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:
Intellectual Disability/Related Disabilities Waiver (ID/RD)

C. Waiver Number:SC.0237
Original Base Waiver Number: SC.0237.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
11/01/25
Approved Effective Date of Waiver being Amended: 01/01/22

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. Added point in time count 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 Administration**	

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

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☒ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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*):

Intellectual Disability/Related Disabilities Waiver (ID/RD)

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.0237
Draft ID: SC.014.06.06

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/22
Approved Effective Date of Waiver being Amended: 01/01/22

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.

South Carolina is seeking to renew the Intellectual Disability/Related Disabilities Waiver (ID/RD). This waiver will serve people with intellectual disabilities and related disabilities who meet the ICF-IID level of care criteria. The services offered in this waiver are meant to prevent and/or delay institutionalization. This waiver reflects the State's commitment to offer viable community options to institutional placement.

Administrative authority for this waiver is retained by the South Carolina Department of Health and Human Services (SCDHHS). The South Carolina Department of Disabilities and Special Needs (SCDDSN) will perform waiver operations under service contracts and an administrative contract with SCDHHS. SCDDSN has the operational responsibility for ensuring that participants are aware of their options under this waiver. SCDDSN utilizes both county Disabilities and Special Need Boards and private providers as waiver service providers. Services in this waiver are provided at the local level through a fee for service service delivery system.

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:

A summary of the amendment was presented to the Medical Care Advisory Committee (MCAC): May 24,2024 and to the Indian Health Organization: December 13, 2023. SCDHHS hosted two public webinars on June 10, 2024, and June 12, 2024.The public was provided the proposed information prior to the meetings and the document was posted online for public viewing and comment.

Copies of the proposed waiver amendment document were available for public review at:
SCDHHS front lobby at 1801 Main Street, Columbia, S.C.
All Healthy Connections Medicaid Community Long Term Care Area Offices, SCDHHS website: https://www.scdhhs.gov/public-notices.

South Carolina Department of Disabilities and Special Needs website: www.ddsn.sc.gov
Family Connection SC website: www.familyconnectionsc.org
South Carolina Developmental Disabilities Council website: www.scddc.state.sc.us
SCDHHS Website: https://www.scdhhs.gov/service/waiver-management-field-management

The public was be provided the opportunity to submit comments through the mail at SCDHHS Office of Waiver and Facility Services, P.O. Box 8206 Columbia, S.C. 29202-8206 and electronically to comments@scdhhs.gov.

Public comments are provided below.
1.How do we sign up for this caregiver training? A client has to be assessed to need the behavior supports waiver service before the caregiver coaching service can be accessed.
2. I appreciate the state offering a new service like this, it seems like a good additional service for caregivers who need extra support to help care for their loved ones.
3. When you say behavior support, do you mean ABA therapy? No. Behavior support is an ID/RD waiver service. ABA therapy is offered through Medicaid State Plan.
4. Who will determine if we can access the new service? The case manager will assess the client to see if there is a need for behavior supports. If needed, the case manager will provide information to the caregiver.
5. Just go to DSS office and inquire about this service?… Caregiver coaching is available only through SCDHHS/SCDDSN.
6. Is the coaching in person or virtual? Service delivery may be virtual or in person.
7. Once coaching is approved, how soon can we expect to get started? If approved by CMS, on or after 10/1/24.
8. Is it expected that the proposed amendment (adding support services) will increase the wait times for people to receive waiver? The implementation of caregiver coaching will not have any impact on the waiver waitlist.
9. Will behavioral coaching be a required service or optional? Caregiver coaching is an optional service.
10.As far as Foster Care, would the social worker send a referral to get the waiver signed. How does that work? Caregiver coaching is an IDRD waiver service, therefore a referral from a social worker is not needed.
11.Are we filling out an application to acquire the coaching services or are we waiting for our case manager to contact us to offer? The case manager will assess the client first to see if there is a need for the behavior support waiver service. If needed, the caregiver will then be able to access the caregiver coaching service.
12.Can you please explain this in much more detail, exactly what the new offering is? Per the waiver document, “In an effort to provide a support system to caregivers who are caring for family members with challenging behaviors, Caregiver coaching services may be provided. The purpose of caregiver coaching is to enable the health, safety, well-being and continued community integration of waiver participants by equipping family caregivers with the skills and resources necessary to manage the participants’ chronic medical condition(s) and associated behavioral needs at home. This service is not provided directly to waiver participants, but to their family caregiver(s). The waiver participant does not have to be actively receiving behavioral services in order for the family caregivers to receive caregiver coaching.” After the review of public comments, the definition has been modified.
13.What are the qualifications for becoming a caregiver coach, who can provide the service? Per the waiver document, providers must have the National Committee for Quality Assurance Accreditation of Case Management.
14.Will this training be provided to those providing respite and PCA in the home as many of us caregivers have undergone significant parent training since our children were born yet need our staff within the home providing PCA to be able to support our child’s behavior as well. Caregiver coaching is only provided to those clients assessed to need the Behavior Supports service not those assessed to need respite or PCA. The caregiver coaching service is only offered to the parent or caregiver of the person needing behavior supports, it is not offered to any paid caregivers.
15. Is this addition to the waiver accepted at a therapist session? Please elaborate. My adult son goes to therapy. Will

the waiver pay for this service? The caregiver coaching service is not a therapy; it is not for the client it is for the caregiver. Therefore, it will not pay for mental health services.
16. Can you describe what the coaching service will look like? How will it be executed in the home for family members? At a minimum caregiver coaching will be delivered telephonically. There may be other service delivery models but at minimum the service will be delivered telephonically.

Public comments cont'd in Main B, Optional.

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: Chorey

First Name: Jacob

Title: Program Manager II

Agency: SC Department of Health and Human Services

Address: PO Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202

Phone: (803) 898-2699 **Ext:** ☐ **TTY**

Fax: (803) 255-8204

E-mail: Jacob.Chorey@scdhhs.gov

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

Last Name: Ritter

First Name: Melissa

Title: Director of Special Serevices

Agency: SC Department of Disabilities and Special Needs

Address: 400 Otarre Parkway

Address 2:

City: Cayce

State: **South Carolina**

Zip: 29033

Phone: (803) 898-5120 **Ext:** ☐ **TTY**

Fax: (803) 898-9660

E-mail: mritter@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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: South Carolina

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

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:

The number of participants served at any point in time will be determined based on state legislative appropriation. Because the point in time number is less than the number of participants currently enrolled in the waiver, the SMA intends to reach this number over time through attrition resulting from waiver disenrollments. This will ensure that the change will not adversely impact those currently enrolled in the program.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Public comment cont'd.

17. Please elaborate how the service will be delivered telephonically. What exactly will the coach be doing? The service will be provided telephonically. The service is highly individualized and generally, coaches are required to conduct a structured assessment to identify the strengths and needs. It will allow the caregiver to self-care and to mitigate the risk of burnout to help better care for clients with behavioral health issues. The service is highly individualized for the family and their associated needs.

18. How is this different from the Behavior Supports Service that needs to be provided by a BCBA but it is very difficult to find one to provide these services. Behavior Support is for the client and caregiver coaching is for the caregiver. The services are similar, but the client does not necessarily need to be receiving the Behavior Support service in order for the caregiver to receive the caregiver coaching service. The client just needs to be assessed to need the service.
19. What type of assessment tool will be used to assess the caregiver? The assessment tool will vary dependent on the provider. The tool essentially will be used to identify strengths and weaknesses of the caregivers and to highlight self-care strategies.
20. I have a question about environmental modifications. May I have your email to ask questions when this is over? My email address is Michelle.Abney@scdhhs.gov.
21. Will caregivers be able to receive in-person training also if telephonically is not a good fit? At minimum the service required to be delivered telephonically, we are not limiting providers if in-person training is desired, it may be offered by the provider.
22. Realize all cases are different, but can you provide an example of how this support can help a caregiver and their family? Services are highly individualized. The coach will work with the caregiver to identify strengths and weaknesses, identify behaviors that trigger the waiver participant and establish strategies to mitigate the risk of stress and burnout.
23. How does an agency become a caregiver coaching provider? After the provider has acquired the required certification, they must be qualified through DDSN. Once qualified through SCDDSN they may apply to enroll with SCDHHS.
24. Will the case managers be professionally trained to provide this service to the caregivers? The case manager will not provide caregiver coaching to the caregiver. The case managers will work with the coaches and the coaches will be trained to provide caregiver coaching to the caregiver.

Appendix I: Financial Accountability - I-2: Rates, Billing and Claims (con't)

a. Rate Determination Methods.

The rate for caregiver coaching was established using an Independent Rate Model (IRM). The IRM uses a “ground-up” approach to develop rates based on a sum of independently determined rate inputs and components. The SMA used the independent rate model build-up for caregiver coaching established in another state as a starting point to develop base assumptions. The SMA then made specific adjustments based on knowledge and background of similar services in South Carolina:

- Wage inputs are based on May 2022 Bureau of Labor Statistics (BLS) data for South Carolina, trended to October 2024 based on Federal Reserve Economic Data;
- Employee related expenses, such as State Unemployment Insurance, Workers’ Compensation, health insurance, and retirement, are based on information provided by the SMA for the rate build-up of residential habilitation services;
- Paid holidays and PTO per year assumptions are based on information provided by the SMA for the rate build-up of residential habilitation services.

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 SC Department of Disabilities and Special Needs (SCDDSN)

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 ID/RD 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
• Appendices

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
• Appendices

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.

The following describes the roles of each entity:

-CMS Approved QIO: Conducts validation reviews of a representative sample of initial level of care determinations performed by SCDDSN. Reports are produced and shared with SCDDSN, who 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.:*

SCDDSN contracts with a CMS-certified QIO for oversight and review of waiver services and providers participating in this waiver.

SCDDSN contracts with local Disabilities and Special Needs (DSN) Board providers and approved qualified providers. Waiver case managers and early intervention staff prepare the Plans of Service and complete reevaluations of ICF/IID levels of care.

SCDDSN contracts with a FMS to operate as the fiscal agent for Respite, Adult Attendant Care, and In-Home Supports.

SCDHHS contracts with a CMS-certified QIO to validate a representative sample of ICF/IID level of care determinations made by SCDDSN.

SCDHHS contracts with an independent entity to periodically perform focused evaluations, validation reviews and trend analysis.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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
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	☒	☒	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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	Frequency of data	Sampling Approach*(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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):*

Performance Measure:
Policy changes related to the ID/RD 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:

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**

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 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)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☒	**Intellectual Disability**	0		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Related Disability as defined by Section 44-20-30 of the South Carolina State Code of Laws and 42 CFR 435.1009, as amended by 42 CFR 435.1010.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver

participants. Complete Items B-2-b and B-2-c.

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

At the time of waiver enrollment the individual/family is informed that the waiver, apart from Residential Habilitation, is not a source of 24 hour care, advised of any waiver service limits noted in Appendix C, and makes an informed decision as to whether the waiver is the appropriate form of long term care services. Any participant denied admission to the waiver due to expected high costs is given the opportunity to appeal this denial.

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:

To avoid an adverse impact on the participant, services in the excess of the individual cost limit may be authorized if approved by SCDHHS. The State will assure that, in the aggregate, the cost of this waiver will not exceed the cost of care in an ICF/IID. If the individual's health remains unstable, and/or the waiver is unable to meet the newly assessed needs, the participant will receive assistance with transitioning to another form of long term care, and will receive reconsideration and fair hearing rights.

☐ **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	13630
Year 2	13630
Year 3	13630
Year 4	13630
Year 5	13630

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	13230
Year 2	13230
Year 3	13230
Year 4	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	8000
Year 5	8000

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/IID	
New Housing Participants	
Military	
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/IID

Purpose *(describe):*

Individuals discharged from ICF/IID

Describe how the amount of reserved capacity was determined:

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

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	25
Year 4	25
Year 5	25

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 South Carolina Department of Disabilities and Special Needs 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	25
Year 2	25
Year 3	25
Year 4	90
Year 5	90

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):*

Military

Purpose *(describe):*

Eligible family members of a member of the armed services who maintains a South Carolina residence, regardless of where the service member is stationed, will maintain waiver status. A family member on the waiting list would return to the same place on the waiting list when the family returns to South Carolina. An eligible family member previously enrolled in the waiver program would be reinstated into the waiver program once South Carolina Medicaid eligibility is established upon their return to South Carolina. No services will be provided outside the South Carolina Medicaid Service Area.

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	10
Year 2	10
Year 3	10
Year 4	5

Waiver Year	Capacity Reserved
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):*

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	340
Year 2	340
Year 3	340
Year 4	280
Year 5	280

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)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in**

section 1902(a)(10)(A)(ii)(XV) of the Act)

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

☒ **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 $69.00 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:

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.

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.

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:

This waiver uses the ICF/IID level of care when assessing potential waiver eligibility. The initial level of care evaluation is performed by the SCDDSN's Eligibility Division. LOC reevaluations are primarily completed by Waiver Case Management (WCM) providers. Final determination for LOC reevaluation is conducted by the SCDDSN Eligibility Division (SCDDSN is the Operating Agency specified in Appendix A). Internal policy dictates when this is necessary.

DETERMINATION OF DDSN ELIGIBILITY

In accordance with S.C. Code Ann.§ 44-20-390-430 (2018), no individual believed to have Intellectual Disability, a Related Disability, Head Injury, Spinal Cord Injury, Similar Disability or Autism Spectrum Disorder may be admitted to the services of DDSN until he/she has been determined eligible by DDSN on the basis of acceptable data to have Intellectual Disability, a Related Disability, Head Injury, Spinal cord Injury, Similar Disability or Autism Spectrum Disorder unless he/she is an infant at risk of a developmental disability and in need of DDSN services. The Determination of Eligibility for DDSN services is made by DDSN using the accurate and complete set of documents collected and submitted as part of Intake or appropriate testing which confirms the presence of ASD.
The criteria for DDSN eligibility are:

A. Intellectual Disability Definition

S.C. Code Ann. § 44-20-30 (2018) defines "Intellectual Disability" as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
Diagnostic Criteria

DDSN evaluates referred individuals in accordance with the definition of Intellectual Disability outlined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition, (DSM-5).
Intellectual Disability refers to substantial limitations in present functioning. Diagnosis of Intellectual Disability based on the DSM-5 definition requires the following three (3) criteria be met:

1. Significantly sub-average intellectual functioning; an IQ of approximately 70 or below on an individually administered intelligence test (for infants, a clinical judgment of significantly sub-average intellectual functioning); and
2. Concurrent deficits in present overall adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his/her age by his/her cultural group) with deficits in at least two (2) of the following adaptive skills areas:

- communication,
- self-care,
- home living,
- social/interpersonal skills,
- use of community resources,
- self-direction,
- functional academic skills,
- work,
- leisure,
- health, and safety; and

3. The onset of Intellectual Disability is prior to age 22.

There must be concurrent deficits in intellectual and adaptive functioning that fall approximately two (2) or more standard deviations below the mean (approximately 70 or below) on standardized measures in order to meet criteria for diagnosis of Intellectual Disability. However, a score of 70 on any intelligence and/or adaptive test does not equate to a diagnosis of Intellectual Disability.

DDSN relies on qualified testing providers to administer psychological testing to applicants. This includes testing conducted by school psychologists and other professionals who regularly administer psychological tests to persons with disabilities. The tests are then analyzed by the DDSN Eligibility Division to determine if they are reliable and valid, and to determine whether they are consistent with other psychological tests, school records including academic achievement scores, placement in special education and Individualized Education Plan (IEP) data, medical reports, psychiatric and mental health records, family history, and other pertinent information. In order to ensure the reliability and validity of the tests administered to applicants, only standardized measures are used to determine if criteria for Intellectual Disability are met.
Therefore, DDSN maintains a list of all approved psychometric tests that must be used for eligibility purposes.

In the event that assessment results are unavailable or updated assessment information is needed, DDSN will contact the intake provider to assist in coordinating for testing to take place at a location convenient to the applicant.

B. Related Disability Definition and Diagnostic Criteria
S.C. Code Ann.§ 44-20-30 and 42 CFR 435.1009 defines eligibility for DDSN services under "Related Disability" as follows:

A severe, chronic condition found to be closely related to Intellectual Disability or to require treatment similar to that required for persons with Intellectual Disability and must meet all four
(4) of the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with Intellectual Disability and requires treatment or services similar to those required for these persons; and

2. The Related Disability is likely to continue indefinitely; and

3. It results in substantial functional limitations in three (3) or more of the following areas of major life activity:
- Self-care,
- Understanding and use of language,
- Learning,
- Mobility,
- Self-direction,
- and Capacity for Independent Living; and

4. The onset is before age 22 years.

DDSN relies on qualified testing providers to administer psychological testing to applicants. This includes testing conducted by school psychologists and other professionals who regularly administer psychological tests to persons with disabilities. The tests are then analyzed by the DDSN Eligibility Division to determine if they are reliable and valid, and to determine whether they are consistent and congruent with other psychological tests, school records including academic achievement scores, placement in special education and Individualized Education Plan (IEP) data, medical reports, psychiatric and mental health records, family history, and other pertinent information. In order to ensure the reliability and validity of the decisions made, DDSN uses standardized measures to determine if criteria for a Related Disability are met.
Specifically, a standardized test of functional abilities that yields a composite score of two standard deviations or more below the mean (i.e., Composite < 70) must be met to qualify for eligibility under the Related Disability category. DDSN maintains a list of all approved psychometric tests that will be used to determine if criteria for a related condition are met.

In the event that assessment results are unavailable or updated assessment information is needed, DDSN will contact the intake provider to assist in coordinating for testing to take place at a location convenient to the applicant.

C. High-Risk Infant Definition
S.C. Code Ann.§ 44-20-30 defines "high-risk infant" as a child less than 36 months of age whose genetic, medical or environmental history is predictive of a substantially greater risk for a developmental disability than that for the general population.
Diagnostic Criteria

Children younger than 36 months of age are served under this category when they:

- Exhibit significant documented delays in three or more areas of development; or

Have an approved diagnosis confirmed by a medical professional and exhibit significant documented delays in two areas of development.

This category of eligibility allows DDSN to provide services to infants and young children under 36 months in instances where the future diagnosis is not absolutely clear due to situations (genetic, environmental or medical) present at birth or

manifesting themselves thereafter, including accident and injury. In such instances, eligibility may be established in a time-limited fashion until a more comprehensive and conclusive assessment can be made regarding the presence or absence of a qualifying disability (not to exceed 36 months of age). Infants and young children under 36 months are eligible to receive all DDSN services for which they qualify based on need and resource availability. Once the child turns 36 months of age, he/she must qualify for DDSN eligibility in another category, such as Intellectual Disability, a Related Disability, Autism, Traumatic Brain Injury or Spinal Cord Injury to continue to receive services from DDSN. The one exception is for those children ages three (3) to six (6) years of age eligible in the at-risk category. These children may continue to receive Early Intervention services (i.e., family training and case management provided by an Early Interventionist) until further notified by the State Director. Any child 36 months of age or older whose eligibility is not updated by DDSN's Eligibility Division by their 37th month of age must have their file closed. The child is no longer eligible to receive any service from DDSN.

Case Managers are responsible for ensuring Level Of Care information is obtained.

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:
ID/RD waiver enrollees have an initial Level of Care determination (LOC) completed within 30 days prior to waiver enrollment. Numerator = Number of new ID/RD waiver enrollees whose LOC determination was completed within 30 days prior to waiver enrollment; Denominator= total number of new enrollees in the ID/RD 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 ID/RD waiver initial LOC determinations that were conducted using the appropriate instrument; Denominator= total number of ID/RD 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**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

Performance Measure:
Initial LOC determinations conducted using appropriate criteria. Numerator = Number of ID/RD waiver initial LOC determinations that were conducted using the appropriate criteria. Denominator = Total number of ID/RD 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:	☐ **Annually**

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

Performance Measure:
Adverse LOC Determinations are reviewed by the SCDHHS QIO Contractor as required by SCDHHS. N = # of Adverse LOC Determinations the Contractor agreed with and D = the total # 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 IDRD 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**
	☐ **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 written 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 FOC 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	**Adult Day Health Care, Adult Day Health Care Services**
Statutory Service	**Personal Care Services**
Statutory Service	**Residential Habilitation**
Statutory Service	**Respite Care**
Statutory Service	**Waiver Case Management (WCM)**
Extended State Plan Service	**Adult Dental Services**
Extended State Plan Service	**Adult Vision**
Extended State Plan Service	**Audiology Services**
Extended State Plan Service	**Incontinence Supplies**
Extended State Plan Service	**Nursing Services**

Service Type	Service
Other Service	Adult Attendant Care Services
Other Service	Adult Companion Services
Other Service	Adult Day Health Care Nursing
Other Service	Adult Day Health Care Transportation--Ending 6/30/22
Other Service	Behavior Support Services
Other Service	Career Preparation Services
Other Service	Community Services
Other Service	Day Activity
Other Service	Employment Services
Other Service	Environmental Modifications
Other Service	Independent Living Skills
Other Service	Nursing Services - Ending 06/30/2023
Other Service	Personal Care 2, Personal Care 1- Ending 06/30/2023
Other Service	Personal Emergency Response System (PERS)
Other Service	Pest Control Treatment
Other Service	Pest Control-Bed Bugs
Other Service	Private Vehicle Assessment/Consultation
Other Service	Private Vehicle Modifications
Other Service	Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation
Other Service	Specialized Medical Equipment, Supplies and Assistive Technology
Other Service	Support Center Services

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care, Adult Day Health Care Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

04 Day Services

Sub-Category 2:

04050 adult day health

Category 3:

Sub-Category 3:

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

Service Definition *(Scope):*

Services are furnished five or more hours per day as specified in the service plan, in a licensed, non-institutional, community based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. These services include off-site outings and other efforts designed to promote socialization and integrate participants into the community. Meals provided as a part of these services shall not constitute a “full nutritional regimen” (3 meals per day). Physical, occupational and speech therapies indicated in the participant's plan of care are not furnished as component parts of this service. Authorization of services will be based on the participant's need for the service as identified and documented in his/her plan of care.

Transportation is offered in accordance with the participant’s service plan to enable access to adult day health care services. This service is offered in addition to medical transportation required under 42 CFR §431.53; The Consolidated Appropriations Act, 2021, Division CC, Title II, Section 209; and transportation services under the State Plan, defined at §440.170(a) (if applicable), and does not replace them. Transportation is not provided as part of another category such as round-the-clock services or day services.

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	Non-Emergency Medical Transportation (NEMT) broker
Agency	Non-Emergency Medical Transportation (NEMT) broker
Agency	Adult Day Health Care Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Non-Emergency Medical Transportation (NEMT) broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the U.S. Department of Health and Human Services;

2. Each such individual driver has a valid driver's license;

3. Each such provider has in place a process to address any violation of a state drug law; and,

4. Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Non-Emergency Medical Transportation (NEMT) broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the U.S. Department of Health and Human Services;

2. Each such individual driver has a valid driver's license;

3. Each such provider has in place a process to address any violation of a state drug law; and,

4. Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Adult Day Health Care Provider

Provider Qualifications

License *(specify):*

SC Code of Laws 1976 as amended § 44-7-260

Certificate *(specify):*

Other Standard *(specify):*

SCDHHS Contract Scope of Service

Verification of Provider Qualifications

Entity Responsible for Verification:

SC Department of Health and Environmental Control (SCDHEC); SCDHHS

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Services

HCBS Taxonomy:

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

08 Home-Based Services | 08030 personal care

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

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

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

Service Definition *(Scope):*

Active, hands-on assistance in the performance of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to the waiver participant in or outside his/her home. Personal care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide.

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

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

A unit is defined as 15 minutes of service provided by one aide. When authorized in conjunction with Adult Companion, the combined total hours per week of all services may not exceed 34 hours per week. However, 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.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Provider
Individual	Personal Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Services

Provider Category:

Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CLTC Standards for Waiver Services-Personal Care Scope of Services

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Services

Provider Category:

Individual

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Scope of Service as defined in the UAP/SCDDSN Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN/UAP

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:

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.

Participants who receive Residential Habilitation paid at a daily rate are not allowed to receive the Adult Companion service.

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 dual diagnosis of intellectual disability and mental illness 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 dual diagnosis of intellectual disability and mental illness or those who have a diagnosis of intellectual disability and display extremely challenging behaviors. Includes people being discharged from a SCDDSN 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 person’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 person’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. SPL II is delivered in a licensed SLPII setting that is typically single or double-occupancy residence.

*CTH Tier 2: 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 person’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 person 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: 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.

*SLP I: delivered to waiver participants who need support in their own apartment or home setting. Support is provided through a 15-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

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:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves; furnished on a short term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s):
Individual's home or place of residence, or other residence selected by the recipient/representative.
Foster home
Medicaid certified ICF/IID
Group home
Licensed respite care facility

Other community care residential facility approved by the State that is not a private residence (Specify type):
Community Residential Care Facility (CRCF)
Licensed Nursing Facility (NF)

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

Limit up to 68 hours of in-home respite/month as determined by SCDDSN assessment. In-home respite is provided outside of a Medicaid certified ICF/IID or Medicaid NF. Exceptions may be granted in 2 instances:

1. An exception of up to 240 units per month of in-home respite may be authorized due to the following special need circumstances: A) the caregiver's hospitalization or need for medical treatment; B) the participant's need for constant hands-on/direct care and supervision due to a medically complex condition or severity/degree of disability; or C) seasonal relief for those participants over age 12 who attend public school and whose parents work full time and care is needed during summer break from school. These exceptions must be approved by SCDDSN.

2. 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	Personal Care Provider
Agency	Medicaid Certified Nursing Facility
Agency	DSS Licensed Foster Home
Agency	Licensed Community Residential Care Facility
Individual	Certified Respite Caregiver
Agency	Medicaid Certified ICF/IID
Agency	DDSN/DSN Board/Contracted Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CLTC Standards for Waiver Services-Respite Scope of Services

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

Frequency of Verification:

Upon enrollment, and at least every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

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 and GA

Certificate *(specify):*

Other Standard *(specify):*

Contracted with SCDHHS for Institutional Respite

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHEC; SCDHHS

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

Provider Category:

Agency

Provider Type:

DSS Licensed Foster Home

Provider Qualifications

License *(specify):*

SC Code Ann. §63-11-10 thru 63-11-790 (Supp 2008).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SC Department of Social Services

Frequency of Verification:

Prior to the provision of services; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Licensed Community Residential Care Facility

Provider Qualifications

License *(specify):*

S.C. Code Ann. § 44-7-260 and S.C. Code Ann. Regs. 61-84, Equivalent for NC & GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHEC; SCDHHS

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

Provider Category:

Individual

Provider Type:

Certified Respite Caregiver

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):*

CLTC Standards for Waiver Services- Respite Scope of Services

SCDDSN Respite Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

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

Provider Category:

Agency

Provider Type:

Medicaid Certified ICF/IID

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN; SCDHEC

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted Provider

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):*

SCDDSN Respite Standards/SCDDSN Residential Habilitation Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

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:

Case Management

Alternate Service Title (if any):

Waiver Case Management (WCM)

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

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 who 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:

Adult Dental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services

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

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

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

Service Definition *(Scope):*

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 dental under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from dental 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.

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

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

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 Dental Hygienists
Individual	Licensed Dental Hygienist
Agency	Licensed Dentists
Individual	Board Certified Oral Surgeon
Agency	Board Certified Oral Surgeons
Individual	Licensed Dentist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:

Agency

Provider Type:

Licensed Dental Hygienists

Provider Qualifications

License *(specify):*

Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:

Individual

Provider Type:

Licensed Dental Hygienist

Provider Qualifications

License *(specify):*

Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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: Extended State Plan Service

Service Name: Adult Dental Services

Provider Category:

Agency

Provider Type:

Licensed Dentists

Provider Qualifications

License *(specify):*

Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:

Individual

Provider Type:

Board Certified Oral Surgeon

Provider Qualifications

License *(specify):*

Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:

Agency

Provider Type:

Board Certified Oral Surgeons

Provider Qualifications

License *(specify):*

Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:

Individual

Provider Type:

Licensed Dentist

Provider Qualifications

License *(specify):*

Code of laws of SC; 1976 as amended; 40-15-70 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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:

Adult Vision

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 are provided when the limits of adult vision under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from adult vision 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.

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

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

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 Optometrists, Licensed Ophthalmologists, or Licensed Opticians

Provider Category	Provider Type Title
Individual	Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Vision

Provider Category:

Agency

Provider Type:

Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians

Provider Qualifications

License *(specify):*

SC Code of Laws 1976 as amended; 40-37-5 thru 40-37-420 et seq.; 40-38-5 thru 40-38-390 et seq.; 40-47-5 thru 40-47-1620 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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: Extended State Plan Service
Service Name: Adult Vision

Provider Category:

Individual

Provider Type:

Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians

Provider Qualifications

License *(specify):*

SC Code of Laws 1976 as amended; 40-37-5 thru 40-37-420 et seq.; 40-38-5 thru 40-38-390 et seq.; 40-47-5 thru 40-47-1620 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled Providers

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:

Audiology 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:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that are provided when the limits of audiology under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from audiology 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.

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

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

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 Audiologists
Agency	Licensed Audiology Providers

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Audiologists

Provider Qualifications

License *(specify):*

Code of Laws of SC, 1976 as amended; 40-67-10 et seq.

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: Extended State Plan Service
Service Name: Audiology Services

Provider Category:

Agency

Provider Type:

Licensed Audiology Providers

Provider Qualifications

License *(specify):*

Code of Laws of SC, 1976 as amended; 40-67-10 et seq.

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: 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):*

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 include: *one (1) box of disposable gloves monthly; *up to two (2) cases of diapers/briefs monthly; *up to two (2) cases of under-pads monthly; *up to eight (8) boxes of wipes monthly;*up to two (2) boxes of liners monthly.

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. 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.

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):*

South Carolina business license

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:	**Sub-Category 2:**
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. 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.
Nursing Services are 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 Providers

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 Providers

Provider Qualifications

License *(specify):*

RN/LPN licensure covered under Code of Laws of SC, 1976 as amended; 40-33-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with SCDHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS, Nursing Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Attendant Care Services

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 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.

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

Up to 28 hours per week based on SCDDSN assessed need. When Adult Attendant Care is authorized in conjunction with Adult Companion and/or Personal Care, the combined total hours per week of services may not exceed 34. The unit of service is one hour provided by one Attendant Care Aide. However, 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.

Cost of incidental transportation is included in the rate paid to the provider.

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 Attendant Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Attendant Care Services

Provider Category:
Individual

Provider Type:

Independent Attendant Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Scope of Service as defined in the UAP/SCDDSN Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN/UAP

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:

Adult Companion Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Non-medical care, supervision and socialization, provided to a functionally impaired adult individual. Companions may

assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care but may entail hands-on assistance or training to the recipient in performing activities of daily living and independent living skills. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care and is not diversional in nature. Reimbursement will not be made to any family members residing in the same residence as the individual.

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

Up to 28 hours per week based on SCDDSN assessed need. One unit of service equals one hour provided by one Companion worker. When Adult Companion is authorized in conjunction with Adult Attendant Care and Personal Care, the combined total hours per week of services cannot exceed 34. However, 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
Individual	DDSN/DSN Board/Contracted Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Individual

Provider Type:

DDSN/DSN Board/Contracted Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Adult Companion provider qualifications include the following minimum qualifications:
1. Demonstrate an ability to read, write and speak English;
2. Fully ambulatory;
3. Capable of performing all companion care duties;
4. Capable of following a service plan with participant and/or representative supervision;
5. Be at least 18 years of age;
6. Capable of following billing procedures and completing required paperwork;
7. No known conviction of abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C.

Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Ann. Title 63, Chapter 7);
8. No known conviction for any crime against another person;
9. No known felony conviction of any kind;
10. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);
11. No record of exclusion or suspension from the Medicare or Medicaid Programs;
12. Upon request will provide references to the participant and/or representative;
13. All Companions shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Companions Medicaid enrollment date.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS
SCDDSN

Frequency of Verification:

Upon enrollment/At least every 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day Health Care Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Day Health Care Nursing Services are provided in and by the adult day health care center and are limited to the following skilled procedures: ostomy care, urinary catheter care, decubitus/ wound care, tracheotomy care, tube feedings,

nebulizer treatment.

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

Adult Day Health Care Nursing and Nursing Services, as defined in the ID/RD Waiver, cannot be received simultaneously. Recipients must be 18 or older.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health Care Nursing

Provider Category:

Agency

Provider Type:

Adult Day Health Care Providers

Provider Qualifications

License *(specify):*

Code of Laws of SC, 1976 as amended:44-7-260

Certificate *(specify):*

Other Standard *(specify):*

SCDHHS Contracted Providers

Verification of Provider Qualifications

Entity Responsible for Verification:

SC Department of Health and Environmental Control; SCDHHS

Frequency of Verification:

Upon enrollment; At least every 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day Health Care Transportation--Ending 6/30/22

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):*

The Adult Day Health Care Transportation service is prior-authorized for participants receiving the Adult Day Health Care (ADHC) service, who reside within 15 miles of the ADHC Center. Transportation will be provided using the most direct route, door to door, from the Center to the participant's place of residence or other location, as agreed to by the provider and as indicated on the service authorization.

The SMA is transitioning the ADHC transportation service to its Non-Emergency Medical Transportation (NEMT) broker. ADHC Transportation is being incorporated into the ADHC service and is no longer a standalone service, effective 7/1/22.

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

Adult Day Health Care Transportation Services are limited to participants who reside within 15 miles of the ADHC Center. Participants receiving Residential Habilitation services paid at a daily rate cannot receive 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	Adult Day Health Care Center Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health Care Transportation--Ending 6/30/22

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center Providers

Provider Qualifications

License *(specify):*

SC Code Ann. §44-7; 25 SC Code Ann. Regs. 61-75 (1976)

Certificate *(specify):*

Other Standard *(specify):*

Providers shall acquire and maintain auto insurance covering the minimum legal limits for operating a vehicle in the state of South Carolina. Failure to maintain required insurance results in termination of contract with the SMA.

ADHC Transportation service must be provided in an enclosed vehicle with adequate ventilation, heat and air conditioning, with provision for wheelchair users and ambulatory participants as needed. ADHC Transportation does not include ambulance transportation, even when medically necessary.

Providers who are directly providing transportation to participants must be able to provide assistance to the participant from the door of the participant's residence to the vehicle and from the vehicle to the door of the participant's residence, or other location, as agreed to by the provider and as indicated on the service authorization when necessary.

The service provider must be capable of maintaining a participant record containing documentation supporting services provided and billed. Providers must be able to use the automated systems mandated by the SMA to document and bill for the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA

Frequency of Verification:

Upon enrollment; At least every 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavior Support are those services which use current, empirically validated practices to identify functions of target behaviors, prevent the occurrence of problem behavior, teach appropriate, functionally equivalent replacement behavior and react therapeutically to problematic behavior. These services include:

a) Initial behavioral assessment for determining the need for and appropriateness of Behavior Support Services and for determining the function of the behaviors. Behavioral assessment (i.e., functional assessment and/or analysis) includes direct observation and collection of antecedent-behavior-consequence data, an interview of key persons, a preference assessment, collection of objective data (including antecedent-behavior-consequence data) and analysis of behavioral/functional assessment data to determine the function of the behaviors.
b) Behavioral intervention (including staff/caregiver training), based on the functional assessment, that is primarily focused on replacement and prevention of the problem behavior(s) based on their function; and
c) an assessment of the success of the intervention through progress monitoring that includes analysis of behavioral data, any changes (including medication) and any needed modifications.

To provide a support system to unpaid caregivers who are caring for family members with challenging behaviors, caregiver coaching services may be provided. The purpose of caregiver coaching is to enable the health, safety, well-being and continued community integration of waiver participants by equipping family caregivers with the skills and resources necessary to manage the participants' behavioral and associated needs at home. This service is not provided directly to waiver participants, but to their family caregiver(s). A participant has to be assessed by a case manager to need the behavior support service before the family caregiver can access caregiver coaching. The waiver participant does not have to be actively receiving behavioral services in order for the family caregivers to receive caregiver coaching.

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

Caregiver Coaching is limited to a maximum of 16 units per person/per month. Each unit is 30 mins.

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	Caregiver Coaching Provider
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:

Agency

Provider Type:

Caregiver Coaching Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

- National Committee for Quality Assurance (NCQA) – Case Management for LTSS for community-based organizations
- National Committee for Quality Assurance (NCQA) - Managed Behavioral Healthcare Organizations Accreditation
- Commission on Accreditation of Rehabilitation Facilities (CARF) – Behavioral Health Accreditation
- The Joint Commission (TJC) – Behavioral Health Care Accreditation
- Council on Accreditation (COA) – Private Organizations Accreditation; Public Agencies Accreditation

Other Standard *(specify):*

SCDDSN Standards and Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:

Verified/approved by DDSN and enrolled by DHHS

Frequency of Verification:

Upon enrollment and thereafter upon revalidation by DHHS.

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):*

SCDDSN Standards and Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:

Verified/approved by DDSN and enrolled by DHHS

Frequency of Verification:

Upon enrollment; Verification of continuing education upon revalidation by SCDHHS.

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:

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 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 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: Other 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:

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:

Community Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Services are aimed at developing one's awareness of interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital. Services will be provided in facilities licensed by the state. On site attendance at the licensed facility is not required to receive services that originated from the facility.

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	Community Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Services

Provider Category:

Agency

Provider Type:

Community Services Provider

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs 88-105 thru 88-920 (1976)

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN Community Services Standards

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 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:

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:

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 Services are supports and services provided in the therapeutic settings to enable participants to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Day Activity Services. On site attendance at the licensed facility is not required to receive services that originate from the facility.

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	Day Activity Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Day Activity

Provider Category:

Agency

Provider Type:

Day Activity Provider

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs 88-105 thru 88-920 (1976)

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN Standards for Day Activity Services

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 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:

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):*

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence, and without which, the individual would require institutionalization. Home is defined as non-government subsidized living quarters, and modifications to any government-subsidized housing (i.e., group homes or community residential care facilities) are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, and/or modification of bathroom facilities which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project. 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, awning additions, etc. The following adaptations are excluded from this waiver benefit: modifications that add square footage to the home, pools, decks, stairs, elevators, breezeways, carports and hot tubs/whirlpools. All modifications shall be provided in accordance with applicable State or local building codes. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. Approval of a request for environmental modification is a multi-step process. The modification is initially determined by the waiver case manager/early interventionist based on the recipient's need as documented in the plan of care. According to State procurement policy, bids for the modification are obtained by the waiver case manager/early interventionist (WCM/EI) and submitted with documentation of the need. This information is reviewed by SCDDSN staff for programmatic integrity and cost effectiveness. The environmental modification service must be within the lifetime monetary cap of $15,000 per recipient. The WCM/EI will assist in identifying all appropriate resources, both waiver and non-waiver. Should it become necessary, the WCM/EI will assist with transitioning the client into institutional placement.

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

$15,000 lifetime monetary cap per waiver recipient.

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	SCDDSN/DSN Board/Contracted Provider
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:

Agency

Provider Type:

SCDDSN/DSN Board/Contracted Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN Contract

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: 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:

SCDDSN

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:

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	DSN Boards/Contracted 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:

DSN Boards/Contracted 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:

Nursing Services - Ending 06/30/2023

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

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 statute. These services are provided to a participant in their home. Continuous and individual skilled care provided by a licensed 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.

This service will end 6/30/23 in favor of the new consolidated Nursing Services.

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. 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. A participant can receive up to 56 units per week. However, 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 Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Services - Ending 06/30/2023

Provider Category:

Agency

Provider Type:

Nursing Providers

Provider Qualifications

License *(specify):*

RN/LPN licensure covered under Code of Laws of SC, 1976 as amended; 40-33-10 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with SCDHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS; Nursing Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Care 2, Personal Care 1- Ending 06/30/2023

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):*

Active, hands-on assistance in the performance of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to the waiver participant in his/her home; outside the home, and/or to assist an individual to function in the workplace or as an adjunct to the provision of employment services, based on the determination of its need by the waiver case manager. The service location must be defined in the Plan of Service. ADLs include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, and assistance with ambulation. If it is determined that a participant requires more than one personal care aide, this must be prior approved by SCDDSN/SCDHHS and documented on the Plan of Service. IADLs include light housework, laundry, meal preparation and shopping. These IADL activities are for the specific needs of the participant, not the general needs of the household. IADLs may also include home safety, assistance with communication, medication monitoring to include informing the participant that it is time to take medication prescribed by his/her physician or handing the participant a medication container, and limited assistance with financial matters such as delivering payments as directed by the participant on his/her behalf. Personal care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide except as allowed by the Nurse Practice Act and prior approved by a licensed physician.
Authorizations to providers will be made at two different payment levels. Based on SCDDSN assessed need, the higher level service, Personal Care 2 (PC2), may be considered appropriate when the care needed is for assistance with ADLs alone or in conjunction with assistance with IADLs/home support.

Based on SCDDSN assessed need, the lower level service, Personal Care 1 (PC1), may be considered appropriate when the only needed care is for IADLs/home support activities. PC1 does not include hands-on care. Unless prior-approved, 2 aides may not be authorized for service delivery at the same time. However, 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.

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

This service will end 6/30/23 so that the consolidated services of PCI an PCII called "Personal Care Services" may begin.

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

Personal Care 2 (PC2): Up to 112 units (28 hours) per week as determined by SCDDSN assessment. A unit is defined as 15 minutes of service provided by one aide. When PC2 is authorized in conjunction with Adult Attendant and/or Adult Companion, the combined total hours per week of all services may not exceed 28 hours per week.
Personal Care 1 (PC1): Up to 24 units (6 hours) per week as determined by SCDDSN assessment. A unit is defined as 15 minutes of service provided by one aide. However, 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.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Care 2, Personal Care 1- Ending 06/30/2023

Provider Category:

Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CLTC Standards for Waiver Services-Personal Care II Scope of Services

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

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 individuals at high risk of institutionalization to secure help in an emergency. The participant may wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a help button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone in their own home for significant parts of the day or night, and who would otherwise require extensive routine supervision.

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

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

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

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

PERS Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CLTC Standards for Waiver Services-Personal Emergency Response (PERS) Services

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:

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 aid 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 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):*

SC Business License

Certificate *(specify):*

Certification by Clemson University

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

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-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 to enhance safety, sanitation, and cleanliness of the participant's home or residence.

The Provider must obtain an authorization from participant's 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 provider owned or controlled residential settings. Pest control-bed bug services are secured through a bid process with award given to the lowest bid, subject to $1,000 cap per treatment.

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):*

SC Business License

Certificate *(specify):*

Certification by Clemson University

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS

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, training in use of equipment, repairs not covered by warranty, and replacement of parts or 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 certified by Professional Resource in Management (PRIME) or by 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	SCDDSN/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:

SCDDSN/DSN Board/Contracted provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN Contract

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: 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), Medicaid enrolled Rehabilitation Engineering Technologists (RET).

Statutory Authority: 1976 Code §§ 40-36-10

Chapter 94
94-04. General Licensing Provisions for Occupational Therapists.

An applicant for initial licensure as an occupational therapist must:
1) be a graduate of an occupational therapy educational program approved by the Board; and
2) submit an application on a form approved by the Board, along with the required fee; and
3) pass an examination approved by the Board; and
4) submit proof satisfactory to the Board that the applicant is in good standing with the National Board for Certification in Occupational Therapy (NBCOT) or other Board-approved certification program.

PT Licensure Requirements:
SECTION 40-45-220. Qualifications of applicants for licensure; burden to demonstrate eligibility; background checks.

(A)(1) To be eligible for licensure as a physical therapist an applicant must:

(a)(i) be a graduate of a physical therapy educational program approved by the board;

(ii) pass an examination administered or approved by the board; and

(iii) speak the English language as a native language or demonstrate an effective proficiency of the English language in the manner prescribed by and to the satisfaction of the board; or

(b)(i) provide satisfactory evidence that his or her education is equivalent to the requirements of physical therapists educated in United States educational programs as determined by the board. If the board determines that an applicant's education is not equivalent, it may require completion of additional course work before proceeding with the application process;

(ii) speak the English language as a native language or demonstrate an effective proficiency of the English language in the manner prescribed by and to the satisfaction of the board;

(iii) pass an examination administered or approved by the board;

(iv) submit evidence satisfactory to the board on a form approved by the board of not less than one thousand clinical practice hours under the on-site supervision of a licensed physical therapist in this State or in a state with licensure requirements equal to or more stringent than this State.

(2) In addition to other requirements established by law and for the purpose of determining an applicant's eligibility for initial licensure as a physical therapist, the department may require a state criminal records check, supported by fingerprints, by the South Carolina Law Enforcement Division, and a national criminal records check, supported by fingerprints, by the Federal Bureau of Investigation. The results of these criminal records checks must be reported to the department. The South Carolina Law Enforcement Division is authorized to retain the fingerprints for certification purposes and for notification of the department regarding criminal charges. Costs of conducting a criminal history background check must be borne by the applicant. The department shall keep information received pursuant to this section confidential, except that information relied upon in denying licensure may be disclosed as may be necessary to support the administrative action. The results of these criminal records checks must not be shared outside the department.

(

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) certified by Professional Resource in Management (PRIME).

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:

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):*

This service offers modifications to a privately owned vehicle used to transport the waiver recipient and for any equipment needed by the recipient which makes the vehicle accessible to the recipient. Modification to any government-subsidized vehicle is not permitted. The private vehicle modification service may not be used for general repair of the vehicle or regularly scheduled upkeep or maintenance of the vehicle except for maintenance of the modifications and does not cover factory installed modifications prior to purchase. This service may not be used to purchase or lease a vehicle. Payment may not be made to adapt vehicles that are owned or leased by paid providers of waiver services. To ensure cost-neutrality, the private vehicle modification service must be within a monetary cap of $7,500 per vehicle and a lifetime cap of 2 vehicles. The approval process for vehicle modifications is initially determined by the Waiver Case Manager or Early Interventionist based on the recipient's needs as identified and documented in the plan of care, the consultation/assessment results (if applicable), and the availability of a privately-owned vehicle that would be used for transportation on a routine basis. The criterion used in assessing a recipient'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; 2) The individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve this barrier. According to State procurement policy, bids for the vehicle modification are obtained and submitted along with the documentation of the need to SCDDSN. Each request is reviewed programmatically and fiscally before approval is given. The approval process is the same for any privately owned vehicle modification, regardless of ownership.

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

$7,500 per vehicle and a lifetime cap of 2 vehicles.

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	SCDDSN/DSN Board/Contracted provider
Agency	SCDHHS Enrolled Provider

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:

SCDDSN/DSN Board/Contracted provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN contract

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: Private Vehicle Modifications

Provider Category:

Agency

Provider Type:

SCDHHS Enrolled 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: 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):*

Specialized Medical 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), Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional Resource in Management (PRIME).

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.

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	SCDDSN/DSN Boards/Contracted Provider
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:

SCDDSN/DSN Boards/Contracted Provider

Provider Qualifications

License *(specify):*

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 for verifying and documenting licensure or certification:

- Licensed Occupational Therapist
- Licensed Physical Therapist

Certificate *(specify):*

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 verifying and documenting licensure or certification:

- 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)
- Environmental Access Consultant/contractor certified by Professional Resources in Management (PRIME)

Other Standard *(specify):*

Enrolled with SCDDSN

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Prior to each assessment/consultation

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):*

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: 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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Specialized medical equipment, supplies and assistive technology to include devices, controls, or appliances, specified in the plan of care which enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, remote supports, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

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:

The limit is 2 cases per month of liquid nutrition for waiver participants without a feeding tube. Liquid nutrition for waiver participants on a feeding tube is provided by Medicaid State Plan and is not covered by the waiver.

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	SCDDSN/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

Provider Category:

Agency

Provider Type:

SCDDSN/DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN contract

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

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Providers

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: 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:

Support Center Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Support Center Services include non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the participant's home to individuals who, because of their disability, are unable to care for and supervise themselves. Services provided are necessary to prevent institutionalization and maintain the participant's health and safety. The care, supervision and assistance will be provided in accordance with a plan of care. An array of non-habilitative activities and opportunities for socialization will be offered throughout the day but not as therapeutic goals.

Activities can occur in natural settings that do not isolate participants from others without disabilities.

Transportation will be provided from the individual's residence to the service provision site when the service start time is before 12:00 Noon. Transportation will be available from the individual's service provision site to his/her 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	Support Center Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Center Services

Provider Category:

Agency

Provider Type:

Support Center Services Provider

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs 88-105 thru 88-920 (1976)

Certificate *(specify):*

Other Standard *(specify):*

SCDDSN Standards for Support Center Services

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 provider performance.

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, all Waiver Case Managers and anyone providing direct care to waiver participants 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 SCDDSN'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 and Personal Care 2 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:

CNA Registry - www.pearsonvue.com
OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

SCDHHS Provider Compliance monitors contract compliance for nursing and personal care providers. This occurs at least every eighteen months.

Additionally, abuse registry screenings must be completed for all staff of SCDDSN 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. SCDDSN, through Contract Compliance 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

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

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

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

Data 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** Specify:	☐ **Annually**	☐ **Stratified** 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	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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**

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

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

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

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

Performance Measure:
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 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:
Non-licensed/non-certified providers continue to meet waiver requirements. Numerator = The number of non-licensed/non-certified providers that continue to meet required licensing, certification and other state standards. 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:	☐ **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: 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** 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**

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

	Ongoing	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:

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:

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.)*

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.)*

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

08/15/2025

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. Over the next three years, 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). Case Managers are offered a two (2) day training on the use of various tools to help develop a person centered plan.
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 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-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 ID/RD, CS and 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 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.

Monitoring and follow up methods include the following:

- Waiver case manager explains the participant's right to freedom of choice when 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. A standardized case management monitoring tool will be implemented to provide a structure for ongoing monitoring. In addition to ensuring the plans are effectively addressing the needs of the participants, SCDDSN staff check for compliance with policy.

- At a minimum, the waiver case manager makes contact with the participant and/or representative monthly to determine services meet the participants' needs and continue 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 waiver 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 waiver 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, SCDDSN 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, SCDDSN 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 website. 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 ID/RD waiver participants include services, supports and goals that are consistent with assessed needs in accordance with waiver policy. Numerator = The number of ID/RD participant support plans that include services, supports and goals consistent with assessed needs. Denominator = The total number of ID/RD 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:	☒ **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 = # of service plans that appropriately address the needs of waiver participants. D = # of service plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

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 ID/RD waiver participants are developed at least annually.
Numerator = the number of ID/RD participants whose support plans were developed at least annually; Denominator= Total number of ID/RD 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**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

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

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

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:
ID/RD 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 ID/RD waiver support plans within type, amount, scope, frequency, and duration as specified on the plan. Denominator = The total number of ID/RD 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**

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:

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

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

When the Quality Improvement Organization (QIO) finds an indicator out of compliance, they will record the citation in the provider's Quality Assurance report. Upon receipt of the report, the provider will have 30 days to submit a Plan of Correction (POC) to address individual and systemic remediation efforts. The QIO will then approve the POC or return it to the provider with a request for additional information. Approximately six months after the POC is approved, the QIO will conduct a follow-up review with the provider to ensure implementation of the POC and to determine if the remediation was successful. SCDDSN has also established benchmarks for technical assistance to be coordinated by SCDDSN staff. The technical assistance is an ongoing process that may incorporate on-site instruction or training through counterpart meetings. Lower scoring providers may also be reviewed by the QIO on a more frequent basis. SCDDSN tracks all QIO reporting information, including Appeals, the Plans of Correction, follow-up, and remediation. All documentation is maintained on the QIO Portal and is available for SCDHHS review. This information is analyzed to determine provider specific and system-wide training and technical assistance issues. The frequency of data aggregation and analysis is annually. Documentation of all technical assistance is available. SCDDSN QIO reviews, provider plans of correction and QIO follow-up review results are available to SCDHHS.

In addition, 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**
☐ **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:

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 Personal Care services.

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
Adult Attendant Care Services	☒	☐
Respite Care	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver

service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

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

Provide the following information

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

SCDDSN currently uses a FMS to provide these services to participants in the ID/RD Waiver. The FMS is a private entity. This service was added to the State's current contract which was secured in response to a Request for Bid (RFB).

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

A monthly fee per participant is charged for FMS.

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

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

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

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

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

☒ **Other**

Specify:

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:

WCM providers will provide detailed information to the participant or responsible party (RP) about participant/RP direction as an option including the benefits and responsibilities. If the participant/RP wants to pursue this service, additional information about the risks and responsibilities will be shared by the WCM. 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/RP has chosen to direct their services, WCMs continue to monitor service delivery 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
Adult Dental Services	☐
Employment Services	☐
Adult Day Health Care Nursing	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Attendant Care Services	☒
Nursing Services	☐
Nursing Services - Ending 06/30/2023	☐
Personal Care Services	☐
Support Center Services	☐
Audiology Services	☐
Pest Control-Bed Bugs	☐
Incontinence Supplies	☐
Pest Control Treatment	☐
Private Vehicle Assessment/Consultation	☐
Adult Vision	☐
Independent Living Skills	☐
Adult Day Health Care, Adult Day Health Care Services	☐
Residential Habilitation	☐
Private Vehicle Modifications	☐
Adult Day Health Care Transportation--Ending 6/30/22	☐
Adult Companion Services	☐
Specialized Medical Equipment, Supplies and Assistive Technology	☐
Respite Care	☒
Career Preparation Services	☐
Personal Care 2, Personal Care 1- Ending 06/30/2023	☐
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	☐
Community Services	☐
Day Activity	☐
Waiver Case Management (WCM)	☐
Behavior Support Services	☐
Environmental Modifications	☐
Personal Emergency Response System (PERS)	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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	1147	
Year 2	1147	
Year 3	1147	
Year 4	1147	
Year 5	1147	

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.

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 participants.

• **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 Process

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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:
ID/RD waiver participants receive information about how to report Abuse, Neglect and Exploitation (ANE) annually. Numerator = Total number of ID/RD participants receiving annual information Denominator = total number of ID/RD 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**
	☐ **Other** Specify:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of 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**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

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 ID/RD 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:*

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 IDRD waiver service rates that remain consistent with approved methodology. N = The number of IDRD rates that remain consistent with approved methodology. D = The number of IDRD 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.*

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 financial policy requires SCDDSN to void/replace incorrect claims using the web-based system. SCDDSN reviews and amends its financial policies and procedures upon review and approval by SCDHHS. 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.

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:* *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 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 ID/RD 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 Intermediate Care Facility for Individuals with Intellectual Disabilities, 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 which were provided for SFY 2020 and SFY 2022 that would not be 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 January 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 for ID/RD Daily Residential Habilitation 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 ID/RD DRH service waiver rates effective January 1, 2022, 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 January 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 DRH rate based upon the 8 tiered service rates of $226.71 is 2.13% higher than the DRH 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.

The service 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 above applies to the following ID/RD services directly administered by the SCDDSN:
Respite/Institutional/ICF/IID
Respite/In-Home-Hourly
Day Activity
Career Preparation
Community Services
Employment Services Individual
Employment Services Group
Support Center Services
Private Vehicle Modifications
Adult Companion Services
Residential Habilitation Services/Daily Residential Habilitation Services/Hourly
Adult Attendant Care Services
Specialized Medical Equipment /Supplies/Assistive Technology Environmental Modifications
Behavior Support

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. 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.

Personal Care, Adult Day Health Care and Adult Day Health Nursing services provided by a Community Long Term Care (CLTC) provider (i.e. private agency) are paid the rate as established for South Carolina's Community Choices waiver.

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.

The rates for Adult Dental, Adult Vision, Audiology, and Nursing are taken directly from the State Plan service rates for the 21 and under population.

Participants are notified of rate changes by their case managers as appropriate. Participants registering to be included on the SCDHHS provider distribution list receive alerts and bulletins via email.

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

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 SCDDSN. Providers billing SCDHHS directly may bill either by use of a CMS 1500 claim form or by the SCDHHS electronic billing system/web-tool.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***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.

The South Carolina Department of Health and Human Services 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 ("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:

Currently SCDDSN will receive payment for the listing of services identified in Appendix I, I-2a.However effective for services provided on or after January 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:

No supplemental payments are provided to SCDDSN subsequent to the claims payments. At fiscal year-end, a cost report is required that reflects the total costs incurred by SCDDSN and / or its local Boards for the discrete services provided under this waiver. SCDHHS reviews the cost report to substantiate CPE and to verify the actual Medicaid expenditures of the individual services. Upon completion of the review, actual Medicaid expenditures of the waiver, in the aggregate, are compared to total Medicaid claims payment for the waiver (i.e. in the aggregate). If SCDDSN has been overpaid based on the aggregate comparison. SCDHHS will recoup the federal portion of the overpayment from SCDDSN and return it to CMS via the quarterly expenditure report. It should be noted that the comparison noted above is specific to each waiver operated by SCDDSN. That is the aggregation of expenditures and claims payments is made per waiver and does not consolidate all waivers together. This is the methodology that is currently employed for rates as of Jun 9, 2021. However, beginning with our proposed rate changes effective July 1, 2022, non-state owned governmental and private Boards that directly enroll/ contract with SCDHHS may receive payment rates which result in Medicaid reimbursement in excess of allowable Medicaid reimbursable cost. Since the source of the state matching funds will come from IGTs from SCDDSN to SCDHHS, there will be no recoupment of revenue in excess of cost in the event that Medicaid payments exceed allowable Medicaid reimbursable costs for these Boards.

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 autism 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:

SCDDSN receives state appropriations to provide services under this waiver. A portion of these funds will be transferred to the SCDHHS via an IGT for payments that will be made directly to private providers enrolled with the SCDHHS. Additionally, beginning with our proposed rate changes effective July 1, 2022, non-state- owned governmental and private Boards that directly enroll/ contract with SCDHHS state matching funds will come from IGTs from SCDDSN to SCDHHS.

For services provided by SCDDSN, these funds will be directly expended by SCDDSN as CPE.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

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: 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	51664.70	7327.12	58991.82	124872.60	10623.93	135496.53	76504.71
2	59581.34	7546.93	67128.27	127370.06	10942.65	138312.71	71184.44
3	58006.22	7773.34	65779.56	129917.46	11270.93	141188.39	75408.83
4	60388.16	8006.54	68394.70	132515.81	11609.05	144124.86	75730.16
5	61558.90	8246.73	69805.63	135166.12	11957.33	147123.45	77317.82

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:
		ICF/IID
Year 1	13630	13630
Year 2	13630	13630
Year 3	13630	13630
Year 4	13630	13630
Year 5	13630	13630

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The estimate for the average length of stay is based on the most recent approved #0237 waiver 372 report (2019), which is 342.6 days per person.

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 2020 per capita expenditures trended to the appropriate waiver year. 3% unit cost trend was applied to claims consistent with the waiver service trend used in the CY 2021 Prime Capitation Rates. For IDRD waiver services that did not have experience in SFY2020, experience from the Community Choices waiver, the most recent IDRD 372 report, and approved HCBS waiver from other states to estimate the Number of Users and Average Units Per User.

Effective July 1, 2023 the reimbursement for Personal Care I and Personal Care II will be at the same rate and therefore do not need to be tracked separately as they have prior to July 1, 2023. A similar approach is being made for LPN and RN Nursing Services. Therefore, only one service line was included for WY 2-5. We have continued to split the services for the January 1 to June 30, 2023 time period and composite into a single line for the remainder of WY 2.

Fee schedule change for Respite and changes in maximum allowable charge on modifications.

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

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

Personal care rates were updated in January 2022 to begin alignment with the expected consolidation of services in July 2023. The rate for Personal Care II ($25/hr) is the rate utilized for the consolidated personal care service.

Nursing service rates were updated in January 2022 also to begin alignment with expected consolidation of services in July 2023. The rate for Nursing Services is $42/hr., which is equivalent of the currently approved RN nursing rate. The rate for Enhanced Nursing (state plan private duty nursing) is $45 and reflects the $3.00 add-on as specified in the Medicaid state plan rate methodology section 4.19B.

For Caregiver Coaching, the Number of Users and Average Units Per User was based on SFY 2020 data for IDRD Waiver members and discussions with SCDHHS trended to the appropriate waiver year. For IDRD waiver services that did not have experience in SFY 2020, we used experience from the Community Choices waiver, the most recent IDRD 372 report, and approved HCBS waivers from other states to estimate the Number of Users and Average Units Per User. The average cost per unit was based on the IDRD 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:*

The expenditures for each component of the cost neutrality formula were developed based on SFY 2020 per capita expenditures trended to the appropriate waiver year. 3% unit cost trend was applied to claims consistent with the waiver service trend used in the CY 2021 Prime Capitation Rates. The SMA is transitioning transportation as a component of ADHC services. Input from ADHC providers currently providing transportation, in conjunction with the NEMT broker, was utilized to establish a base (minimum) blended rate for transportation. This incorporates an expected range distribution of mileage for participants and the expected percentage of participants in ambulatory and wheelchair-use categories. This methodology was utilized for cost projections in Appendix J.

Updates to projections for personal care, LPN nursing, and RN nursing services were based on increases made in South Carolina's Community Choices waiver and State Plan services rates for personal care and nursing respectively, in accordance with rate methodology as described in section I-2-a.

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:*

The expenditures for each component of the cost neutrality formula were developed based on SFY 2020 per capita expenditures trended to the appropriate waiver year. 2% unit cost trend was applied to ICF/IID claims consistent with the inpatient service trend used in the CY 2021 Prime Capitation Rates.

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

The expenditures for each component of the cost neutrality formula were developed based on SFY 2020 per capita expenditures trended to the appropriate waiver year. 2% unit cost trend was applied to ICF/IID claims consistent with the inpatient service trend used in the CY 2021 Prime Capitation Rates.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Health Care, Adult Day Health Care Services	
Personal Care Services	
Residential Habilitation	
Respite Care	
Waiver Case Management (WCM)	
Adult Dental Services	
Adult Vision	
Audiology Services	
Incontinence Supplies	
Nursing Services	
Adult Attendant Care Services	
Adult Companion Services	
Adult Day Health Care Nursing	
Adult Day Health Care Transportation--Ending 6/30/22	
Behavior Support Services	
Career Preparation Services	
Community Services	
Day Activity	

Waiver Services	
Employment Services	
Environmental Modifications	
Independent Living Skills	
Nursing Services - Ending 06/30/2023	
Personal Care 2, Personal Care 1- Ending 06/30/2023	
Personal Emergency Response System (PERS)	
Pest Control Treatment	
Pest Control-Bed Bugs	
Private Vehicle Assessment/Consultation	
Private Vehicle Modifications	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	
Specialized Medical Equipment, Supplies and Assistive Technology	
Support Center Services	

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
Adult Day Health Care, Adult Day Health Care Services Total:						**11529350.55**
Adult Day Health Care, Adult Day Health Care Services	Per day	1174	123.87	60.00	**8725402.80**	
Adult Day Health Care Transportation	Round Trip	574	139.41	35.04	**2803947.75**	
Personal Care Services Total:						**0.00**
Personal Care Services	15 mins	0	0.00	0.01	**0.00**	
Residential Habilitation Total:						**458845054.96**
Daily Residential Habilitation	Day	6002	333.77	226.71	**454165318.19**	
Hourly Residential Habilitation	15 Mins	384	652.05	18.69	**4679736.77**	
Respite Care Total:						**36648183.41**
ICF/IID Respite					**121002.39**	

GRAND TOTAL: 704189850.01

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 51664.70

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	8	53.99	280.15		
Respite - In-home hourly	15 Mins	4201	2115.32	4.05	35990160.25	
Nursing Facility Respite	Day	33	9.25	120.00	36630.00	
Respite - In-home hourly (2 Participants)	15 Mins	57	2115.37	2.53	305057.51	
Respite - In-home hourly (3 Participants)	15 Mins	57	2115.37	1.62	195333.27	
Waiver Case Management (WCM) Total:						18264081.48
Waiver Case Management - With Travel	15 Mins	13255	16.87	27.28	6100131.27	
Waiver Case Management - Without Travel	15 Mins	13590	52.56	16.77	11978650.01	
Transitional WCM with Travel	Per Claim	614	1.00	301.49	185114.86	
Transitional WCM without Travel	Per Claim	1	1.00	185.34	185.34	
Adult Dental Services Total:						1640549.63
Adult Dental Services	Visit	7599	4.38	49.29	1640549.63	
Adult Vision Total:						164403.58
Adult Vision	visit	1628	4.75	21.26	164403.58	
Audiology Services Total:						21137.53
Audiology Services	Visit	457	1.92	24.09	21137.53	
Incontinence Supplies Total:						5409924.58
Incontinence Supplies	Per Item	6762	322.60	2.48	5409924.58	
Nursing Services Total:						0.00
Nursing Services	Per Hour	0	0.00	0.01	0.00	
Adult Attendant Care Services Total:						796793.76
Adult Attendant Care Services	15 Mins	80	2459.24	4.05	796793.76	
Adult Companion Services Total:						558529.59
Adult Companion Services	15 mins	147	1046.70	3.63	558529.59	

GRAND TOTAL: 704189850.01

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 51664.70

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Nursing Total:						**214.50**
Adult Day Health Care Nursing	Per day	13	1.10	15.00	**214.50**	
Adult Day Health Care Transportation--Ending 6/30/22 Total:						**656174.99**
Adult Day Health Care Transportation--Ending 6/30/22	1 Way Trip	574	139.41	8.20	**656174.99**	
Behavior Support Services Total:						**98728.50**
Behavior Support Services	30 Mins	65	50.63	30.00	**98728.50**	
Caregiver Coaching (Effective 10/01/2024)	30 Mins	0	0.00	0.01	**0.00**	
Career Preparation Services Total:						**32112863.73**
Career Preparation Services	1/2 day = 2-3 hrs	2985	291.31	36.93	**32112863.73**	
Community Services Total:						**6935845.46**
Community Services	1/2 day = 2-3 hrs	1115	168.44	36.93	**6935845.46**	
Day Activity Total:						**39186962.18**
Day Activity	1/2 day = 2-3 hrs	3185	333.16	36.93	**39186962.18**	
Employment Services Total:						**17953755.17**
Individual	15 Mins	1319	121.45	24.74	**3963163.69**	
Group	1/2 day = 2-3 hours	1886	200.87	36.93	**13990591.48**	
Environmental Modifications Total:						**1500000.00**
Environmental Modifications	Lifetime	200	1.00	7500.00	**1500000.00**	
Independent Living Skills Total:						**1866777.85**
Independent Living Skills	15 Mins	476	463.57	8.46	**1866777.85**	
Nursing Services - Ending 06/30/2023 Total:						**7814208.15**
LPN Nursing - Ending 06/30/2023	Hour	119	1545.86	29.05	**5343960.73**	
RN Nursing - Ending 06/30/2023	Hour	51	1261.36	38.40	**2470247.42**	
Personal Care 2, Personal Care 1- Ending 06/30/2023						**60247812.52**

GRAND TOTAL: 704189850.01

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 51664.70

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Personal Care 1 - Ending 06/30/2023	15 Mins	555	856.48	3.60	**1711247.04**	
Personal Care 2 - Ending 06/30/2023	15 Mins	3104	3995.43	4.72	**58536565.48**	
Personal Emergency Response System (PERS) Total:						**39627.00**
Monthly Monitoring	Month	131	9.90	30.00	**38907.00**	
Installation	Per Installation	24	1.00	30.00	**720.00**	
Pest Control Treatment Total:						**96854.40**
Pest Control Treatment	Visit	608	3.54	45.00	**96854.40**	
Pest Control-Bed Bugs Total:						**96720.00**
Pest Control-Bed Bugs	Visit	93	1.04	1000.00	**96720.00**	
Private Vehicle Assessment/Consultation Total:						**3000.00**
Private Vehicle Assessment/Consultation	Per Claim	5	1.00	600.00	**3000.00**	
Private Vehicle Modifications Total:						**1145901.70**
Private Vehicle Modifications	Per Claim	43	2.08	12811.96	**1145901.70**	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						**2376.00**
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per Item	2	3.96	300.00	**2376.00**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**7383.39**
Specialized Equipment	Per Claim	9	1.58	331.07	**4707.82**	
Specialized Supplies	Per Claim	17	61.24	2.57	**2675.58**	
Support Center Services Total:						**546635.42**
Support Center Services	1/2 day = 2-3 hrs	78	219.76	31.89	**546635.42**	

GRAND TOTAL: 704189850.01

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 51664.70

Average Length of Stay on the Waiver: 345

Appendix J: Cost Neutrality Demonstration

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*
Adult Day Health Care, Adult Day Health Care Services Total:						***12195066.48***
Adult Day Health Care, Adult Day Health Care Services	*Per day*	*1174*	*123.87*	*64.00*	***9307096.32***	
Adult Day Health Care Transportation	*Round Trip*	*574*	*139.41*	*36.09*	***2887970.16***	
Personal Care Services Total:						***80482452.00***
Personal Care Services	*15 mins*	*3104*	*4148.58*	*6.25*	***80482452.00***	
Residential Habilitation Total:						***475589207.38***
Daily Residential Habilitation	*Day*	*6002*	*333.77*	*235.08*	***470932834.90***	
Hourly Residential Habilitation	*15 Mins*	*384*	*625.05*	*19.40*	***4656372.48***	
Respite Care Total:						***56226803.33***
ICF/IID Respite	*Day*	*8*	*53.99*	*280.15*	***121002.39***	
Respite - In-home hourly	*15 Mins*	*4201*	*2115.32*	*6.25*	***55540370.75***	
Nursing Facility Respite	*Day*	*33*	*9.25*	*120.00*	***36630.00***	
Respite - In-home hourly (2 Participants)	*15 Mins*	*58*	*2115.37*	*2.63*	***322678.54***	
Respite - In-home hourly (3 Participants)	*15 Mins*	*58*	*2115.37*	*1.68*	***206121.65***	
Waiver Case Management (WCM) Total:						***18959339.78***
Waiver Case Management - With Travel	*15 minute*	*13255*	*16.87*	*28.32*	***6332687.59***	
Waiver Case Management - Without Travel	*15 Minute*	*13590*	*52.56*	*17.41*	***12435795.86***	
Transitional WCM with Travel	*Per Claim*	*614*	*1.00*	*310.53*	***190665.42***	

GRAND TOTAL: ***812093614.50***

Total Estimated Unduplicated Participants: ***13630***

Factor D (Divide total by number of participants): ***59581.34***

Average Length of Stay on the Waiver: *345*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional WCM without Travel	Per Claim	1	1.00	190.90	190.90	
Adult Dental Services Total:						1689809.39
Adult Dental Services	Visit	7599	4.38	50.77	1689809.39	
Adult Vision Total:						169352.70
Adult Vision	Visit	1628	4.75	21.90	169352.70	
Audiology Services Total:						21769.29
Audiology Services	Visit	457	1.92	24.81	21769.29	
Incontinence Supplies Total:						5584438.27
Incontinence Supplies	Per Item	6762	322.60	2.56	5584438.27	
Nursing Services Total:						10428041.40
Nursing Services	Per Hour	170	1460.51	42.00	10428041.40	
Adult Attendant Care Services Total:						881391.62
Adult Attendant Care Services	15 Mins	80	2459.24	4.48	881391.62	
Adult Companion Services Total:						692392.05
Adult Companion Services	15 mins	147	1046.70	4.50	692392.05	
Adult Day Health Care Nursing Total:						214.50
Adult Day Health Care Nursing	Per day	13	1.10	15.00	214.50	
Adult Day Health Care Transportation--Ending 6/30/22 Total:						0.00
Adult Day Health Care Transportation--Ending 6/30/22	1 Way Trip	0	0.00	0.01	0.00	
Behavior Support Services Total:						102480.18
Behavior Support Services	30 Mins	65	50.63	31.14	102480.18	
Caregiver Coaching (Effective 10/01/2024)	30 Mins	0	0.00	0.01	0.00	
Career Preparation Services Total:						33338943.82
Career Preparation Services	1/2 day = 2-3 hrs	2985	291.31	38.34	33338943.82	

GRAND TOTAL: 812093614.50

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 59581.34

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Services Total:						**7200658.40**
Community Services	1/2 day = 2-3 hrs	1115	168.44	38.34	**7200658.40**	
Day Activity Total:						**40683133.76**
Day Activity	1/2 day = 2-3 hours	3185	333.16	38.34	**40683133.76**	
Employment Services Total:						**18640103.65**
Individual	15 Mins	1319	121.45	25.69	**4115346.61**	
Group	1/2 day = 2-3 hours	1886	200.87	38.34	**14524757.04**	
Environmental Modifications Total:						**1500000.00**
Environmental Modifications	Lifetime	100	1.00	15000.00	**1500000.00**	
Independent Living Skills Total:						**1939595.42**
Independent Living Skills	15 Mins	476	463.57	8.79	**1939595.42**	
Nursing Services - Ending 06/30/2023 Total:						**4570170.01**
LPN Nursing - Ending 06/30/2023	Hour	119	772.93	35.00	**3219253.45**	
RN Nursing - Ending 06/30/2023	Hour	51	630.68	42.00	**1350916.56**	
Personal Care 2, Personal Care 1- Ending 06/30/2023 Total:						**40062970.60**
Personal Care 1 - Ending 06/30/2023	15 Mins	555	428.24	5.50	**1307202.60**	
Personal Care 2 - Ending 06/30/2023	15 Mins	3104	1997.72	6.25	**38755768.00**	
Personal Emergency Response System (PERS) Total:						**39627.00**
Monthly Monitoring	Month	131	9.90	30.00	**38907.00**	
Installation	Per Installation	24	1.00	30.00	**720.00**	
Pest Control Treatment Total:						**96854.40**
Pest Control Treatment	Visit	608	3.54	45.00	**96854.40**	
Pest Control-Bed Bugs Total:						**96720.00**
Pest Control-Bed Bugs	Visit				**96720.00**	

GRAND TOTAL: 812093614.50

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 59581.34

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		93	1.04	1000.00		
Private Vehicle Assessment/Consultation Total:						**3000.00**
Private Vehicle Assessment/Consultation	Per Claim	5	1.00	600.00	**3000.00**	
Private Vehicle Modifications Total:						**332175.00**
Private Vehicle Modifications	Per Claim	43	1.00	7725.00	**332175.00**	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						**2376.00**
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per item	2	3.96	300.00	**2376.00**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**7607.88**
Specialized Equipment	Per Claim	9	1.58	341.00	**4849.02**	
Specialized Supplies	Per Claim	17	61.24	2.65	**2758.86**	
Support Center Services Total:						**556920.19**
Support Center Services	1/2 day = 2-3 hours	78	219.76	32.49	**556920.19**	

GRAND TOTAL: 812093614.50
Total Estimated Unduplicated Participants: 13630
Factor D (Divide total by number of participants): 59581.34
Average Length of Stay on the Waiver: 345

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
Adult Day Health Care, Adult Day Health Care						**12560702.42**

GRAND TOTAL: 790624806.13
Total Estimated Unduplicated Participants: 13630
Factor D (Divide total by number of participants): 58006.22
Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:						
Adult Day Health Care, Adult Day Health Care Services	Per Day	1174	123.87	65.92	**9586309.21**	
Adult Day Health Care Transportation	Round Trip	574	139.41	37.17	**2974393.21**	
Personal Care Services Total:						**82929118.54**
Personal Care Services	15 mins	3104	4148.58	6.44	**82929118.54**	
Residential Habilitation Total:						**489851595.68**
Daily Residential Habilitation	Day	6002	333.77	242.13	**485056012.06**	
Hourly Residential Habilitation	15 Mins	384	625.05	19.98	**4795583.62**	
Respite Care Total:						**57954692.00**
ICF/IID Respite	Day	8	53.99	288.55	**124630.52**	
Respite - In-home hourly	15 Mins	4201	2115.32	6.44	**57228798.02**	
Nursing Facility Respite	Day	33	9.25	123.60	**37728.90**	
Respite - In-home hourly (2 Participants)	15 Mins	60	2115.37	2.71	**343959.16**	
Respite - In-home hourly (3 Participants)	15 Mins	60	2115.37	1.73	**219575.41**	
Waiver Case Management (WCM) Total:						**19526569.06**
Waiver Case Management - With Travel	15 Mins	13255	16.87	29.17	**6522757.66**	
Waiver Case Management - Without Travel	15 Mins	13590	52.56	17.93	**12807226.87**	
Transitional WCM with Travel	Per Claim	614	1.00	319.85	**196387.90**	
Transitional WCM without Travel	Per Claim	1	1.00	196.62	**196.62**	
Adult Dental Services Total:						**1740400.49**
Adult Dental Services	Visit	7599	4.38	52.29	**1740400.49**	
Adult Vision Total:						**174456.48**
Adult Vision	Visit	1628	4.75	22.56	**174456.48**	
Audiology Services Total:						**22427.37**

GRAND TOTAL: 790624806.13

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 58006.22

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Audiology Services	Visit	457	1.92	25.56	22427.37	
Incontinence Supplies Total:						5737137.76
Incontinence Supplies	Per Item	6762	322.60	2.63	5737137.76	
Nursing Services Total:						10740882.64
Nursing Services	Per Hour	170	1460.51	43.26	10740882.64	
Adult Attendant Care Services Total:						906967.71
Adult Attendant Care Services	15 Mins	80	2459.24	4.61	906967.71	
Adult Companion Services Total:						713933.14
Adult Companion Services	15 mins	147	1046.70	4.64	713933.14	
Adult Day Health Care Nursing Total:						220.94
Adult Day Health Care Nursing	Per day	13	1.10	15.45	220.94	
Adult Day Health Care Transportation--Ending 6/30/22 Total:						0.00
Adult Day Health Care Transportation--Ending 6/30/22	1 Way Trip	0	0.00	0.01	0.00	
Behavior Support Services Total:						196363.01
Behavior Support Services	30 Mins	65	50.63	32.07	105540.77	
Caregiver Coaching (Effective 10/01/2024)	30 Mins	59	48.00	32.07	90822.24	
Career Preparation Services Total:						34338938.22
Career Preparation Services	1/2 day = 2-3 hours	2985	291.31	39.49	34338938.22	
Community Services Total:						7416640.59
Community Services	1/2 day = 2-3 hours	1115	168.44	39.49	7416640.59	
Day Activity Total:						41903415.55
Day Activity	1/2 day = 2-3 hours	3185	333.16	39.49	41903415.55	
Employment Services Total:						19199118.85
Individual	15 Mins	1319	121.45	26.46	4238694.87	

GRAND TOTAL: 790624806.13

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 58006.22

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	1/2 day = 2-3 hours	1886	200.87	39.49	14960423.98	
Environmental Modifications Total:						1545000.00
Environmental Modifications	Lifetime	100	1.00	15450.00	1545000.00	
Independent Living Skills Total:						1996966.85
Independent Living Skills	15 Mins	476	463.57	9.05	1996966.85	
Nursing Services - Ending 06/30/2023 Total:						0.00
LPN Nursing - Ending 06/30/2023	Hour	0	0.00	0.01	0.00	
RN Nursing - Ending 06/30/2023	Hour	0	0.00	0.01	0.00	
Personal Care 2, Personal Care 1- Ending 06/30/2023 Total:						0.00
Personal Care 1 - Ending 06/30/2023	15 Mins	0	0.00	0.01	0.00	
Personal Care 2 - Ending 06/30/2023	15 Mins	0	0.00	0.01	0.00	
Personal Emergency Response System (PERS) Total:						40815.81
Monthly Monitoring	Month	131	9.90	30.90	40074.21	
Installation	Per installation	24	1.00	30.90	741.60	
Pest Control Treatment Total:						99760.03
Pest Control Treatment	Visit	608	3.54	46.35	99760.03	
Pest Control-Bed Bugs Total:						99621.60
Pest Control-Bed Bugs	Visit	93	1.04	1030.00	99621.60	
Private Vehicle Assessment/Consultation Total:						3090.00
Private Vehicle Assessment/Consultation	Per claim	5	1.00	618.00	3090.00	
Private Vehicle Modifications Total:						342140.25
Private Vehicle Modifications	Per claim	43	1.00	7956.75	342140.25	
Specialized Medical Equipment, Supplies and Assistive Technology						2447.28

GRAND TOTAL: 790624806.13

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 58006.22

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment/Consultation Total:						
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per item	2	3.96	309.00	**2447.28**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**7836.64**
Specialized Equipment	Per Claim	9	1.58	351.23	**4994.49**	
Specialized Supplies	Per Claim	17	61.24	2.73	**2842.15**	
Support Center Services Total:						**573547.23**
Support Center Services	1/2 day = 2-3 hours	78	219.76	33.46	**573547.23**	

GRAND TOTAL: 790624806.13
Total Estimated Unduplicated Participants: 13630
Factor D (Divide total by number of participants): 58006.22
Average Length of Stay on the Waiver: 345

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
Adult Day Health Care, Adult Day Health Care Services Total:						**12938264.61**
Adult Day Health Care, Adult Day Health Care Services	Per day	1174	123.87	67.90	**9874247.50**	
Adult Day Health Care Transportation	Round Trip	574	139.41	38.29	**3064017.11**	
Personal Care Services Total:						**85375785.08**
Personal Care Services	15 mins	3104	4148.58	6.63	**85375785.08**	
Residential Habilitation Total:						**504539474.74**
Daily Residential					**499599879.60**	

GRAND TOTAL: 823090677.48
Total Estimated Unduplicated Participants: 13630
Factor D (Divide total by number of participants): 60388.16
Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation	Day	6002	333.77	249.39		
Hourly Residential Habilitation	15 Mins	384	625.05	20.58	4939595.14	
Respite Care Total:						59674159.31
ICF/IID Respite	Day	8	53.99	297.21	128370.94	
Respite - In-home hourly	15 Mins	4201	2115.32	6.63	58917225.29	
Nursing Facility Respite	Day	33	9.25	127.31	38861.38	
Respite - In-home hourly (2 Participants)	15 Mins	61	2115.37	2.79	360014.82	
Respite - In-home hourly (3 Participants)	15 Mins	61	2115.37	1.78	229686.87	
Waiver Case Management (WCM) Total:						20115238.55
Waiver Case Management - With Travel	15 Mins	13255	16.87	30.04	6717299.97	
Waiver Case Management - Without Travel	15 Mins	13590	52.57	18.47	13195453.76	
Transitional WCM with Travel	Per Claim	614	1.00	329.45	202282.30	
Transitional WCM without Travel	Per Claim	1	1.00	202.52	202.52	
Adult Dental Services Total:						1792655.77
Adult Dental Services	Visit	7599	4.38	53.86	1792655.77	
Adult Vision Total:						179637.59
Adult Vision	Visit	1628	4.75	23.23	179637.59	
Audiology Services Total:						23094.22
Audiology Services	Visit	457	1.92	26.32	23094.22	
Incontinence Supplies Total:						5911651.45
Incontinence Supplies	Per Item	6762	322.60	2.71	5911651.45	
Nursing Services Total:						11063655.35
Nursing Services	Per Hour	170	1460.51	44.56	11063655.35	
Adult Attendant Care Services Total:						934511.20

GRAND TOTAL: 823090677.48

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 60388.16

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Attendant Care Services	15 Mins	80	2459.24	4.75	934511.20	
Adult Companion Services Total:						733935.57
Adult Companion Services	15 mins	147	1046.70	4.77	733935.57	
Adult Day Health Care Nursing Total:						227.51
Adult Day Health Care Nursing	Per Day	13	1.10	15.91	227.51	
Adult Day Health Care Transportation--Ending 6/30/22 Total:						0.00
Adult Day Health Care Transportation--Ending 6/30/22	1 Way Trip	0	0.00	0.01	0.00	
Behavior Support Services Total:						483010.11
Behavior Support Services	30 Mins	65	50.63	33.04	108732.99	
Caregiver Coaching (Effective 10/01/2024)	30 Mins	59	192.00	33.04	374277.12	
Career Preparation Services Total:						35365019.43
Career Preparation Services	1/2 day = 2-3 hours	2985	291.31	40.67	35365019.43	
Community Services Total:						7638257.10
Community Services	1/2 day = 2-3 hours	1115	168.44	40.67	7638257.10	
Day Activity Total:						43155530.78
Day Activity	1/2 day = 2-3 hours	3185	333.16	40.67	43155530.78	
Employment Services Total:						19772703.14
Individual	15 Mins	1319	121.45	27.25	4365246.99	
Group	1/2 day = 2-3 hours	1886	200.87	40.67	15407456.15	
Environmental Modifications Total:						1591350.00
Environmental Modifications	Lifetime	100	1.00	15913.50	1591350.00	
Independent Living Skills Total:						2058751.46
Independent Living Skills	15 Mins	476	463.57	9.33	2058751.46	
Nursing Services - Ending 06/30/2023 Total:						8538065.92

GRAND TOTAL: 823090677.48

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 60388.16

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LPN Nursing - Ending 06/30/2023	Hour	119	1545.86	31.74	5838805.97	
RN Nursing - Ending 06/30/2023	Hour	51	1261.36	41.96	2699259.95	
Personal Care 2, Personal Care 1- Ending 06/30/2023 Total:						0.00
Personal Care 1 - Ending 06/30/2023	15 Mins	0	0.00	0.01	0.00	
Personal Care 2 - Ending 06/30/2023	15 Mins	0	0.00	0.01	0.00	
Personal Emergency Response System (PERS) Total:						43299.10
Monthly Monitoring	Month	131	9.90	32.78	42512.38	
Installation	Per installation	24	1.00	32.78	786.72	
Pest Control Treatment Total:						102751.76
Pest Control Treatment	Visit	608	3.54	47.74	102751.76	
Pest Control-Bed Bugs Total:						102610.25
Pest Control-Bed Bugs	Visit	93	1.04	1060.90	102610.25	
Private Vehicle Assessment/Consultation Total:						3182.70
Private Vehicle Assessment/Consultation	Per claim	5	1.00	636.54	3182.70	
Private Vehicle Modifications Total:						352404.35
Private Vehicle Modifications	Per claim	43	1.00	8195.45	352404.35	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						2520.70
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per item	2	3.96	318.27	2520.70	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						8069.80
Specialized Equipment	Per claim	9	1.58	361.77	5144.37	
Specialized Supplies	Per claim	17	61.24	2.81	2925.43	

GRAND TOTAL: 823090677.48

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 60388.16

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Center Services Total:						**590859.92**
Support Center Services	1/2 day = 2-3 hours	78	219.76	34.47	**590859.92**	

GRAND TOTAL: 823090677.48
Total Estimated Unduplicated Participants: 13630
Factor D (Divide total by number of participants): 60388.16
Average Length of Stay on the Waiver: 345

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
Adult Day Health Care, Adult Day Health Care Services Total:						**13325498.61**
Adult Day Health Care, Adult Day Health Care Services	Per day	1174	123.87	69.93	**10169456.96**	
Adult Day Health Care Transportation	Round Trip	574	139.41	39.44	**3156041.65**	
Personal Care Services Total:						**87951223.55**
Personal Care Services	15 mins	3104	4148.58	6.83	**87951223.55**	
Residential Habilitation Total:						**519672877.44**
Daily Residential Habilitation	Day	6002	333.77	256.87	**514584470.40**	
Hourly Residential Habilitation	15 Mins	384	625.05	21.20	**5088407.04**	
Respite Care Total:						**61494462.00**
ICF/IID Respite	Day	8	53.99	306.13	**132223.67**	
Respite - In-home hourly	15 Mins	4201	2115.32	6.83	**60694517.16**	
Nursing Facility Respite	Day	33	9.25	131.13	**40027.43**	

GRAND TOTAL: 839047783.97
Total Estimated Unduplicated Participants: 13630
Factor D (Divide total by number of participants): 61558.90
Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - In-home hourly (2 Participants)	15 Mins	63	2115.37	2.87	382480.05	
Respite - In-home hourly (3 Participants)	15 Mins	63	2115.37	1.84	245213.69	
Waiver Case Management (WCM) Total:						20715147.39
Waiver Case Management - With Travel	15 Mins	13255	16.87	30.95	6920786.76	
Waiver Case Management - Without Travel	15 Mins	13590	52.56	19.02	13585803.41	
Transitional WCM with Travel	Per Claim	614	1.00	339.33	208348.62	
Transitional WCM without Travel	Per Claim	1	1.00	208.60	208.60	
Adult Dental Services Total:						1846242.40
Adult Dental Services	Visit	7599	4.38	55.47	1846242.40	
Adult Vision Total:						185050.69
Adult Vision	Visit	1628	4.75	23.93	185050.69	
Audiology Services Total:						23787.40
Audiology Services	Visit	457	1.92	27.11	23787.40	
Incontinence Supplies Total:						6086165.15
Incontinence Supplies	Per Item	6762	322.60	2.79	6086165.15	
Nursing Services Total:						11393876.66
Nursing Services	Per Hour	170	1460.51	45.89	11393876.66	
Adult Attendant Care Services Total:						964022.08
Adult Attendant Care Services	15 Mins	80	2459.24	4.90	964022.08	
Adult Companion Services Total:						757015.31
Adult Companion Services	15 mins	147	1046.70	4.92	757015.31	
Adult Day Health Care Nursing Total:						234.38
Adult Day Health Care Nursing	Per day	13	1.10	16.39	234.38	
Adult Day Health Care Transportation--Ending 6/30/22 Total:						0.00

GRAND TOTAL: 839047783.97

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 61558.90

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Transportation--Ending 6/30/22	1 Way Trip	0	0.00	0.01	0.00	
Behavior Support Services Total:						497482.87
Behavior Support Services	30 Mins	65	50.63	34.03	111991.03	
Caregiver Coaching (Effective 10/01/2024)	30 Mins	59	192.00	34.03	385491.84	
Career Preparation Services Total:						36434578.66
Career Preparation Services	1/2 day = 2-3 hours	2985	291.31	41.90	36434578.66	
Community Services Total:						7869264.14
Community Services	1/2 day = 2-3 hours	1115	168.44	41.90	7869264.14	
Day Activity Total:						44460701.74
Day Activity	1/2 day = 2-3 hours	3185	333.16	41.90	44460701.74	
Employment Services Total:						20370035.24
Individual	15 Mins	1319	121.45	28.07	4496604.88	
Group	1/2 day = 2-3 hours	1886	200.87	41.90	15873430.36	
Environmental Modifications Total:						1639091.00
Environmental Modifications	Lifetime	100	1.00	16390.91	1639091.00	
Independent Living Skills Total:						2120536.07
Independent Living Skills	15 Mins	476	463.57	9.61	2120536.07	
Nursing Services - Ending 06/30/2023 Total:						0.00
LPN Nursing - Ending 06/30/2023	Hour	0	0.00	0.01	0.00	
RN Nursing - Ending 06/30/2023	Hour	0	0.00	0.01	0.00	
Personal Care 2, Personal Care 1- Ending 06/30/2023 Total:						0.00
Personal Care 1 - Ending 06/30/2023	15 Mins	0	0.00	0.01	0.00	
Personal Care 2 - Ending 06/30/2023	15 Mins	0	0.00	0.01	0.00	
Personal Emergency Response System (PERS)						43299.10

GRAND TOTAL: 839047783.97

Total Estimated Unduplicated Participants: 13630

Factor D (Divide total by number of participants): 61558.90

Average Length of Stay on the Waiver: 345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Monthly Monitoring	Month	131	9.90	32.78	**42512.38**	
Installation	Per installation	24	1.00	32.78	**786.72**	
Pest Control Treatment Total:						**105829.57**
Pest Control Treatment	Visit	608	3.54	49.17	**105829.57**	
Pest Control-Bed Bugs Total:						**105688.85**
Pest Control-Bed Bugs	Visit	93	1.04	1092.73	**105688.85**	
Private Vehicle Assessment/Consultation Total:						**3278.20**
Private Vehicle Assessment/Consultation	Per claim	5	1.00	655.64	**3278.20**	
Private Vehicle Modifications Total:						**362976.33**
Private Vehicle Modifications	Per claim	43	1.00	8441.31	**362976.33**	
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation Total:						**2596.33**
Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation	Per item	2	3.96	327.82	**2596.33**	
Specialized Medical Equipment, Supplies and Assistive Technology Total:						**8307.38**
Specialized Equipment	Per claim	9	1.58	372.62	**5298.66**	
Specialized Supplies	Per claim	17	61.24	2.89	**3008.72**	
Support Center Services Total:						**608515.44**
Support Center Services	1/2 day = 2-3 hours	78	219.76	35.50	**608515.44**	

GRAND TOTAL: ***839047783.97***

Total Estimated Unduplicated Participants: ***13630***

Factor D (Divide total by number of participants): ***61558.90***

Average Length of Stay on the Waiver: 345