitation); 3. Tier 3 (Intensive Support Residential Habilitation); 4. Tier 2; 5. Tier 1; 6. Supervised Living Program (SLP) II; 7. CTH I Tier 2; and 8. CTH Tier 1. SLP I is a separate hourly rate for residential habilitation services.

*High Management (Intensive Support Residential Habilitation) is delivered through the Community Training Home II (CTH II) model which is shared by up to three (3) people who have a brain injury, spinal cord injury or similar disability or those who have a diagnosis of intellectual disability and display extremely challenging behaviors.

Tier 4 (Intensive Support Residential Habilitation) is delivered through the CTH-II model which is shared by up to four (4) people who may have been involved with the criminal justice system and individuals with severe behaviors requiring heightened staffing levels.

Tier 3 (Intensive Support Residential Habilitation) is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people who have a diagnosis of brain injury, spinal cord injury or similar disability or those who have a diagnosis of intellectual disability/related disabilities and display extremely challenging behaviors. Includes people being discharged from a DDSN Regional Center (ICF/IID) or community ICF/IID. Also includes people who need additional supports to prevent or delay institutional placement and to participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the participant’s ability to perform Activities of Daily Living without support from another.

Tier 2 is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need additional supports (greater than included in Tier 1) to prevent or delay institutional placement and to participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the participant’s ability to perform Activities of Daily Living without support from another.

Tier 1 is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need support to live in and participate in their community. Those supports include a degree of care, supervision, and skills training provided throughout the day.

Supervised Living Program (SLP) II includes people who need support to live in and participate in their community. The supports delivered include a degree of care, supervision, and skills training provided throughout the day. SLP-II is delivered in a licensed SLP-II setting that is typically single or double-occupancy residence.

CTH Tier 2 is delivered to waiver participants who need additional supports (greater than included in CTH Tier) to enable them to live in the setting and participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the participant’s ability to perform activities of daily living without support. Those additional supports are typically services/supports specifically intended to provide relief/assistance to the supports provider and are necessary due to the amount/intensity of supports the participant requires. CTH Tier 2 services are delivered to up three (3) people in the CTH-I licensed home of the support provider.

CTH Tier 1 is delivered to waiver participants who need support to live in and participate in their community. CTH Tier 1 services are delivered to up three (3) people in the CTH-I licensed home of the support provider.

Supervised Living Program (SLP) I is delivered to waiver participants who need support in their own apartment or home setting. Support is provided through a 15 minute-unit and support is available 24 hours per day by phone. An annual assessment is completed for each participation to verify support needs in their own setting.

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

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

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

☒ **Provider managed**

☐ **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	Residential Habilitation Providers
Agency	Supported Living Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Residential Habilitation Providers

Provider Qualifications

License *(specify):*

Code of Laws of SC, 1976 as amended: 40-20-710 through 44-10-1000; 44-20-10 et seq.; and 44-21-10 et seq.; SC licensing regulations: no. 61-103

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN Residential Habilitation Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Annually; SCDDSN QIO Reviews are conducted on a 24 month cycle depending on past performance of the provider organization.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Supported Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The support provider (SP) qualifications are as the following:
• SPs must meet requirements for criminal background checks.
• Staff must have a driver's license check prior to transporting people who receive services.
• The provider must designate a staff member who is responsible for developing and monitoring the person's residential plan and who meets the following qualifications: a) a bachelor's degree in human services from an accredited college or university; b) is at least 21 years of age; c) has at least one (1) year of experience (e.g., paid or voluntary) working directly with persons with an intellectual disability or a related disability.
• SPs must be at least eighteen 18 years of age and have a high school diploma or its equivalent.
• SPs must pass an initial physical exam prior to working in the home.
• SPs must pass initial tuberculosis screening prior to working in the home and annually thereafter

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home

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

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

Service Definition *(Scope):*

Respite Care is assistance and supervision provided to a HASCI Waiver participant due to a short-term absence of or need for relief by those normally providing unpaid care. It can be provided on a periodic and/or emergency basis to relieve one or more unpaid caregivers. The service may include hands-on assistance or direction/cueing for personal care and/or general supervision to assure safety. It may include skilled nursing procedures only if these are specifically delegated by a licensed nurse or as otherwise permitted by State law.

Respite Care may be provided in a variety of community or institutional settings. Federal Financial Participation (FFP) will not be claimed for cost of room and board except if Respite Care is provided in a facility approved by the State that is not a private residence.

The State has identified the following non-institutional respite care locations for HASCI participants, in which, respite care can be provided on an hourly basis. The following include the non-institutional locations:

- Participant’s home or place of residence, or other residence selected by the participant/representative
- Group Home

o Licensed residence (CTH-I or CTH-II) o Licensed foster care home

o Licensed Community Residential Care Facility (CRCF)

Institutional Respite Care on a daily basis may be provided in the following locations:

- Medicaid-certified hospital
- Medicaid-certified nursing facility (NF)
- Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID); this may be at a Regional Center or a community ICF-IID.

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

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

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

☒ **Provider managed**

☐ **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	Medicaid certified ICF/ID
Agency	Respite Provider Agencies
Agency	Hospital
Agency	Community Residential Care Facility (CRCF)
Agency	DDSN/DSN Board/Contracted providers
Agency	Medicaid Certified Nursing Facility
Agency	Foster Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Medicaid certified ICF/ID

Provider Qualifications

License *(specify):*

SC Code Ann. §44-7-250 thru 44-7-260 Reg. #61-13

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DDSN/Respite care standards policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN; DHEC

Frequency of Verification:

Upon Enrollment; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Respite Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

MOA and Service Contract with DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon Contract; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Hospital

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHEC and DHHS

Frequency of Verification:

Upon Enrollment and CMS Revalidation Requirements

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Community Residential Care Facility (CRCF)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHEC and DHHS

Frequency of Verification:

Upon contract;Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted providers

Provider Qualifications

License *(specify):*

SC Code Ann. §44-20-10 thru 44-20-5000 (Supp. 2008); §44-20-710 (Supp. 2008)

Certificate *(specify):*

Other Standard *(specify):*

DDSN Respite Care Standards policy, Pre-service Training Requirements and Orientation (567-01- DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers.

The DSN Board or qualified provider must comply with SCDDSN Respite Program Standards and must ensure that Respite Care workers meet the stipulated minimum qualifications.

The DSN Board or qualified provider must comply with SCDDSN Directives 567-01-DD, Employee Orientation, Pre-Service and Annual Training Requirements and 735-02-DD, Relatives/Family Members Serving as Paid Caregivers of Respite Services.

If Respite Care will be provided in a participant's home or other private residence, the DSN Board or qualified provide must certify Respite Care workers using SCDDSN's Home Supports Caregiver Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Upon enrollment and annually; QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Medicaid Certified Nursing Facility

Provider Qualifications

License *(specify):*

SC Code Ann. §44-7-250 thru 44-7-260 Reg. 61-17, Equivalent for NC & GA

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DHHS for Institutional Respite

Verification of Provider Qualifications

Entity Responsible for Verification:

DHEC and DHHS

Frequency of Verification:

Upon Contract;Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

Yes, SC Code; Sec. 20-7-2250

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SC Department of Social Services (DSS)

Frequency of Verification:

Upon enrollment;Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Waiver Case Management (WCM)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that assist participants in gaining access to needed waiver, State plan, and other services regardless of the funding sources for the services to which access is gained. Waiver case managers are responsible for initiating and/or conducting the process to evaluate and/or re-evaluate the individual's level of care as specified in waiver policy. Waiver case managers are responsible for conducting assessments and developing service plans as specified in waiver policy. This includes the ongoing monitoring of the provision of services included in the participant's service plan. Waiver case managers are responsible for the ongoing monitoring of the participant's health and welfare, which may include crisis intervention, and referral to non-waiver services.

The waiver also includes Transitional Waiver Case Management. Transitional WCM is used when a person in an institutional setting is being
discharged from the setting and entering a Waiver program. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive days prior to discharge. The state can choose a limit less than 180 days.

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

Participants may receive no more than 10 hours per month. In exceptional cases, where medical necessity has been demonstrated, additional hours can be approved through a prior authorization process.

Participants may not receive Medicaid Targeted Case Management in place of Waiver Case Management.

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	Waiver Case Management Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Waiver Case Management Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Possess a bachelor's degree from an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse, and documentation of at least one year of experience working with people with intellectual disabilities and related disabilities, autism, traumatic brain injury and/or spinal cord injury and/or one year of case management experience. The degree must be from an institution accredited by a nationally recognized educational accrediting body.

WCM may not be provided by a family member. A family member is defined as a relative, legal guardian, spouse, foster parent, or anyone with an in-law or step relationship.

The DSN Board or qualified provider must comply with SCDDSN or SCDHHS Waiver Case Management Standards as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Qualified waiver case managers must meet these standards prior to employment. The provider agency that employs the case manager is responsible for ensuring case manager qualifications.

Frequency of Verification:

Upon employment and annually per standards.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Incontinence Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Incontinence Supplies are standard diapers, briefs (protective underwear), under pads, liners, wipes, and gloves needed by a HASCI Waiver participant age 2 years and older who is incontinent of bladder and/or bowel according to medical criteria. It is an Extended State Plan Service to allow additional items above the limits covered by the Medicaid State Plan under Home Health services.

The service is defined and described in the approved State Plan and will not duplicate any service available to adults age 21 and older in the State Plan. Items/services allowed under the waiver are the same as the standard items/services for children under age 21 covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)services mandate; items/services requiring a prior authorization are not allowed.

Services that are provided when the limits of Incontinence Supplies under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from Incontinence Supplies services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: Services are for those 21 and over and the additional amount of services in addition to State Plan services includes:
-up to 192 diapers per month (2 cases)
-up to 160 briefs per month (2 cases)
-up to two (2) cases of under pads per month
-up to 260 liners per month (2 cases)
-up to 560 wipes per month (8 boxes)
-up to four (4) boxes of gloves per month

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

All medically necessary Incontinence Supplies services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. This waiver service is only provided to individuals age 21 and over.

*The limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized.

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	Incontinence Supply Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Incontinence Supplies

Provider Category:

Agency

Provider Type:

Incontinence Supply Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with SCDHHS to provide incontinence supplies

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

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:

Extended State Plan Service

Service Title:

Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing

Category 2: 05 Nursing

Sub-Category 2: 05010 private duty nursing

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of practice in the state Nurse Practice Act. These services are provided to a participant in their home. Continuous and individual skilled care provided by a licensed registered nurse or licensed practical nurse, under the supervision of a registered nurse, licensed in accordance with the State Nurse Practice Act, in accordance with the participant's plan of care as deemed medically necessary by an authorized health care provider. Services are not allowable when a participant is in an institutional setting.

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

All medically necessary nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. This waiver service is only provided to individuals age 21 and over. The service is defined and described in the approved State Plan and will not duplicate any service available to adults age 21 and older in the State Plan.

Medicaid Waiver Nursing is limited to 60 hours per week. Unused units in a particular week cannot be transferred to another week.

*The limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized.

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 Agencies
Individual	Registered Nurses

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Nursing Agencies

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Contract Scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency

Frequency of Verification:

Upon Enrollment Annually/Biannually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nursing Services

Provider Category:

Individual

Provider Type:

Registered Nurses

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Contract Scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency

Frequency of Verification:

Upon Enrollment Annually/Biannually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11020 health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that are provided when occupational therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from occupational therapy furnished under the State plan. The provider qualifications specified in the State plan apply.

All medically necessary Specialized Medical Supplies and Therapy Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. This waiver service is only provided to individuals age 21 and over.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **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	Occupational Therapists
Agency	Occupational Therapy Groups

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapists

Provider Qualifications

License *(specify):*

Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Occupational Therapy Groups

Provider Qualifications

License *(specify):*

Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11020 health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that are provided when physical therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from physical therapy furnished under the State plan. The provider qualifications specified in the State plan apply.

All medically necessary Specialized Medical Supplies and Therapy Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

This waiver service is only provided to individuals age 21 and over.

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	Physical Therapists
Agency	Physical Therapy Groups

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapists

Provider Qualifications

License *(specify):*

Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Physical Therapy Groups

Provider Qualifications

License *(specify):*

Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech and Hearing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11020 health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that are provided when speech, hearing and language services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from speech, hearing and language services furnished under the State plan. The provider qualifications specified in the State plan apply.

All medically necessary Specialized Medical Supplies and Therapy Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

This waiver service is only provided to individuals age 21 and over.

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	Audiology Groups
Agency	Speech Pathology Groups
Individual	Speech Pathologists
Agency	Speech Therapy Group
Individual	Speech Therapists
Individual	Audiologists

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:

Agency

Provider Type:

Audiology Groups

Provider Qualifications

License *(specify):*

Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing, and Regulation; Medicaid agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:

Agency

Provider Type:

Speech Pathology Groups

Provider Qualifications

License *(specify):*

Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing, and Regulation; Medicaid agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:

Individual

Provider Type:

Speech Pathologists

Provider Qualifications

License *(specify):*

Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:

Agency

Provider Type:

Speech Therapy Group

Provider Qualifications

License *(specify):*

Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing, and Regulation; Medicaid agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:

Individual

Provider Type:

Speech Therapists

Provider Qualifications

License *(specify):*

Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech and Hearing Services

Provider Category:

Individual

Provider Type:

Audiologists

Provider Qualifications

License *(specify):*

Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Peer Guidance for Participant-Directed Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10050 peer specialist
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Peer Guidance for Participant-Directed Care prepares and assists capable individuals who desire to manage their own personal care. It is information, advice, and encouragement provided by a trained Peer Mentor to help a participant with participant in recruiting, training, and supervising primary and back-up attendant care/personal assistance providers and self advocacy.
The Peer Mentor is a participant who successfully lives in the community with a high degree of independence and who directs his or her own personal care needs. The Peer Mentor serves as a role model and shares information and advice from his or her experiences and helps promote independence.

The Peer Mentor will use the "Peer Support Curriculum" from the Shepherd Center in Atlanta, Georgia or other curriculum approved by SCDDSN.
Service Unit.

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

12 units per calendar 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	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Peer Guidance for Participant-Directed Care

Provider Category:

Agency

Provider Type:

DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*

Contracted with SCDDSN, Peer Mentors must be registered with and trained by the SCDDSN approved providers.
The DSN Board or qualified provider must employ or contract with a Peer Mentor who meets the following minimum qualifications and is responsible to verify these qualifications are met:

- The individual is a HASCI Waiver participant and lives successfully in the community

- Be at least 18 years old, with maturity and ability to deal effectively with the job
- Have a high degree of independence and direct his or her own personal care
- Able to communicate effectively
- Free from communicable diseases
- Provide a SLED check
- Be trained/approved by SCDDSN approved provider
- Use the Peer Support Curriculum from the Shepherd Center in Atlanta, Georgia and/or

other curriculum approved by SCDDSN, as a guide in providing peer guidance to participants in the HASCI Waiver who desire to manage their own care

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Disabilities and Special Needs

Frequency of Verification:

Upon enrollment or service authorization

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:

Behavior Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavior Support addresses behavioral challenges experienced by a HASCI Waiver participant by using evidence based, validated practices to identify causes and appropriate interventions that prevent or reduce occurrence. Behavior Support includes functional behavior assessments and analyses; development of behavioral support plans; implementing interventions designated in behavior support plans; training key persons to implement interventions designated in behavioral support plans; monitoring effectiveness of behavioral support plans and modifying as necessary; and educating family, friends, or service providers concerning strategies and techniques to assist the participant in modifying inappropriate behaviors, including the necessary education for the waiver participant to do this independently when possible.

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

For a HASCI Waiver participant who receives Residential Services, behavior support is a component of Residential Services and included in the rate paid to the residential provider.
If the participant needs Behavior Support, the residential provider must directly provide or obtain it.

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	Behavior Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support Services

Provider Category:

Individual

Provider Type:

Behavior Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A provider must follow the DDSN standards and qualifications. The DSN Board or qualified provider must comply with SCDDSN Behavior Support Standards. A DSN Board or qualified provider of Residential Habilitation that currently serves a specific HASCI Waiver participant in need of Behavior Support must employ or contract with an individual enrolled with SCDHHS as a provider of Behavior Support Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verified and approved by DDSN; Enrolled by DHHS

Frequency of Verification:

Upon enrollment; verification of continuing education every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Employment Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Employment Services (Individual) are the ongoing supports to individuals who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Transportation is not included as part of the service or the rate paid for individual job placement.

Employment - Group are the on-going supports to individuals who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self- employment, in an integrated work setting in the general workforce for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Employment Services – Group are provided in group settings, such as mobile work crews or

enclaves and employees may be paid directly by the employer/business or by the Employment Services – Group provider.

Employment Services – Group is not a prerequisite for Employment Services – Individual.

For Employment Group--Transportation will be provided from the individual's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the individual's habilitation site to their residence when the service start time is after 12:00 Noon.

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

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

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

☒ **Provider managed**

☐ **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	Employment Services Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Services

Provider Category:

Agency

Provider Type:

Employment Services Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employment Services will be provided by staff who:
- Are at least 18 years of age.
- Have a valid high school diploma or its certified equivalent.
- Have references from past employment if the person has a 5 year work history.
- Are capable of aiding in the activities of daily living and implementing the Employment Services Plan of each person for whom they are responsible.
- Have a valid driver's license if duties require transportation of individuals.
- Have a background check
- Pass an initial physical exam prior to working in the program.
- Pass initial tuberculosis screening prior to working in the program and annually thereafter.

- Must be trained and be deemed competent in accordance with DDSN Directives.
- Participate in the staff development/in-service education program operating in their provider agency which requires all staff to complete in-service education programs and staff development opportunities in accordance with SCDDSN directives.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Initially and annually. SCDDSN QIO Reviews are conducted on a 24 month cycle depending on past performance of the provider organization.

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:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental Modifications are physical adaptations to the home, required by the HASCI waiver participant's Support Plan, which are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home. The home must be a privately owned residence occupied by the participant. Modifications to publicly funded group homes or community residential facilities are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways modification of bathroom or kitchen facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant, floor covering to facilitate wheelchair access, fencing necessary for a participant's safety.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning,
etc. Environmental modifications will not be approved solely for the needs or convenience of other occupants of the home or care providers. Modifications that add to the total square footage of the home are available only when this modification proves to be the most cost effective solution. All services shall be provided in accordance with applicable state and local building codes and shall be subject to the state procurement act.

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

Home Modifications are subject to the guidelines established by the SCDDSN Head and Spinal Cord Injury Division (Guidance in Waiver Manual) and must be within the limit of $20,000 per modification.

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	Licensed Occupational and Physical Therapists
Individual	Certified ADA Coordinators
Individual	Vendors with a retail or wholesale business license contracted to provide services
Individual	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
Agency	DDSN/DSN Boards/Contracted Providers
Individual	Licensed Contractors

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:

Licensed Occupational and Physical Therapists

Provider Qualifications

License *(specify):*

Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA. Chapter 45 section 40-45-5 et. Seq. SC cod of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DDSN or Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Certified ADA Coordinators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified ADA Coordinator

Other Standard *(specify):*

Enrolled with DHHS/DDSN

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

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:

Vendors with a retail or wholesale business license contracted to provide services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DHHS/DDSN

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

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:

Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Rehabilitation Engineering Society of North America (RESNA)

Other Standard *(specify):*

Contracted with DDSN or Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Upon enrollment or service authorization

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:

DDSN/DSN Boards/Contracted Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider must employ or contract with the following, but is responsible to verify and document licensure:

- Contractor licensed by the South Carolina Department of Labor, Licensing and Regulation (LLR) not enrolled with SCDHHS as a DME provider
- Vendor with a retail or wholesale business license that is not enrolled with SCDHHS as a DME provider

In addition to the above, the DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection; the provider is responsible to verify and document licensure or certification:

- Licensed Occupational Therapist
- Licensed Physical Therapist
- Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
- Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
- ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Annually

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:

Licensed Contractors

Provider Qualifications

License *(specify):*

SC Code Ann. 40-59-15 (Supp. 2007)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Upon Service Authorization

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:

Health Education for Participant-Directed Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Health Education for Participant-Directed Care prepares capable individuals who desire to manage their own personal care or a family member or other responsible party who desires to manage the personal care of an individual not capable of self-management.
Health Education for Participant-Directed Care is instruction provided by a licensed registered nurse who are provided the "Key to Independence Manual" from the Shepherd Center in Atlanta, Georgia and/or other curricula approved by SCDDSN/DHHS in the provision of this service. The training provided by an RN will regard the nature of specific medical conditions, the promotion of good health, and the prevention/monitoring of secondary medical conditions.

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

Ten units per calendar 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	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Education for Participant-Directed Care

Provider Category:

Agency

Provider Type:

DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider must employ or contract with a licensed RN to perform this service and is responsible to verify the credentials of the RN.

The RN employed or contracted by the provider must:

- be licensed as a Registered Nurse by South Carolina Board of Nursing or the equivalent licensing body in North Carolina or Georgia
- use Key to Independence Manual from the Shepherd Center in Atlanta, Georgia and/or other curriculum approved by SCDDSN, as a guide in providing education on bladder and bowel care, skin care, respiratory care, sexuality, substance abuse issues, and monitoring of health status and medical conditions
- address the participant's specific medical conditions and functional limitations, promotion of good health, and prevention/monitoring of secondary medical conditions

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Disabilities and Special Needs

Frequency of Verification:

Upon enrollment or service authorization

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:

Independent Living Skills

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that develop, maintain and improve the community-living skills of a waiver participant. The service includes direct training from a qualified staff person to address the identified skill development needs of a waiver participant in the areas of:
• communication skills;
• community living and mobility;
• interpersonal skills;
• reduction/elimination of problem behavior;
• self-care; and
• sensory/motor development involved in acquiring functional skills.

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

The service is limited to 15 hours (60 units) per week.

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	Independent Living Skills Providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Independent Living Skills

Provider Category:

Individual

Provider Type:

Independent Living Skills Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The ILS Trainer (ILST) directly delivering the service must meet the following criteria:
• have a high school diploma or equivalent;
• have at least one year of experience working with the target population; and
• meet the minimum training requirements outlined in the ILS Service Standards.
Supervision of ILS:
The person responsible for supervision of delivery of ILS Training must meet the following criteria:
• have a bachelor's degree;
• have at least five years of experience working with the target population; and
• meet the training requirements outlined in the ILS Service Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Upon enrollment/Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Systems

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:**

Service Definition *(Scope):*

PERS is an electronic device which enables a HASCI Waiver participant at high risk of institutionalization to secure help in an emergency. PERS provides ongoing monitoring, as the system is connected to the participant's telephone and programmed to signal an emergency response center staffed by trained professionals. The participant may wear a "help" button that allows for mobility. PERS services are limited to those individuals who live alone, or who are alone for any part of the day or night, and who would otherwise require extensive routine supervision.

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

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

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Personal Emergency Response providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency

Frequency of Verification:

Upon enrollment or service authorization

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 Bed Bugs

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Pest control bed bug services aid in maintaining an environment free of bed bugs and other potential disease carriers to enhance safety, sanitation, and cleanliness of the participant's home/or residence.

The Provider must obtain an authorization from their WCM to designate the amount, frequency and duration of service for participants.

All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services for bed bugs must be completed by the provider within 14 days of acceptance of the WCM authorization for service.

For bed bugs all providers must go into the participant's home/or residence to inspect and treat the participant's home/or residence. A responsible adult who is eighteen years of age or older must be at the participant's home/or residence at the time of the treatment or the provider will need to reschedule for a time when the responsible adult who is eighteen years of age or older will be present at the participant's home/or residence.

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

Services are limited to one time per year.
This service does not apply to residential habilitation settings.

This must be shown to be a need to ensure health and safety as identified in the individual's person-centered plan.

Must not be covered through other resources such as through the lease agreement.

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 Bed Bugs

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:

DHHS

Frequency of Verification:

Upon enrollment/annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control Treatment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Pest Control Treatment aids in maintaining an environment free of insects such as roaches and other potential disease carriers to enhance safety, sanitation, and cleanliness of the participant's home/or residence.

The Provider must obtain an authorization from their WCM to designate the amount, frequency and duration of service for participants.

Pest control authorizations are for a maximum of once every other month. The Provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services must be completed by the provider within 14 days of acceptance of the WCM authorization for service.

Pest Control treatments need to include both in-home and exterior treatment. All providers must go into the participant's home/or residence to inspect and treat the home environment. A responsible adult who is eighteen years of age or older must be at the participant's home/or residence at the time of the treatment or the provider will need to reschedule for a time when

the responsible adult who is eighteen years of age or older will be present at the participant's home/or residence.

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

Pest control treatment is limited to every other month. This service does not apply to residential

This must be shown to be a need to ensure health and safety as identified in the individual's person-centered plan.

Must not be covered through other resources such as through the lease agreement.
habilitation settings.

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 Treatment

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:

DHHS

Frequency of Verification:

Upon enrollment/annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Vehicle Assessment/Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Private vehicle assessment/consultation may be provided once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. The criterion used in assessing a participant's need for this service are: 1) The parent or family member cannot transport the individual because the individual cannot get in or out of the vehicle; or 2) the individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve this barrier.

Private vehicle assessment/consultation may include the specific modifications/equipment needed, any follow-up inspection after modifications are completed, and training in use of equipment.

The consultation/assessment does not require submission of bids.

Private Vehicle Assessments/Consultations can be completed by Licensed Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors or vendors who are contracted through the DSN Board to provide the service.

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

The reimbursement for the Consultation/Assessment may not exceed $600.00.

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	DDSN/DSN Board/Contracted provider
Agency	OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners, Assistive Technology Suppliers, Environmental Access/Consultants/contractors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Vehicle Assessment/Consultation

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Environmental Assessments/Consultations can be completed by vendors who are contracted through the DSN Board to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Vehicle Assessment/Consultation

Provider Category:

Agency

Provider Type:

OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners, Assistive Technology Suppliers, Environmental Access/Consultants/contractors

Provider Qualifications

License *(specify):*

Licensed Medicaid enrolled Occupational (OT) or Physical Therapists (PT), and Rehabilitation Engineering Technologists (RET).

Certificate *(specify):*

Assistive Technology Practitioners (ATP) and Assistive Technology Suppliers (ATS) certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors (EACC).

Other Standard *(specify):*

DHHS Medicaid enrolled provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Modifications to a privately owned vehicle to be driven by or routinely used to transport a HASCI Waiver participant. It may include any equipment necessary to make the vehicle accessible to the participant. Modifications of a vehicle owned by a publicly funded agency are not permitted. Modifications can include follow up inspections, training in use of equipment, repairs not covered by warranty, and replacement of parts or equipment. The approval process for private vehicle modifications is initiated based upon the needs specified in the participant's Support Plan and following confirmation of the availability of a privately owned vehicle to be driven by or routinely used to transport the participant. The approval process is the same for any private vehicle modification, regardless of ownership. Each request must receive prior approval following programmatic and fiscal review and shall be subject to the state procurement act. Programmatic approval alone may be given for emergency repair of equipment to ensure safety of the participant. These modifications are in order to accommodate the special needs of the participant.

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

Private Vehicle Modifications are subject to the guidelines
established by the SCDDSN Head and Spinal Cord Injury Division (Guidance in Waiver Manual) and must be within the limit of $30,000 per vehicle.

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	DDSN/DSN Board/contracted providers
Agency	DHHS Enrolled Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider must employ or contract with the following, but is responsible to verify and document licensure:

- Contractor licensed by the South Carolina Department of Labor, Licensing and Regulation (LLR) not enrolled with SCDHHS as a DME provider

- Vendor with a retail or wholesale business license that is not enrolled with SCDHHS as a DME provider

In addition to the above, the DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection; the provider is responsible to verify and document licensure or certification:

- Licensed Occupational Therapist
- Licensed Physical Therapist
- Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
- Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
- ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:

Agency

Provider Type:

DHHS Enrolled Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

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:

Psychological Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10010 mental health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Psychological Services address the affective, cognitive, and substance abuse problems of a HASCI Waiver participant age 21 years or older. It includes psychiatric, psychological, and neuropsychological evaluation; development of treatment plans; individual/family counseling to address the participant's affective, cognitive, and substance abuse problems; cognitive rehabilitation therapy; and alcohol/substance abuse counseling. The service may include consultation with family members/others or service providers to assist implementing the participant's treatment plan and assist in goal-oriented counseling/therapy.

Psychological Services funded by the HASCI Waiver may be provided only if a participant is unable to access or has exhausted benefits under Rehabilitative Behavioral Health Services funded by Medicaid State Plan or needs services not available under Medicaid State Plan. Current Rehabilitative Behavioral Health Services do not include neuropsychological evaluation/treatment or cognitive rehabilitation therapy.

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

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

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	Psychological Service Provider

Provider Category	Provider Type Title
Individual	Psychological Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychological Services

Provider Category:

Agency

Provider Type:

Psychological Service Provider

Provider Qualifications

License *(specify):*

Code of Law of SC, 1976 amended; 40-55-20 et seq., 40-75-5 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled by DHHS.

A DSN Board or qualified provider of Residential Habilitation that currently serves a specific HASCI Waiver participant in need of Psychological Services must employ or contract with an individual enrolled with SCDHHS as a provider of Psychological Services or must employ or contract with a professional enrolled with SCDHHS as a Licensed Independent Practitioner of Rehabilitative Services (LIPS) provider.
The DSN Board or qualified provider must comply with SCDDSN Psychological Services Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN/DHHS

Frequency of Verification:

Upon Enrollment and verification of continuing education every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychological Services

Provider Category:

Individual

Provider Type:

Psychological Service Provider

Provider Qualifications

License *(specify):*

Code of Law of SC, 1976 amended, 40-55-20 et. seq. 40-75-5 et. seq.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled by DHHS.

A DSN Board or qualified provider of Residential Habilitation that currently serves a specific HASCI Waiver participant in need of Psychological Services must employ or contract with an individual enrolled with SCDHHS as a provider of Psychological Services or must employ or contract with a professional enrolled with SCDHHS as a Licensed Independent Practitioner of Rehabilitative Services (LIPS) provider.
The DSN Board or qualified provider must comply with SCDDSN Psychological Services Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN/DHHS

Frequency of Verification:

Upon enrollment and verification of continuing education every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Equipment and Assistive Technology Assessment/Consultation may be provided (if not covered under the State Plan Medicaid) once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. Consultation and assessment may include specific needs related to the participant's disability for which specialized medical equipment and assistive technology will assist the participant to function more

independently. Assessment and consultation cannot be used to determine the need for supplies.

Assistive technology and assessments/consultations must be provided by Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), or Medicaid-enrolled Environmental Access/Consultants/contractors.

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

The reimbursement for the Consultation/Assessment may not exceed $300.00.

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

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	DDSN/DSN Board/Contracted Providers
Agency	Durable Medical Equipment Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In addition to the above, the DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection for medical equipment or assistive technology; the provider is responsible to verify and document licensure or certification:

o Licensed Occupational Therapist o Licensed Physical Therapist
o Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
o Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)

o ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)
o Environmental Access Consultant/contractor

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

SCDHHS Medicaid enrolled provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

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:

Specialized Medical Equipment, Supplies and Assistive Technology

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:**

Service Definition *(Scope):*

Supplies, Equipment and Assistive Technology means medical supplies and equipment and specialized appliances, devices, remote supports, or controls necessary for the personal care of a HASCI Waiver participant or to increase his or her ability to perform activities of daily living or interact with others. It includes items needed for life support and ancillary supplies and equipment necessary for the proper functioning of such items. Excluded are items not of direct medical or remedial benefit to the participant.

The service may also include temporary rental of an item, follow-up inspection after items are received, training in use of equipment/assistive technology, repairs not covered by warranty, and batteries/replacement parts for equipment or AT devices not covered by warranty or any other funding sources.

Items funded by the HASCI Waiver may be in addition to supplies and equipment furnished under the Medicaid State Plan or which are not available under the Medicaid State Plan.

Motorized wheelchairs are available under the Medicaid State Plan if medically justified.

Items covered through remote supports are: medication dispensers, door sensors, window sensors, stove sensors, water sensors, pressure pads, GPS Tracking Watches and the remote monitoring equipment necessary to operate the remote supports technology.

These remote support items will be “placed” in accordance with the specific item type (medication dispensers in the location selected by the person, door sensors on doors, window sensors on windows, stove sensors on stove, water sensors on faucets, pressure pads on the person’s bed/chair, and GPS tracking watches would be worn by the individual). Video cameras/monitors will not be included or allowed as part of the service. The individual has the ability to turn/take off the remote support equipment at his/her discretion. Remote supports will assist with preserving the individual’s independence in his/her living environment through the implementation of technology which will in turn lessen the requirement for supervision with tasks such as taking medication and cooking, while maintaining the person’s safety. Remote supports allow the person dignity of risk and the ability to manage their lives more independently. For example, the GPS tracking watch allows the person independently access the community, and arrive at their planned location, while at the same time, allowing their designated responder the ability to ensure their safe arrival at the destination. Remote supports are limited to waiver participants who have natural supports willing to be identified as designated responders. As such, the person responsible for responding will be the natural support identified by the waiver participant and will be on-call. The participant must designate the remote supports responder, which allows him/her to select someone he/she is comfortable with. Only the designated responder will have access to information generated from the remote support, and the person can elect to terminate the designees’ access and name an alternate responder at any point.

Per the outlined service, the remote supports provider is required to inform the participant, and anyone identified by the participant, of what impact the remote supports will have on the participant’s privacy. This information must be provided to the participant in a form of communication understood by the participant.

After this has been completed, the remote supports provider must obtain either the participant's consent in writing or the written consent of a legally responsible party for the participant. This process must be completed prior to the utilization of remote supports and any time there is a change to the devices or services. This information will be provided to the participant and service plan team for discussion and inclusion of the Remote Supports in the Support Plan.

The case manager's monitoring of the service and its effectiveness will ensure the individual's needs are being met and health and welfare needs are being addressed.

As with all waiver services, back up plans are necessary to ensure the participant's health and welfare. Natural supports must be identified to assist in the event of an equipment/technology failure.

All technology will be evaluated to ensure it meets HIPPA requirements prior to use, and policy will include requirements that this be vetted in advance as part of person-centered service planning. The state will include review of the proposed methodology by the HIPAA compliance officer(s) prior to implementation of the service.

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

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

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	Durable Medical Equipment Provider
Agency	DDSN/DSN Board/Contracted Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment, Supplies and Assistive Technology

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with SCDHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment, Supplies and Assistive Technology

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider must employ or contract with the following, but is responsible to verify and document licensure:

- Contractor licensed by the South Carolina Department of Labor, Licensing and Regulation (LLR) not enrolled with SCDHHS as a DME provider
- Vendor with a retail or wholesale business license that is not enrolled with SCDHHS as a DME provider

In addition to the above, the DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection for medical equipment or assistive technology; the provider is responsible to verify and document licensure or certification:

o Licensed Occupational Therapist o Licensed Physical Therapist
o Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
o Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
o ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)
o Environmental Access Consultant/contractor

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Annually

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:

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):

Direct care workers at Community Residential Care Facilities, Home Health Agencies, Personal Care Agencies, Adult Day Health Care Agencies, Nursing Homes providing respite, Waiver Case Managers and SCDDSN direct care staff are required to have following:

a. National federal fingerprint-based criminal background check if prospective employee cannot establish South Carolina residency for the 12 months preceding the date of the employment application and/or prospective employee will work with children under the age of 18.
b. South Carolina Law Enforcement Division (SLED) – not required if a. above is performed
c. DSS Child Abuse and Neglect Central Registry
d. Medicaid Exclusion List
e. Proof of current licensure as a SC Registered Nurse, if applicable
f. Nurse Registry, if applicable
g. Sex Offender Registry

Compliance reviews are conducted by DDSN's QIO and DHHS Provider Compliance to ensure mandatory investigations are conducted.

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (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):

Nursing providers are required to check the Certified Nursing Assistant (CNA) Registry and the Office of Inspector General (OIG) Exclusions List for all staff. Anyone appearing on either of these lists is not allowed to provide services to waiver participants or participate in any Medicaid-funded programs. The website addresses are:

Nurse Aid Registry: https://cna365.examroom.ai/registry/?StateCode=SC
OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

DHHS staff monitor contract compliance for nursing and personal care providers at least every eighteen months.

Additionally, abuse registry screenings must be completed for all staff of DDSN-contracted service providers. The SC Department of Social Services maintains the abuse registry list and screens those names submitted by contracted providers against the registry. DDSN, through its QIO and licensing reviewers, ensures that mandated screenings have been conducted.

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

SCDHHS, SCDDSN and case management providers are continuously improving their understanding and implementation of the principles of person-centered planning (PCP). PCP as a framework helps guide case managers to the most effective services and supports; ensures participants direct and are actively engaged in the process; and, encourages involvement of other people chosen and/or approved by the participant including friends, relatives, providers, members of the community, etc. The resulting plan is a valuable document written in plain language.

o More specifically, the person-centered service plan focuses on the participant's goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, education, employment, community participation, wellness and relationship opportunities. PCP encourages the use of natural and community supports as well as the creation of plans that view participants in the context of their culture. All of the elements that compose a participant's individuality and a family's uniqueness are acknowledged and valued in the planning process. PCP supports mutually respectful partnerships between participants and providers/professionals.

o The participant signs the service plan indicating agreement with the services and supports detailed and confirmation of choice of qualified service providers.

o Case managers are responsible for monitoring service delivery and ensuring that services on the plan of care are delivered in the amount, scope and duration that are required. Self-directed services include the completion of task sheets verifying delivery of activities as specified in the service plan.

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 SCDHHS and/or sub-contract with SCDDSN. Potential providers are made aware of the requirements for enrollment through either the operating or administrating agency by contacting them directly. All potential providers are given a packet of information upon contacting the agencies that describe the requirements for enrollment, the procedures used to qualify and the timeframes established for qualifying and enrolling providers. Additionally, potential providers can find information regarding enrollment requirements and timeframes at the following two websites:

http://www.scdhhs.gov
http://www.ddsn.sc.gov

The time frame established for providers when enrolling is 45 to 60 days after submission of a completed online application.

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:
New providers meet required licensing, certification and other state standards prior to the provision of waiver services. Numerator = The number of new providers who meet licensing, certification and other state standards prior to the provision of services. Denominator = Number of new providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN Procurement-New 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Waiver providers continue to meet required licensing, certification and other state standards. Numerator = The number of existing providers that continue to meet required licensing, certification and other state standards. Denominator = The number of existing providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Provider Compliance reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%,+-5 & 50/50
☐ **Other**	☐ **Annually**	☐ **Stratified**

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

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

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

	☒ **Other** Specify: 100% within 24 months	

Data Aggregation and Analysis:

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

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

For each performance measure 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:
New non-licensed/non-certified providers meet waiver requirements prior to the provision of waiver services. Numerator = the number of new non-licensed/non-certified providers meeting waiver requirements prior to service provision Denominator = the total number of new non-licensed/non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN Procurement-New 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:

Performance Measure:
Non-licensed/non-certified providers continue to meet waiver requirements. Numerator = The number of non-licensed/non-certified providers that continue to meet waiver requirements. Denominator = The number of non-licensed/non-certified providers.

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

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

	100% within 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Provider Compliance reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%,+-5 & 50/50
☒ **Other** Specify: DDSN QIO	☐ **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: SCDDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure 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:
Providers continue to meet Abuse, Neglect, and Exploitation (ANE) minimum specified state training requirements. Numerator = The number of providers who meet training requirements. Denominator = The total number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Provider Compliance reviews

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%,+-5 & 50/50
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Specify: SCDDSN QIO Contractor		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: 100% within 24 months.	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers that continue to meet state Medication Administration certification standards. Numerator = Number of providers that continue to meet state Medication Administration certification standards. Denominator = Total number of providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: SCDDSN QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: 100% within 24 months	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
SCDDSN QIO Contractor	
	☐ **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.

New providers are reviewed within one year of having service authorizations. Thereafter, a sample of existing providers is completed every 18 months that is representative.

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.

Providers must meet minimum requirements prior to enrollment as a service provider and accepting new participants. On an annual basis, SCDDSN will review 100% of provider enrollment reports to track the acceptance of new providers and ensure compliance.

On an annual basis, SCDDSN will review QIO Contract Compliance Data to ensure providers are compliant with ANE training requirements for all staff. Where non-compliance is noted, the Provider will be required to develop a Plan of Correction and a follow-up review will be coordinated to ensure compliance.

On a quarterly basis, SCDDSN will review QIO Contract compliance Data to ensure day service providers are compliant with Medication Technician Certification training. Where non-compliance is noted, the provider will be required to develop a Plan of Correction and a follow-up review will be coordinated to ensure compliance.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: SCDDSN QIO Contractor	☒ **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 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 resides with a paid unrelated caregiver or with an agency provider who provides HCBS services the majority of the day. All OIDD licensed day settings and 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, Day Services programs, and Residential Habilitation programs 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. It is through SCDHHS's established systems of quality assurance and compliance review that ongoing compliance of HCBS standards will be monitored.

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 are established compliance systems in place at SCDHHS and OIDD that monitor 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. For the OIDD operated waivers, SCDHHS will conduct ongoing monitoring to include compliance site visits in addition to the monitoring completed by OIDD and the Quality Improvement Organization (QIO).

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:

Case Management Support 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:

☐ **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:***

To comply with the conflict of interest regulation at (42 CFR 441.301(c)(1)(vi)), the South Carolina Department of Health and Human Services (SCDHHS) created a compliance transition plan that will prevent a conflict of interest between case management and direct service provision that currently exists with Disabilities and Special Needs (DSN) Board providers. SCDHHS and South Carolina Department of Disabilities and Special Needs (SCDDSN) will work with providers to transition waiver participants receiving both case management and direct services from the same provider into a conflict-free service provision environment. This will include appropriate policy changes, technical assistance for providers and ongoing support for waiver participants during the transition. The transition will be complete on or before Dec. 31, 2023.

(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.

SCDHHS, SCDDSN and case management providers are continuously improving their understanding and implementation of the principles of person-centered planning (PCP). PCP as a framework helps guide case managers to the most effective services and supports; ensures participants direct and are actively engaged in the process; and, encourages involvement of other people chosen and/or approved by the participant including friends, relatives, providers, members of the community, etc. The resulting plan is a valuable document written in plain language.

More specifically, the person-centered service plan focuses on the participant's goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, education, employment, community participation, wellness and relationship opportunities. PCP encourages the use of natural and community supports as well as the creation of plans that view participants in the context of their culture. All of the elements that compose a participant's individuality and a family's uniqueness are acknowledged and valued in the planning process. PCP supports mutually respectful partnerships between participants and providers/professionals.

The participant signs the service plan indicating agreement with the services and supports detailed and confirmation of choice of qualified service providers.

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):

The person-centered service plan is directed by the participant/representative and developed by the WCM qualified provider based on the comprehensive assessment of the waiver participant's strengths, needs, and personal priorities (goals) and preferences. The participant/representative, family, legal guardian, caregivers, professional service providers (including physicians) and others of the participant's choosing may provide input. Service Plans are individualized for each waiver participant, stressing the importance of community support. An initial service plan is developed within 60 days of waiver enrollment, updated as needed, and a new service plan is completed within 365 days.

Participants/representatives are informed in writing at the time of enrollment of the names and definitions of waiver services that are funded through the waiver when the WCM qualified provider has identified the need for the service.

Participation in the planning process (assessment, plan development, implementation) by the participant/representative, knowledgeable professionals and others of the participant/representative's choosing, helps to assure that the participant's personal priorities and preferences are recognized and addressed by the person-centered service plan. The state utilizes standardized assessment tools which are completed prior to planning. The tools identify the participant's preferences, abilities and areas where support is required including areas of potential risk. The areas assessed include medical, general functioning, financial, emotional/behavioral, living environment, vocational/education, relationships and community access. When potential risk factors are identified those are discussed during planning and addressed in the plan as emergency or back-up plan through the authorization of waivers services or through natural resources.

All needs identified during the assessment process must be addressed. As part of the Service Plan development process, it is determined if the participant has health care needs that require consistent, coordinated care by a physician, therapist, or other health care professionals. The WCM qualified provider must utilize information about the participant's strengths, priorities and preferences to determine how those needs (to include health care needs) will be addressed. The Service Plan will include a statement of the participant's need; the specific service to meet the need; the amount, frequency, duration of the service; and the type of provider who will furnish the service.

The WCM qualified provider will have primary responsibility for coordinating services but must rely on the participant/representative to choose a service provider from among those available, make him/herself available for and honor appointments scheduled with providers for initial service implementation and ongoing monitoring of services. The appointments must be convenient times and locations for the participant to facilitate collaboration with all parties involved with the development and ongoing monitoring of the service plan.

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

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

Every calendar month the WCM provider will contact the participant/representative to conduct monitoring of the service plan and waiver services/other services. Non face-to-face contacts are required during months in which a face-to-face contact is not conducted. Based on the results of the monitoring, amendments may be needed to the service plan.

On at least a quarterly basis the WCM provider will conduct a face-to-face contact with the participant/representative during which the effectiveness of the service plan will be discussed along with the participant's/representative's satisfaction with the services/providers. Every six months, the WCM provider will visit the participant in the home/residence to monitor the health and welfare of the participant.

The state utilizes standardized assessment tools which are completed prior to planning. The tools identify the participant's preferences, abilities and areas where support is required including areas of potential risk. The areas assessed include medical, general functioning, financial, emotional/behavioral, living environment, vocational/education, relationships and community access. When potential risk factors are identified those are discussed during planning and addressed in the plan as emergency or back-up plan through the authorization of waivers services or through natural resources.

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.

Participants' needs, including potential risks associated with their situations, are assessed and aimed at minimizing risks as addressed in the plan and during the annual plan process by helping participants/representatives identify ways to be safe within the choices made. The service plan includes a section for describing the plan to be implemented during an emergency or natural disaster and describing how care will be provided in the unexpected absence of a caregiver/supporter.

A standardized assessment tool is used for all waiver participants. This tool assesses the person's current situation, health and safety risk factors, and his/her personal preferences. The WCM provider agency also conducts training with staff annually to review proper reporting procedures for abuse, neglect, exploitation, and unexplained deaths.

Additionally, Back-up plans are a required portion of the electronic version of the support plan and must be completed by the case manager at the time of annual planning. WCM providers will encourage representatives to make back-up plans for emergencies when they take vacations or are away from home for extended periods of time.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Participants/representatives are encouraged to ask friends and peers about provider websites, and other resources of information to assist them in choosing a provider. Additionally, participants/representatives are supported in choosing qualified providers by being encouraged to contact support and advocacy groups. Participants/representatives may request a list of providers of specified waiver services when service needs change, or when a change is requested, or when selection of another provider is needed. Participants/representatives can contact their WCM provider with questions about available providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The format and content of the questions for the service plan document as well as the intended planning process must be reviewed and approved by SCDHHS prior to implementation. Participant plans are available upon request.

In addition, SCDHHS QA reviews service plans on an annual basis. Providers are informed of required corrective actions based on these reviews.

The State incorporates quality assurance/quality improvement activities into waiver administration and waiver operation. Both SCDHHS and SCDDSN contract with (different) CMS approved Quality Improvement Organizations (QIO) to conduct quality functions. SCDDSN uses their QIO to perform provider and participant record reviews by making on-site visits, interviewing participants and staff, and making observations to ensure services are implemented based on assessed need. In addition, the provider's administrative capabilities are reviewed to ensure compliance with SCDDSN standards, contracts, policies, and procedures. Any deficiencies require a written Plan of Correction (POC) within 30 days that addresses the deficiency both individually and systemically. A follow-up review is conducted approximately six (6) months after the original review to ensure successful remediation and implementation of the POC.

SCDHHS will conduct a retrospective review of person-centered service plans to determine whether service plans address the needs of waiver participants. Findings are summarized and issued to SCDDSN and the provider. The retrospective review of service plans is a statistically valid representative sampling methodology that is used for all SCDHHS reviews used for performance measures and the review of service plans. This pulls representative samples from the total participants enrolled in the three 1915c waivers and the SCDDSN provider network with follow up reviews. The representative sampling methodology uses a 95% confidence level and a 5% margin of error. SCDHHS will pull the sample annually and adjust the methodology as additional participants are enrolled for services and supports.

SCDHHS maintains a monthly status report for the HASCI Waiver, which contains the data of all individuals that are enrolled in each waiver and determined to be eligible for services. To determine the appropriate sample size, SCDHHS determines the total number of combined waiver enrolled recipients. SCDHHS utilizes a standard sample size calculator with a 95% Confidence Level and a 5% Confidence Interval.

Reviews are conducted by SCDHHS waiver administration staff.

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:

Within 365 days of the previous plan.

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**

☐ **Other**
Specify:

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 waiver case manager is primarily responsible for monitoring the implementation of the service plan and participant health and welfare. SCDHHS and SCDDSN perform oversight activities to ensure case management providers are meeting the State's expectations in this area.

Monitoring and follow up methods include the following:
- Waiver case manager explains the participant's right to freedom of choice when it comes to selecting a provider for services. A list of qualified providers is readily available and the WCM will assist the participant in contacting any provider as needed.

- SCDDSN staff review all service plans prior to implementation. In addition to ensuring the plans are effectively addressing the needs of the participants, DDSN staff check for compliance with policy.

- At a minimum, the waiver case manager makes contact with the participant and/or representative monthly to determine whether services are meeting the participants' needs and are continuing to be effective. If services are not meeting the needs of the participant, additional assessments will be conducted and the plan revised to address the need. Waiver case managers may also make referrals for and monitor non-waiver services (such as medical appointments or food pantry) as necessary to ensure that participants' needs are met as a whole .

Quarterly, the case manager makes a face-to-face contact with the participant/representative. Annually, or more often if necessary, a new service plan is developed by the case manager in consultation with the participant/representative.

- As issues arise, waiver case managers work with the participant/representative and service providers to have them addressed. If the issue rises to the level that the case manager is unable to resolve, the waiver administrators at SCDDSN are contacted for assistance. SCDHHS waiver administrators are further contacted if issues arise surrounding policy or compliance. Appropriate reports are made in instances of ANE or any other circumstance that policy dictates. Monitoring and follow-up actions are documented in activity notes in the participant's record. Monitoring and follow-up actions are reviewed as part of quality assurance activities carried out by SCDHHS and/or SCDDSN. When necessary, SCDHHS and/or SCDDSN require case management providers to execute corrective actions.

- SCDHHS and/or SCDDSN quality assurance and licensing programs measure compliance with indicators related to health and welfare, approve required plans of correction, and conduct follow-up reviews to ensure successful remediation.

- Monitoring ensures that services are furnished in accordance with the service plan, participants have access to waiver services identified in the service plan, and assesses effectiveness of back-up plans.

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).*

The following monitoring safeguards are employed in addition to those described in D-2a:

- SCDDSN monitors allegations of abuse, neglect and exploitation (ANE) and other critical incidents (CI). As part of its activities, DDSN tracks the reporting process, requires corrective actions, ensures remediation has taken place, and provides technical assistance regarding prevention.

- Participants must be given free choice of provider for any service. SCDDSN's QIO conducts reviews of service plans to ensure compliance, approves all required plans of correction, and conducts a follow-up review to ensure successful remediation.

- SCDDSN maintains an electronic documentation system in which the assessments and service plans are completed. The system ensures the user completes the assessment consistent with policy. Once completed, a decision is required whether or not to formally address each need as identified by the assessment. The phrase "to formally address" means the need is included in the service plan and the services/interventions are in response to the need and are authorized. The decision is made by the participant and those chosen by the participant to assist in the planning.

- SCDDSN staff review all service plans prior to implementation. In addition to ensuring the plans are effectively addressing the needs of the participants, SCDDSN staff check for compliance with policy.

- SCDDSN's QIO performs reviews on a regular basis. For each finding noted in a QIO report, the provider is required to submit a plan of correction to the QIO. The QIO then conducts a follow-up review approximately six months later to ensure successful implementation of the plan of correction. The plan of correction addresses remediation at the individual level, and when warranted, includes a systems review and aggregated remediation. To ensure prompt follow up on identified problems, DDSN begins monitoring remediation activities shortly after receiving a provider's QIO report.

SCDDSN also monitors QIO reports to identify system-wide issues that require training, technical assistance, and/or policy changes. Systemic issues are communicated to the provider network in an effort to collect input, provide guidance, and reduce overall citations. These issues are addressed through quarterly counterpart meetings attended by SCDDSN personnel. Policy revisions are implemented in collaboration with providers and after receipt of public input. Current and proposed SCDDSN Directives and Standards are available to the public for review at any time on the SCDDSN Web-site. Information derived from monitoring is compiled and reported to the State.

(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:
Support plans for HASCI waiver participants include services, supports and goals that are consistent with assessed needs in accordance with waiver policy. Numerator = The number of HASCI participant support plans that include services, supports and goals consistent with assessed needs. Denominator = The total number of HASCI participant support plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Plan Review Process 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: DDSN QIO Contractor	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SCDHHS will conduct a retrospective review of person-centered service plans to determine whether service plans address the needs of waiver participants. N = Number of service plans that appropriately address the needs of waiver participants.

D = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Provider Compliance Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, +-5 & 50/50
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(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:

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.

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:
Support plans for HASCI waiver participants are developed at least annually.
Numerator = The number of HASCI participants whose support plans were developed at least annually; Denominator= Total number of HASCI support plans.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Waiver Plan Review Process 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**

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

Performance Measure:
Support plans for HASCI waiver participants are revised when warranted by a change in participant needs. Numerator = The number of HASCI participants whose support plans are revised when warranted by a change in participants needs. Denominator = Total number of HASCI participant support plans requiring a change due to a change in participants needs.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%,+-5 & 50/50
☒ **Other** Specify: SCDDSN QIO	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: 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:
HASCI Waiver participants receive authorized services and supports in the type, amount, scope, frequency, and duration as specified in the support plan, in accordance with waiver policy. Numerator = Number of HASCI waiver support plans within type, amount, scope, frequency, and duration as specified on the plan. Denominator = The total number of HASCI waiver support plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Case Management Monitoring Tool

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

Data Aggregation and Analysis:

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

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:
HASCI waiver participants are offered choice among qualified providers. N = The number of HASCI support plans wherein choice of qualified providers was offered. D = The total number of HASCI waiver support plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Case Management Monitoring Tool

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

Agency		
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:

Performance Measure:
HASCI waiver participants are offered choice among waiver services. N= The number of HASCI support plans wherein choice of waiver services was offered. D= The total number of HASCI waiver support plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Case Management Monitoring Tool

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

SCDDSN will ensure support plans are developed for participants annually and monitored through the review of a report available in Therap, the agency's electronic record. The CM monitoring tool will also provide quarterly oversight to ensure plans are developed in accordance with policy and procedures and choice among providers and services. When non-compliance is discovered, the provider will be required to develop a plan of correction, with additional training and technical assistance provided by the SCDDSN, as needed.

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 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.

This Waiver offers Adult Attendant Care and Respite as participant-directed service with employer authority. The participant or the participant's representative can choose to direct Adult Attendant Care or Respite. The person directing the service will be assessed to determine their ability to consent and/or ability to direct services.

Detailed information will be provided to the participant and/or representative about participant-directed Adult Attendant Care and Respite including the benefits and responsibilities. If the participant or representative wants to pursue any of these services, additional information about the risks and liabilities will be shared including the hiring, management, and firing of workers and the role of the Financial Manager. Service delivery will be monitored as well as the participant's health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

1) Licensed CRCF (up to sixteen individuals unrelated to proprietor)

2) Temporary living arrangement such as a hotel/motel, shelter or camp

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 or their representatives interested in self-directed Adult Attendant Care or Respite are pre-screened. The pre-screening assesses three main areas of ability (communication, cognition patterns and mood/behavior patterns) that are critical to self-direction and ensuring the health and welfare of the participant.

If participant-directed or representative-directed services are not appropriate, the participant is referred to agency-based Respite and/or agency-based Attendant Care.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

At the time of the initial assessment, the WCM will introduce and provide information about the participant or representative directed Adult Attendant Care and Respite. The WCM will provide this information initially or at the request of the participant/representative. If the participant/representative is interested, the WCM will provide more details about the benefits and responsibilities of the participant-directed Adult Attendant Care and Respite and determine continued interest. The WCM will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant/representative direction.

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:

When a service is determined to be needed that has the option for participant direction, a screening must be completed to determine who can direct the service. This screening must be completed prior to service authorization. The screening is designed to determine the waiver participant's likely ability to consent regarding services and to help determine the participant's likely ability to direct his/her own services. To "consent" generally means that the waiver participant can:
• Appreciate the nature and implication of his/her condition; and
• Appreciate the nature and implication of services; and
• Make reasoned decisions regarding those services in an unambiguous manner. Waiver participants must be able to consent in order to direct their own services and/or when desired, must be able to consent to allow another (a representative) to direct his/her services. The Waiver participant freely choices this representative. The extent of the decision-making authority exercised by the non-legal representative is that of an employer of record.

A participant may choose to have Adult Attendant Care and Respite waiver services directed by a representative and may choose anyone (subject to SCDDSN or Medicaid Policy) willing to understand and assume the risks, rights, and responsibilities of directing the participant's care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant's preferences, and must agree to a predetermined frequency of contact with the participant. A representative may not be paid to be a representative and may not be paid to provide waiver services to the participant.

The representative must be willing to complete the necessary paperwork and serve as the Employer of Record.
The representative must be at least 21 years of age.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Attendant Care/Personal Assistance Services	☒	☐
Respite Care Services	☒	☐

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:

SCDDSN currently uses a FMS to provide these services to participants in the HASCI Waiver. The FMS is a private entity.

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

The State compensates the FMS entity through an administrative contract from SCDDSN. The payment to the FMS does not affect the participant's waiver budget. The percentage of FMS costs relative to service costs is estimated to be 4%.

SCDDSN monitors the performance of the FMS monthly by monitoring expenditures. Additionally, an independent audit of the FMS is conducted yearly. The FMS is responsible for securing an external audit of their program on an annual basis by a CPA.

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:

The FMS assists the participants in verifying support worker citizenship status.

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.

An annual independent audit is required to verify that expenditures are accounted for and disbursed according to generally accepted accounting practices.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

For the self-directed attendant care service, waiver case managers will provide detailed information to the participant or responsible party (RP) about participant/RP direction as an option including the benefits and responsibilities of the option. If the participant/RP wants to pursue this service, additional information about the risks, responsibilities, and liabilities of the option will be shared by the waiver case manager. Information about the hiring, management and firing of workers as well as the role of the Financial Management System is also provided. Once the participant has chosen to direct their services, waiver case managers continue to monitor service deliver and the status of the participant’s health and safety.

☒ **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
Attendant Care/Personal Assistance Services	☒
Occupational Therapy	☐
Private Vehicle Assessment/Consultation	☐
Employment Services	☐
Nursing Services	☐
Speech and Hearing Services	☐
Incontinence Supplies	☐
Psychological Services	☐
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	☐
Physical Therapy	☐
Health Education for Participant-Directed Care	☐
Waiver Case Management (WCM)	☐
Day Activity	☐
Environmental Modifications	☐
Peer Guidance for Participant-Directed Care	☐
Pest Control Treatment	☐
Independent Living Skills	☐
Specialized Medical Equipment, Supplies and Assistive Technology	☐
Private Vehicle Modifications	☐
Respite Care Services	☒
Personal Emergency Response Systems	☐
Behavior Support Services	☐
Pest Control Bed Bugs	☐
Residential Habilitation	☐
Career Preparation Services	☐

☒ **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:

-DDSN contracts with the University of South Carolina (USC) School of Medicine, Center for Disability Resources (CDR) to provide information and other supports for participants who choose Self-Directed Attendant Care.

-Information and supports are for participants choosing self-directed care that is provided by USC-CDR through an administrative contract with DDSN.

-The method of compensating entities for furnishing information and assistance supports is through an Administrative interagency contract between DDSN and USC-CDR. The contracting entity is reimbursed on a quarterly basis using actual expenses submitted by the contracting entity to DDSN.

-A licensed RN employed by USC-CDR assists the participant or Responsible Party as follows:
• Reviews all requirements and procedures to be the "Employer of Record" with the participant or Responsible Party (Employer) and each prospective caregiver (Attendant);
• Assists with completing necessary paperwork, care schedules, and back-up arrangements;
• Obtains required criminal history background check and documentation of First Aid Training and TB testing for each perspective caregiver;
• Notifies the Fiscal Agent when each perspective caregiver has completed all requirements;
• Maintains a file on each caregiver (Attendant) with documentation that requirements are met;
• Provides guidance for recruiting and training caregivers;
• Observes participant or Responsible Party and caregivers in actual provision of personal care; and
• Assists with problem resolution.

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:

Protection and Advocacy of South Carolina has agreed to provide this advocacy when requested. The Case manager will provide
their phone number and contact names to participants.The advocacy organization does not provide direct services.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The WCM provider will accommodate the participant by providing a list of qualified providers from which an agency can be selected in order to maintain service delivery. The WCM provider and SCDDSN will work together to ensure the health and safety of the participant in this transition and will work to avoid any break in service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead,

including how continuity of services and participant health and welfare is assured during the transition.

If the participant or his/her representative are no longer able to communicate or if they experience cognitive deficits which keep them from acting in their best or the participant's best interest, the WCM provider will transition services from participant direction to agency directed services. Additionally, if it is determined that fraudulent activity has occurred, involuntary termination will occur related to the specific conditions of the activity. The WCM provider will use criteria in making this determination. The participant and/or representative will be informed of the opportunity and means of requesting a fair hearing, and choosing an alternate provider, and the Service Plan will be revised to accommodate changes.

When it is determined that participant/representative direction of services is no longer appropriate, alternate, provider-directed services will be authorized to ensure continuity of care and assure participant health and welfare. This waiver targets only those individuals who elect to self-direct the service or have an appropriate representative to do so. However, if waiver participants/representatives become unable/unwilling to direct the service and it becomes necessary to terminate the service, agency-directed respite and personal care are available to ensure continuity of care.

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	312	
Year 2	312	
Year 3	312	
Year 4	312	
Year 5	312	

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:

For self-directed attendant care, the costs for background checks will be handled by UAP (University Affiliated Programs/USC). For self-directed respite, the cost for background checks will be the responsibility of the employer however, the participant can request assistance with funding through the WCM as a household employer expense.

☐ **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.

SCDDSN RECONSIDERATION PROCESS

"SCDHHS decisions" are decisions made regarding programs and services funded by Medicaid. The final authority for Medicaid decisions rests with the South Carolina Department of Health and Human Services (SCDHHS). However, before a Medicaid participant can request a fair hearing through SCDHHS, decisions made by SCDDSN (and its network of providers) must first be submitted to SCDDSN for reconsideration. The reconsideration by SCDDSN is required to ensure that established Medicaid policy and procedures were followed and appropriately applied when the decision was made.

Actions to suspend, reduce or terminate HCB Waiver services may be halted while those actions are being reconsidered. In order to halt the action, thereby allowing the HCB Waiver service to continue while the decision is being reconsidered, the participant, legal guardian or representative must specifically request that the action be halted, the services continue, and the decision be reconsidered. The request must be made in writing and submitted within 10 calendar days of receipt of written notification of the decision/action. If, upon completion of the SCDDSN reconsideration and SCDHHS fair hearing, the SCDHHS decision is upheld, the participant or legal guardian may be required to repay the cost of the HCB Waiver services received during the pendency of the reconsideration/hearing.

If not requesting that actions to suspend, reduce or terminate HCBS Waiver services be halted, a request for SCDDSN reconsideration of a SCDHHS decision must be made in writing within 30 calendar days of receipt of written notification of the decision/action. The request must clearly state the basis of the complaint, previous efforts to resolve the complaint, and relief sought. If the decision was the denial of a request to exceed a waiver service limit, documentation justifying the need for the amount in excess of the limit must be submitted.

If needed, assistance with completion of the reconsideration request can be provided. The request must be dated and signed by the participant, legal guardian or representative assisting the participant. The request for reconsideration must be mailed to or e- mailed to:
State Director
SC Department of Disabilities and Special Needs 3440 Harden Street Extension
Columbia, SC 29203 Appeals@DDSN.SC.GOV
The State Director or a designee will issue a written decision within 10 working days of receipt of the written reconsideration request. The written decision will be mailed to the participant, legal guardian or representative. If the State Director upholds the decision/action, the reason(s) for upholding shall be specifically identified in the written notification.

SCDHHS MEDICAID FAIR HEARING PROCESS

If the participant, legal guardian or representative fully completes the SCDDSN reconsideration process and is dissatisfied with the result, the participant, legal guardian or representative has the right to request an appeal with the State Medicaid Agency, which is the South Carolina Department of Health and Human Services (SCDHHS).

The fair hearing request may be made electronically using the SCDHHS website indicated below or it may be mailed to SCDHHS. This must be done no later than 30 calendar days after receipt of the SCDDSN notification.

The purpose of a SCDHHS fair hearing is to prove error(s) in fact or law pertaining to a decision made and/or action taken by SCDDSN that adversely affects a waiver participant. The appeal must clearly state the specific issue(s) that are disputed and what action is requested. A copy of the reconsideration notification received from SCDDSN must be uploaded using the SCDHHS website indicated below or included with the mailed appeal.

The participant, legal guardian or representative is encouraged to file the appeal electronically at www.scdhhs.gov/appeals. OR
The hearing request may be mailed to:

SC Department of Health and Human Services Division of Appeals and Hearings

P.O. Box 8206
Columbia, SC 29202-8206

A fair hearing request to SCDHHS is valid if filed electronically or mailed to the above address and postmarked no later than the 30th calendar day following receipt of the SCDDSN reconsideration notification. Unless a valid appeal request is made to SCDHHS, the SCDDSN reconsideration decision will be final and binding.

If a valid hearing request is made, the participant, legal guardian or representative will be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request, which may include a scheduled hearing.

A beneficiary may request an expedited hearing. SCDHHS will grant or deny these requests as quickly as possible. If the request to expedite is granted, the hearing will be resolved as quickly as possible instead of the standard 90-day timeframe. If the request to expedite is denied, the hearing will follow the standard 90-day timeframe.

SCDHHS may grant expedited review if it is determined the standard hearing timeframe could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. SCDHHS may consider, among other facts:
· The medical urgency of the beneficiary's situation
· Whether a needed procedure has already been scheduled
· Whether a beneficiary is unable to schedule a needed procedure due to lack of coverage
· Whether other insurance will cover most of the costs of the requested treatment.

For more information on the SCDHHS appeals process, please refer to www.scdhhs.gov/appeals. Prior to entrance to the Waiver and annually thereafter, participants are provided an Acknowledge of Rights and Responsibilities form by the Waiver Case Manager (WCM) that includes information about their rights, including the right to a fair hearing.

Notice of appeal rights is provided to the individual at the time of any adverse action, including but not limited to choice of provider of service, denial, reduction, suspension or termination of service.

In all instances when notice of an adverse action must be made to a participant, notice is provided in writing by the Waiver Case Manager and instructs the participant to request assistance if needed. Notices are kept in the participant's case management file.

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:

SCDDSN operates the Complaint/Grievance System for all services delivered through the waiver and all waiver participant.

• **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).

A complaint is an expression of dissatisfaction or allegation of wrongdoing. Complaints may range in severity such that some can be easily addressed via discussion/follow-up with a service provider while others may require incident reporting, investigation, and referral to law enforcement and/or protective services. The types of concerns handled through this process may include but are not limited to concerns about service planning, restrictions of personal rights and freedoms; program, support and placement decisions; access to files/records; or ability to give informed consent.

SCDDSN maintains two levels of complaint management. Service providers and SCDDSN maintain methods to receive complaints. All efforts are made to resolve concerns at the most immediate (provider) level that can properly address the concern. Concerns involving health and safety of participants receiving services receive immediate review and necessary action is taken if health or safety is at risk. Participants are provided with information about the complaint process in a manner that is understandable to the individual. Supports are provided, if needed, to participants who wish to express a concern but need assistance in understanding or following the process.

SCDDSN requires that providers develop policy and procedures to receive, document and manage complaints about a service that are submitted by or on behalf of a person receiving services. Providers are required to offer/provide assistance to the people they support to prepare and file a complaint. The provider shall assure that there is no retaliation or threat of intimidation relating to the filing or investigation of a complaint. Providers have that ability to assign staff as appropriate to investigate, resolve and document complaint activities. In general, most complaints at the provider level are resolved within 10 business days of receipt. The resolution is communicated to the participant and other parties as applicable.

In the event a compliant cannot be resolved at the provider level, or the person desires to contact SCDDSN directly, SCDDSN maintains a telephone line and email address to receive complaints. SCDDSN will respond to an oral or written complaint from any source, including an anonymous source, regarding the delivery of a service, allegation of ANE or other issue regarding a participant. Complaints typically are made when the participant who receives services or their representative feel their concerns have not been satisfied through traditional resolution processes at the provider level. Contact with someone outside of the situation provides an opportunity for objective and impartial review of the concern. Once a complaint is received by SCDDSN it is assigned to the appropriate staff to resolve the issue. General information about the compliant is documented and the resolution is tracked by SCDDSN staff. In general, SCDDSN resolves most complaints within 10 business days of receipt. The resolution is communicated to the participant and other parties as applicable.

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

Policy reference: 535-08-DD

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).

All waiver participants are afforded the protections from abuse, neglect and exploitation described in this appendix. The entities responsible for reporting and follow-up vary depending on the nature of the incident, the participant's age, living situation and service array.

SCDHHS and SCDDSN are aligning incident management reporting requirements in order to increase positive outcomes for participants, streamline reporting and increase trend analysis abilities across the waiver. This will be achieved via policy changes, training and procurement of a new enterprise incident management technology solution.

Providers are required to manage incidents via protective service requirements (Omnibus Adult Protection Act (S.C. Code Ann. §43-35-5, et seq. (1976, as amended). In addition to the protections afforded the participant from protective services, SCDDSN contracted case management providers document incidents, offer supports and services to mitigate risk and prevent future occurrences of the same or similar nature.

SCDDSN uses a secure, Web-based Incident Management System (IMS) for incident reporting and management which contains three different modules: Abuse, Neglect, Exploitation (ANE) reporting, Critical Incident reporting, and Death reporting. SCDDSN qualified direct service and case management providers are considered reporting entities and use the IMS to report incidents to SCDDSN. The SCDDSN incident lifecycle contains an initial notification process (known as the initial report submission), a final notification process (known as the final report submission), and an approval process (known as the closure of the incident). Reports are required to be entered into the IMS within 24 hours (or the next business day) of recognition/discovery.

The following are required to be reported as incidents to SCDDSN:

Death- SCDDSN requires service providers to submit a Report of Death for any fatality among residential service providers or when the fatality occurs during the provision of a DDSN contracted service, per SCDDSN Directive 505- 02-DD.

Abuse-SCDDSN uses the South Carolina Omnibus Adult Protection Act-SECTION 43-35-10 and S.C Code Ann. 63-7- 20 (Supp. 2014), et seq., Child Protection Reform Act definitions of abuse for adults and children.

Neglect- SCDDSN uses the South Carolina Omnibus Adult Protection Act-SECTION 43-35-10 and S.C Code Ann. 63-7- 20 (Supp. 2014), et seq., Child Protection Reform Act definitions of neglect for adults and children.

Exploitation- SCDDSN uses the South Carolina Omnibus Adult Protection Act-SECTION 43-35-10 and S.C Code Ann. 63-7-20 (Supp. 2014), et seq., Child Protection Reform Act definitions of exploitation for adults and children.

Serious Injuries-A serious injury, either discovered or observed, requiring hospitalization or urgent medical treatment, including any loss of consciousness, fractures (excluding fingers and toes), head injury or wound requiring more than five
(5) sutures/staples.

Physical Aggression/Assault-The physical aggression or assault displayed between two persons supported resulting in serious injury or hospitalization.

Restraints-Includes any restraint resulting in an injury or the use of any restraint that is not part of a health-related protection as ordered by a physician and/or an approved Behavior Support Plan also reviewed by the Human Rights Committee. This includes Manual Restraints, Mechanical Restraints, and Chemical Restraints.

Choking-A choking incident where the individual is unable to breathe or is unable to breathe in a

normal way due to airway obstruction and requires intervention by staff (i.e., Heimlich maneuver, back thrusts).

Elopement-Any time an individual is missing from their designated location for a period of more than one (1) hour beyond their documented need for supervision

Law Enforcement Involvement-Assistance/Intervention is required from Law Enforcement and a Report/Case ID is issued as a result of that involvement.

Medical Follow-up Not Provided-The person supported does not receive the prescribed medical and/or rehabilitative follow-up for his/her condition resulting in a serious adverse reaction, infection, or further complications. Includes the failure to seek appropriate/timely treatment.

Medication Error Resulting in Adverse Reaction-Includes incidents in which the individual experienced life-threatening or adverse consequences due to a medication error and outside medical intervention was required, including observation in an emergency room.

Sexual Aggression/Assault-Sexual aggression/assault between two persons supported that includes the direct threat of or actual physical contact.

Suicide, Suicidal Ideations/Threats of Self-Harm-Threats/attempt of suicide, suicidal ideation, or threats of self-harm.

Provider Staff use of malicious or profane language-Use of malicious or profane language includes, but is not limited to, threatening, obscene or derogatory language, teasing and taunting.

SCDDSN has several directives that outline the requirements for incident reporting and investigation. The following directives apply:
100-09-DD-Critical Incident reporting
505-02-DD- Death or Impending Death of Persons Receiving Services From SCDDSN
534-02-DD- Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from SCDDSN or a DSN Board or Contracted Service Provider

• SCDDSN qualified direct service and case management providers are considered reporting entities
• Reports are required to be entered into the IMS within 24 hours (or the next business day) of recognition/discovery.
• SCDDSN uses a secure, Web-based Incident Management System (IMS) for incident reporting and management which contains three different modules: Abuse, Neglect, Exploitation (ANE) reporting, Critical Incident reporting, and Death reporting

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

Waiver participants and/or their family members and legal representatives are provided written information about what constitutes abuse, neglect, and exploitation, how to report, and to whom to report. They are informed of their rights, annually and this information is explained by their waiver case managers.

The participants/their family/legal guardian are provided information about ANE during the service planning process and during case management monitoring.

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.

When an event occurs, or is alleged to have occurred, that is considered an incident per policy, the initial notification to SCDDSN is made by the reporting entity (SCDDSN qualified direct service or case management provider) by submitting the first section of the incident report within 24 hours (or the next business day) of discovery or recognition. Once the initial report is submitted, SCDDSN will review to ensure that the incident description is complete and prompt action was taken to protect the participant's health, safety, and rights. If the report is incomplete or the actions included are insufficient, SCDDSN will contact the reporting entity and ensure the report is corrected and the actions taken are sufficient to protect the health, safety and rights of the person(s) involved.
Reporting entities are required to complete an internal review (investigation) of the incident. The internal review is submitted to SCDDSN as part of the final report submission (within 10 business days of discovery/recognition of the incident). SCDDSN policies require the provider, upon completion of the internal review, to notify the participant and/or responsible party of the outcome of the review. The Case Management provider is also informed in order to ensure that any health and safety concerns are addressed.

When an event occurs that could be classified as possible abuse, neglect or exploitation, providers are required to manage incidents via protective service requirements (Omnibus Adult Protection Act (S.C. Code Ann. §43-35-5, et seq. (1976, as amended). In addition to the protections afforded the participant from protective services, case management providers document incidents, offer supports and services to mitigate risk and prevent future occurrences of the same or similar nature. If a case management provider is unable to mitigate an incident with the assistance of protective services, SCDHHS and SCDDSN will collaborate to offer additional support and guidance to the participant, their family, providers, and other stakeholders. Additional support includes but is not limited to, service changes, environmental/living situation changes, referrals to outside agencies, support with legal proceedings and support to access community resources.

In addition, depending on the nature of the incident, a report/referral for investigation must be made outside of SCDDSN. Upon vetting of the report an investigation may be conducted by child or adult protective services, the State Long Term Care Ombudsman Program, the Attorney General's Office, and local/state law enforcement (SLED). The appropriate State Investigative Agency is determined through State Law by the age of the victim, suspected perpetrator, and the location of the alleged incident. These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing. These incidents are defined as physical abuse, or psychological abuse, threatened or sexual abuse, neglect, and exploitation. Mandatory reporters have a duty to report if they have information, facts or evidence that would lead a reasonable person to believe that a child or vulnerable adult has been or is at risk for ANE.

Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected ANE to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the ANE.

The reporting entity is required to submit the final report of the incident to SCDDSN within ten business days of the initial report submission. In cases where all the activities related to the incident have not yet finished by this deadline, the reporting entity submits an addendum to the report. Where appropriate, the final section of the incident will include the investigation determination (from protective services, Ombudsman program, SLED) as well as the corrective actions that were carried out or planned in order to mitigate and prevent the reoccurrence of the incident. When the reporting entity submits the final incident report, SCDDSN reviews the report and ensures that the incident was managed effectively and according to policy and that the investigation determination is included (as applicable), corrective actions are appropriate, planned, and prevents reoccurrence, and other pertinent information is included as necessary. SCDDSN returns reports to the appropriate reporting entity for correction when the above standards are not met. Reports are considered "closed" upon review and acceptance by SCDDSN. Addenda are required as the State Investigative Agencies render a final disposition related to any allegation of ANE.

SCDDSN evaluates the initial and final incident reports to ensure that:
• The provider took prompt action to protect the participant's health, safety and rights. This may include, but is not limited to contacting emergency services such as 911, arranging medical care, separating the perpetrator and victim, arranging counseling or referring to a victim assistance program.
• When applicable, the provider met the mandatory reporting requirements by contacting the appropriate protective services agency for children or vulnerable adults
• Law enforcement (SLED) was notified as appropriate.
• The provider notified the family or guardian of the incident within 24 hours (unless otherwise indicated in the individual support plan).
• The alleged perpetrator was suspended per policy.
• The incident was correctly categorized;
• Safeguards to prevent reoccurrence are in place;
• Corrective actions have occurred, or are planned to occur, in response to the incident to prevent reoccurrence.
• Changes were made in the participant's plan of support necessitated by or in response to the incident;
• The participant or participant's family received notification of the findings by the reporting entity, unless otherwise indicated in the individual plan;

SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of an incident. In situations where this occurs, SCDDSN will compile findings from the activity and issue corrective action plans as appropriate based on the discovery data.

Case Managers identify unreported incidents as they conduct monitoring of services and supports. SCDDSN identifies unreported incidents as part of routine monitoring activities conducted by SCDDSN or the SCDDSN QIO. When an unreported incident is identified, the reviewer communicates this finding to the provider who is required to ensure that an incident report is filed. SCDDSN will review such reports and ensure appropriate action is taken to mitigate the incident and ensure action is taken to prevent reoccurrence.

SCDDSN also partners with the following entities with regards to the review and investigation of incidents. The type of partnership and activities conducted are dependent on the specific nature of the incident and investigation findings.

SCDSS Child Protective Services and local and state law enforcement are responsible for overseeing the reporting of and response to allegations of ANE. In addition to investigations by the State Long Term Care Ombudsman, SCDSS, the State Attorney General's Office, and law enforcement, other agencies have jurisdiction to make inquiry into incidents of ANE and may conduct their own investigation. These agencies include:

• SLED/Child Fatalities Review Office- The Child Fatalities Review Office of SLED will investigate all deaths involving abuse, physical and sexual trauma as well as suspicious and questionable deaths of children. The State Child Fatalities Review Office will also review the involvement that various agencies may have had with the child prior to death.
• Disability Rights South Carolina (DSRC) has statutory authority to investigate abuse and neglect of people with disabilities.
• Vulnerable Adult Fatalities (VAF) Review- The VAF Review Office of SLED will investigate all deaths per the applicable statute involving abuse, physical and sexual trauma, as well as, suspicious and questionable deaths of vulnerable adults. The State Vulnerable Adult Investigations Unit (VAIU) will also review the involvement that various agencies may have had with the person prior to death.

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.

SCDDSN is responsible for the oversight of and response to incidents. SCDDSN evaluates all reports on an ongoing basis.

SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of an incident. In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate.

SCDDSN provides technical assistance when a need is identified SCDDSN may require the completion of a plan of correction (POC) and/or a directed plan of correction (DPOC) document when performance improvements are needed due to sentinel events, patterns of non-compliances or other issues that require significant remediation. Data from the IMS is used to support implementing quality improvement, risk management and incident management processes for all levels of the support and service system. Through a review of the data, SCDDSN identifies factors that put participants at risk and facilitates the development of interventions and improvement activities to mitigate future risk or reoccurrence.

Key data elements of the IMS include:
- o Evidence of recognition of incidents.
- o Evidence of prompt and appropriate action in response to incidents
- o Timely reporting of incidents.
- o Investigation and review of incidents.
- o Corrective action in response to incidents.

SCDDSN quality management and quality improvement staff meet on a regular basis to discuss findings from incident management activities and discuss if sanctions are needed to facilitate improvement activities. Providers that are significantly out of compliance with issues related to incident management, without evidence of improvement, are subject to sanctions such as suspension of permission to enroll new participants, recoupment of waiver funds, administrative sanctions and contract termination.

SCDDSN and SCDHHS staff meet quarterly to review results of risk management meetings, incident reporting, performance measure results, and quality improvement strategy results.

SCDDSN is responsible for the oversight of and response to incidents and the incident management system. SCDDSN evaluates all reports on an ongoing basis.

Appendix G: Participant Safeguards

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

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

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

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

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

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

Individuals with disabilities are entitled to exercise their civil, political, social, economic and cultural rights on an equal basis with others. Each individual who receives services from SCDDSN is encouraged and assisted to exercise his/her rights as a citizen and as a service recipient.
SCDDSN uses person-centered planning activities (behavior support strategies/plans, appropriate psychotropic medication use), staff training in crisis prevention curriculums, monitoring for the use of prohibited practices, and Human Rights Committees, to promote and protect the rights of all individuals served.
Consistent with SCDDSN's values and principles, it is expected that all interventions to protect rights and support people with challenging behavior:
• Ensure the health, safety, and well-being of each person;
• Ensure that each person is treated with dignity and respect;
• Encourage participation, choice, control and responsibility;
• Encourage relationships with family and friends, and connections in the community;
• Result in personal growth and accomplishment;
• Be person-centered and community inclusive;
• Be responsive, effective and accountable;
• Be practical, positive and appropriate;
• Be strengths-based and results-oriented;
• Offer opportunities to be productive and maximize potential; and
• Feature best and promising practices.
Restraints may be employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the person's needs. Restraints may only be used in an emergency or with the approval of a Human Rights Committee (HRC). The following types of restraints may be used:
Physical Restraint-A type of restrictive procedure that is a manual method that restricts, immobilizes, or reduces a person's ability to move arms, legs, head or other body parts freely.
Mechanical Restraint- a mechanical device that involuntarily restricts the freedom of movement or voluntary functioning of a limb or portion of a person's body as a means to control their physical movements and normal access to their body.

The use of the following are prohibited by SCDDSN policy:
• A restrictive procedure used as retribution, for the convenience of staff persons or as a substitute for staffing or
appropriate services;
• The use of medication for disciplinary purposes, for the convenience of staff, as a substitute for training or engagement,
or in quantities that interfere with someone's quality of life;
• Seclusion;
• Enclosed cribs;
• Interventions that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
• Encouraging/using someone supported to discipline a peer;
• Prone restraints;
• Time out rooms;
• Aversive conditioning;
• Use of handcuffs;
• Technique that inhibits breathing, the respiratory or digestive system;
• Use of a technique that involves a chokehold, pressure on the neck or other means of restraint involving the head/neck;
• Any technique that inflicts pain;
• Use of pressure point techniques;
• Any technique that causes hyperextension of joints and pressure on the chest or joints;
• Use of a technique in which the person is not supported and allows for free fall to the floor;
• As needed (PRN) orders for psychotropic medications (chemical restraints) or mechanical restraint.
Except when prescribed by a physician while treating the person in a hospital setting or prescribed

as part of the palliative care provided by Hospice;
• The planned use of restrictive procedures prior to the exhaustion of less intrusive measures;
• The use of a physical restraint for more than 60 cumulative minutes within a 2-hour period;
• The use of a mechanical restraint without proper monitoring, supervision, and release;
• The use of a restrictive procedure when not necessary to protect the person or others from harm;
• Coercion/use of intimidation or use of force to gain compliance; and
• Access to or the use of personal funds or property used as a reward or punishment.

In order to promote and protect rights and support people with challenging behavior all providers must demonstrate that staff have been appropriately trained in a crisis prevention curriculum. Appropriate training of a curriculum includes competency-based assessment of staff skills and re-certification on the schedule required by the curriculum for trainers and staff.

Providers may only utilize a SCDDSN approved curricula for teaching and certifying staff to prevent and respond to disruptive behavior and crisis situations. A crisis prevention management curriculum is only approved once it has been determined that it aligns with SCDDSN philosophies and it has a strong focus of training in the area of interpersonal skills (e.g., active listening, problem solving, negotiation, and conflict management). In addition, SCDDSN does not approve training curricula that include techniques involving the use of force (such as chokeholds of any kind or other techniques that inhibit breathing etc.) for self- defense or control that entities such as law enforcement would utilize. Providers may not train staff on any aspect of an approved crisis prevention management curriculum that includes a SCDDSN prohibited practice.

Only the techniques included in the approved system/curriculum shall be used. Techniques included in the chosen system/curriculum shall only be employed by staff members who have been fully trained and deemed competent in the application of the techniques.

Any system on the list may be selected for use. Providers may elect to use more than one of the currently approved curricula based on the needs of the people supported or the organization. At the present time, the below list includes approved curricula:
1. MANDT
2. CPI – Crisis Prevention Institute
3. PCM – Professional Crisis Management
4. Therapeutic Options Training Curriculum
5. PCS - Life Experience Model
6. TCI – Therapeutic Crisis Intervention System
7. Safety-Care
8. Ukeru Systems

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

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

Providers are required to report (1) the use of an emergency restraint or (2) when the use of a restraint has resulted in an injury as a Critical Incident. Additional data collection about the use of a planned restraint is documented in the electronic health record per the person’s behavior support plan as applicable.

SCDDSN is responsible for the oversight of restraints.
SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of a

restraint. In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate.
SCDDSN provides technical assistance when a need is identified SCDDSN may require the completion of a plan of correction (POC) and/or a directed plan of correction (DPOC) document when performance improvements are needed due to sentinel events, patterns of non-compliances or other issues that require
significant remediation

Case Managers may identify unreported, improper and unauthorized restraints as they conduct monitoring of services and supports. SCDDSN identifies unreported, improper and unauthorized restraints as part of routine monitoring activities conducted by SCDDSN or the SCDDSN QIO. When unreported, improper and unauthorized restraints are identified, the reviewer identifying this communicates this finding to the provider who is required to ensure that an incident report is filed. SCDDSN will review such reports and ensure appropriate action is taken to mitigate the incident and ensure action is taken to prevent reoccurrence.

SCDDSN currently has two directives that outline the requirements for the management of restraints. The following directives apply:
- 600-05-DD Behavior Support, Psychotropic Medications and Prohibited Practices
- 567-04-DD DDSN Approved Crisis Prevention Curricula List and Curriculum Approval Proces

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:

SCDDSN is responsible for oversight of the use of restraints. SCDDSN reviews restraint incident reports on an ongoing basis to ensure that reported restraints align with SCDDSN requirements. SCDDSN also uses information from routine monitoring activities and reviews conducted by the QIO to inform oversight activities. When issues are discovered, SCDDSN ensures that improper and unauthorized restraints are reported as abuse as appropriate.

SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of a restraint incident/event. In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate.

Monitoring ensures the following:
- Services are furnished in accordance with the service plan.
- Participant access to waiver services identified in service plan
- Effectiveness of back-up plans.

SCDDSN provides technical assistance when a need is identified SCDDSN may require the completion of a plan of correction (POC) and/or a directed plan of correction (DPOC) document when performance improvements are needed due to sentinel events, patterns of non-compliances or other issues that require significant remediation. Data from restraint incident reports is used to support implementing quality improvement, risk management and incident management processes for all levels of the support and service system. Through a review of the data, SCDDSN identifies factors that put participants at risk and facilitates the development of interventions and improvement activities to mitigate future risk or reoccurrence.

SCDDSN quality management and quality improvement staff meet on a regular basis to discuss findings from reviews of restraint reports and discuss if sanctions are needed to facilitate improvement activities. Providers that are significantly out of compliance with issues related to the use of restraints, without evidence of improvement, are subject to sanctions such as suspension of permission to enroll new participants, recoupment of waiver funds, administrative sanctions and contract termination.

Appendix G: Participant Safeguards

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

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

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

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

◉ **The 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.

Individuals with disabilities are entitled to exercise their civil, political, social, economic and cultural rights on an equal basis with others. Each individual who receives services from SCDDSN is encouraged and assisted to exercise his/her rights as a citizen and as a service recipient.

SCDDSN uses person-centered planning activities (behavior support strategies/plans, appropriate psychotropic medication use), staff training in crisis prevention curriculums, monitoring for the use of prohibited practices, and Human Rights Committees, to promote and protect the rights of all individuals served.

Consistent with SCDDSN's values and principles, it is expected that all interventions to protect rights and support people with challenging behavior:
• Ensure the health, safety, and well-being of each person;
• Ensure that each person is treated with dignity and respect;
• Encourage participation, choice, control and responsibility;
• Encourage relationships with family and friends, and connections in the community;
• Result in personal growth and accomplishment;
• Be person-centered and community inclusive;
• Be responsive, effective and accountable;
• Be practical, positive and appropriate;
• Be strengths-based and results-oriented;
• Offer opportunities to be productive and maximize potential; and
• Feature best and promising practices.

Restrictive Intervention: Any intervention that limits a person's ability to acquire positive reinforcement, results in loss of objects or activities a person values, or requires a person to engage in behavior the person would not engage in given freedom of choice.

It is important to note that what may or may not be a restrictive intervention is situational and is based on assessed needs, person-centered planning, and approval from a HRC. Therefore, SCDDSN has not issued a list of permissible restrictive interventions due to the individualized nature of these considerations consistent with the HCBS Settings Regulation, rights modification.

Case Managers identify improper restrictive interventions as they conduct monitoring of services and supports. SCDDSN identifies improper restrictive interventions as part of routine monitoring activities conducted by SCDDSN or the SCDDSN QIO. SCDDSN will review such reports and ensure appropriate action is taken to mitigate the incident and ensure action is taken to prevent reoccurrence.

SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of a restrictive intervention incident/event. In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate.
SCDDSN provides technical assistance when a need is identified SCDDSN may require the completion of a plan of correction (POC) and/or a directed plan of correction (DPOC) document when performance improvements are needed due to sentinel events, patterns of non-compliances or other issues that require significant remediation.

SCDDSN has two directives that outline the requirements for the management of restrictive interventions. The following directives apply:
• 600-05-DD Behavior Support, Psychotropic Medications and Prohibited Practices
• 567-04-DD DDSN Approved Crisis Prevention Curricula List and Curriculum Approval Process

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:

SCDDSN is responsible for oversight of the use of restraints for all waiver participants. SCDDSN uses information from routine monitoring activities and reviews conducted by the QIO to inform oversight activities.

SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of a discovered unauthorized/inappropriate restrictive intervention. In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate.

SCDDSN provides technical assistance when a need is identified SCDDSN will require the completion of a plan of correction (POC) and/or a directed plan of correction (DPOC) document when performance improvements are needed due to sentinel events, patterns of non-compliances or other issues that require significant remediation. Data from oversight activities is used to support implementing quality improvement, risk management and incident management processes for all levels of the support and service system. Through a review of the data, SCDDSN identifies factors that put participants at risk and facilitates the development of interventions and improvement activities to mitigate future risk or reoccurrence.

SCDDSN quality management and quality improvement staff meet on a regular basis to discuss findings from reviews of restrictive interventions and discuss if sanctions are needed to facilitate improvement activities. Providers that are significantly out of compliance with issues related to the use of restrictive procedures, without evidence of improvement, are subject to sanctions such as suspension of permission to enroll new participants, recoupment of waiver funds, administrative sanctions and waiver contract
termination.

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:

Seclusion: The involuntary confinement of an individual in an area from which the individual is prevented from leaving. Verbal instruction or any explicit or implicit intimidation that indicates to an individual that they may not leave a room is also considered seclusion, regardless of whether the individual has the ability to physically remove himself or herself from the situation. Examples include, but are not limited to the following prohibited acts:

• Placing an individual in a locked room. A locked room includes a room with any type of engaged locking devic such as a key lock, spring lock, bolt lock, foot pressure lock, device or object, or physically holding the door shut
• Placing an individual in a room from which they are unable to exit independently due to the general accessibility of the room (i.e. wheelchair ramps, transitions etc.), features of the door hardware (i.e. handles that do not meet the accessibility needs of the individual), or any other obstacle that prevents an individual from exiting.

SCDDSN is responsible for oversight of the use of seclusion. SCDDSN uses information from routine monitoring activities and reviews conducted by the QIO to inform oversight activities.
SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of a seclusion incident. In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate. A directed plan of correction (DPOC) document is issued when performance improvements are needed due to sentinel events, patterns of non-compliances or other issues that require significant
remediation.

○ **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.

First-line responsibility for monitoring participant medication regimens resides with the medical professionals who prescribe and the pharmacists who dispense medications. The second line medication monitoring occurs through two methods outlined below.

First, Waiver Case Managers (WCM) monitor the participant's services to ensure that a person's health care needs are addressed. For participants taking any type of medication, the WCMs review the person's overall health care needs (including medications) during each face-to-face monitoring visit in the participant's home (every 6 months) using the service plan monitoring tool. Monitoring to detect potentially harmful practices related to medication occurs for all waiver participants that take medication. Monitoring is designed to detect potentially harmful practices and ensure follow up to address such practices. If concerns or issues related to medication administration are discovered at a face-to-face monitoring visit, the WCM communicates this information directly with the appropriate entity, caregiver etc. that can assist with remediation of the issues discovered.

Second, SCDDSN conducts oversight of medication administration as part of routine monitoring activities conducted by SCDDSN or the SCDDSN QIO. These activities are conducted for providers of Residential Habilitation and Day services (Day Activity, Career Preparation, Support Center, and Employment Services – Group) where medication administration may occur.
Reviews of medications for participants, particularly those with complex medication regimens or behavior modifying medications as part of their treatment program, can occur through a number of methods. The type of reviews are based upon the person's needs and may include discussions with plan team members; training sessions specific to the person's needs, monitoring of the frequency and appropriateness of psychotropic drug reviews by prescribing physicians and oversight activities conducted by SCDDSN or the SCDDSN QIO. SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of a person's medication regimen or a medication error(s). In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate.
SCDDSN provides technical assistance when a need is identified SCDDSN may require the completion of a plan of correction (POC) and/or a directed plan of correction (DPOC) document when performance improvements are needed due to sentinel events, patterns of non-compliances or other issues that require significant
remediation.

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.

SCDDSN oversees medication technician certification programs by requiring providers to submit curricula for initial approval and be reapproved every three years. The submitted curriculum must meet DDSN standards established in policy and designed to teach proper medication administration to unlicensed staff. The minimum standards include sixteen hours of classroom instruction and practicum experience taught by a Registered Nurse (RN), an LPN (Licensed Practical Nurse) Supervised by an RN, or a Registered Pharmacist. Supervised medication passes for the staff are also required.

SCDDSN has established a procedural directive, Medication Error Reporting, to standardize the definition and reporting system for medication errors/events in order to improve the health and safety of SCDDSN waiver participants. SCDDSN recognizes that medication errors represent one of the largest categories of treatment- caused risks to waiver participants. Medication errors are required to be reported within the electronic service record and analyzed per the directive. The provider's system of tracking, trending and analyzing their medication error data is reviewed by the SCDDSN QIO as part of routine oversight and monitoring activities.

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)*

• **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).

SCDDSN was granted the statutory authority for selected unlicensed persons to administer medications to SCDDSN service recipients in community settings. SCDDSN policy requires that staff receive training on medication assistance/administration prior to service.

SCDDSN sets forth the minimum requirements for medication administration or assistance, which includes: checking physician’s orders, knowing common medications prescribed for the individuals supported and identifying their interactions/side effects, administering medications/treatments accurately and in accordance with agency policy, and recording medication administration on the appropriate forms. Staff must demonstrate knowledge/understanding of these minimum competencies on an annual basis.
The SCDDSN Standards or Directives referenced include:
-Employee Orientation, Pre-Service and Annual Training (567-01-DD)
-Residential Certification Standards
-Day Facilities Licensing Standards
-Medication Error/Event Reporting (100-29-DD)
-Medication Technician Certification (603-13-DD)

• **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:

Significant Medication Errors are reported to SCDDSN as a Critical Incident. All Medication Error/Event
reports are subject to periodic review by SCDDSN or its QIO.

SCDDSN has adopted the NCC MERP definition of Medication Errors: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. SCDDSN has followed the general guidelines of the NCC MERP Taxonomy of Medication Errors in developing a Medication Error/Event Report Form. SCDDSN Service Providers are required to develop their own data collection system to track, monitor and analyze medication errors/events. At the provider level reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including medication technician certification), changes in procedure, securing additional technical assistance from a consulting pharmacist, and improving levels of supervision. SCDDSN may request all data related to medication error/event reporting at any time or during any of the Service Provider's QIO reviews.

Types of Medication Errors/Events
According to the above definition, there are some kinds of medication errors that are outside the control of SCDDSN and its network of service providers (e.g., naming; compounding; packaging etc.). If provider agency staff discovers errors of this type, the pharmacist should be notified immediately in order for corrective action to occur. The types of medication errors/events that are within the direct control of SCDDSN and its network of service providers, and therefore of most interest, can be divided into three categories: 1) bona fide or true medication errors; 2) transcription and documentation errors; and 3) red flag events.
1) MEDICATION ERRORS
- Wrong person given a medication
- Wrong medication given
- Wrong dosage given
- Wrong route of administration
- Wrong time
- Medication not given by staff (i.e., omission)
- Medication given without a prescriber's order
2) TRANSCRIPTION & DOCUMENTATION ERRORS
- Transcription error (i.e., from prescriber's order to label, or from label to MAR)
- Medication not documented (i.e., not signed off)
3) RED FLAG EVENTS
- Person refuses medication (this event should prompt the organization to make every effort to determine why the person refused the medication. Specific action taken should be documented. Each organization must develop a reporting system for these events).

Reporting Procedure
The first person finding the medication error is responsible to report the error or event to supervisory/administrative staff, such as the employee's supervisor, program director, nurse in charge or Executive Director/Facility Administrator. A medication error resulting in serious adverse reactions must be considered a critical incident and reported according to policy. The person finding the error or identifying the event completes the Medication Error/Event Report form and submits it to the supervisor/administrator. The Provider Administration will assure this data is available to the quality assurance and risk management staff/team for analysis, trend identification, and follow-up activity as needed. In addition, the Medication Error/ Event records are reviewed during the providers annual licensing review. The QIO also reviews Medication Error/Event data and the providers analysis and risk management activities during their scheduled reviews.

Each provider must adopt a method for documenting follow-up activities such as utilizing memoranda or the meeting minutes of risk management/quality assurance. This information must be included as part of the
data collection system related to medication error/event reporting.

- **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.

SCDDSN monitors performance of providers in the administration of medication to waiver participants both directly and indirectly. As described in section G-3bi, SCDDSN utilizes multiple processes to assess medications and participant health and safety.

SCDDSN may conduct on-site inspections, reviews or investigations based on the circumstances of a medication error(s). In situations where this occurs, SCDDSN will compile findings from the activity and take action as appropriate.

SCDDSN provides technical assistance when a need is identified SCDDSN may require the completion of a plan of correction (POC) and/or a directed plan of correction (DPOC) document when performance improvements are
needed due to sentinel events, patterns of non-compliances or other issues that require significant remediation.

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:
Number and percent of critical incidents (including abuse, neglect, or exploitation (ANE) and unexplained deaths (UD) that are initially reported within the required timeframe. Numerator = Number of critical incidents (including ANE and UD) that are initially reported within the required timeframe. Denominator = Total number of critical incidents (including ANE and UD)

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN Incident Management System (IMS)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
HASCI waiver participants receive information about how to report Abuse, Neglect and Exploitation (ANE) annually. Numerator = Total number of HASCI participants receiving annual information Denominator = total number of HASCI participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Case Management Monitoring Tool

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of substantiated instances of abuse, neglect, exploitation (ANE) and unexplained death (UD) for which corrective actions are executed or planned appropriately. N= Number of substantiated instances of abuse, neglect, exploitation (ANE) and unexplained death (UD) for which corrective actions are executed or planned appropriately. D= Number of substantiated instances of ANE and UD.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN Incident Management System (IMS)

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

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents (including ANE and UD) finalized, including strategies to mitigate/prevent future incidents, within the required timeframe. N = Number of critical incidents (including ANE+UD) finalized, including strategies to mitigate/prevent future incidents, within the required timeframe. D = Total number of critical incidents (including ANE and UD).

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN Incident Management System (IMS)

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 policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of waiver participants where proper restrictive intervention policies were followed. Numerator = number of participants with where proper procedures were followed. Denominator = number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN Incident Management System (IMS)

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants whose identified health care needs are being addressed. Numerator = number of HASCI support plans wherein identified health care needs are being addressed. Denominator = Number of support plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Case Management Monitoring Tool

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

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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.

Allegations of ANE and UD are reviewed in real time by a full-time Incident Management coordinator. Through the Web-based Incident Management System, staff monitor the reporting process, including timeliness of reporting, safety plans, individual and systemic remediation, and any additional risk management strategies employed by the provider agency. Data is tracked for trends across various data points. Where non-compliance is discovered, the provider receives individualized technical assistance. When trends are observed across multiple reports from the same provider, a plan of correction will be required. In addition, the SCDDSN Case Management Monitoring Tool data is reviewed annually to ensure participants receive information about how to report ANE. SCDDSN monitors compliance and will work with the providers to develop a Plan of Correction, as needed, for any non-compliance.

ii. Remediation Data Aggregation

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

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

SCDDSN and SCDHHS have established a risk and quality management workgroup that meets on a quarterly basis. This group reviews and analyzes aggregate discovery and remediation data in each of the six waiver assurance areas. This group also reviews and analyzes data outside of formal performance measures that includes, but is not limited to, LOC Determination reviews, critical incident reports, ANE reports, results of QIO provider reviews, licensing/certification reviews and any received participant complaints. Improvement activities are selected by this group and align with SCDDSN's overarching mission, vision and values.

Improvement activities focus on the health and safety of individuals and the achievement of individual outcomes through person-centered planning. DDSN assigns staff to implement quality improvements based on the scope of the design change and the expertise required. DDSN involves additional stakeholders as appropriate to improvement activities, including people and their families, providers, case management entities, etc., and other State agencies in consideration of the design change involved and specific input needed.

DDSN and DHHS use QIO organizations to facilitate compliance, monitoring and oversight activities. These organizations supply data for analysis for waiver performance measures and other systemic quality improvement priorities set by DDSN and DHHS.

Information used for trending and prioritizing opportunities for system improvements is also obtained through in person interview and observations of participant's process. The questions on the tool are designed to monitor satisfaction and outcomes of participants receiving services through indicators organized into areas of satisfaction, dignity and respect, choice and control, inclusion, and physical setting.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☒ **Other** Specify: SCDDSN QIO Contractor; SCDHHS QIO Contractor	☐ **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.

SCDDSN uses a Plan-Do-Check-Act (PDCA) Model of continuous quality improvement. The steps in this model involve planning and implementing system design changes followed by monitoring of data results to check the effectiveness of the selected strategies. Using the analysis of performance data collected to identify next steps, the cycle is repeated. Depending on the area of focus, specific units within SCDDSN are assigned responsibility for designing, initiating, monitoring and analyzing the effectiveness of system design changes and providing periodic, routine reports on progress to the risk and quality management group. Stakeholders are engaged in this process where appropriate.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

On an annual basis, SCDDSN and SCDHHS assess program and operational performance as well as SCDDSN's overall Quality Improvement Strategy (QIS). Results of this review may demonstrate a need to revise the QIS, including changing priorities, using different approaches to ensure progress, modifying roles and responsibilities of key entities, and modifying data sources in order to retrieve the information needed for measurement.

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).*

SCDDSN has established a post-payment review process to ensure the integrity of provider billings for Medicaid payment of waiver services.

SCDDSN performs a post payment desk review of a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that authorized services from the person's service plan were delivered. The population of claims used for the post payment desk review will be chosen to ensure that service providers receive a review at least every three years. Providers will submit documentation to SCDDSN substantiate claims. This will be done via email to a dedicated mailbox. If SCDDSN finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review and SCDDSN may initiate an expanded review or audit.

Through the post payment claim desk review, the SCDDSN ensures waiver services billed were actually rendered by pulling a random, representative sample of claims using a 95% confidence level and 5% margin of error and reviews claims for accuracy and to assure:

- *The person was eligible for services at the time of the claim*
- *The service was authorized in the persons service plan*
- *There is sufficient documentation to support the service was delivered per the waiver service definition.*

**Supporting documentation will vary depending on the nature of the service delivered. Documentation includes but is not limited to:*
Provider service notes, medication administration records, behavior support data, medical appointment records, community
integration notes, meeting notes etc.

- *The units of service align with the authorized units in the service plan.*

Results of post-payment reviews will be communicated with the provider. Fraudulent and/or inaccurate billings discovered during the desk review process will trigger an expanded review by SCDDSN's internal audit team or referral to Program Integrity depending on the nature and extent of the findings. Inappropriate billings are required to be refunded by the provider and further remediation up to termination of service contracts may occur.

DDSN's Internal Audit Division conducts periodic reviews of the billing systems and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS. DDSN Internal Audit Division will also conduct special request audits, investigate fraud cases, provide training and technical assistance, and review the audited financial statements of the local DSN Boards. All findings will be shared with DHHS within 30 days of completion. DDSN Internal Audit Division will conduct a review of the contracted fiscal agent, and likewise, all findings related to waiver participants will be shared with DHHS within 30 days of completion. DHHS will review DDSN Internal Audit Division annual reports, special request audits, and fraudulent case investigations and request remedial action(s) as determined necessary. An independent audit of the financial statements of waiver providers is only required for DSN Boards and DDSN qualified providers of residential habilitation or providers with revenue exceeding $250,000.

The Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity audits any payments to service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office. In addition, the DHHS Division of Audits reviews DHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged.
DHHS's PI reviews documentation of DDSN providers that service note level which support activities billed and issues recoupments of all discrepancies. DDSN does not conduct program integrity reviews.

Program Integrity (PI) makes scheduled visits with DSN Boards, other qualified providers or DDSN, based on complaints, referrals and findings to ensure records and meeting space is available. PI also makes unannounced visits for other reasons. Those visit schedules are not shared and their findings are independent. PI conducts both desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. During such reviews, PI staff will request medical records and related documents as well as conduct interviews and perform investigations. PI staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered,

medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements.

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:
Number and percent of claims that are supported by documentation that services were delivered as authorized in the persons service plan. N = number of claims reviewed that are supported by documentation that services were delivered as authorized in the persons service plan. D = number of claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SCDDSN Post Payment Claims Reviews

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%,+-5 & 50/50*

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SCDHHS Provider Compliance Reviews

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%,+-5 & 50/50*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator= Number and percent of claims that were paid at the correct rate as specified in the Waiver application. Denominator = Total number of paid claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SCDDSN Post Payment Claims Reviews

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

☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%,+-5 & 50/50*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number of HASCI waiver service rates that remain consistent with approved methodology. N = The number of HASCI rates that remain consistent with approved methodology. D = The number of HASCI waiver service rates changes.

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

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.*

SCDDSNs Internal Audit Division conducts periodic reviews of the billing systems and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with SCDHHS in a timely manner.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction 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.*

SCDDSN will conduct a post-payment claims review, including a stratified sample of service claims. Data will be reviewed quarterly for reviews conducted in the prior quarter. When there is evidence of improper payment for services, SCDDSN will provide training and technical assistance to the provider as part of their Plan of correction. Improperly billed claims will be reversed.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The SCDHHS, Department of Reimbursement Methodology and Policy, in collaboration with the SCDHHS Division of Community Options, and the SCDDSN, is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rates changes and rate setting methodology either through Medical Care Advisory Committee meetings, monthly IHS (Indian Health Services) conference calls, public hearings, or through meetings with association representatives. The SCDHHS receives contractually required annual cost report submissions from SCDDSN for the HASCI waiver services provided by the Disabilities and Special Needs Boards (38) across the state.

The costs of the Boards are initially accumulated and compiled into one consolidated report. The costs are separated by medical service/waiver service. The SCDDSN also contracts with SCDHHS for the services of ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities), TCM (Targeted Case Management), Early Intervention, Rehabilitative Behavioral Health services, as well as two other HCBS waivers. As an OHCDS, the SCDDSN uses the CMS form 2552 to distribute or step down the cost of general service and supporting cost centers to the benefitting state plan and waiver services. Utilization statistics (units of service) for the specific waiver services are accumulated by SCDDSN for the total population of users of the services and reported in the cost report.

Upon receipt of the annual report, staff of the Department of Reimbursement Methodology and Policy review the report for accuracy, reasonableness, and compliance with Medicaid/Medicare allowable cost definitions. Samples of cost and service data from individual Boards are reviewed for compliance and then traced into the applicable supporting worksheets within the consolidated cost report. Upon the completion and determination of allowable costs, the average cost per unit for each waiver service is calculated by dividing the total allowable cost per service by the total units of service for that service (i.e. for the total population of service recipients). The SCDHHS uses Medicare cost principles as reflected in the CMS Provider Reimbursement Manual (HIM-15) as our guidance for establishing allowable cost definitions for non-institutional cost reports required by SCDHHS.

Effective for services beginning on or after January 1, 2022 the SCDHHS will use the consolidated SFY 2019 cost report to rebase rates for both state plan and waiver services after ensuring that only allowable Medicaid reimbursable costs are included. The SCDHHS will also ensure compliance with the CMS approved SCDDSN central office cost allocation methodology between waiver and state plan services to ensure that no central office costs are included in the Medicaid waiver service rates as well as ensure that no direct and indirect costs relating to room and board are included in the Medicaid waiver service rates. Standard desk review procedures as previously described will be applied to the SFY 2019 cost report to assure adherence with SC Medicaid reimbursement policies relating to accuracy, reasonableness, and compliance with Medicare allowable cost definitions. After review and subsequent determination of average SFY 2019 per unit (per service) costs, a trend factor will be applied to approximate allowable Medicaid costs at the point of implementation using the midpoint to midpoint trend methodology and the use of the Medicare Economic Index. Further adjustments may be required to per unit rates in the event that material changes have been made in regards to service descriptions since June 30, 2019, as well as building in an adjustment to account for the direct care worker salary increase add-ons provided during SFY 2020 that would not be reflected in the base year cost reporting period. For rates effective July 1, 2022, an additional adjustment was made to the rates to account for a three percent (3%) COLA increase that was provided by the SC General Assembly during SFY 2023 that would not have been reflected in the base year cost reporting period. The trended rates will be further tested and evaluated against "constructed market rates" developed by an outside consultant or neighboring border states Medicaid waiver rates to ensure compliance with economic and efficient requirements. The SCDHHS has developed individual service rates that will be consistently used in all of the SCDDSN waivers during this process. The above process will be applied against waiver services provided under this waiver during SFY 2019. Any new waiver service rates that will be implemented on or after July 1, 2022 will be developed by an outside consultant via a rate modeling approach based upon the service description of each new service. This includes Independent Living Skills.

The residential habilitation rates were developed utilizing an independent rate model with components for clinical staff and supervisory salary and wages, employee related expenses, transportation and fleet vehicle expenses, and administration, program support and overhead.

Prior to July 1, 2021, the aggregate rate paid by the South Carolina Department of Health and Human Services (SCDHHS) to the South Carolina Department of Disabilities and Special Needs (SCDDSN) for HASCI Daily Residential Habilitation (DRH) services amounted to $196.99. Due to the funding received by SCDDSN from the South Carolina General Assembly during State Fiscal Year (SFY) 2022, this rate was increased to $204.78 for services provided on and after July 1, 2021. To develop the HASCI DRH service waiver rates, the SCDHHS first determined an aggregate DRH

unit cost rate based upon the SFY 2019 SCDDSN Medicaid Cost Report. During this exercise, the HASCI and ID/RD DRH service costs and units were combined to establish one aggregate unit cost for DRH services. Other adjustments were made to the SFY 2019 DRH services aggregate unit cost rate to take into account the following items: (1) an adjustment downward in order to exclude the SCDDSN central office costs; (2) an adjustment upward in order to include the last of the Direct Care Worker pass thru cost for SFY 2020 which was not reflected in the SFY 2019 Medicaid cost report and; (3) a trend rate of 7.32% was applied during the development of the SFY 2019 DRH unit cost rate in order to trend the base year unit cost (i.e. SFY 2019) to the midpoint of the payment period (i.e. calendar year 2022). Therefore, the aggregate DRH unit cost rate effective July 1, 2022 amounts to $221.99. This aggregate cost based DRH unit cost rate of $221.99 was used as a benchmark rate to test the reasonableness of the 8-tiered DRH service rate computations.

To develop the 8-tiered DRH service rates, the SCDHHS employed its contracting actuary to develop the rates. Data supplied by SCDDSN and DSN Boards were used to develop assumptions used by the actuaries to model these rates using current salary and projected worker hours required for each tier. Based upon the assumptions used to generate the 8-tiered service rates for the DRH services and based upon data supplied by SCDDSN regarding the total number of projected units per tier, the aggregate DRH unit rate of the 8-tiered service rates amounts to $226.71.

To summarize, the aggregate DHR rate based upon the 8 tiered service rates of $226.71 is 2.13% higher than the DHR rate of $221.99 based upon the use of the SFY 2019 SCDDSN Medicaid cost report trended forward to the midpoint of the calendar year 2022 rate period.

Further, the January 1, 2022 HASCI DRH tiered rates were further adjusted effective July 1, 2022 to take into account the legislatively approved three percent (3%) COLA increase granted by the SC General Assembly.

The serviced delivery model is consistent across the tiers in that all tiers include care, supervision, and skills training. The settings in which the service is provided and the type and level of supervision are proportionate to the specific needs and preferences of the person. Please see the Main B. Optional section for information on the outlier protocol.

SCDHHS and SCDDSN have executed contracts for the purchase and provision of administrative services relating to the administration of the waiver programs.

The rate narrative applies to the following services directly administered by the SCDDSN: Attendant Care (DSN Boards and UAP)*
Career Preparation Employment Services Day Activity
Respite Care (Institutional and Non-Institutional) Health Education
Peer Guidance Psychological Counseling Residential Habilitation
Specialized Medical Equipment and Supplies (manual pricing) Environmental Modifications (manual pricing)
Private Vehicle Modification (manual pricing)
Private Vehicle Assessment/Consultation (manual pricing)

Waiver case management rates (travel/without travel) were constructed based on the governmental provider's salary and fringe data, estimates of associated direct operational costs and application of an indirect rate for support costs. Productivity standards, again supplied by the governmental provider, applied against annual hours per FTE were used to develop the hourly (and billable 15 minute) rate.

The SMA reviews rates on an ongoing basis. The frequency of rebasing rates is not on any specific schedule; however, the rate review process is completed at least every five years to ensure waiver service payments are adequate to maintain an ample provider base and to ensure quality of services. It is subject to several factors, including provider requests for new rates, new data regarding the adequacy of rates, availability of funding, and, most importantly, whether the existing rate is sufficient to support an adequate network of providers. Working collaboratively alongside the waiver provider associations and committees, SMA staff (Program and Reimbursement) continually monitor and gauge the effectiveness of reimbursement rates and methodologies. Historically, annual cost report filings, comparable Medicaid service rates, and surveys of other states' waiver rates were used to validate and substantial the periodic provider group requests for updates to waiver rates. Due to changing trends in SMA rate development strategies and design as well as CMS guidance in recent years, the SMA has shifted from rate justifications based on cost report data to the construction (rate build-up) of rate models based on market salary data, associated direct operational costs and application of an indirect rate for

support costs. When trend rates are applied to provider rates during the rate setting process, the trend factor used is normally the CMS Medicare Economic Index.

Incontinence supplies for the seven waivers administered by SCDHHS are reimbursed from a fee schedule developed based on market analysis and last updated on July 11, 2011.

PERS Installation (and Monthly fee) rates are based upon prevailing market rates in South Carolina for persons receiving this service by private payment.

The rates for pest control services are based on rates established for South Carolina's Community Choices waiver. The state rate was established by taking the average of the initial and follow up rates for private pay treatments. The rate cap for pest control/bed bug services is also based on the Community Choices waiver service rate cap for the similar service.

I-2-A narrative continuation under Main (Optional).

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers maintain the option of billing directly to SCDHHS or they may voluntarily reassign their right to direct payments to the SCDDSN. Providers billing SCDHHS directly may bill either by use of a CMS 1500 form or by the DHHS's electronic billing system/webtool.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Claims for waiver services are submitted to MMIS through either the use of a CMS 1500 claim form or through the SCDHHS electronic billing system. Providers of most waiver services are given a service authorization which reflects the service identified on the service plan. This authorization form is produced by the WCM/EI provider and contains the frequency, date and type of service authorized along with a unique authorization number. Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is a special indicator in MMIS that indicates the participant is enrolled in the waiver program.

This recipient special program (RSP) indicator and Medicaid eligibility is required for payment of all waiver claims. Other waiver services are authorized simply by the presentation of the waiver participant's Medicaid card. When the Medicaid number is entered into the proper electronic system, it will identify the waiver benefit available to the individual. This is all linked to the RSP in MMIS identifying an individual as a waiver participant.

SCDHHS ensures the integrity of the Medicaid Program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds
through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with then applicable Medicaid laws, regulations, and policies.

POST PAYMENT REVIEW
The Division of Program Integrity conducts post-payment reviews of all health care provider types. These reviews sample claims and determine if services have been billed as authorized. Whenever a recoupment is identified, the Division of Program Integrity notifies the Financial Department of the SMA who reimburses CMS utilizing the "CMS 64 Summary Sheet."

Program Integrity uses several methods to identify areas for review:
• A toll-free Fraud and Abuse Hotline and the Fraud and Abuse email account for complaints of provider and beneficiary fraud and abuse.
• The automated Surveillance and Utilization Review System (SURS) which creates provider profiles and exception reports that identify excessive or aberrant billing practices.
• Referrals from other sources

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION
The Division conducts payment reviews, analysis of provider payments, and review of provider Records to determine the following:
• Medical reasonableness and necessity of the service provided
• Indications of fraud or abuse in billing the Medicaid program
• Compliance with Medicaid program coverage and payment policies
• Compliance with state and federal Medicaid laws and regulations
• Compliance with accepted medical coding conventions, procedures, and standards
• Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

The Division of Program Integrity conducts both announced and unannounced desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. During such reviews, Program Integrity staff will request medical records and related documents as well as conduct interviews and perform investigations. Program Integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements.

SANCTIONS
Sanctions including but not limited to suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:
• Allow immediate access to records
• Repay in full the identified overpayment
• Make arrangements for the repayment of identified overpayments
• Abide by repayment terms
• Make payments which are sufficient to remedy the established overpayment
Failure to provide requested records may result in one or more of the following actions by SCDHHS:
• Immediate suspension of future payments
• Denial of future claims
• Recoupment of previously paid claims

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by Program Integrity/SUR, or other grounds as determined by Program Integrity/SUR. A provider is removed from prepayment review only when determined appropriate by Program Integrity/SUR. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions.

RECOVERY AUDIT CONTRACTOR
The South Carolina Department of Health and Human Services, Division of Program Integrity, contracts with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71.

The SCDDSN Internal Audit Division periodically conducts audits of SCDDSN's billing system to ensure billing is appropriate for the service provided.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds

expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A financial management services entity contracted with SCDDSN is used to make payments for in-home services and respite delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed periodically.

For more information about billing Medicaid directly, providers/others may go to the DHHS website at https://medicaidelearning.remote-learner.net/mod/page/view.php?id=1084

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with*

efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Effective for services provided on or after April 1, 2022, SCDDSN Boards will have the ability to receive payment directly for the listing of services identified in Appendix I, I-2a.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- (●) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

SCDDSN

ii. Organized Health Care Delivery System. *Select one:*

- ( ) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- (●) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) SCDDSN operates as an organized health care delivery system (OHCDS). This system of care is comprised of SCDDSN and the local DSN County Boards and together they form an OHCDS. The OHCDS establishes contracts with other qualified providers to furnish home and community-based services to people served in this waiver. SCDDSN provides a limited set of waiver services directly, to include residential habilitation programs for individuals with a head and spinal cord injury and respite provided in ICF-IID settings. DSN County Boards contract with DDSN for provision of a range of waiver services.
(b) Providers of waiver services may direct bill their services to SCDHHS.
(c) At a minimum, waiver participants are given a choice of providers, regardless of their affiliation with the OHCDS, annually or more frequently if requested or warranted
(d) SCDDSN will assure that providers that furnish waiver services under contract with the OHCDS meet applicable provider qualifications through the states procurement process.
(e) SCDDSN assures that contracts with providers meet applicable requirements via QIO reviews of the provider, as well as periodic record reviews.
(f) SCDDSN requires its local DSN County Boards to perform annual financial audits.

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:*

Residential habilitation is provided in this waiver and costs associated with room and board are excluded from Medicaid reimbursement. Guidance is provided to residential providers to identify costs that are considered room and board and which are to be excluded from reimbursable cost. Continual monitoring and training is provided to assure that room and board costs are excluded. Through annual audits, financial testing of residential cost is performed by independent CPA firms to assure that these costs are excluded.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*49467.06*	*11553.52*	*61020.58*	*79864.41*	*3393.78*	*83258.19*	*22237.61*
2	*51514.57*	*11900.13*	*63414.70*	*81461.70*	*3495.59*	*84957.29*	*21542.59*
3	*65998.55*	*12257.13*	*78255.68*	*83090.94*	*3600.46*	*86691.40*	*8435.72*
4	*71906.09*	*12624.85*	*84530.94*	*84752.75*	*3708.47*	*88461.22*	*3930.28*
5	*75873.23*	*13003.59*	*88876.82*	*86447.81*	*3819.73*	*90267.54*	*1390.72*

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:
		Nursing Facility	ICF/IID
Year 1	1407	1347	60
Year 2	1407	1347	60
Year 3	1114	1066	48
Year 4	1051	1006	45
Year 5	1025	981	44

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.*

Year 1 - 11.14 months; 339 days
Year 2 - 11.14 months; 339 days
Year 3 - 11.14 months; 339 days
Year 4 - 11.14 months; 339 days
Year 5 - 11.14 months; 339 days

The average length of stay (ALOS) has been projected based on the currently approved waiver application. The SMA assumes the ALOS will remain consistent with data observed during SFY21 over the course of the 5-year renewal period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The expenditures for each component of the cost neutrality formula were developed based on SFY 2022 per capita expenditures trended to the appropriate waiver year.

Factor D = the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program. Factor D expenditures were developed in Appendix J-2.

The HASCI Fee Schedule for November 2022 was used to identify services, procedure codes and modifiers, and allowable reimbursement for HASCI Waiver members.

Waiver services illustrated in Appendix J-2 were aggregated based on procedure code and modifiers.

Number of Users and Average Units Per User was based on SFY 2022 data for Head and Spinal Cord Injury Waiver members and discussions with SCDHHS
trended to the appropriate waiver year. For Head and Spinal Cord Injury Waiver services with no experience during SFY 2022, we used experience from the IDRD
waiver to estimate the Number of Users and Average Units Per User.

The average cost per unit was based on the HASCI Waiver Fee Schedule. Starting in waiver year 2, the average cost per unit was trended at 3.0% per year.

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

Factor D' = the estimated annual average per capital Medicaid cost for all other services provided to individuals in the waiver program.

The State trended Factor D' at a 3% growth rate to remain consistent with recent budget trends and adjustments in other waivers

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 = the estimated annual average per capita Medicaid cost for nursing facility and ICF-IID care that would be incurred for individuals served in the waiver, were the waiver not granted.

The State trended Factor G at a 2% growth rate to remain consistent with recent budget trends and adjustments in other waivers

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' = the estimated annual average per capita Medicaid costs for all services other than those included in the factor G for individuals served in the waiver, were the waiver not granted.

The State trended Factor G' at a 3% growth rate to remain consistent with recent budget trends and adjustments in other waivers

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	
Attendant Care/Personal Assistance Services	

Waiver Services	
Career Preparation Services	
Day Activity	
Residential Habilitation	
Respite Care Services	
Waiver Case Management (WCM)	
Incontinence Supplies	
Nursing Services	
Occupational Therapy	
Physical Therapy	
Speech and Hearing Services	
Peer Guidance for Participant-Directed Care	
Behavior Support Services	
Employment Services	
Environmental Modifications	
Health Education for Participant-Directed Care	
Independent Living Skills	
Personal Emergency Response Systems	
Pest Control Bed Bugs	
Pest Control Treatment	
Private Vehicle Assessment/Consultation	
Private Vehicle Modifications	
Psychological Services	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	
Specialized Medical Equipment, Supplies and Assistive Technology	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						45733774.47
DSN Board	Per Hour	7	413.67	25.00	72392.25	
Self Directed	Per Hour	237	1572.56	17.92	6678725.22	
Agency					38982657.00	

GRAND TOTAL: 69600154.42

Total Estimated Unduplicated Participants: 1407

Factor D (Divide total by number of participants): 49467.06

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Hour	876	1780.03	25.00		
Career Preparation Services Total:						**455335.04**
Career Preparation Services	Per 1/2 Day	53	224.08	38.34	**455335.04**	
Day Activity Total:						**588232.22**
Day Activity	Per 1/2 Day	62	247.46	38.34	**588232.22**	
Residential Habilitation Total:						**9958566.00**
Daily Residential	Per Day	177	164.58	341.42	**9945789.94**	
Hourly Residential	Per Hour	1	164.64	77.60	**12776.06**	
Respite Care Services Total:						**4275351.22**
Institutional NF/Hospital Based	Per Day	1	26.00	120.00	**3120.00**	
Respite In-home	Per 15 Min	301	2226.48	6.25	**4188565.50**	
Respite In-home (Group of 2)	Per 15 Min	1	2226.00	2.63	**5854.38**	
Respite In-home (Group of 3)	Per 15 Min	1	2226.00	1.68	**3739.68**	
Institutional ICF/IID Based	Per Day	5	52.88	280.15	**74071.66**	
Waiver Case Management (WCM) Total:						**1906904.08**
Transitional Waiver Case Management - With Travel	Per15 Min	32	1.00	141.60	**4531.20**	
Waiver Case Management - With Travel	Per 15 Min	935	17.21	28.32	**455707.03**	
Transitional Waiver Case Management - Without Travel	Per 15 Min	1	1.00	87.05	**87.05**	
Waiver Case Management - Without Travel	Per 15 Min	1312	63.33	17.41	**1446578.79**	
Incontinence Supplies Total:						**1029929.48**
Incontinence Supplies	Per Claim	1322	214.03	3.64	**1029929.48**	
Nursing Services Total:						**3196856.04**
Nursing Services	Per Hour	98	776.69	42.00	**3196856.04**	
Occupational Therapy						**46472.24**

GRAND TOTAL: 69600154.42

Total Estimated Unduplicated Participants: 1407

Factor D (Divide total by number of participants): 49467.06

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Occupational Therapy	Per Service	178	17.12	15.25	46472.24	
Physical Therapy Total:						21329.28
Physical Therapy	Per Service	96	14.00	15.87	21329.28	
Speech and Hearing Services Total:						7802.77
Speech and Hearing Services	Per Service	22	17.42	20.36	7802.77	
Peer Guidance for Participant-Directed Care Total:						12108.91
Peer Guidance for Participant-Directed Care	Per Hour	53	11.00	20.77	12108.91	
Behavior Support Services Total:						2983.52
Behavior Support Services	Per 30 Min	1	95.81	31.14	2983.52	
Employment Services Total:						87499.64
Employment Services (Group)	Per 1/2 Day	8	181.47	38.34	55660.48	
Employment Services (Individual)	Per Hour	24	12.91	102.76	31839.16	
Environmental Modifications Total:						419544.32
Environmental Modifications	Per Mod	39	1.49	7219.83	419544.32	
Health Education for Participant-Directed Care Total:						95473.25
Health Education for Consumer Directed Care	Per Hour	7	656.67	20.77	95473.25	
Independent Living Skills Total:						1172.67
Independent Living Skills	Per 15 Min	1	133.41	8.79	1172.67	
Personal Emergency Response Systems Total:						96877.20
Recurring Maintenance	Per Month	304	10.56	30.00	96307.20	
Initial Installation	Per Item	19	1.00	30.00	570.00	
Pest Control Bed Bugs Total:						21000.00
Pest Control Bed Bugs	1 x Year	21	1.00	1000.00	21000.00	

GRAND TOTAL: 69600154.42

Total Estimated Unduplicated Participants: 1407

Factor D (Divide total by number of participants): 49467.06

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pest Control Treatment Total:						**92228.85**
Pest Control Treatment	6 x Year	437	4.69	45.00	**92228.85**	
Private Vehicle Assessment/Consultation Total:						**2400.00**
Private Vehicle Assessment/Consultation	Per Assessment	4	1.00	600.00	**2400.00**	
Private Vehicle Modifications Total:						**217440.19**
Private Vehicle Modifications	Per Mod	24	1.21	7487.61	**217440.19**	
Psychological Services Total:						**41928.87**
Counseling/Mental Health Services	Per 30 Min	4	137.05	33.49	**18359.22**	
Drug/Alcohol Counseling	Per Hour	13	45.00	40.29	**23569.65**	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						**300.00**
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per Assessment	1	1.00	300.00	**300.00**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**1288644.16**
Specialized Equipment	Per Claim	285	1.89	1425.10	**767630.12**	
Specialized Supplies	Per Claim	424	34.43	35.69	**521014.04**	

GRAND TOTAL: 69600154.42

Total Estimated Unduplicated Participants: 1407

Factor D (Divide total by number of participants): 49467.06

Average Length of Stay on the Waiver: 339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						**47106682.18**
DSN Board	Per Hour	7	413.67	25.75	**74564.02**	
Self Directed	Per Hour	237	1572.56	18.46	**6879981.45**	
Agency	Per Hour	876	1780.03	25.75	**40152136.71**	
Career Preparation Services Total:						**468992.72**
Career Preparation Services	Per 1/2 Day	53	224.08	39.49	**468992.72**	
Day Activity Total:						**605876.11**
Day Activity	Per 1/2 Day	62	247.46	39.49	**605876.11**	
Residential Habilitation Total:						**10257247.57**
Daily Residential	Per Day	177	164.58	351.66	**10244087.90**	
Hourly Residential	Per Hour	1	164.64	79.93	**13159.68**	
Respite Care Services Total:						**4405287.55**
Institutional NF/Hospital Based	Per Day	1	26.00	123.60	**3213.60**	
Respite In-home	Per 15 Min	301	2226.48	6.44	**4315897.89**	
Respite In-home (Group of 2)	Per 15 Min	1	2226.00	2.71	**6032.46**	
Respite In-home (Group of 3)	Per 15 Min	1	2226.00	1.73	**3850.98**	
Institutional ICF/IID Based	Per Day	5	52.88	288.55	**76292.62**	
Waiver Case Management (WCM) Total:						**1963926.59**
Transitional Waiver Case Management - With Travel	Per Claim	32	1.00	145.85	**4667.20**	
Waiver Case Management - With Travel	Per 15 Min	935	17.21	29.17	**469384.68**	
Transitional Waiver Case Management - Without Travel	Per Claim	1	1.00	89.66	**89.66**	
Waiver Case Management - Without Travel	Per 15 Min	1312	63.33	17.93	**1489785.05**	
Incontinence Supplies Total:						**1061053.73**

GRAND TOTAL: 72481005.74

Total Estimated Unduplicated Participants: 1407

Factor D (Divide total by number of participants): 51514.57

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Incontinence Supplies	Per Claim	1322	214.03	3.75	1061053.72	
Nursing Services Total:						3292761.72
Nursing Services	Per Hour	98	776.69	43.26	3292761.72	
Occupational Therapy Total:						47874.03
Occupational Therapy	Per Service	178	17.12	15.71	47874.03	
Physical Therapy Total:						21960.96
Physical Therapy	Per Service	96	14.00	16.34	21960.96	
Speech and Hearing Services Total:						8036.54
Speech and Hearing Services	Per Service	22	17.42	20.97	8036.54	
Peer Guidance for Participant-Directed Care Total:						12470.37
Peer Guidance for Participant-Directed Care	Per Hour	53	11.00	21.39	12470.37	
Behavior Support Services Total:						3072.63
Behavior Support Services	Per 30 min	1	95.81	32.07	3072.63	
Employment Services Total:						90123.47
Employment Services (Group)	Per 1/2 Day	8	181.47	39.49	57330.00	
Employment Services (Individual)	Per Hour	24	12.91	105.84	32793.47	
Environmental Modifications Total:						432130.37
Environmental Modifications	Per Item	39	1.49	7436.42	432130.37	
Health Education for Participant-Directed Care Total:						98323.20
Health Education for Consumer Directed Care	Per Hour	7	656.67	21.39	98323.20	
Independent Living Skills Total:						1207.36
Independent Living Skills	Per 15 min	1	133.41	9.05	1207.36	
Personal Emergency Response Systems Total:						99783.52
Recurring Maintenance					99196.42	

GRAND TOTAL: 72481005.74

Total Estimated Unduplicated Participants: 1407

Factor D (Divide total by number of participants): 51514.57

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Month	304	10.56	30.90		
Initial Installation	Per Item	19	1.00	30.90	587.10	
Pest Control Bed Bugs Total:						21630.00
Pest Control Bed Bugs	1 x Year	21	1.00	1030.00	21630.00	
Pest Control Treatment Total:						94995.72
Pest Control Treatment	6 x Year	437	4.69	46.35	94995.72	
Private Vehicle Assessment/Consultation Total:						2472.00
Private Vehicle Assessment/Consultation	Per Assessment	4	1.00	618.00	2472.00	
Private Vehicle Modifications Total:						223963.45
Private Vehicle Modifications	Per Mod	24	1.21	7712.24	223963.45	
Psychological Services Total:						43184.92
Counseling/Mental Health Services	Per Hour	4	137.05	34.49	18907.42	
Drug/Alcohol Counseling	Per Hour	13	45.00	41.50	24277.50	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						790657.40
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per Assessment	285	1.89	1467.85	790657.40	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						1327291.65
Specialized Equipment	Per Item	285	1.89	1467.85	790657.40	
Specialized Supplies	Per Claim	424	34.43	36.76	536634.24	

GRAND TOTAL: 72481005.74

Total Estimated Unduplicated Participants: 1407

Factor D (Divide total by number of participants): 51514.57

Average Length of Stay on the Waiver: 339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Attendant Care/Personal Assistance Services Total:						***48514560.89***
DSN Board	*Per Hour*	*7*	*413.67*	*26.52*	***76793.70***	
Self Directed	*Per Hour*	*237*	*1572.56*	*19.01*	***7084964.65***	
Agency	*Per Hour*	*876*	*1780.03*	*26.52*	***41352802.55***	
Career Preparation Services Total:						***483006.68***
Career Preparation Services	*Per 1/2 Day*	*53*	*224.08*	*40.67*	***483006.68***	
Day Activity Total:						***623980.29***
Day Activity	*Per 1/2 Day*	*62*	*247.46*	*40.67*	***623980.29***	
Residential Habilitation Total:						***10564971.17***
Daily Residential	*Per Day*	*177*	*164.58*	*362.21*	***10551416.36***	
Hourly Residential	*Per Hour*	*1*	*164.64*	*82.33*	***13554.81***	
Respite Care Services Total:						***4535295.49***
Institutional NF/Hospital Based	*Per Day*	*1*	*26.00*	*127.31*	***3310.06***	
Respite In-home	*Per 15 Min*	*301*	*2226.48*	*6.63*	***4443230.28***	
Respite In-home (Group of 2)	*Per 15 Min*	*1*	*2226.00*	*2.79*	***6210.54***	
Respite In-home (Group of 3)	*Per 15 Min*	*1*	*2226.00*	*1.78*	***3962.28***	
Institutional ICF/IID Based	*Per Day*	*5*	*52.88*	*297.21*	***78582.32***	
Waiver Case Management (WCM) Total:						***1883875.95***
Transitional Waiver Case Management - With Travel	*Per Claim*	*32*	*1.00*	*150.22*	***4807.04***	
Waiver Case Management - With Travel	*Per 15 Min*	*1114*	*17.21*	*30.04*	***575925.08***	
Transitional Waiver Case Management - Without Travel	*Per Claim*	*1*	*1.00*	*92.35*	***92.35***	

GRAND TOTAL: 73522388.66

Total Estimated Unduplicated Participants: 1114

Factor D (Divide total by number of participants): 65998.55

Average Length of Stay on the Waiver: *339*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Case Management - Without Travel	Per 15 Min	1114	63.33	18.47	1303051.48	
Incontinence Supplies Total:						920337.56
Incontinence Supplies	Per Claim	1114	214.03	3.86	920337.56	
Nursing Services Total:						3391712.03
Nursing Services	Per Hour	98	776.69	44.56	3391712.03	
Occupational Therapy Total:						49306.28
Occupational Therapy	Per Service	178	17.12	16.18	49306.28	
Physical Therapy Total:						22619.52
Physical Therapy	Per Service	96	14.00	16.83	22619.52	
Speech and Hearing Services Total:						8277.98
Speech and Hearing Services	Per Service	22	17.42	21.60	8277.98	
Peer Guidance for Participant-Directed Care Total:						12843.49
Peer Guidance for Participant-Directed Care	Per Hour	53	11.00	22.03	12843.49	
Behavior Support Services Total:						3165.56
Behavior Support Services	Per 30 Min	1	95.81	33.04	3165.56	
Employment Services Total:						92821.84
Employment Services (Group)	Per 1/2 Day	8	181.47	40.67	59043.08	
Employment Services (Individual)	Per Hour	24	12.91	109.02	33778.76	
Environmental Modifications Total:						445094.71
Environmental Modifications	Per Mod	39	1.49	7659.52	445094.71	
Health Education for Participant-Directed Care Total:						101265.08
Health Education for Consumer Directed Care	Per Hour	7	656.67	22.03	101265.08	
Independent Living Skills Total:						1244.72
Independent Living					1244.72	

GRAND TOTAL: 73522388.66

Total Estimated Unduplicated Participants: 1114

Factor D (Divide total by number of participants): 65998.55

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skills	15 Min	1	133.41	9.33		
Personal Emergency Response Systems Total:						**102786.71**
Recurring Maintenance	Per Month	304	10.56	31.83	**102181.94**	
Initial Installation	Per Item	19	1.00	31.83	**604.77**	
Pest Control Bed Bugs Total:						**22278.90**
Pest Control Bed Bugs	1 x Year	21	1.00	1060.90	**22278.90**	
Pest Control Treatment Total:						**97844.56**
Pest Control Treatment	6 x Year	437	4.69	47.74	**97844.56**	
Private Vehicle Assessment/Consultation Total:						**2546.16**
Private Vehicle Assessment/Consultation	Per Assessment	4	1.00	636.54	**2546.16**	
Private Vehicle Modifications Total:						**230682.43**
Private Vehicle Modifications	Per Mod	24	1.21	7943.61	**230682.43**	
Psychological Services Total:						**44480.45**
Counseling/Mental Health Services	Per 30 Min	4	137.05	35.53	**19477.55**	
Drug/Alcohol Counseling	Per Hour	13	45.00	42.74	**25002.90**	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						**318.27**
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per Assessment	1	1.00	318.27	**318.27**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**1367071.94**
Specialized Equipment	Per Item	285	1.89	1511.89	**814379.55**	
Specialized Supplies	Per Claim	424	34.43	37.86	**552692.40**	

GRAND TOTAL: 73522388.66

Total Estimated Unduplicated Participants: 1114

Factor D (Divide total by number of participants): 65998.55

Average Length of Stay on the Waiver: 339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Attendant Care/Personal Assistance Services Total:						***49976759.60***
DSN Board	*Per Hour*	*7*	*413.67*	*27.32*	***79110.25***	
Self Directed	*Per Hour*	*237*	*1572.56*	*19.58*	***7297401.78***	
Agency	*Per Hour*	*876*	*1780.03*	*27.32*	***42600247.57***	
Career Preparation Services Total:						***497614.46***
Career Preparation Services	*Per 1/2 Day*	*53*	*224.08*	*41.90*	***497614.46***	
Day Activity Total:						***642851.59***
Day Activity	*Per 1/2 Day*	*62*	*247.46*	*41.90*	***642851.59***	
Residential Habilitation Total:						***10882028.10***
Daily Residential	*Per Day*	*177*	*164.58*	*373.08*	***10868066.63***	
Hourly Residential	*Per Hour*	*1*	*164.64*	*84.80*	***13961.47***	
Respite Care Services Total:						***4672098.99***
Institutional NF/Hospital Based	*Per Day*	*1*	*26.00*	*131.13*	***3409.38***	
Respite In-home	*Per 15 Min*	*301*	*2226.48*	*6.83*	***4577264.38***	
Respite In-home (Group of 2)	*Per 15 Min*	*1*	*2226.00*	*2.87*	***6388.62***	
Respite In-home (Group of 3)	*Per 15 Min*	*1*	*2226.00*	*1.84*	***4095.84***	
Institutional ICF/IID Based	*Per Day*	*5*	*52.88*	*306.13*	***80940.77***	
Waiver Case Management (WCM) Total:						***1830829.07***
Transitional Waiver Case Management - With Travel	*Per 15 Min*	*32*	*1.00*	*154.73*	***4951.36***	
Waiver Case Management - With	*Per 15 Min*				***559814.62***	

GRAND TOTAL: ***75573300.35***

Total Estimated Unduplicated Participants: ***1051***

Factor D (Divide total by number of participants): ***71906.09***

Average Length of Stay on the Waiver: *339*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Travel		1051	17.21	30.95		
Transitional Waiver Case Management - Without Travel	Per 15 Min	1	1.00	95.12	95.12	
Waiver Case Management - Without Travel	Per 15 Min	1051	63.33	19.02	1265967.97	
Incontinence Supplies Total:						895283.21
Incontinence Supplies	Per Claim	1051	214.03	3.98	895283.21	
Nursing Services Total:						3492945.80
Nursing Services	Per Hour	98	776.69	45.89	3492945.80	
Occupational Therapy Total:						50769.02
Occupational Therapy	Per Service	178	17.12	16.66	50769.02	
Physical Therapy Total:						23304.96
Physical Therapy	Per Service	96	14.00	17.34	23304.96	
Speech and Hearing Services Total:						8527.09
Speech and Hearing Services	Per Service	22	17.42	22.25	8527.09	
Peer Guidance for Participant-Directed Care Total:						13234.10
Peer Guidance for Participant-Directed Care	Per Hour	53	11.00	22.70	13234.10	
Behavior Support Services Total:						3260.41
Behavior Support Services	Per 30 Min	1	95.81	34.03	3260.41	
Employment Services Total:						95620.68
Employment Services (Group)	Per 1/2 Day	8	181.47	41.90	60828.74	
Employment Services (Individual)	Per Hour	24	12.91	112.29	34791.93	
Environmental Modifications Total:						458447.22
Environmental Modifications	Per Mod	39	1.49	7889.30	458447.22	
Health Education for Participant-Directed Care Total:						104344.86
Health Education for					104344.86	

GRAND TOTAL: 75573300.35

Total Estimated Unduplicated Participants: 1051

Factor D (Divide total by number of participants): 71906.09

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Directed Care	Per Hour	7	656.67	22.70		
Independent Living Skills Total:						**1282.07**
Independent Living Skills	Per 15 Min	1	133.41	9.61	**1282.07**	
Personal Emergency Response Systems Total:						**105854.49**
Recurring Maintenance	Per Month	304	10.56	32.78	**105231.67**	
Initial Installation	Per Item	19	1.00	32.78	**622.82**	
Pest Control Bed Bugs Total:						**22947.33**
Pest Control Bed Bugs	1 x Year	21	1.00	1092.73	**22947.33**	
Pest Control Treatment Total:						**100775.39**
Pest Control Treatment	6 x Year	437	4.69	49.17	**100775.39**	
Private Vehicle Assessment/Consultation Total:						**2622.56**
Private Vehicle Assessment/Consultation	Per Assessment	4	1.00	655.64	**2622.56**	
Private Vehicle Modifications Total:						**237602.67**
Private Vehicle Modifications	Per Mod	24	1.21	8181.91	**237602.67**	
Psychological Services Total:						**45821.67**
Counseling/Mental Health Services	Per 30 Min	4	137.05	36.60	**20064.12**	
Drug/Alcohol Counseling	Per Hour	13	45.00	44.03	**25757.55**	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						**327.82**
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per Item	1	1.00	327.82	**327.82**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**1408147.19**
Specialized Equipment	Per Claim	285	1.89	1557.25	**838812.71**	
Specialized Supplies	Per Claim	424	34.43	39.00	**569334.48**	

GRAND TOTAL: 75573300.35

Total Estimated Unduplicated Participants: 1051

Factor D (Divide total by number of participants): 71906.09

Average Length of Stay on the Waiver: 339

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						**51477656.28**
DSN Board	Per Hour	7	413.67	28.14	**81484.72**	
Self Directed	Per Hour	237	1572.56	20.17	**7517292.84**	
Agency	Per Hour	876	1780.03	28.14	**43878878.72**	
Career Preparation Services Total:						**512459.76**
Career Preparation Services	Per 1/2 Day	53	224.08	43.15	**512459.76**	
Day Activity Total:						**662029.74**
Day Activity	Per 1/2 Day	62	247.46	43.15	**662029.74**	
Residential Habilitation Total:						**11208418.38**
Daily Residential	Per Day	177	164.58	384.27	**11194038.72**	
Hourly Residential	Per Hour	1	164.64	87.34	**14379.66**	
Respite Care Services Total:						**4808974.10**
Institutional NF/Hospital Based	Per Day	1	26.00	135.06	**3511.56**	
Respite In-home	Per 15 mins	301	2226.48	7.03	**4711298.47**	
Respite In-home (Group of 2)	Per 15 mins	1	2226.00	2.96	**6588.96**	
Respite In-home (Group of 3)	Per 15 mins	1	2226.00	1.89	**4207.14**	
Institutional ICF/IID Based	Per Day	5	52.88	315.31	**83367.96**	
Waiver Case Management (WCM) Total:						**1839692.29**

GRAND TOTAL: 77770060.85

Total Estimated Unduplicated Participants: 1025

Factor D (Divide total by number of participants): 75873.23

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional Waiver Case Management - With Travel	Per 15 Min	32	1.00	159.37	5099.84	
Waiver Case Management - With Travel	Per 15 Min	1025	17.21	31.87	562194.77	
Transitional Waiver Case Management - Without Travel	Per 15 Min	1	1.00	97.98	97.98	
Waiver Case Management - Without Travel	Per 15 Min	1025	63.33	19.60	1272299.70	
Incontinence Supplies Total:						899461.07
Incontinence Supplies	Per Claim	1025	214.03	4.10	899461.08	
Nursing Services Total:						3597985.36
Nursing Services	Per Hour	98	776.69	47.27	3597985.36	
Occupational Therapy Total:						52292.70
Occupational Therapy	Per Service	178	17.12	17.16	52292.70	
Physical Therapy Total:						24003.84
Physical Therapy	Per Service	96	14.00	17.86	24003.84	
Speech and Hearing Services Total:						8783.86
Speech and Hearing Services	Per Service	22	17.42	22.92	8783.86	
Peer Guidance for Participant-Directed Care Total:						13630.54
Peer Guidance for Participant-Directed Care	Per Hour	53	11.00	23.38	13630.54	
Behavior Support Services Total:						3358.14
Behavior Support Services	Per 30 Min	1	95.81	35.05	3358.14	
Employment Services Total:						98479.54
Employment Services (Group)	Per 1/2 Day	8	181.47	43.15	62643.44	
Employment Services (Individual)	Per Hour	24	12.91	115.66	35836.09	
Environmental Modifications Total:						472200.70
Environmental Modifications	Per Mod	39	1.49	8125.98	472200.70	

GRAND TOTAL: 77770060.85

Total Estimated Unduplicated Participants: 1025

Factor D (Divide total by number of participants): 75873.23

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Health Education for Participant-Directed Care Total:						**107470.61**
Health Education for Consumer Directed Care	Per Hour	7	656.67	23.38	**107470.61**	
Independent Living Skills Total:						**1319.42**
Independent Living Skills	Per 15 Min	1	133.41	9.89	**1319.42**	
Personal Emergency Response Systems Total:						**109051.43**
Recurring Maintenance	Per Month	304	10.56	33.77	**108409.80**	
Initial Installation	Per Item	19	1.00	33.77	**641.63**	
Pest Control Bed Bugs Total:						**23635.71**
Pest Control Bed Bugs	1 x Year	21	1.00	1125.51	**23635.71**	
Pest Control Treatment Total:						**103808.69**
Pest Control Treatment	6 x Year	437	4.69	50.65	**103808.69**	
Private Vehicle Assessment/Consultation Total:						**2701.24**
Private Vehicle Assessment/Consultation	Per Assessment	4	1.00	675.31	**2701.24**	
Private Vehicle Modifications Total:						**244730.82**
Private Vehicle Modifications	Per Mod	24	1.21	8427.37	**244730.82**	
Psychological Services Total:						**47191.41**
Counseling/Mental Health Services	Per 30 Min	4	137.05	37.69	**20661.66**	
Drug/Alcohol Counseling	Per Hour	13	45.00	45.35	**26529.75**	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						**337.65**
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per Item	1	1.00	337.65	**337.65**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**1450387.57**
Specialized Equipment					**863973.05**	

GRAND TOTAL: 77770060.85

Total Estimated Unduplicated Participants: 1025

Factor D (Divide total by number of participants): 75873.23

Average Length of Stay on the Waiver: 339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Claim	285	1.89	1603.96		
Specialized Supplies	Per Claim	424	34.43	40.17	586414.51	

GRAND TOTAL: 77770060.85

Total Estimated Unduplicated Participants: 1025

Factor D (Divide total by number of participants): 75873.23

Average Length of Stay on the Waiver: 339