

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Request Information

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**A.** The **State of South Dakota** 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:**  
Assistive Daily Living Services Waiver

**C. Waiver Number:** SD.0264  
**Original Base Waiver Number:** SD.0264.90.R2

**D. Amendment Number:**

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

07/01/16

**Approved Effective Date of Waiver being Amended:** 06/01/12

### 2. Purpose(s) of Amendment

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

- Amendment of the ADLS waiver is due to difficulties participants have in hiring and directing their own personal attendants through the self-directed model. While the waiver will continue to support self-direction as the main philosophy behind the waiver, it is also clear that more alternatives are needed to assist participants in obtaining the personal attendant services in a way that will better meet their needs. One purpose of the amendment is to allow participants to hire in-home health providers using the traditional method as a supplement to hiring personal attendants through the self-directed Employer of Choice model.
- DRS will add services for participants in order to better meet their needs in the community. Specifically, additional services will include Environmental Accessibility Adaptations, Vehicle Modifications, Respite Care, and Specialized Medical and Adaptive Equipment and Supplies.
- Increase incontinence supplies to \$200 per month.
- Case Management will be removed as a service from the waiver, and this process will be provided by state DRS Service Coordinators as a Medicaid administrative activity. DRS is currently out of compliance with conflict-free case management, and will be resolving that non-compliance issue by hiring Case Managers that do not provide any direct services to the participants.
- Cost share formula will be revised to 300% of Federal Poverty Level.
- DRS will change language to use the average per capita expenditures under the waiver not to exceed 100% of the average per capita expenditures during the same year for the level of care provided in a nursing facility. Currently the state is using individual costs of HCBS compared with individual cost of nursing facilities.

- Increase amount of Personal Attendant hours per week, with the ability to increase over the stipulated amount on a permanent basis upon approval of ADLS Waiver Manager. Currently, ADLS Waiver Manager can only approve an increase in hours if it is of a temporary nature.
- Revise wording to allow the participant to select the designation of a representative to broaden the accessibility of self-direction.

### 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)
<input checked="" type="checkbox"/> Waiver Application	Application, 2. I, Att
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	Appendix A-2b;
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	Appendix B-1; B-2
<input checked="" type="checkbox"/> Appendix C – Participant Services	Appendix C-C1/C3;
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	Appendix D-1; D-2
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	Appendix E-1
<input checked="" type="checkbox"/> Appendix F – Participant Rights	Appendix F-1
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	Appendix G-2
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	Appendix I-2
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	Appendix J-2

- 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:

Revise Post-Eligibility treatment of income, revise language for participant direction of services.

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

### 1. Request Information (1 of 3)

- A.** The State of South Dakota requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
Assistive Daily Living Services Waiver
- C. Type of Request:** amendment

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

- 3 years  5 years

**Original Base Waiver Number: SD.0264****Draft ID: SD.003.04.01****D. Type of Waiver** *(select only one):*Regular Waiver **E. Proposed Effective Date of Waiver being Amended: 06/01/12****Approved Effective Date of Waiver being Amended: 06/01/12****1. Request Information (2 of 3)**

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**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:

The state does not additionally limit the waiver to subcategories of nursing facility 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)**

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

Select one:

 **Not applicable** **Applicable**

Check the applicable authority or authorities:

 **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I** **Waiver(s) authorized under §1915(b) of the Act.**

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

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):* **§1915(b)(1) (mandated enrollment to managed care)** **§1915(b)(2) (central broker)** **§1915(b)(3) (employ cost savings to furnish additional services)**

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

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

#### H. Dual Eligibility 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

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

The Assistive Daily Living Services (ADLS) waiver is for individuals who are at least 18 years old with quadriplegia resulting from ataxia, cerebral palsy, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, traumatic brain injury, congenital conditions, accidents and injuries to the spinal cord, and other neuromuscular or cerebral conditions or diseases, or an individual with four limbs absent due to disease, trauma or congenital conditions.

The goal of the ADLS program is:

To support eligible individuals with quadriplegia to live independently in their homes and in the communities of their choice as an alternative to living in a nursing home.

The objectives of the ADLS Waiver are to:

- Promote independence for participants through the provision of services while ensuring health and safety;
- Offer an alternative to costly institutional care through an array of services and supports that promote independence; and
- Support participants to exercise their rights and responsibilities for their program regardless of the method of service delivery.

Organizational structure: Administrative authority remains with the Department of Social Services, the State Medicaid Agency. The Department of Human Services/Division of Rehabilitation Services, through a Memorandum of Understanding with the Department of Social Services, operates the Assistive Daily Living Services Waiver.

The Department of Social Services and the Department of Human Services jointly develop policies and procedures and Administrative Rules.

The ADLS waiver provides services that are not available under the State Medicaid Plan. When used in conjunction with non-waiver Medicaid services and other natural supports, the ADLS waiver supports individuals to live independently in a home and community based setting. This waiver is operated on a statewide basis.

Services are provided by qualified providers. All providers must have current Medicaid Provider Agreements. Providers are reviewed annually by the ADLS Waiver Manager.

The ADLS Waiver Manager reviews all program applications. Applicants are provided contact information to ensure they are financially eligible for the program. Applicants are referred to a DRS Service Coordinator to be assessed for the program. Once the assessment is completed by the DRS Service Coordinator, it is sent to the ADLS Waiver Manager. Level of Care is determined following review of the assessment by the DRS Utilization Review Team (URT), in consultation with the Department of Social Services (state Medicaid agency), Division of Medical Services Program

Specialist. All parties are notified of the LOC determination. All program participants are assessed for eligibility on an annual basis and a new level of care is issued annually.

All providers and a statistically valid sample of program participants are reviewed on an annual basis to ensure that all health, safety and welfare assurances are met, that a service plan is in effect, and being followed, and that services are provided and invoiced as described in the Service Plan. Any problems identified are remediated until a satisfactory resolution is determined.

Waiver services that are crucial in helping the participants to remain in their home may include consumer preparation services, personal attendant services, private duty nursing, environmental accessibility adaptations, vehicle modifications, respite care, specialized medical equipment and supplies, personal emergency response, and incontinence supplies. The range of services is vital in making sure that the appropriate supports are in a menu of choices that best meet the needs of the participant.

### 3. Components of the Waiver Request

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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

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

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

- Not Applicable**  
 **No**  
 **Yes**

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

- No**  
 **Yes**

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

- Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements 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

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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:

- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
- 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,
- Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence

or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
As DRS began to prepare to write the ADLS waiver amendment, several mechanisms were identified to receive input and support for the ADLS waiver.

South Dakota obtained public input about current operations of the ADLS waiver by sending a survey to current participants of the ADLS waiver, as well as residents in nursing homes who have quadriplegia. The surveys were mailed, with self-addressed stamped envelopes provided to encourage responses. The survey was also available on a Survey Monkey, with the survey monkey web address posted on the mailed survey to allow people to submit their survey through Survey Monkey, if they chose. When surveys were received, the results were aggregated and analyzed. Of the 98 surveys mailed out to all current ADLS participants, DRS received 44 returned surveys by mail, a 45% response rate. Of the 34 surveys sent to people with quadriplegia in South Dakota nursing homes, 11 surveys were returned by mail, a 32% response rate. Although the Survey Monkey was an option for both populations, no surveys were submitted using that online option. Services identified within the survey as a need were added to the amendment request. Survey results also identified a need to allow traditional method of personal attendant services through an in-home service provider based on difficulty participants have had in hiring PA's through the self-directed method. Narrative responses within the survey identified participant difficulty in hiring and retaining qualified PA's. Comments and public input have been gathered through the public input process.

A workgroup was established, comprised of current ADLS participants, family members, ADLS provider agency staff, SSMA staff, DHS staff, including DHS Budget & Finance, Division Director and ADLS Waiver Manager, as well as SD Advocacy Services. Survey results were reviewed during the workgroup meeting, challenges of the waiver and potential changes to the waiver were discussed. Based on discussion during the workgroup meeting, member comments were reviewed and appropriate action has been taken to incorporate changes or modifications to the waiver amendment to benefit the participant, service delivery and quality of care. For example, PA services were increased to 50 hours per week with the ability of the ADLS Waiver Manager to approve additional hours above

that, if warranted. In addition, ability to hire in-home providers for personal attendant services was discussed at length, which resulted in flexibility to personal attendant service provision while still maintaining the self-direction philosophy that this waiver was founded on.

Public notice was provided in both electronic and non-electronic formats and the entire waiver amendment document was made available on the DHS website to allow for general public comment. Public notice was published on the DHS website, in the Legislative Research Council (LRC) register, and flyers were posted in provider agency offices, Department of Social Services local offices, Vocational Rehabilitation local offices, Centers for Independent Living, and with the SD Coalition of Citizens with Disabilities and SD Advocacy Services. Communication was mailed to current ADLS participants and stakeholders, including the Board of VR and Statewide Independent Living Council, who were notified of the waiver amendment to allow for public review and comment. The state met with the Tribal Consultation Committee and DSS Medical Advisory Committee to review with them the proposed changes to the waiver.

The formal public comment period occurred from February 8 to March 9, 2016. A public meeting is held via webinar/conference call February 18, 2016, providing information to stakeholders regarding the proposed amendment, with an opportunity for stakeholders to ask questions and get clarification. In addition to receiving input at the public meeting during the formal public comment period, there is opportunity for public comment through email, toll-free phone number, and mailing address. As a result of the public comment period, (add language here as result of public comments).

**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)

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

**Last Name:**

Schwartz

**First Name:**

Ann

**Title:**

Deputy Division Director

**Agency:**

Department of Social Services, Division of Medical Services

**Address:**

700 Governors Drive Kneip Building

**Address 2:**

c/o 500 East Capitol Avenue

**City:**

Pierre

**State:**

**South Dakota**

**Zip:**

**Phone:**Ext:   TTY**Fax:****E-mail:****B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:**Last Name:****First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****South Dakota****Zip:****Phone:**Ext:   TTY**Fax:****E-mail:**

## 8. Authorizing Signature

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

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Signature: 

State Medicaid Director or Designee

Submission Date: 


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**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 Dakota**Zip: Phone:  Ext:   TTYFax: 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:

Case Management will be removed as a service in the waiver. It will be provided by a state employee who does not provide any other direct services to the ADLS participant. The transition plan will include hiring DRS Service Coordinators who will provide case management statewide. DRS Service Coordinators will provide all services and supports the current Case Managers provide, in addition to providing options of new services which are being added and supporting the process of hiring PA's through self-direction, as well as through the in-home service provider model, when needed. ADLS participants will be notified of the change in advance. There will be time for transition where the current Case Managers can provide training to new Service Coordinators during the transition period. The ADLS Waiver Manager will also provide training to the DRS Service Coordinators immediately upon hire. ADLS participants will be notified in advance that effective July 1, 2016, they will have a new DRS Service Coordinator assisting and supporting them with the waiver services and their service plan. Participant services shall remain uninterrupted during this transition time period.

Services to be added include respite care, environmental accessibility adaptations, specialized medical supplies and equipment and vehicle modifications. During the transition period, DRS will be working with vendors to establish a process to be able to obtain needed equipment and services through Medicaid approved vendors/providers. This may take time to get established, and the intent of the waiver is to have this process completed so that ADLS participants can be able to receive all new needed services by January 1, 2017.

Increasing the limit of \$200 per month for incontinence supplies can begin July 1, 2016. Increasing the personal attendant rate to extend beyond the current limit of 42 hours, if needed, will begin on July 1, 2016. The DRS Service Coordinator will contact participants to prepare for their annual level of care review and development of their service plan according to their regularly scheduled meeting time, unless an earlier meeting is warranted. If warranted, the DRS Service Coordinator will meet with the participant prior to their annual level of care review to increase personal attendant hours and incontinence supplies, as necessary.

The cost share change will also go into effect on July 1, 2016. Department of Social Services (DSS) Office of Economic Assistance will run a query of all active ADLS participants in mid-June 2016 and adjust the budget as necessary based on the new formula. DSS will complete a Notice of Action and mail it out to all current ADLS participants informing them of the change in their cost share.

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

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

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

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

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

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

Services in the ADLS Waiver are provided only to individuals living in their own home or the family home and are intended to maximize independence and safety and support full community access and integration. Individuals do not live in congregate settings. The waiver services are provided in their home, where they have opportunities to seek employment and work in competitive, integrated settings; are able to engage in the community; control their own resources; and receive services to the same degree of access as individuals not receiving Medicaid HCBS. This setting is selected by the individual from other options, including institutional care. The participants are offered choice of settings and service options as identified in their person-centered service plan, based on their individual needs, preferences and resources.

The Department of Human Services and Department of Social Services (SSMA) presume all settings in the 1915(c) waiver to meet the requirements of the federal regulation for the ADLS waiver. The settings for the ADLS waiver will not be changing, and there are no plans in the future to include any type of congregate living. At each waiver renewal, the ADLS

waiver will evaluate services and service providers to determine if any services may be subject to the settings requirements in the federal regulations.

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

### Additional Needed Information (Optional)

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Provide additional needed information for the waiver (optional):

### Appendix A: Waiver Administration and Operation

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**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:

**Department of Human Services (DHS), Division of Rehabilitation Services (DRS)**

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

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**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:

The Department of Human Services (DHS) Division of Rehabilitation Services (DRS) operates the Assistive Daily Living Services (ADLS) Waiver. DHS/DRS is a separate executive branch agency from the Department of Social Services (DSS), which is the designated Single State Medicaid Agency (SSMA). A Memorandum of Understanding (MOU) signed by the Cabinet Secretary of each department sets forth the responsibilities of each department.

DSS, to exercise administrative authority and supervision of the waiver, is responsible:

- To pay DHS Medicaid claims through the DSS Medicaid Management Information System;
- To approve the Home and Community-Based Services (HCBS) Waiver programs operated by DHS and submit approved waiver requests to the federal government;
- To monitor DHS operation of HCBS Waiver programs through review of annual reports detailing: dissemination of information concerning the programs to potential participants; assistance offered to prospective participants in enrolling; management of waiver enrollment and expenditures against approved limits; evaluation of level of care against federal and state standards; review of waiver payment amounts or rates; and review of participant service plans to ensure all waiver requirements are met;
- To review changes proposed by DHS in DSS Medicaid regulations; to make recommendations to DHS regarding compliance with federal statutes, rules, and regulations; and to submit changes in Medicaid rules and regulations proposed by DHS in accordance with South Dakota's Administrative Procedures Act;
- To review and approve Medicaid State Plan amendments proposed by DHS and to forward approved amendments to the federal government;
- To furnish DHS on a timely and regular basis with such reports and information as may be required to ensure that DHS can satisfy state and federal fiscal responsibility requirements;
- To seek review and comment from DHS prior to the promulgation of any rules, regulations, or standards that may affect the services, programs, or providers of services for eligible individuals with intellectual/developmental disabilities and adults who have quadriplegia;
- To assist DHS as requested in maintaining the rate-setting and financial accountability standards required by CMS. DSS serving as the SSMA has provided through approved rate setting and financial accountability assurances to the federal government that Title XIX funds are used for the sole purpose of providing Title XIX services;
- To provide assurance to the federal government by completing random reviews of the reported Title XIX expenditures;
- To maintain the State's Title XIX Medicaid Administrative Rules chapter and to have primary responsibility for the State's Title XIX State Plan;
- To maintain primary responsibility for the Title XIX eligibility determination process;
- To perform the administrative hearings process for DHS when the issue is Title XIX-related;
- To immediately forward all proposed hearing decisions regarding non-financial eligibility issues for the Title XIX Medicaid Waiver Programs administered by DHS to the Cabinet Secretary of DHS for review prior to the issuance of a final decision. Unless contrary to the rules relating to the time limit for issuance of final decisions, DSS will give DHS seven days upon receipt of the proposed decision to review and submit comments to DSS regarding the proposed decision. If the review must be completed in less than seven days, DSS will promptly notify DHS of the necessary timeframe for review;
- To immediately notify and forward requests for a hearing regarding non-financial eligibility issues for the Title XIX Medicaid Waiver Programs administered by DHS to the Division Director within DHS who administers the program. The Title XIX programs are Intermediate Care Facilities for the Mentally Retarded or Developmentally Disabled (ICF/MR-DD); Home and Community-Based Services; and Assistive Daily Living Services for Individuals with Quadriplegia; and
- To make disability determinations through the DSS Disability Incapacity Consultation Teams.

As the SSMA, DSS will continue its role with regard to federal reporting and cost allocation matters involving Title XIX. The primary reason for this is that the United States Department of Health and Human Services looks to the SSMA for one set of reports from each state on Title XIX projected and actual expenditures. In addition, the SSMA has responsibility for drawing all Title XIX cash from the United States Treasury for each state. DSS fiscal staff will continue to be responsible for the following financial activities:

- Preparation and submission of quarterly projections of Title XIX expenditures for future quarters to the federal government;
- Preparation and submission of federally mandated reports of actual Title XIX expenditures to the federal government;
- Explanation of variances between projected and actual Title XIX expenditures to the federal government;
- Drawdown of all Federal Title XIX cash for the state;
- Review of cost allocation plans involving Title XIX funding prior to submission to the federal government; and
- Review of responses to federal reviews and audits involving Title XIX prior to submission to the federal government.

DHS, to exercise operational authority and supervision of the waiver, will have the responsibility:

- To develop regulations for new or revised DHS program objectives; to present and defend Medicaid regulations proposed by DHS to the Legislative Research Council and the Interim Rules Review Committee;
- To notify the State Medicaid Director (SMD) and seek review and comment from the SMD or designee on new or proposed changes to Title XIX Medicaid Waiver Programs and changes in regulations or standards of existing programs so DSS may assess the administrative and financial impact on the Medicaid budget;
- To develop proposed Medicaid State Plan and Waiver amendments as required for DHS Title XIX programs and services and to submit such proposals, along with summary information on proposed changes, to DSS for review, approval and submission to CMS;
- To provide documentation and assurances to DSS supporting appropriate expenditures and related nonfederal match (including that provided by local school districts) of Title XIX funds as a provision of accepting those funds;
- To meet sub-recipient audit requirements of the Single Audit Act and associated OMB Circular A-133;
- To maintain program standards and to monitor the provision of services to people with intellectual/developmental disabilities and quadriplegia by community providers;
- To conduct financial recoveries necessitated by erroneous, fraudulent or abusive practices by DHS providers and to work with DSS on proper handling of these recoveries;
- To accept total responsibility for that portion of the state's federally-established quality control error rate resulting from DHS errors, including any financial penalties and development of appropriate corrective action;
- To accept total responsibility should there be federal audit exceptions related to DHS' involvement with Title XIX Medicaid funding;
- To assist in the resolution of pended and denied claims;
- To cooperate with DSS and the SMD in the administration of the Medicaid Program; to comply with all rules and regulations governing the Medicaid Program; to provide information necessary for DSS to function effectively as the SSMA;
- To operate all approved DHS HCBS waiver programs in compliance with all federal and state statutes, rules, and regulations, and provide reports detailing program implementation, participants served, and other performance measures specified by DSS;
- To work cooperatively with DSS as the administrative authority when implementing HCBS waiver changes, amendments and renewals initiated by DHS as the operating agency; and
- To review all proposed hearing decisions regarding non-financial eligibility issues for the Title XIX Medicaid Waiver Programs administered by DHS and submit any comments or recommendations within seven days of receipt of the proposed decision. If compliance with timeframes set in rules regarding issuance of a final order require a quicker response time, DHS will comply with the necessary response time upon receipt of notice of such from DSS.
- DHS calculates waiver payment amounts and/or rates in preparation for waiver application/renewal and submission of the 372 report to CMS. This information is then sent to the SSMA for review and approval/denial.

During the period prior to waiver application/renewal, DSS and DHS meet jointly to collaborate in completing each of the appendices of the new waiver template. DHS is responsible for drafting and

forwarding each appendix to DSS, to include the state Medicaid Director (SMD), Director of Economic Assistance, and the Chief Financial Officer, for review and approval/denial.

### Appendix A: Waiver Administration and Operation

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**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.:*

- 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

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**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

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**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:

### Appendix A: Waiver Administration and Operation

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- 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:

## Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## 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:**

**The number and percent of level of care determinations completed by the delegated agency within 45 days of receiving a level of care packet. Numerator-The number of level of care decisions completed within 45 days/Denominator-The total number of level of care determinations completed.**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

The number and percent of annual reviews showing the designated agency maintains program participation within approved waiver limits. Numerator-The total number of active waiver participants/Denominator-The total number of waiver participants in the approved waiver.

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

	<input type="text"/>	
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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

The number and percent of annual reviews showing the designated agency maintains program expenditures within the approved waiver limits. Numerator-The total waiver expenditures/Denominator-The total waiver expenditures in the approved waiver.

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

		<input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The number and percent of individual findings of non-compliance regarding level of care evaluations that were appropriately and timely remediated by the delegated agency. Numerator-The number of non-compliant level of care evaluations remediated/Denominator-The total number of non-compliant level of care evaluations.

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b>

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The number and percent of waiver claims paid that were authorized via the service plan. Numerator-The total number of waiver services not authorized via the service plan for which a claim was filed and the claim was remediated/Denominator-The total number of waiver services not authorized via the service plan for which a claim is filed.

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval = + or - 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The number and percent of inappropriate provider claims identified via the designated agencies post-payment review process that were appropriately and timely reported to the SSMA for remediation. Numberator-The number of inappropriate claims identified and remediated/Denominator-The total number of inappropriate claims identified.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = + or - 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The number and percent of providers enrolled by DHS according to policy. Numerator-The total number of providers enrolled according to policy/Denominator-The total number of providers enrolled.

**Data Source (Select one):**

**Presentation of policies or procedures**

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Upon enrollment of new provider	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Upon enrollment of a new provider

**Performance Measure:**

The number and percent of provider agreements executed by DHS only to providers that met state Medicaid qualifications. Numerator -The number of provider agreements executed to providers that meet Medicaid qualifications/Denominator-The total number of executed provider agreements

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

---

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Upon enrollment of a new provider	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

The number and percent of provider rates established by DHS that are approved by the SSMA prior to implementation. Numerator-The number of provider rates approved by

**the SSMA prior to implementation/Denominator-The total number of rates implemented.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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:**

The number and percent of program policies developed by DHS that were approved by the SSMA prior to implementation. Numerator-The number of policies approved by SSMA prior to implementation/Denominator-The total number of policies implemented.

Data Source (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Specify: <input type="text"/>	
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**The number and percent of record reviews required to be completed by DHS.**

**Numerator-The number of record reviews completed by DHS/Denominator-The total required record reviews.**

Data Source (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

The number and percent of untimely service plan renewals that were appropriately and timely remediated. Numerator-The number of untimely annual service plan renewals remediated/Denominator-The total number of untimely annual service plans.

Data Source (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

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

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
For each of these performance measures, DRS has implemented the Systemic Monitoring and Reporting Technology (SMART) system. The SMART system allows DRS to aggregate the data for these measures for a specified time period. Additionally, DRS is able to query the data to monitor for systemic trends in DRS procedures. The Assistive Daily Living Services (ADLS) Waiver Manager is responsible for completing the aggregation and analysis of this information. Each time an error is found within a level of care determination, this is corrected. The data reported to the SSMA by DRS is reviewed within other performance measures contained within this waiver. As a result, each error that is found is remediated at an individual level and also monitored for systemic issues. Ultimately, the data shared with the SSMA for these measures has been addressed. DRS is able to provide to the SSMA what remediation activities have been completed. The SSMA will provide additional guidance if they do not feel the remediation activities are sufficient to ensure compliance with the written waiver. In addition, the data related to each of these performance measures is also presented quarterly to the Internal Waiver Review Committee.

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Internal Waiver Review Committee	<input type="checkbox"/> Annually

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> <b>Aged or Disabled, or Both - General</b>					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> <b>Intellectual Disability or Developmental Disability, or Both</b>					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Waiver services are limited to individuals who are at least 18 years old and:

1. Are diagnosed as having quadriplegia resulting from ataxia, cerebral palsy, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, traumatic brain injury, congenital conditions, accidents and injuries to the spinal cord, and other neuromuscular or cerebral conditions or diseases, or an individual with four limbs absent due to disease, trauma or congenital conditions;
2. Require nursing facility level of care;
3. Must be a recipient of SSI or must qualify for SD Medicaid as determined by the SSMA;
4. Are medically stable and free from life-threatening conditions; and
5. Have demonstrated the ability and competence to manage and direct their services, or ability to select a representative to manage and direct their services.

**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:*

Participants over the age of 65 may choose to stay on the ADLS waiver. Many of the services provided through the waiver are not covered services under Medicare, so often times they choose to continue on the waiver. Dual eligible participant's benefits are first billed to Medicaid, any services not covered are billed to Medicare.

Participants who decide to transfer from the ADLS waiver are assisted in transitioning to a comparable system that meets their health, safety and welfare needs.

## Appendix B: Participant Access and Eligibility

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### 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:

The average cost of a nursing home stay for an individual with quadriplegia is calculated annually by DSS Provider Reimbursement and Audits. If it is determined that waiver costs exceed the nursing home rate, then long term care options are discussed and the appropriate referral or assistance is provided. This is determined when the DRS Service Coordinator assesses the individual and what their needs are, which includes services covered under the waiver, as well as services needed outside of the waiver, to include natural supports available to the participant. As

part of the assessment process, a service plan is developed to ascertain the amount of waiver services the person would require to meet their needs. When the participant’s service needs exceed the average cost of nursing home stay, the applicant will be offered the opportunity to request a Fair Hearing upon denial of entrance into the waiver.

**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:

The participant and the DRS Service Coordinator will determine if the participant needs temporary services that exceed the established cost limit for the program. This information and applicable documentation, if requested, will be shared with the ADLS Waiver Manager. The ADLS Waiver Manager may authorize additional services in a short term amended service plan that may exceed cost limits in order to ensure continuity of care and health and safety assurances until the issue is resolved. The DRS Service Coordinator and the participant may identify other state funded programs for supportive services during this time, if determined necessary. The situation will be assessed at the end of the established amended service plan. The plan may be extended as determined appropriate by the ADLS Waiver Manager, at which time, if determined that there will be no end to the addition services, then the DRS Service Coordinator will discuss long term care options with the program participant.

- 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	130
Year 2	134
Year 3	138
Year 4	138
Year 5	138

**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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

**Appendix B: Participant Access and Eligibility**

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

- c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:
- Not applicable. The state does not reserve capacity.**
  - The State reserves capacity for the following purpose(s).**

**Appendix B: Participant Access and Eligibility**

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

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:
- The waiver is not subject to a phase-in or a phase-out schedule.**
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

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

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

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

Waiver applications are processed and reviewed for eligibility on a first come, first served basis. Waiver applicants must meet all eligibility requirements in order to receive waiver services. Financial eligibility and level of care eligibility must be determined prior to any services being authorized.

If a waiting list develops, DRS will assign a level of priority for entrants to the waiver. The first level is "priority status" which is defined as individuals who are at a significant risk of institutionalization. All other individuals are placed in the second level, which is "applicant status".

Significant risk means:

Individuals at imminent risk of being institutionalized;

Individuals currently residing in an abusive, neglectful or exploitive situation; and

Individuals whose health, welfare or safety is in jeopardy.

Individuals in "priority status" will be placed at the top of the waiting list and receive services on a first come, first serve basis. Individuals in applicant status will receive services on a first come, first serve basis but after those in priority status.

Any individual who is at risk of abuse, neglect or exploitation will be prioritized on the priority level list. They will be referred to Adult Protective Services if that has not already occurred. Other programs will be explored through the Department of Social Services, Adult Services and Aging (DSS/ASA) to ensure that services are provided imminently to lessen any abuse or neglect that may occur if services were not in the home. DRS would also work with DSS/ASA to expedite admittance to a skilled nursing facility until ADLS services are available.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

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

a.

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

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

2. **Miller Trust State.**

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

- No  
 Yes

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

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

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

*Select one:*

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

Specify percentage:

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

Specify:

---

*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*

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- 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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- 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 five-year period beginning January 1, 2014, 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 §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

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

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

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

**Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver

services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan**

Select one:

- SSI standard  
 Optional State supplement standard  
 Medically needy income standard  
 **The special income level for institutionalized persons**

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

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

- The following formula is used to determine the needs allowance:

Specify:

- Other

Specify:

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

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

Specify:

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

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

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

- The amount is determined using the following formula:

*Specify:*

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

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

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

- The amount is determined using the following formula:

*Specify:*

- Other

*Specify:*

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

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

Select one:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

(select one):

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

Specify percentage:

- The following dollar amount:

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

- The following formula is used to determine the needs allowance:

Specify formula:

- Other

Specify:

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

Select one:

- Allowance is the same  
 Allowance is different.

Explanation of difference:

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

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

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*  
 **The State does not establish reasonable limits.**  
 **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

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

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

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

**Answers provided in Appendix B-5-a indicate 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 (6 of 7)

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

*Specify the entity:*

- Other**  
*Specify:*

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

The DRS utilization review team (URT) conducts the initial level of care evaluation. The URT consists of a Certified Rehabilitation Counselor (CRC) and a DRS Program Specialist who has a minimum of 2 years of experience working with individuals with disabilities, preferably individuals with quadriplegia.

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

The initial level of care (LOC) evaluation is conducted by the DRS Utilization Review Team (URT). This team consists of a Certified Rehabilitation Counselor and a DRS Program Specialist that has at least two years of experience working with people with significant disabilities, preferably quadriplegia. The URT conducts re-evaluation on an annual basis using Level of Care criteria to assess whether an individual has a continued need for ADLS waiver services. The LOC criteria used to determine initial eligibility and to reevaluate whether an individual has a continued need for ADLS waiver services includes:

Assessment of their ability to direct and manage their services, or ability to select a representative to direct and manage their services;

Assessment of functional limitations, to include assessment of the participant's continued need for assistance with their activities of daily living; and

Financial eligibility.

The ADLS Assessment is the primary instrument used to determine level of care. The assessment gathers information that will be used by the URT team to determine if the applicant/participant meets or continues to meet the waiver and program requirements. Also assessed is the individual's ability to manage and self-direct their services, or ability to select a representative to direct and manage their services.

The assessment assesses cognitive skills for daily decision making, the individual's ability to perform activities of daily living (ADL's), such as eating, bathing, grooming, dressing, transferring, and bladder/bowel care. It also assesses instrumental activities of daily living (IADL's), including preparing meals, laundry, managing money, telephone use, housework, and shopping. The assessment includes a medication list, information on health conditions, continence, pain and nutritional issues, as well as personal goals the individual would like to achieve. Other information taken into account may be a social history and natural supports available to the individual. Services assessed include waiver services the individual needs or is utilizing and information on medical services and other supportive services that the individual needs or is currently utilizing. Other sections of the assessment include the participant rights/fair hearing/freedom of choice form, and the personal attendant service plan. Initially, the assessment documents are reviewed by the ADLS Waiver Manager. A level of care (LOC) form is signed, indicating that the individual is eligible for the program and meets nursing facility level of care. The LOC form and the assessment are reviewed by a DRS Certified Rehabilitation Counselor (CRC). If the CRC agrees with the ADLS Waiver Manager's recommendation, then the LOC form is signed by the CRC indicating that the individual meets or continues to meet program requirements. The ADLS Waiver Manager, in consultation with the URT, makes a LOC recommendation to DSS who issues a "Notice of Action". This notice also notifies the applicant/participant of eligibility status and the right to appeal that determination. The service plan is approved in FoCoS, and the provider is notified that they can provide waiver services.

- 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.

The instrument used to determine institutional level of care and ADLS Waiver services are different. The institutional level of care is completed and reviewed by the Department of Social Services (DSS), Adult Services and Aging (ASA). As described above the ADLS waiver level of care is reviewed by the DRS URT. Much of the same information is obtained. Areas of the assessments are similar, such as decision making, physical functional status, activity of daily living needs, medications, health and supportive services

and natural supports available to the individual. Reliability and comparability are validated when an individual is able to seamlessly transfer from one waiver to another waiver as their needs change.

- 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:

A person seeking waiver service may contact the ADLS Waiver Manager for an application, or can find the application on the DRS website, which is also a screening tool to determine if they meet the basic eligibility requirements of the waiver. The DSS Adult & Disability Resource Center (ADRC) is knowledgeable about the eligibility criteria and services available to people with quadriplegia, and will refer individuals to the ADLS Waiver Manager, when appropriate. The ADRC provides objective information and assistance to help individuals identify and access public and private long-term services and supports within their local communities. There are five call centers in communities around South Dakota, with toll free numbers available for people to call and make appropriate referrals to agencies that can assist an individual.

Applicants are referred to a DRS Service Coordinator to complete the level of care assessment in their home. The DRS Service Coordinator contacts the applicant to complete the LOC assessment and gather necessary documentation for eligibility. That information is then sent to the ADLS Waiver Manager for a LOC determination. The ADLS Waiver Manager, in consultation with the URT, makes a LOC recommendation to DSS who issues a "Notice of Action". This notice also notifies the applicant/participant of eligibility status and the right to appeal that determination.

Reevaluation is conducted at least annually, utilizing the same process as used for initial evaluation.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

*Specify the other schedule:*

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

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

*Specify the qualifications:*

- 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*):

The FoCoS system is an electronic web-based case management and Medicaid claims clearinghouse that is used by DRS Service Coordinators and providers who submit Medicaid claims for services provided through the waiver. Service plans are added to FoCoS annually during the initial and reassessment of the LOC process. FoCoS has a "reminder" feature that notifies the DRS Service Coordinator and ADLS Waiver Manager that a level of care is due within 60 days, then again reminded when a level of care is due within 30 days of the last LOC assessment. FoCoS has a report that the ADLS Waiver Manager can run to identify whether annual re-evaluations are timely. DRS Service Coordinators are informed that the evaluation must be completed within twelve months of the previous assessment. If a re-evaluation due date is surpassed, the ADLS Waiver Manager will e-mail the DRS Service Coordinator that re-evaluation must be completed in 10 days. Any issues with delinquent re-evaluation error rates are required to complete a corrective action plan.

- 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:

Appropriate paper and electronic documentation is retained in the office of the ADLS Waiver Manager. Each program participant has an individual file in the ADLS Waiver Manager’s office. All LOC documents are maintained in those files. ADLS Waiver Manager follows DHS records retention policy as follows: Information is retained in the office for at least two years, then transferred to storage for four years. Information is then destroyed after six years provided all litigation, claims or audit findings involving the records have been resolved and final action taken.

**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:**

**The percentage of new participants who had a level of care completed prior to the initiation of services. Numerator-The number of new participants to the waiver with a level of care completed prior to initiation of services/Denominator-Total number of new participants.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

The percentage of participant LOC redeterminations completed within 12 months of the most recent participant LOC; Numerator-The number of participant LOC redeterminations completed within 12 months of the initial or most recent LOC/Denominator-The total number of waiver participants for whom an annual redetermination is due.

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = + or - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**The percentage of participant level of care determinations completed accurately.**

**Numerator-The number of participant level of care made**

**accurately/Denominator-The total number of sampled participant level of care.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = + or - 5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The percentage of participant LOC determinations completed utilizing the approved waiver process. Numerator-The number of LOC determinations completed with utilized the approved process as described in the waiver/Denominator-Total number of LOC determinations completed.

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

	<input type="text"/>
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**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = + or - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- 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.

LOC reviews are conducted and documented by DRS URT. The ADLS Waiver Manager is responsible for aggregating quarterly and annual data for remediation by the SSMA and the IWRC. The SSMA and IWRC monitor performance measures related to timeliness of initial LOC determinations and the accuracy of initial determinations.

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

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

The primary discovery activities that have the potential to reveal individual problems related to level of care include complaint referrals to DRS, LOC reviews and administrative hearing requests contesting ineligibility. When an individual problem is discovered, DRS takes immediate action to assess, and if necessary, ensure the safety of the individual and other waiver participants. The problem would be documented and systemically remediated through the discovery activity that revealed the problem. If the individual has or is requesting a LOC determination, the problem may also be documented in the individual's case file.

A.1) If it is discovered that a participant has received waiver services prior to an approved level of care, DRS will immediately ensure that any claims have been denied. The ADLS Waiver Manager will immediately ensure the completion of a LOC to determine the participant's eligibility status and conduct immediate training with the program provider.

B.1) The DRS completes all annual redeterminations for each waiver participant. This process is completed within 12 months of the prior recertification or initial certification. If information is not received by the appropriate parties by the specified date, they are contacted and are provided a timeline of 10 business days to submit the information and the redetermination is completed. The Waiver Manager will provide training as necessary to ensure a full understanding of the necessity for timely information submission.

C.1 and C.2) If an initial level of care decision, either approval or denial, is found to be incorrect, this is remediated on a case by case basis. The identified portion of the process or inappropriate application of the instrument is identified and immediately corrected. If this results in a waiver participant no longer meeting eligibility criteria for the waiver, this information is sent to the SSMA. The SSMA provides the person with their right to appeal. The person is referred to additional community resources they may be eligible for. Any payments that may have been made for waiver services will require that claim adjustments be completed. If the process or application of the instrument resulted in a determination of ineligibility and the review shows the person is eligible, their LOC would be considered complete and they are immediately contacted and waiver services are started. Additional training is provided on a case by case basis to the person who made the incorrect level of care determination.

The Waiver Manager completes a quality assurance review of annual redeterminations completed. This is completed using a 95% confidence level and 5% confidence interval with historical data of the total population of waiver recipients to determine a valid sample size of participants due for a LOC redetermination. During the QA review, the sample of LOC redeterminations are reviewed to ensure the appropriate determination was made. If a redetermination decision is found to be inaccurate and waiver participant is no longer eligible for waiver services, DRS notifies the SSMA immediately. The SSMA provides the person with their rights to appeal at that time. DRS refers the person who has been determined to not be eligible for services to other community resources. If a redetermination decision is found to be inaccurate and the participant remains eligible for the waiver, DRS will notify the SSMA immediately. The SSMA will provide the participant information related to the reinstatement of their waiver services. DRS will also contact provider agencies chosen by the participant to authorize for services to begin.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Internal Waiver Review Committee	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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).

Eligible individuals are informed of the feasible alternatives available under the waiver and are allowed the option of choosing either institutional or waiver services. DRS Service Coordinators provide this information when services are initiated and at annual reevaluation. Applicants/participants are given a form "Consumer's Approval of Documented Need for Services and Planned Services" and "Consumer Notification of Freedom of Choice" to acknowledge receipt of this information.

**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.

This form is maintained within the applicant/participant file in the office of the ADLS Waiver Manager. All Freedom of Choice forms are maintained in those files. ADLS Waiver Manager follows DHS records retention policy as follows: Information is retained in the office for at least two years, then transferred to storage for four

years. Information is then destroyed after six years provided all litigation, claims or audit findings involving the records have been resolved and final action taken.

## 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):

DRS Service Coordinators will make arrangements with foreign language interpreters to provide services to people with limited English proficiency who receive waiver services. All forms and materials will be translated in each participant's language of choice. Service Coordinators will refer participants to English classes within each participant's geographic location to improve English proficiency.

## 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	Personal Attendant Care		
Statutory Service	Respite		
Extended State Plan Service	Incontinence Supplies		
Supports for Participant Direction	Consumer Preparation Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	In Home Nursing		
Other Service	Personal Emergency Response (PERS)		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Vehicle Modifications		

## 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 Attendant Care

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

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

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

**Service Definition (Scope):**

Personal attendant services include a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability.

Personal attendant services provided through the ADLS waiver differ from State Plan services in scope, nature, supervision arrangements and provider type. The waiver services are based upon consumer direction, the state plan services are not. The method of delivery is different in the waiver due to the expectation that participants of personal attendant services recruit, screen, train, and direct their personal care attendants. The waiver encourages the employment of spouses, parents or adult children, for example to provide these services, the state plan does not allow for relatives to be paid for these services. Because personal attendant services in the waiver differ in scope, nature, supervision arrangements and provider type and training, participants on the ADLS waiver are not required to access state plan services prior to accessing services through the ADLS waiver.

Following are the personal attendant services covered under the ADLS waiver:

- (1) Practicing infection control methods;
- (2) Handling and disposing of body fluids;
- (3) Bathing techniques including bed, tub, and shower;
- (4) Caring for hair, including shaving;
- (5) Maintaining oral hygiene, including brushing teeth and cleaning dentures;
- (6) Dressing and undressing a consumer;
- (7) Assisting with toileting;
- (8) Caring for a consumer who is incontinent;
- (9) Feeding or assisting a consumer with eating, unless there is another person in the home who is able to perform the task;
- (10) Planning and preparing meals including shopping for and purchasing food, unless there is another person in the home who is able to perform the task;
- (11) Performing routine eye care;
- (12) Taking a consumer's temperature;
- (13) Caring of nails and feet;
- (14) Applying an ace wrap and anti-embolic stockings;
- (15) Assisting the consumer apply or remove a prosthesis or orthotic;
- (16) Assisting a consumer with self-administration of medications;
- (17) Changing dressings on non-infected sores;
- (18) Caring for skin including giving back rubs;
- (19) Turning and positioning the consumer in bed;
- (20) Transferring the consumer;
- (21) Maintaining the consumer's home in a clean and safe condition, unless there is another person in the home who is able to perform the task;
- (22) Making a wrinkle-free bed, unless there is another person in the home who is able to perform the task;
- (23) Laundering and mending clothes, unless there is another person in the home who is able to perform the task;
- (24) Assisting the consumer with paying bills, balancing a checkbook, and managing a home budget, unless there is another person in the home who is able to perform the task;
- (25) Performing range of motion exercises designed for the specific consumer;
- (26) Performing routine ostomy care;
- (27) Assisting with a bladder and bowel program;
- (28) Assisting the consumer into and out of a vehicle;
- (29) Providing ventilator management if the personal attendant is a family member. A consumer who was receiving ventilator management by someone other than a family member before the effective date of this rule change is not affected by this change;

(30) Performing tracheostomy care if the personal attendant is a family member. A consumer who was receiving tracheostomy care by someone other than a family member before the effective date of this rule change is not affected by this change;

(31) Providing chest physiotherapy;

(32) Providing nebulizer therapy;

(33) Applying topical medications; and

(34) Caring for service animal.

A personal care attendant must have:

-Completed a basic nurse aide or home health aide training course, as evidenced by a certificate of completion signed by the Director of the training program, provided the trainee also received training in disability awareness and in the philosophy of consumer direction;

-A personal care attendant training program supervised by a registered nurse at a qualified provider agency, as evidenced by a certificate of completion, or

-A personal care attendant competency assessment as evidenced by a certificate of competency signed by a licensed nurse, a physician, or the program participant.

The provider agency must maintain a copy of the signed certificate in the personal care attendant's personnel file. If the personal care attendant is certified through a personal care attendant competency assessment and provides services for more than one individual, there must be a separate certification for each individual served.

In addition, the personal care attendant must meet the following qualifications:

-Must be employed by a provider agency that has a contract with the Department of Human Services to provide assistive daily living services;

-Must produce proof of having a social security number;

-Must be able to read, write, and communicate;

-During the last three years, may not have on record a conviction for an offense that would directly affect the individual's fitness to be a personal attendant. For purposes of this subdivision, the provider agency must develop and use a system for screening each applicant and for including the consumer in the screening process;

-May not have an infectious or contagious disease or condition which results in a medical condition that is prolonged or potentially life-threatening;

-Must be capable of performing the needed services;

-Must be capable of maintaining confidentiality; and

-Must have demonstrated competency to perform the duties.

A participant's spouse, parent, or adult child, for example, may receive reimbursement for providing personal care attendant services if the requirements of this chapter are met.

The ADLS waiver is a self-directed waiver, which allows participants the ability to hire, manage, direct and supervise their personal attendants, while the provider serves as an Agency with Choice, supporting the participant to recruit, refer for employment, train and direct their personal attendant by providing Consumer Preparation services.

In specific circumstances the ADLS participant will be allowed to utilize personal attendant services through an in-home services provider agency. Participants may choose, as a supplement to the self-directed hiring of their personal attendants through a contracted provider agency, to also choose in-home services provider services in which the agency performs both the managing of the attendant care employee and the hiring and fiscal responsibilities. The circumstances in which they can be allowed to choose the in-home services provider agency can be:

1. To be used as part of their backup emergency plan when personal attendants are unable to work as scheduled due to unforeseen circumstances, and the ADLS participant has made every attempt to contact all other backup personal attendants listed on their backup plan;
2. To be used up to a maximum of 7 hours per week to fill in gaps in their PA schedule where they are unable to find a PA to cover that designated time. ADLS participants will continue to utilize Consumer Preparation Services to assist them in filling those gaps to hire personal attendants using the self-directed model;
3. To be used for a maximum of 30 days immediately upon discharge from a nursing home or other institution to assist a participant to transition more quickly out of a nursing home into the community, receiving personal attendant services while working toward hiring personal attendants through the self-directed hiring process.
4. Under extraordinary circumstances when DRS deems it necessary to provide health, safety and welfare to the participant.

Participants or the participant's representative or legal guardian must agree to and be capable of recruiting, hiring, training, managing and terminating attendants, as well as reviewing personal attendant time sheets for accuracy and completing the certificate of competency when hiring a personal attendant.

Housekeeping activities that are incidental to the performance of care may also be furnished. Housekeeping activities include meal preparation, incidental laundry, incidental housekeeping, and grocery shopping.

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

Personal Attendant Care services are limited to no more than 50 hours per week per DRS policy. DRS Utilization Management policy does allow exceptions to the 50 hour limit and the time limited exception allowances are listed in policy. All requests for exception must be pre-approved by the ADLS Waiver Manager. Personal Attendant services are reimbursable when provided according to the participant's approved service plan. The number of hours included in a participant's service plan is based on a level of care assessment, the individual's needs and other support systems in place. Both self-directed and limited traditional personal attendant care services must be included on a participant's service plan. This will occur for participants who choose self-direction but utilize in-home services personal attendants for reasons identified in the Service Definition section. The overall amount of the attendant care services authorized on the service plan is monitored and tracked by the operating agency.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Center for Independent Living
Agency	In-home Services Provider
Agency	Home Health Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Personal Attendant Care**

**Provider Category:**

Agency ▼

**Provider Type:**

Center for Independent Living

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

Certified as a center for independent living (CIL) by DHS and the United States Department of Health and Human Services. Provider must have a current signed Medicaid Provider Agreement.

**Other Standard** (specify):

The CIL serves as an Agency with Choice in supporting the participant to recruit, refer for employment, train and direct a personal care attendant. The CIL can establish a staffing pool of personal attendants for participants to choose from to support those participants struggling to hire personal attendants to cover all scheduled times. The CIL supports the participant by providing Consumer Preparation Services. Under both models the participant is expected to direct their care and participate in the training of their personal attendant. The center for independent living supports the participant in this process by providing Consumer Preparation Services.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CILs must maintain personnel records verifying that each personal care attendant meets specified standards. The ADLS Waiver Manager verifies these requirements during annual on-site reviews.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Personal Attendant Care**

**Provider Category:**

Agency 

**Provider Type:**

In-home Services Provider

**Provider Qualifications****License (specify):**


**Certificate (specify):**

Certified as a qualified provider by the ADLS Waiver Manager. Provider must have a current signed Medicaid Provider Agreement.

**Other Standard (specify):**

All in-home services providers must be enrolled Medicaid providers with a signed provider agreement with DSS.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

The ADLS Waiver Manager is responsible for verification of provider qualifications.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Personal Attendant Care**

**Provider Category:**

Agency 

**Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**


**Certificate (specify):**

Certified as an ADLS waiver provider by the ADLS Waiver Manager. Provider must have a current signed Medicaid Provider Agreement through DSS.

**Other Standard (specify):**

The home health agency can serve as an Agency With Choice provider and support the participant to recruit, refer for employment, train and direct a personal care attendant, or the home health agency can use their established staffing pool to provide a choice of personal attendants to support those

participants struggling to hire personal attendants to cover all scheduled times. Under both models the participant is expected to direct their own care, and to participate in the training of their personal attendant. The home health agency supports the participant in this process by providing Consumer Preparation Services.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

Home health agencies must maintain personnel records verifying that each personal care attendant meets specified standards. The ADLS Waiver Manager verifies these requirements during on-site reviews.

##### 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):

#### HCBS Taxonomy:

##### Category 1:

##### Sub-Category 1:

##### Category 2:

##### Sub-Category 2:

##### Category 3:

##### Sub-Category 3:

##### Category 4:

##### Sub-Category 4:

#### Service Definition (Scope):

Respite care services are provided to assist participants unable to care for themselves, furnished on an intermittent, occasional or emergency basis, as approved due to the absence or need for relief of those persons normally providing the care. Federal financial participation is not to 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 can be provided in the following locations:

- 1) Participant's home or place of residence;
- 2) Adult foster home;
- 3) Medicaid certified hospital;

- 4) Medicaid certified ICF/IDD;
- 5) Group home;
- 6) A home approved in the plan of care, which may be a private residence; or
- 7) Other community care residential facility approved by the State that is not a private residence, such as a licensed day care.

Respite care is a service that can be provided in a hospital, ICF/IID, group home, or other community care residential facility, but the service is temporary, short term in nature, so is not impacted by the residential settings rule.

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

N/A

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Long-term care facility
Agency	Private and hospital-based in-home service providers
Agency	Assisted Living facilities
Agency	Home Health Agency
Agency	Independent Living Center

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Long-term care facility

**Provider Qualifications**

**License** (specify):

Long term care facilities are licensed by the South Dakota Department of Health.

**Certificate** (specify):

**Other Standard** (specify):

Long term care facilities must be Medicaid providers with a signed Provider Agreement with DSS.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ADLS Waiver Manager verifies qualified provider status. DRS Service Coordinators and ADLS participants have the responsibility of monitoring the service plan to ensure the skills of the respite care provider and training is provided.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**Agency **Provider Type:**

Private and hospital-based in-home service providers

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Providers must be enrolled Medicaid providers under the Department of Social Services, with a signed provider agreement.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

ADLS Waiver Manager verifies qualified provider status. DRS Service Coordinators and ADLS waiver participants have the responsibility of monitoring the service plan to ensure the skills of the respite care provider and training is provided.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**Agency **Provider Type:**

Assisted Living facilities

**Provider Qualifications****License (specify):**

Assisted Living facilities are licensed by the South Dakota Department of Health.

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

Assisted Living facilities must be Medicaid Providers with a signed provider agreement with DSS.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

ADLS Waiver Manager verifies qualified provider status. DRS Service Coordinators and ADLS participants have the responsibility of monitoring the service plan to ensure the skills of the respite care provider and training is provided.

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Agency ▼

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

Not applicable

**Certificate (specify):**

Certified as an ADLS waiver qualified provider by the ADLS Waiver Manager. Provider must have a current signed Medicaid Provider Agreement.

**Other Standard (specify):**

The home health agency can serve as an Agency with Choice provider. Oversight of the agency employee will be provided by the participant, legal guardian or non-legal representative. The respite care provider must be able to follow written or verbal instructions given by the participant, legal guardian or non-legal representative and have the ability or skills necessary to meet the participant's needs as delineated in the service plan. The respite care employee will receive training which is commensurate with the service or support to be provided, from the participant, legal guardian, or non-legal representative in performance of all respite care services.

Agency employees must meet the following qualifications:

1. Be at least 18 years of age;
2. Pass a criminal background check;
3. Be able to follow written or verbal instructions provided by the participant, legal guardian or non-legal representative of the participant;
4. Have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the service plan.

The Agency with Choice model does require employees to undergo a background check and the needed training for the services provided. The participant or the managing employer trains the respite care worker also on specific needs and services that the participant will require.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ADLS Waiver Manager verifies qualified provider status. Qualified providers have the responsibility of verifying respite care provider age at time of hire. DRS Service Coordinators and participants have the responsibility of monitoring the service plan to ensure the skills of the respite care provider and training is provided. Home health agencies must maintain personnel records verifying that each respite care worker meets specified standards.

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency ▼

**Provider Type:**

Independent Living Center

**Provider Qualifications**

**License (specify):**

Not applicable

**Certificate (specify):**

Certified as an ADLS waiver qualified provider by the ADLS Waiver Manager. Provider must have a current signed Medicaid Provider Agreement through DSS.

**Other Standard (specify):**

The Center for Independent Living can serve as an Agency with Choice provider. Oversight of the agency employee will be provided by the participant, legal guardian or non-legal representative. The respite care provider must be able to follow written or verbal instructions given by the participant, legal guardian or non-legal representative and have the ability or skills necessary to meet the participant's needs as delineated in the service plan. The respite care employee will receive training which is commensurate with the service or support to be provided, from the participant, legal guardian, or non-legal representative in performance of all respite care services.

Agency employees must meet the following qualifications:

1. Be at least 18 years of age;
2. Pass a criminal background check;
3. Be able to follow written or verbal instructions provided by the participant, legal guardian or non-legal representative of the participant;
4. Have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the service plan.

The Agency with Choice model does require employees to undergo a background check and the needed training for the services provided. The participant or the managing employer trains the respite care worker on specific needs and services that the participant will require.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

ADLS Waiver Manager verifies qualified provider status annually. Qualified providers have the responsibility of verifying respite care provider age at time of hire. DRS Service Coordinators and participants have the responsibility of monitoring the service plan to ensure the skills of the respite care provider and training is provided. Centers for Independent Living must maintain personnel records verifying that each respite care worker meets specified standards.

**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:**

**Service Title:**

Incontinence Supplies

**HCBS Taxonomy:****Category 1:**

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

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



**Service Definition (Scope):**

Expendable or reusable supplies related to the needs of incontinency and/or neurogenic bladder not otherwise covered by State Plan services.

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

Supplies are limited to \$200 per month per participant. Additional supplies may be authorized on a case by case basis and must be approved by the ADLS Waiver Manager. Service plans which include all services cannot exceed the nursing home rate for an individual with quadraplegia. Plans in excess of this limit require approval by the ADLS Waiver Manager.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Durable Medical Equipment suppliers
Agency	Private and hospital-based in-home providers
Agency	Pharmacy

**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:**

Durable Medical Equipment suppliers

**Provider Qualifications**

**License (specify):**



**Certificate (specify):**



**Other Standard (specify):**

Providers must be enrolled Medicaid providers with signed Provider Agreements through DSS.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Ongoing as providers are chosen by program participants as they determine the need for this service.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Extended State Plan Service**

**Service Name: Incontinence Supplies**

---

**Provider Category:**

Agency 

**Provider Type:**

Private and hospital-based in-home providers

**Provider Qualifications****License (specify):**


**Certificate (specify):**


**Other Standard (specify):**

Provider must be enrolled Medicaid providers with a current signed Medicaid Provider Agreement.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Ongoing as providers are chosen by program participants as they determine the need for this service.

**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:**

Pharmacy

**Provider Qualifications****License (specify):**

Pharmacies are licensed by the South Dakota Board of Pharmacy.

**Certificate (specify):**


**Other Standard (specify):**

Pharmacies must be enrolled Medicaid providers. Enrollment includes providing verification of current, valid licensure and signing a Provider Agreement.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Ongoing as providers are chosen by program participants as they determine the need for this service.

## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction ▼

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

**Support for Participant Direction:**

Information and Assistance in Support of Participant Direction ▼

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

Consumer Preparation Services

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

▼

**Sub-Category 3:**

**Category 4:**

▼

**Sub-Category 4:**

**Service Definition (Scope):**

- (1) Instructing and supporting participants in the methods of identifying personal needs and effectively communicating those needs to the personal care attendant;
- (2) Instructing and supporting the participant in personal health maintenance tasks;
- (3) Instructing and supporting the participant in managing a personal attendant, including interviewing, selecting, training, supervising, and scheduling the attendant;
- (4) Instructing and supporting the participant on the appropriate personal and professional relationships to be maintained by the participant and the participant's personal care attendant.

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

▲ ▼

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Center for Independent Living
Agency	Home Health Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Consumer Preparation Services****Provider Category:**

Agency ▾

**Provider Type:**

Center for Independent Living

**Provider Qualifications****License (specify):**

**Certificate (specify):**

Certified as an Center for Independent Living by the Department of Human Services and the U.S. Department of Health and Human Services.

**Other Standard (specify):**

A provider agency's Consumer Preparation Specialist must meet the following qualifications: Must be employed by a provider agency; must have a minimum of one year experience working with individuals with severe disabilities, experience working with individuals with quadriplegia preferred; must be trained by the provider agency in consumer preparation; and must be able to provide the required services.

Consumer preparation services are provided by staff from a provider agency.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Centers for Independent Living must maintain personnel records verifying that each Consumer Preparation Specialist meets specified standards. The DRS Waiver Manager verifies these requirements during annual on-site reviews.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Consumer Preparation Services****Provider Category:**

Agency ▾

**Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**

**Certificate** *(specify):*

Certified as a ADLS Waiver qualified provider by the DRS Waiver Manager. Provider must have a current signed Medicaid Provider Agreement.

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

Consumer Preparation Specialists must: be employed by a provider agency; have a minimum of one year experience working with individuals with severe disabilities, experience working with individuals with quadriplegia preferred; must be trained by the provider agency in consumer preparation; and must be able to provide the required services.

Consumer preparation services are provided by staff from a provider agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Home Health Agencies must maintain personnel records verifying that each Consumer Preparation Specialist meets specified standards. The DRS Waiver Manager verifies these requirements during annual on-site reviews.

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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### 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 Accessibility Adaptations

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

▼

**Sub-Category 3:**

**Category 4:**

▼

**Sub-Category 4:**

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

Physical adaptations to the private residence of the participant, or the participant’s family, required by the participant’s service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function at a greater independence within the home. Such adaptations include installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. The scope of modifications may include the performance of necessary assessments to determine the types of modifications that are necessary. Excluded are adaptations or improvements to the home which are of general utility, and are not a direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes.

Adaptations can include modifications to vehicles, including hand controls, lifts and tie downs to accommodate wheelchairs. The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services. The scope of vehicle modifications may include the performance of necessary assessments to determine the types of modifications that are necessary.

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

Service plans should not exceed the average daily nursing home rate of a person with quadriplegia as determined annually by the Office of Provider Reimbursement. Service plans in excess of that limit may be approved by the ADLS Waiver Manager on a temporary basis.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Education Cooperative
Agency	Hospitals
Agency	Centers for Independent Living

**Appendix C: Participant Services**

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

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

**Provider Category:**

Agency ▼

**Provider Type:**

Education Cooperative

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

An Education Cooperative recognized by the South Dakota Department of Education.

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

Education cooperatives must be enrolled Medicaid providers with signed provider agreements with DSS.

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturers' specifications.

Vendors of home modifications shall have a current license, certification, or registration as appropriate for the services being purchased. The provider shall also possess a current license to do business, issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Vendors shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of home modifications and shall also be authorized to install, repair, and maintain such systems where possible.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

The education cooperative will work with the Division of Rehabilitation Services to reimburse the vendor/contractor/suppliers hired to complete the environmental accessibility adaptations. DRS Service Coordinator and participant will provide oversight and monitoring of the environmental adaptations throughout the installation process.

##### **Frequency of Verification:**

DRS verifies qualified provider status on an annual basis.

## **Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations**

#### **Provider Category:**

Agency

#### **Provider Type:**

Hospitals

#### **Provider Qualifications**

##### **License (specify):**

Hospitals are licensed by the South Dakota Department of Health.

##### **Certificate (specify):**

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

Hospitals must be enrolled Medicaid providers with signed provider agreements with DSS.

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturers' specifications.

Vendors of home modifications shall have a current license, certification, or registration as appropriate for the services being purchased. The provider shall also possess a current license to do business, issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Vendors shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of home modifications and shall also be authorized to install, repair, and maintain such systems where possible.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

The hospital will work with the Division of Rehabilitation Services to reimburse the vendor/contractor/suppliers hired to complete the environmental accessibility adaptations. DRS Service Coordinator and participant will provide oversight and monitoring of the environmental adaptations throughout the installation process.

**Frequency of Verification:**

DRS verifies qualified provider status on an annual basis.

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations**

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**Provider Category:**

Agency

**Provider Type:**

Centers for Independent Living

**Provider Qualifications****License (specify):**

**Certificate (specify):**

Certified as a center for independent living (CIL) by SD Department of Human Services and the US Department of Health and Human Services. Provider must have a current signed Medicaid Provider Agreement with DSS.

**Other Standard (specify):**

The Center for independent living must be enrolled as a Medicaid provider with a signed provider agreement with DSS.

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturers' specifications.

Vendors of home modifications shall have a current license, certification, or registration as appropriate for the services being purchased. The provider shall also possess a current license to do business, issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Vendors shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of home modifications and shall also be authorized to install, repair, and maintain such systems where possible.

Vendors must be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

The Center for Independent Living will verify the vendor is qualified and that all modifications meet ADA guidelines. Qualified providers have the responsibility of coordinating with the vendor/provider. The Service Coordinator and participant provide oversight and monitoring of the home modifications.

**Frequency of Verification:**

DRS verifies qualified provider status on an annual basis.

## Appendix C: Participant Services

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### 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:**

In Home Nursing

**HCBS Taxonomy:****Category 1:****Sub-Category 1:** **Category 2:****Sub-Category 2:** **Category 3:****Sub-Category 3:** **Category 4:****Sub-Category 4:** **Service Definition (Scope):**

Individual and continuous care provided by licensed nurses within the scope of State law. These services are provided to a participant at home.

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

Service plans, encompassing all services, should not exceed the nursing home rate for an individual with quadriplegia. Service plans in excess of that limit require approval by the ADLS Waiver Manager.

**Service Delivery Method (check each that applies):** Participant-directed as specified in Appendix E Provider managed**Specify whether the service may be provided by (check each that applies):** Legally Responsible Person Relative Legal Guardian**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private and hospital based in-home service providers

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: In Home Nursing****Provider Category:**Agency **Provider Type:**

Private and hospital based in-home service providers

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

In-home nursing service providers must have a current signed Medicaid Provider Agreement. Home Health Agencies must maintain personnel records documenting the skilled nursing services provided. If the in-home nursing provider is not an ADLS waiver provider, all documentation must also be made available between the in-home provider and the ADLS waiver provider.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

The DRS ADLS Waiver Manager verifies these requirements during annual on-site reviews.

**Frequency of Verification:**

Annual review.

**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:**


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 (PERS)

**HCBS Taxonomy:****Category 1:**

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

**Sub-Category 2:****Category 3:**

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

**Sub-Category 4:****Service Definition (Scope):**

Personal Emergency Response System (PERS) is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The

system is connected to the participant's phone and programmed to signal a response center once the "help" button is activated.

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

Service plans which include all services cannot exceed the nursing home rate for an individual with quadriplegia. Plans in excess of this limit require approval by the ADLS Waiver Manager.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Service Provider
Agency	Utility companies
Agency	Telephone cooperative

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response (PERS)**

**Provider Category:**

Agency ▾

**Provider Type:**

Private Service Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Providers must enroll to become Medicaid providers. Enrollment includes signing a standard Provider Agreement.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Ongoing as providers are chosen by program participants as they determine the need for this service.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response (PERS)**

---

**Provider Category:**Agency **Provider Type:**

Utility companies

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Providers must enroll to become Medicaid Providers. Enrollment includes signing a standard Provider Agreement.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Ongoing as providers are chosen by program participants as they determine the need for this service.

**Appendix C: Participant Services**

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

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

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**Provider Category:**Agency **Provider Type:**

Telephone cooperative

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Providers must enroll to become Medicaid providers. Enrollment includes signing a standard provider agreement.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Ongoing as providers are chosen by program participants as they determine the need for this service.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service 

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

**Service Title:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**

**Category 2:**



**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**



**Sub-Category 4:**

**Service Definition (Scope):**

Specialized medical equipment and supplies include devices, controls or appliance that enable participants to increase their ability to perform activities of daily living, enable the participant to perceive, control, or communicate with the environment in which they live, are necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper function of such items, are not available under the State plan and are necessary to address participant's functional limitations, and necessary medical supplies not available under the state plan.

This service includes a wide variety of adaptive positioning devices, mobility aids, adaptive equipment, as well as augmentative communication devices and services. Such adaptations may include devices programmed to automatically dispense medications, telehealth, ted hose, compu-med and mobility devices, such as lift chairs, hooyer lift, scooters, canes, stand aids, grab bars, and augmentative communication devices not otherwise covered by State Plan services. All items shall meet applicable standards of manufacture, design and installation.

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



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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private and hospital-based in-home service providers
Agency	Durable Medical Equipment Supplier
Agency	Pharmacy
Agency	Center for Independent Living

**Appendix C: Participant Services**

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

**Service Type: Other Service**

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

**Provider Category:**

Agency

**Provider Type:**

Private and hospital-based in-home service providers

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

All private and hospital-based in-home service providers must be enrolled as Medicaid waiver providers a signed Provider agreement with DSS.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**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 and Supplies**

**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment Supplier

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Providers must enroll to become Medicaid providers. Enrollment includes signing a standard Provider Agreement.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Providers must be enrolled Medicaid providers with a signed Provider Agreement with DSS.

**Frequency of Verification:**

Annually.

## Appendix C: Participant Services

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

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**Service Type: Other Service**

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

---

**Provider Category:**

Agency

**Provider Type:**

Pharmacy

**Provider Qualifications****License (specify):**

Pharmacies are licensed by the South Dakota Board of Pharmacy.

**Certificate (specify):**

**Other Standard (specify):**

Providers must be enrolled Medicaid providers with a signed Provider Agreement with DSS.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Annually.

## Appendix C: Participant Services

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

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**Service Type: Other Service**

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

---

**Provider Category:**

Agency

**Provider Type:**

Center for Independent Living

**Provider Qualifications****License (specify):**

**Certificate (specify):**

Certified as a center for independent living (CIL) by SD Department of Human Services and the US Department of Health and Human Services. Provider must have a current signed Medicaid Provider Agreement with DSS.

**Other Standard (specify):**

Providers must be enrolled Medicaid providers with a signed Provider Agreement with DSS.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS ADLS Waiver Manager ensures all providers working with ADLS waiver participants are enrolled with SD Medicaid.

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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### 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:**

Vehicle Modifications

**HCBS Taxonomy:****Category 1:**



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



**Sub-Category 2:****Category 3:**



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



**Sub-Category 4:****Service Definition (Scope):**

Vehicle modifications consist of adaptations or alterations to an automobile or van that is the waiver participants primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable to participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

Modifications to vehicles may include adaptive driving features, such as steering and/or breaking controls, lifts or ramps, wheelchair securement/seating systems to accommodate wheelchairs, vehicle body modifications and secondary controls and safety features. The vehicle that is modified may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant;
2. Purchase or lease of a vehicle, and;
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of modifications.

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Centers for Independent Living
Agency	Education Cooperative
Agency	Hospitals
Agency	Mobility Equipment Dealer

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Vehicle Modifications**

**Provider Category:**

Agency

**Provider Type:**

Centers for Independent Living

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Certified as a center for independent living (CIL) by SD Department of Human Services and the US Department of Health and Human Services. Provider must have a current signed Medicaid Provider Agreement with DSS.

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

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturers' specifications.

Vendors of vehicle adaptations shall have a current license, certification, or registration as appropriate for the services being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Vendors shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS verifies quality providers annually. Qualified providers have the responsibility of coordinating with the vendor/supplier. Service Coordinators and participants provide oversight and monitoring of vehicle modifications.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Vehicle Modifications**

**Provider Category:**

Agency 

**Provider Type:**

Education Cooperative

**Provider Qualifications****License (specify):**

**Certificate (specify):**

An Education Cooperative recognized by the South Dakota Department of Education.

**Other Standard (specify):**

Education cooperatives must be enrolled Medicaid providers with signed provider agreements with DSS.

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturers' specifications.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS verifies quality providers annually. Qualified providers have the responsibility of coordinating with the vendor/supplier. DRS Service Coordinators and participants provide oversight and monitoring of vehicle modifications.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Vehicle Modifications**

**Provider Category:**

Agency 

**Provider Type:**

Hospitals

**Provider Qualifications****License (specify):**

Hospitals are licensed by the South Dakota Department of Health.

**Certificate (specify):**

**Other Standard (specify):**

Hospitals must be enrolled Medicaid providers with signed provider agreements with DSS. "Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturers' specifications.

Vendors of vehicle adaptations shall have a current license, certification, or registration as appropriate for the services being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Vendors shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS verifies quality providers annually. Qualified providers have the responsibility of coordinating with the vendor/supplier. Service Coordinators and participants provide oversight and monitoring of vehicle modifications.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Vehicle Modifications**

**Provider Category:**

Agency

**Provider Type:**

Mobility Equipment Dealer

**Provider Qualifications****License (specify):**

**Certificate (specify):**

Mobility equipment dealer must be an enrolled Medicaid provider with signed provider agreements with DSS.

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturers' specifications.

Vendors of vehicle adaptations shall have a current license, certification, or registration as appropriate for the services being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

**Other Standard (specify):**

Vendors shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DRS verifies quality providers annually. Qualified providers have the responsibility of coordinating with the vendor/supplier. DRS Service Coordinators and participants provide oversight and monitoring of vehicle modifications.

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

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

*Check each that applies:*

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
- As an administrative activity.** Complete item C-1-c.

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

The Division of Rehabilitation Services provides case management services to all waiver participants. Case management services are an essential component of waiver coordination and include assessment, reassessment, service plan development, service authorization and monitoring, and case documentation. DRS Service Coordinators function as case managers for ADLS waiver participants.

## Appendix C: Participant Services

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### 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):

There is no state law that requires criminal history and/or background investigations of individuals who provide ADLS waiver services. ADLS providers conduct background screens on their waiver employees. All employee names must also be screened on the OIG list of excluded providers.

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

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

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

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

## Appendix C: Participant Services

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

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

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

## Appendix C: Participant Services

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

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

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

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

Legally responsible individuals (spouse, parent or adult child) can be paid for the provision of personal attendant care and/or respite care, but must be employed by a provider agency and meet all of the qualifications and training requirements for a personal attendant or respite care worker. A legally responsible individual must adhere to the approved service plan. The DRS Service Coordinator is responsible for ensuring that the services provided by a legally responsible individual constitute extraordinary care not typically provided by a spouse, parent or adult child. The ADLS Waiver Manager verifies these requirements during annual on-site reviews.

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

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

Relatives/legal guardians (no limitations) can be paid for the provision of personal attendant care and respite care, but must be employed by a provider agency and meet all of the qualifications and training requirements for a personal attendant or respite care worker. Relatives/legal guardians (no limitations) must adhere to the approved service plan. The DRS Service Coordinator is responsible for ensuring that the services provided by a relative/legal guardian (no limitations) constitutes extraordinary care not typically provided by a spouse, parent or adult child. The ADLS Waiver Manager verifies these requirements during annual on-site reviews.

- Other policy.**

Specify:

- 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:

Information about enrolling as a Medicaid Provider is available on the Department of Social Services website. Potential providers can contact the ADLS Waiver Manager for more information on enrolling to be a waiver provider.

To be eligible to participate in the ADLS program, provider agencies who provide Consumer Preparation Services, Personal Attendant Services and Respite Care must have: experience in delivering services to individuals with severe disabilities; a process for gathering consumer input; a contract with DHS to provide assistive daily living services; and a signed Medicaid provider agreement with DSS. After an assessment by the Service Coordinator has been completed, the Service Coordinator and the participant will complete a service plan. The Service Coordinator will have a list of available providers the participant can choose from for all needed waiver services.

Enrollment of providers is open and continuous to allow the addition of qualified providers to the list on an ongoing basis.

For purposes of service delivery, each provider agency providing personal attendant services must maintain directories, which include information about attendants who meet the personal attendant qualifications, are available to provide services, and have requested to have their names placed into the directory.

DHS has kept provider qualifications sufficiently broad to attract an array of qualified providers. Provider agencies do not have to be in each community that participant's may reside. The program is managed and self-directed by the program participant, and the participant is required to contact their provider agency if they have questions, concerns or need assistance with any services outlined in their service plan. Participant needs are met on a statewide basis with a minimal number of providers.

## **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:**

**Percentage of new providers in compliance with state and federal requirements prior to delivery of services. Numerator - Number of new providers who meet initial certification standards/Denominator - Total number of new providers.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Percentage of providers which continue to be in compliance with state and federal requirements. Numerator - Number of existing providers which continue to meet certification standards/Denominator - Number of total existing providers reviewed.

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

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

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

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

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

**Performance Measure:**

**Number and percent of non licensed and/or non certified provider applicants, by provider type who met initial provider qualifications. Numberator - number of non licensed/non certified provider applicants who met intial waiver provider qualifications/Denominator - number of non licensed/non certified provider applicants.**

**Data Source** (Select one):

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**For non licensed providers of all types, approved provider enrollment documentation**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of non licensed/non certified providers by provider type who continue to meet waiver provider qualifications. Numerator - number of non licensed/non certified providers who continue to meet waiver provider qualifications. Denominator - number of non licensed/non certified providers.**

**Data Source (Select one):**

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>		
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

		<input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

**A list of all non-licensed providers obtained from Provider Enrollment.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**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:**

**Percentage of providers in compliance with new employee (personal attendant) training requirements. Numerator - personal attendants who receive initial training/Denominator - total number of new personal attendants hired.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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.

Annual review of Qualified Providers: Utilizing a comprehensive review tool, 100% of all providers are reviewed each year to ensure they meet all of the program provider requirements. The ADLS Waiver Manager is responsible for aggregating quarterly and annual information for analysis by the Internal Waiver Review Committee (IWRC). Their findings and recommendations are reported to the DRS Director and the SSMA for remediation.

The ADLS Waiver recognizes that certain provider types are non-licensed and non-certified, such as the personal emergency response providers and the incontinence supply providers, but they are monitored to ensure that they are current Medicaid providers with a signed agreement with DSS.

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

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

The primary discovery activities that have the potential to reveal individual problems related to the provision of services by qualified providers include complaint referrals to DRS, annual provider reviews, including Claims Review, requests for administrative hearings and grievances.

When an individual problem is discovered, DRS takes immediate action to assess, and if necessary, ensure the safety of the individual and other waiver participants. If the complaint comes from a program participant, they are asked to first try to remediate the problem with the DRS Service Coordinator and the provider agency. If the complaint comes from any other entity, the ADLS Waiver Manager gathers information critical to resolving issues and problems. DRS reserves the right to also conduct an onsite investigation, if warranted. As appropriate, DRS may make a referral to Adult Protective Services, Adult Services and Aging, Law Enforcement, and/or the Medicaid Fraud Control Unit. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions to include a plan of correction and decertification.

The problem would be individually documented and systemically remediated through the discovery activity that revealed the problem. Additional information may be documented in the individual's file maintained by DRS.

1) Prior to delivering services, a provider is required to meet Administrative Rule and Waiver assurances. Any deficiencies will be recorded by DRS and the provider will be required to address any deficiencies prior to the delivery of any services. DRS will continue to provide technical assistance during this process to ensure all requirements are met prior to certification.

2) If a provider is determined to not meet certification standards, the provider would be subject to sanctions, which may include a plan of correction or decertification. If a provider is placed on a plan of correction, they are not allowed to provide services to any new waiver participants. If a provider is decertified, the DRS will assist waiver participants with transition to a new provider.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Internal Waiver Review Committee	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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

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### 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

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

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

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

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

1. Services in the ADLS Waiver are provided only to individuals living in their own home or the family home and are intended to maximize independence and safety and support full community access and integration. Individuals do not live in congregate settings. The waiver services are provided in their home, where they have opportunities to seek employment and work in competitive, integrated settings, are able to engage in the community, control their own resources, and receive services to the same degree of access as individuals not receiving Medicaid HCBS. This setting is selected by the individual from other options, including institutional care. The participants are offered choice of settings and service options as identified in their person-centered service plan, based on their individual needs, preferences and resources.

The Department of Human Services and Department of Social Services (SSMA) presume all settings in the 1915(c) waiver to meet the requirements of the federal regulation for the ADLS waiver. The settings for the ADLS will not be changing, and there are no plans in the future to include any type of congregate living. Respite care is a service that can be provided in a hospital, ICF/IID, group home, or other community residential facility, but the service is temporary, short term in nature, so is not impacted by the residential settings rule. At each waiver renewal, the ADLS waiver will evaluate services and service providers to determine if any services may be subject to the settings requirements in the federal regulations.

2. At the time of this writing, South Dakota is working closely with CMS regarding a Statewide Transition Plan to move all other HCBS 1915(c) waivers into compliance with the federal HCBS setting requirements. South Dakota is in the process of revising the Statewide Transition Plan, which was originally submitted on March 12, 2015. South Dakota received comments from CMS regarding the initial submission of this plan on October 15, 2015. This plan is being revised to reflect the clarification and comments from CMS, and is due for submission to CMS in March 2016. As part of the process of modifying the Statewide Transition Plan, additional public notice and opportunities for public comment will be required. South Dakota is adding a list of settings subject to heightened scrutiny review to the Statewide Transition Plan as requested by CMS.

South Dakota's analysis of the federal regulation was implemented in two ways: through a review of State Policies, including each Medicaid 1915(c) Waiver and Administrative Rule of South Dakota and an assessment of residential and non-residential HCBS settings in South Dakota by providers, state staff, and individuals. The Department of Social Services and Department of Human Services reviewed the provisions of the federal regulation and compared those requirements to South Dakota's 1915(c) waivers, South Dakota Codified Law, and the Administrative Rules of South Dakota that govern licensure and Medicaid participation. South Dakota found no conflicts between the federal HCBS regulations and any SD codified laws or administrative rules.

There are three additional Medicaid waivers in South Dakota that must meet federal HCBS settings requirements:

#### Family Support 360 Waiver

Services in the Family Support 360 Waiver are provided only to individuals who are children living with natural, adopted, step-families or relatives who act in a parental capacity; adults living independently in the community; or adults living with a family member, legal guardian, or advocate. The services are intended to maximize independence and safety and supports community access and integration. Individuals receiving services from this waiver do not reside in congregate settings. The Department of Social Services and the Department of Human Services presume all settings in the 1915(c) FS 360 waiver to meet the requirements of the federal regulation. The settings for the Family Support 360 will not be changing, and there are no plans in the future to include any type of congregate living. At each waiver renewal, the Family Support 360 waiver will evaluate services and service providers to determine if any services may be subject to the settings requirements in the federal regulation.

#### HCBS ASA Waiver

The Home and Community-Based Services (HCBS) Waiver for South Dakotans is administered by the South Dakota Department of Social Services' Division of Adult Services and Aging (ASA), and is commonly referred to as the ASA waiver in South Dakota. ASA is responsible for assessing individuals, developing care plans, authorizing waiver services, and monitoring service delivery. ASA also conducts all continuous quality improvement (CQI) activities, including data collection, aggregation, analysis, trend identification, and design changes and implementation. The ASA waiver was renewed by CMS on October 1, 2011 and, at that time, was expanded to include two new services – Adult Companion Services and Environmental Accessibility Adaptations. The primary goal of the HCBS (ASA) Waiver is to provide services to the elderly and consumers with a qualifying disability over the age of 18 in their homes or the least restrictive community environment available to them. The waiver provides a wide range of services with the goal of meeting the individual needs of each waiver consumer. Individuals qualifying for the HCBS (ASA) Waiver must meet nursing facility level of care. Adult Day Services are provided in adult day settings; South Dakota currently has two adult day settings that provide services. South Dakota's Adult Day settings are described in detail in the Non-Residential Settings Assessment Section of the Statewide Transition Plan. Adult Day Settings are not licensed by the state of South Dakota. Division of Adult Service and Aging staff perform annual assessments of standalone adult day settings. One setting is co-located with other services for adults; including a nutrition site, a senior activity center, and day resources for veterans. The other setting is a stand-alone day center that also includes day resources for children and veterans. Individuals who receive services at these settings

live in their homes and are integrated into the community. South Dakota has determined these settings meet the intent of the federal regulations and do not require further action to be compliant. South Dakota will require each enrolled setting to sign a supplemental agreement attesting to compliance with the requirements of the federal regulations.

Assisted Living services are provided in assisted livings. Assisted Living Centers must be licensed by the South Dakota Department of Health. Assisted Livings must meet the standards found in Administrative Rule of South Dakota Article 44:70 to be licensed. South Dakota evaluated assisted living settings in the transition plan. The HCBS (ASA) Waiver Assessment Results and Action Items section has results specific to Assisted Livings.

South Dakota chose a three step assessment process for residential settings. The assessment process included collection and analysis of providers' responses to the self-assessment and validation of those responses from state staff and individuals receiving HCBS through the CHOICES and HCBS (ASA) waivers. South Dakota used Survey Monkey to collect electronic responses to the assessments.

Provider responses and clarifying comments made in the assessment were carefully analyzed by South Dakota Medicaid for optimal and non-optimal responses. Optimal responses indicated compliance with the HCBS federal regulation. Non-optimal responses indicated that additional actions were necessary for compliance with the federal regulation. In the assessment, providers had the option to indicate compliance in one of three ways:

Yes, there are no restrictions

Yes, with limits

No

When a provider answered 'Yes, with limits,' the provider was asked to provide additional clarifying information regarding the limit and why it was in place. South Dakota Medicaid analyzed each indicated limit to determine if the limit was acceptable. Limits that undergo due process or implemented for the health and safety of the individual were determined to be acceptable and were coded as an optimal answer in the assessment results.

South Dakota Medicaid used four questions to identify settings subject to heightened scrutiny review according to the federal regulation and guidance released by CMS including:

Is the setting also a Nursing Facility?

Is the setting on the grounds of, or adjacent to an institution?

Is there another group home, supervised apartment, or assisted living on the same block?

Does the setting isolate individuals from the broader community?

Follow-up assessments were performed on-site by Adult Services and Aging Regional Managers. The follow-up assessment assessed the nature of the setting and the community integration options available to individuals living in the setting. The follow-up assessment also assessed the availability of other home and community based services and settings in the community. Finally, the follow-up assessment documented the location of the setting in the community. Specifically, when a setting was adjacent to, or on the grounds of an institution, the follow-up assessment analyzed the other buildings surrounding the setting such as schools, private residences, retail businesses, churches, etc. All providers will be required to reach 100% compliance with all federal requirements by the end of the transition plan period. Providers who do not meet expectations will receive a notification of non-compliance and will be asked to submit a corrective action plan to the Department. South Dakota will add language to supplemental provider agreements for providers to attest to compliance with the provisions of the federal regulation. South Dakota anticipates that all enrolled settings will be able to comply with the federal regulation. However, in the rare likelihood that a provider closes or it is determined that a setting will not be able to meet the new federal requirements, South Dakota's Adult Services and Aging Specialists and DHS Resource Coordinators will provide support to any recipients who must relocate. Recipients will receive detailed information about the options available in their community and the state. In addition, individuals will be given 30 day notification required by ARSD §44:70:09:14 and ARSD 46:11:08:05.

In the federal regulations, CMS identified types of settings that are subject to heightened scrutiny review. These settings are presumed to have the effect of isolating individuals from the broader community or have the qualities of an institution. Of the 132 enrolled assisted living settings, South Dakota identified 59 assisted living settings that will require additional analysis per CMS's guidance on settings subject to heightened scrutiny review. South Dakota performed an on-site review of each of the 59 settings. From initial on-site analysis, South Dakota anticipates that further evaluation will demonstrate all settings meet the home and community based requirements. South Dakota plans to address these settings during the 2016 HCBS (ASA) Waiver renewal.

The Department of Social Services will require all providers to attest to compliance with the HCBS requirements through a signed supplemental agreement. DSS will implement a supplemental agreement for Assisted Living providers starting in State Fiscal year 2016. Compliance with the supplemental agreement will be evaluated during annual on-site reviews of the setting. When non-compliance is identified in a setting, DSS will develop recommendations for the provider and work individually with the provider to identify remedial actions.

CHOICES Waiver

The CHOICES (Community, Hope, Opportunity, Independence, Careers, Empowerment, Success) waiver is a 1915(c) waiver designed to provide for the health and developmental needs of South Dakotans with intellectual/developmental disabilities who would otherwise not be able to live in a home and community base setting and would require institutional

care. The goal of the CHOICES waiver is to assist individuals in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the state of South Dakota; and promote the integrity of their families. The CHOICES waiver serves individuals of any age with intellectual or developmental disabilities. Individuals served by the CHOICES waiver must meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care. The CHOICES waiver was renewed on June 1, 2013.

The objectives of CHOICES are to:

Promote individuality for individuals through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of individual safeguards;

Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and individuality by enhancing and not replacing existing natural supports;

Encourage individuals and families to exercise their rights and share responsibility for the provision of their services and supports; and

Offer a platform for a person-centered system based on the needs and preferences of the individuals.

Supported employment takes place in integrated competitive employment settings; South Dakota presumes these settings to meet federal requirements. Residential habilitation services are provided in individual's homes, including group homes and supervised apartments operated by a Community Support Provider.

Group homes are services by a provider that has round-the-clock responsibility for the health and welfare of residents, except during the time other services (e.g., day services) are furnished.

Supervised apartments are services that support a person in his or her home or apartment, when the provider does not have round-the-clock responsibility for the person's health and welfare. These services can be provided in other community settings, but are primarily furnished in a person's home or apartment. Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in the person's home when the provider does NOT have round-the-clock responsibility for the person's health and welfare.

South Dakota evaluated group home and supervised apartment settings in the transition plan. See the CHOICES Waiver Assessment Results and Action Items Section for specific results related to Group Homes and Supervised Apartments. The provider self-assessment was completed by all of South Dakota's 19 Community Support Providers for 267 HCBS residential setting sites. The Department of Human Services (DHS) Division of Developmental Disabilities (DDD) conducted a two layer quality assurance check on proportionate random sample of provider self-assessments. This included DDD staff assessments of 167 residential settings and individual/guardian interviews at each residential setting. The DHS/DDD utilized the results from the two layer quality assurance check to validate the provider self-assessment results. South Dakota performed site specific follow-up at each setting where a non-optimal response to one of the four questions regarding heightened scrutiny was indicated by a provider in the provider self-assessment. South Dakota determined that no Community Support Provider settings required heightened scrutiny review. From the assessment results, South Dakota determined that over half of South Dakota Community Support Provider settings already substantially meet the intent of the federal regulations. South Dakota identified 112 other settings that will require modifications to setting policy or practice in order to achieve the intent of the federal regulations. DDD will work with stakeholders and providers to remediate any settings with non-optimal results to be started by June 1, 2016 and completed by March 17, 2019.

The Department of Human Services Division of Developmental Disabilities (DHS/DDD) identified three specific practices of continuous quality improvement monitoring (Systemic Monitoring and Reporting Technology (SMART), National Core Indicators (NCI) and Council on Quality and Leadership (CQL)). Each of the three areas has specific quality improvement indicators that correspond with the Home and Community Based Services (HCBS) federal regulation. The DHS/DDD will collect and analyze monitoring information and share the results with stakeholders on a quarterly basis to assist with systemic quality improvements. The South Dakota Department of Health (DOH) conducts biennial physical facility standards compliance reviews for all settings owned or leased by qualified providers.

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

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

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

Service Plan

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

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**

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

*Specify qualifications:*

- Social Worker**

*Specify qualifications:*

- Other**

*Specify the individuals and their qualifications:*

The Division of Rehabilitation Services (DRS) employs Service Coordinators who are responsible for Service Plan development and case management of the service plans developed. DRS Service Coordinators must demonstrate the following knowledge, skills and abilities:

Knowledge of:

- 1) Person-centered practices;
- 2) Available local and state resources;
- 3) Cultural, economic, physical, social and psychological factors that influence family dynamics and interpersonal relationships;
- 4) Federal and state legislation, policies and regulations governing human services programs;
- 5) Basic theories, principles and methods of assessment and intervention;
- 6) Concepts related to consumer rights, confidentiality and professional ethics;
- 7) Principles and techniques of conducting interviews and acquiring information.

Skills:

- 1) Work with computerized case management systems;
- 2) Manage a full caseload of ADLS participants;
- 3) Good interpersonal skills;
- 4) Communicate effectively with agencies, personnel, and participants.

Ability to:

- 1) Transfer participant needs to a service plan;
- 2) Monitor progress toward identified service goals;
- 3) Establish and maintain effective working relationships;
- 4) Maintain participant records and case documentation;
- 5) Prepare reports and compose correspondence;
- 6) Gather and analyze data, reason logically and accurately, and draw valid conclusions;
- 7) Organize time with ability to prioritize and meet deadlines;
- 8) Express information concisely and effectively, both orally and in writing;
- 9) Exercise good judgement in evaluating situations and in making decisions;
- 10) Travel extensively to meet with participants in their home.

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

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

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

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

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

	 
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## 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.

The participant has full authority over the service plan process. When scheduling the assessment and service plan development, they are informed that they can choose when the service planning home visit will take place, and who they would like to include in the process. The DRS Service Coordinator meets with the participant, and any others the participant has invited to develop the plan, which may include family, representative, caregivers and any other persons identified by the participant or family member as having information pertinent to the assessment or service plan development process. It is the participant's responsibility to notify interested parties to attend the assessment.

The program is developed to be managed and self-directed by the participant, therefore the participant or potential participant, must learn about the services available and have full choice of what services they need. The DRS Service Coordinator provides information about waiver options, including the choice between waiver services and institutional care, service options and provider options available to the participant. The participant and their representatives participate in all decisions regarding the type of services, amount, duration and frequency of the services included in the service plan. All services must be justified based on need and available support services. The information is recorded on the service plan, which is signed by the participant, the legal guardian/non-legal representative, and the DRS Service Coordinator. Throughout the entire process of applying for and receiving waiver services, the participant is encouraged to participate as much as possible in the development of the assessment and service plan. The participant is informed that services are to directly reflect the person's individual needs. Therefore, services may be amended at any time to reflect a change in services. The DRS Service Coordinator meets with the participant/legal guardian/non-legal representative during the six month review after the initial service plan has been initiated to address any significant changes needed in the service plan. The DRS Service Coordinator is available to revise the service plan based on any changes in the needs of the participant throughout the year, and is responsible for ongoing monitoring of the services included in the participant's assessment and service plan.

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

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

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

When a person with quadriplegia chooses to apply for waiver services, they complete a screening tool that is part of the application for the waiver. This application is accessible online through the DHS website, through any current ADLS provider agency, or if the ADLS Waiver Manager is contacted, the application can be mailed, emailed or faxed to the person. Once the application and screening tool are received by the ADLS Waiver Manager, if the person meets the basic eligibility criteria for the program, they are referred to DSS Economic Assistance, who will determine financial eligibility for the program, and to a DRS Service Coordinator, who will schedule with them a time to meet to complete an assessment for eligibility. When scheduling the appointment, the applicant chooses the day and time for the home visit. They are also informed that they can invite anyone to the meeting that they choose who may be beneficial and supportive to the applicant during the assessment and service plan process. The initial assessment must be completed within 30 days when able. If the DRS Service Coordinator is unable to meet the

above timelines, documentation must be available to describe the reasons why the timelines were not met.

The ADLS Waiver Assessment is completed during a home visit. The assessment addresses a person's abilities, including the person's needs, strengths, and preferences in the following areas: Cognitive Function, Functional performance as it relates to Activities of Daily Living, Instrumental Activities of Daily Living, Social Life, Health & Safety and Goals. It addresses the extent that a participant is independent, needs some support or assistance, or is dependent in each activity. At the time of the assessment, the DRS Service Coordinator is required by policy to provide:

- a) Information on available services and providers;
- b) The right to choose between institutional or home and community-based services;
- c) The right to a fair hearing;
- d) The right to select necessary services by qualified service providers.

DRS utilizes a Freedom of Choice form that fully discloses to applicants and participants that they have the right to choose their providers. They are also provided information on the full range of waiver services and providers available to provide those services. The applicant/participant is also given the choice between skilled nursing home services or waiver services in the community.

During the service plan process, the participant and DRS Service Coordinator, utilizing a person centered planning approach, review the services available and determine together the amount, scope, and frequency of services to be provided. The service plan is managed and self-directed by the program participant with the DRS Service Coordinator's assistance as needed. Services are coordinated through the ADLS Waiver and other providers as needed (Assistive technology, housing assistance, etc.). The DRS Service Coordinator works with the participant and other providers to assure access to services, and will provide information and referral to the participant on the services that may be beneficial to their needs. The participant is then encouraged to take the responsibility of implementing services whenever possible.

During the Level of Care determination, each service plan is reviewed by the ADLS Waiver Manager to ensure that service plans reflect the full range of a participant's service needs and incorporate and maximize the resources and supports present in the person's life and community.

The ADLS Waiver Manager reviews and approves all service plans, on initiation of services, six months after initiation and annually thereafter at a minimum. Service plans can change anytime throughout the year as a participant's needs change. These changes can be identified through quarterly contacts, during six month or annual review, and any communication with the DRS Service Coordinator by the ADLS participant, his/her family or guardian, or service provider. The service plan addresses services to be utilized under the waiver, but will also include services provided by other entities outside of the waiver, including natural supports, in order to address all needs of the participant and how they are being met.

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

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### 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.

During the service plan development, and on at least an annual basis, the DRS Service Coordinator reviews health and welfare issues with the participant. These issues include risk factors in relation to their personal care. Personal care risk factors may include skin breakdown, bowel and bladder complications, spasms, pain, and falls. Safety risk factors may include fire, weather related emergencies, abuse, neglect, and exploitation. In addition to the above risk factors, due to personal care needs, participants are educated on the need for a back-up plan. The back-up plan is reviewed on at least an annual basis. Education and support is provided to participants who request this information or demonstrate the need for an improved plan.

To ensure the health, safety and welfare of participants of the ADLS program, DRS Service Coordinators are required to complete a Personal Attendant Back-Up Plan form during the planning process. The plan includes information for contacts in the event that a back-up attendant is needed for personal attendant services. The plan also includes who to contact in an emergency, and may include the telephone numbers for family and their

healthcare providers.

The Back-Up Plan form is completed and signed by the participant. A copy is kept in the participant's home, and in the DRS Service Coordinator's case file.

The DRS Service Coordinator is specifically responsible for assuring that these program requirements are met. Personal attendants also play an important role in sharing information and concerns with the participant's DRS Service Coordinator and Consumer Preparation Specialist.

## **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.

Participants must choose a provider for each waiver service selected. When a service plan is developed, the DRS Service Coordinator must inform the individual, their representative or family member of all available qualified providers within the individual's service delivery area. The participant, their representative or family member may choose the providers from which they receive services. The name of the provider that is chosen will be included on the service plan. If the family member or representative chooses a provider for the participant, the DRS Service Coordinator must identify the individual who chose the provider on the service plan. Documentation must also be included in the participant's record that the participant chose a family member or non-legal representative to choose the provider for the participant. Participants may request a change in providers at any time during the waiver year. The Freedom of Choice form and all related documents are included in the participant record and reviewed by the ADLS Waiver Manager during the review process.

Due to the self-direction nature and philosophy of the ADLS waiver, ADLS participants must be capable of and accept the responsibilities of participant-directed care, which includes recruiting, hiring, training, managing and terminating attendants. The participant has a choice of waiver providers available in their service delivery area to select from that can provide Consumer Preparation Specialist services to assist the participant with this process. The participant's choices are documented and reviewed during the annual review process by the ADLS Waiver Manager.

The participant has a choice to select the traditional home health agency model as a limited option and under special circumstances as identified in Appendix C Participant Services C-1: Summary of Services Covered. When this traditional home health agency model is selected, the DRS Service Coordinator will provide a list of qualified home health agencies available in the service delivery area to select from.

When selecting any services identified in the ADLS Waiver, the participant will be provided with a list of all qualified providers that cover the service delivery area that the participant resides in. The list includes contact information, such as address, phone number and web address. The participant can review the list and contact providers to make inquiries before selecting a provider, if they so choose. While the participant chooses the provider, the participant may also invite his or her family members or representative to participate in the decision making process. Any decision made by a family member or representative is done at the participant's request, is well documented in the case file, and their signature is required on the service plan.

The DRS Service Coordinator will leave contact information with the participant at each visit, and may be contacted by the participant at any time. This contact information includes ability to contact by email or toll free phone number, if needed.

## **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):

DSS exercises administrative authority, supervision, and oversight of the waiver and issues policies, rules and regulations related to the waiver. The existing MOU between DHS and DSS indicates the responsibility of DSS to review waiver participant's plans to ensure that waiver requirements are met. A copy of the MOU setting forth the

authority and arrangements for this policy is on file with DHS and DSS.

ADLS Waiver Manager reviews and approves all service plans prior to implementation, and all are subject to Medicaid agency approval. DRS conducts annual reviews which include a representative, random sample of service plans. A new representative random sample is selected each year based on the previous year's review cycle results. For the purpose of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

The review results include appropriateness of services, review of plans for possible changes in service plans, specific services being provided, fiscal review of services rendered, documentation of service coordination, and review of possible abuse, neglect and exploitation. In the event the service plan is deemed inappropriate or service provision is lacking, the DRS Service Coordinator addresses any needed corrective action. The review report is referred to DSS on a quarterly basis for monitoring, oversight and final approval. The SSMA and DRS have real time access to the SMART review system, which allows each the ability to review individual findings, provider agency findings, systemic reports and operating agency reports.

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

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

*Specify the other schedule:*

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

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

Personal attendant service providers

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

### D-2: Service Plan Implementation and Monitoring

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

The DRS Waiver Manager conducts an annual on-site review of the ADLS program. The DRS Waiver Manager is responsible for ongoing monitoring and compliance. The statistically valid sample size is based upon historical data from the previous review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results. For purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level,

and the most recent population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

The reviews include a review of case files to determine appropriateness of services, specific services being provided, documentation of service coordination, and review of possible abuse and neglect incidents reported. Review findings and remediation steps, if indicated, are sent to the Medicaid agency for monitoring and oversight. Findings that require corrective action are addressed with providers and require a corrective action plan with specific steps for correcting findings and timelines for implementation.

The DRS Service Coordinator is responsible for the ongoing monitoring of the participant's service plan to ensure that services are furnished in accordance with the established service plan. The participant and their Service Coordinator review all services annually, or more frequently, if warranted.

The DRS Service Coordinator is also responsible for identifying issues with waiver services or other services and supports the participant needs to alleviate the concern. If a Service Coordinator believes a participant is at risk of harm, they are responsible to arrange for and conduct a safety review that includes a face to face meeting and to take immediate steps necessary to protect the participant, if so indicated. Service Coordinators are also responsible to adhere to and report all alleged incidents of abuse and neglect to the ADLS Waiver Manager.

DRS conducts annual monitoring of the implementation of the service plan and participant health and welfare by ensuring the service plans and assessment process meet the following criteria:

Exercise of free choice of a provider: Initially and annually, participants are given choice of service providers. All participants sign the Freedom of Choice and Right to Fair Hearing form initially and annually. If a conflict between a participant and a provider agency cannot be resolved, the participant is provided a list of other ADLS provider agencies.

Services meet the participant's needs: Participant needs are addressed initially, and annually thereafter. New participant's service plans are reviewed with them six months into the program. This is a self-directed, self-managed program, and participants are encouraged to contact Service Coordinator anytime they need to update their service plan to better suit their needs.

Effectiveness of back-up plans: Back up plans are reviewed with participants annually and anytime throughout the year when a participants needs change.

Participant's health and welfare: Health and Welfare are assessed on an ongoing basis. Participants are trained on what to report to their Service Coordinator. If at any time a DRS Service Coordinator believes a participant is at risk of harm, the DRS Service Coordinator must arrange and conduct a safety check that includes a face-to-face meeting, preferably in the home. When appropriate, the Service Coordinator must take immediate steps necessary to protect the participant. The Service Coordinator is a mandatory reporter, and as outlined in the ADLS Incidents of Abuse, Neglect and Exploitation Program Guide, must follow reporting procedures by reporting incidents of alleged abuse, neglect and exploitation within 24 hours of the incident, or the next working day, whichever comes first. To follow up on the incident with the Division of Rehabilitation Services after mandatory reporting procedures, the Incident Form DRS-ADLS-101 must be submitted within seven calendar days following the incident by the person who reported the incident. All personal attendants are trained on what to report to the Service Coordinator. Any concerns that cannot be remediated at the provider level are shared with the ADLS Waiver Manager to assist in remediating.

Participant's access to non-waiver services in service plan, including health services: Planned Services is a specific section in the program assessment, which includes all waiver and non-waiver services the participant is accessing. Any barriers identified are addressed with the participant, and assistance is provided as requested by the participant.

Prompt follow-up and remediation: All identified risk is remediated in a timely manner. If at any time the participant refuses to take the steps necessary to lessen the identified risk, then termination from the program will be considered. The participant is not terminated until comparable services can be offered to the participant.

Systematic collection of information about monitoring results: Data is collected related to risk factors via participant surveys, annual participant record review, and Service Coordinator notes. Abuse, neglect and exploitation data is

kept on record in the ADLS Waiver Manager’s office. Some data is collected within the SMART system used to collect and aggregate annual file review information.

In addition to maintaining regular contact with the participant, the Service Coordinator communicates with the providers, who are expected to alert the Service Coordinator of critical incidents, changes in the participant’s needs, emergencies, and if services are taking more or less time than authorized. Regular communication between providers and DRS Service Coordinators will ensure services are being provided in accordance with the participant’s needs.

**b. Monitoring Safeguards. Select one:**

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

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

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

### Quality Improvement: Service Plan

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Percentage of participant's service plans that reflect their personal care needs;  
Numerator - Total number of participant service plans that reflect the participants personal care needs. Denominator - Total number of participant service plans reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data</b>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
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<b>collection/generation</b> <i>(check each that applies):</i>		
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/- 5
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Percentage of participant service plans that address participant health and safety risk factors identified in the assessment. Numerator-Number of participant

**service plans which address participant safety factors identified in the assessment/Denominator-Number of service plans reviewed**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/- 5
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**Percentage of participants new to the waiver who had their assessment/service plan completed within 30 days of initial contact with their case manager.**  
**Numerator-Number of new waiver participants who had their assessment/service plan completed within 30 days of initial contact with their case manager/Denominator-Number of assessment/service plans reviewed for new waiver participants**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/-5
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Percentage of participant assessments that have been updated within 12 months of the most recent assessment; Numerator-Number of participant assessments that have been updated within 12 months of the most recent assessment/Denominator-total number of participant assessments reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Percentage of participant assessments that have been updated when the needs of the participant have changed. Numerator-Number of participant assessments that have been updated when the needs of the participant have changed/Denominator-Total number of participant assessments reviewed with an identified change in need.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/-5
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

**Performance Measures**

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

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

**Performance Measure:**

**Percentage of participant assessments that are monitored annually to assure the participant receives the type, scope, amount, duration, and frequency of services as outlined in the assessment; Numerator-number of participant assessments that demonstrate monitoring to assure services are delivered as outline in the assessment/Denominator-total number of participant assessments reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/-5
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
		<input type="checkbox"/> <b>Other</b>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Percentage of participants given choice between institutional care and community based services at the time of their initial assessment for waiver services;Numerator-number of initial LOC assessments that include documentation the participant was given choice between institutional care and community based services/Denominator-total number of initial assessments reviewed.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**  
**Percentage of participants given the choice between qualified providers;**Numerator-number of participants provided choice of qualified providers/Denominator-total number of participant assessments reviewed.

**Data Source** (Select one):  
**Operating agency performance monitoring**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 95% +/-5
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percentage of participants provided the choice of waiver services. Numerator-Number of participants provided choice of waiver services/Denominator-total number of participant records reviewed.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<input type="checkbox"/> <b>State Medicaid Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/-5
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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.

Claims Review: Qualified providers are required to participate in an annual billing review process conducted by a DHS Management Analyst, in which a review is conducted on a statistically valid sample of participants' claims to ensure and validate the accuracy of record keeping, supporting documentation, and the resulting claims submitted for payment. Findings are compiled, reviewed by the ADLS Waiver Manager, and, if necessary, addressed in a plan of correction by the provider, and summarized in a report issued to the provider, the DRS Director and DSS.

Participant Surveys: DRS surveys participants annually to assess their satisfaction with services and any health and safety concerns they may have that are not being met through the program. Other areas addressed in the survey are: satisfaction with their DRS Service Coordinator, degree of participation in their assessment process, participant rights, such as right to choose their providers and their right to choose institutional care over community based care. Data analysis regarding these performance measures is presented to the Internal Waiver Review Committee annually.

All participants are provided with information on how to contact the ADLS Waiver Manager in DRS. Participants can contact the Waiver Manager to assist in remediating any concern they may have regarding their services.

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

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

The primary discovery activities that have the potential to reveal individual problems related to service plans include complaint referrals to DRS and participant surveys. When an individual problem is discovered, DRS takes immediate action to assess, and if necessary, ensure the safety of the participant. The participant's DRS Service Coordinator will meet with the participant to gather information critical to resolving issues and problems. As merited by the situation, DRS may request additional information from the provider. As appropriate, DRS may make a referral to Adult Protective Services, Adult Services and Aging, Law Enforcement, and/or the Medicaid Fraud Control Unit. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions to include a plan of correction, probationary status and decertification.

If a Service Plan is found to not address all participant health and safety risk factors, the DRS Service Coordinator is required to meet with the participant within 7 working days to update the service plan to address the identified areas. The DRS Service Coordinator is then required to submit the plan to DRS for review and approval. If a systemic problem is identified, the qualified provider may also be required to develop and submit a plan of correction to DRS to remediate any deficiencies discovered. DRS reviews the plan of correction and forwards it to the SSMA for their review and approval.

If a Service Plan is determined to not address all the participant's needs, the DRS Service Coordinator is required to meet with the participant within 30 calendar days to update the Service Plan. The Service Plan is then submitted to DRS for review and approval.

If deficiencies are noted during the annual review of qualified providers, the provider is required to develop and submit a plan of correction to DRS. The plan of correction would address the process to ensure that Service Plans are completed within the 30 day timeframe. DRS approves this plan and forwards it to the SSMA for review and approval.

If Service Plans are found to be deficient, the DRS Service Coordinator is required to develop and submit a plan of remediation to DRS. DRS monitors the completion of the approved plan of remediation.

If it is discovered the assessment and service plan is found to not address all participant health and safety risk factors, the DRS Service Coordinator is required to meet with the participant within 7 working days to update the service plan to address the identified areas. The DRS Service Coordinator is required to submit the plan to the ADLS Waiver Manager for review and approval. DRS approves this plan and forwards to the SSMA for review and approval. Once approved by the SSMA the qualified provider is required to complete the plan of correction. DRS monitors the completion of the approved plan of correction.

The ADLS Waiver Manager will complete a 100% quality assurance review of approved level of cares for participants new to the waiver. If it is determined that the choice of institution, choice of provider, or choice of waiver services are missing from a level of care, DRS will immediately notify the DRS Service Coordinator and request the documentation be submitted within 24 hours. DRS will evaluate the level of care upon receipt of this information to determine the next steps which may include voiding of claims if the start date for waiver services is affected.

If, during review of a waiver participant's file/service plan, it is found to not contain annual documentation of the choice of providers or choice of waiver services, the DRS Service Coordinator is required to develop and submit a plan of remediation to DRS within 10 days. The plan of remediation would detail the plan to meet with the participant within 30 calendar days to discuss choice of providers and/or waiver services. Additionally, the DRS Service Coordinator will be provided with training to ensure a full understanding of offering waiver participants choice of providers and waiver services.

ii. **Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify:  Internal Waiver Review Committee	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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

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

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

**Yes. The State requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

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

The ADLS program offers 9 services that allow participants to remain living at home: consumer preparation services, personal attendant, private duty nursing, incontinence supplies, respite, environmental accessibility adaptations, vehicle modifications, specialized medical supplies and equipment, and emergency response services.

Once an applicant is determined eligible for the program, they are supported to manage and direct their services to the fullest extent possible. The program does require participants to manage and self-direct their personal attendant care, but also allows the ability to select a non-legal representative if they choose, to manage and self-direct their services. The ADLS waiver adopts principles of independent living, and the program supports participants to self-direct their services to the highest degree possible.

Eligible participants are referred to qualified providers in their geographic locales. Participants are afforded employer authority as co-employers of Personal Care and Respite Care providers. Participants fully participate in the advertising, interviewing and hiring of their personal attendants and respite care workers. Participants are supported to create their personal attendant schedule, train and determine their personal attendant's proficiency to provide their services, supervise their personal attendants, including discipline and termination if needed. The agency with choice as the employer of record ensures compliance with all IRS, federal and state DOL regulations.

Participants are supported to choose and evaluate vendors/providers of all waiver supplies, equipment and devices. Examples of this include participants who locate a provider of emergency response services or incontinence supplies. Participants are supported to contact the provider to arrange for installation of the required equipment and are encouraged and supported to identify a local provider for their incontinence supplies if they choose to access these services. The ADLS Waiver Manager authorizes these services from the state level, but the participant, with assistance as needed from DRS Service Coordinator, will select, purchase and arrange for delivery of their waiver supplies, equipment and devices. Skilled nursing services are decided between the participant and their physician. Nurse's services are ordered and monitored by the physician. The participant's DRS Service Coordinator receives copies of all pertinent nursing documentation and works with the skilled nursing provider to ensure visits are provided as ordered.

Participants are supported by their DRS Service Coordinator and Consumer Preparation Specialists as needed to manage and self-direct their ADLS services. In addition to the DRS Service Coordinator, families and other people comprising the participant's natural support system may play an integral role in supporting the participant's self-direction. This role is determined by each participant.

## 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*

ADLS waiver participants are required to self-direct their personal attendant services, or designate a non-legal representative to direct and manage their care. This includes finding and hiring of personal attendants, training and determining personal attendant proficiency, ensuring time-forms are completed per the provider specification and approving all time forms for payment. Participants are also required to manage performance issues with their personal attendants, including termination. The DRS Service Coordinator initially discusses with the participant the services that are available through the program and informs the participant about participant-direction opportunities. This includes explaining the rights, responsibilities, benefits and risks associated with consumer direction. The program offers Consumer Preparation Specialist services, which provides training skills on how to recruit, interview, hire, evaluate, manage and dismiss attendants.

Even if a provider has a staffing pool available for personal attendants, the participant is still required to manage their personal attendant staff and services. The ADLS waiver supports independent living principles, and all participants are supported to manage and self-direct their services to the fullest extent possible.

In conditions described below, participants are allowed to hire personal attendants through the traditional home health agency. Participants are informed that choosing to hire a home health agency can affect their ability to manage, direct and control that aspect of their PA services. For example, they may not be able to choose the PA that the home health agency selects to provide the service, and the service may be performed at a time designated by the home health agency. Participants can select the home health agency option in the following conditions:

1. To be used as part of their backup emergency plan when personal attendants are unable to work as scheduled due to unforeseen circumstances, and the ADLS participant has made every attempt to contact all other backup personal attendants listed on their backup plan;
2. To be used up to a maximum of 7 hours per week to fill in gaps in their PA schedule where they are unable to find a PA to cover that designated time. ADLS participants will continue to utilize Consumer Preparation Services to assist them in filling those gaps to hire personal attendants using the self-directed model;
3. To be used for a maximum of 30 days immediately upon discharge from a nursing home or other institution to assist a participant to transition more quickly out of a nursing home into the community, receiving personal attendant services while working toward hiring personal attendants through the self-directed hiring process.
4. When self-directed providers have attempted to work with a participant in managing and directing services, the participant has demonstrated they are unwilling or unable to manage and direct their PA's, resulting in self-directed providers terminating services with the participant.
5. Under extraordinary circumstances when DRS deem it necessary to provide health, safety and welfare to the participant as identified by the ADLS Waiver Manager.

In all other services provided under the ADLS Waiver, the participant is able to select qualified providers that cover their service area.

At each reassessment, the Service Coordinator reviews the participant's ability to demonstrate self-direction. If at any time the participant is having problems with participant direction, he or she needs to work with the DRS Service Coordinator to determine the best course of action, which can include selecting a non-legal representative to direct and manage their care.

## Appendix E: Participant Direction of Services

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### 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.

DRS has developed personal attendant management materials for the participants. The purpose of these materials is to teach the participant about PA management and self-direction, their responsibilities in the role of co-employer, and to provide supports for participants to be successful in this task. All participants are required to receive at least one waiver service per month to be eligible for the program. Personal attendant care is by far the most utilized waiver service utilized by program participants.

General topics covered related to personal attendant services are:

- Recruitment
- Screening
- Interviewing
- Selecting
- Scheduling
- Training
- Supervision
- Preparation of time sheets
- Arranging for emergency back-up
- Determining the attendant's competency to perform the needed services
- Directing the attendant to do the task(s)
- Resolving conflict
- Termination of the attendant if the conflict cannot be resolved; and
- Maintaining an appropriate personal and professional relationship with the personal attendant.

This information is provided by the Consumer Preparation Specialist after a participant has chosen a provider agency, and has been determined eligible for services. This training is ongoing as needed. The primary role of the Consumer Preparation Specialist is to support the participant to understand all of the above requirements. They also support the participant to be as independent as possible in the management and self-direction of their personal attendant services. The above information is provided in alternative formats as an accommodation to individuals who have a visual impairment, individuals with a hearing impairment or individuals who have limited English proficiency.

## Appendix E: Participant Direction of Services

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### E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant is supported to have a family member or friend, for example, assist in the management and self-direction of their personal attendant services.

The DRS Service Coordinator and the Consumer Preparation Specialist work closely with the participant to help them identify someone to delegate these services to. This is generally someone already close to the participant, and supports them to remain as independent as they are able to. The non-legal representative will complete a screen form, which outlines the functions of the authorized representative responsibilities and sign a form acknowledging their responsibilities, some of which include: show a strong commitment to the participant, show knowledge about their preferences, follow the participant's wishes and use sound judgment to act on the participant's behalf, be at least 18 years old and have known the participant for at least two years.

On occasion there is no one to delegate this service to and then alternate services such as skilled nursing facility or switching to another Medicaid waiver program that is not self-directed are explored. Safeguards are monitored by the DRS Service Coordinator and Consumer Preparation Specialist on an ongoing basis, through regular on-site visits to the participant's home for example.

## 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
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Personal Attendant Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## 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:*

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

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

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

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

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

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Accessibility Adaptations	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
In Home Nursing	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Consumer Preparation Services	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Incontinence Supplies	<input type="checkbox"/>
Personal Emergency Response (PERS)	<input type="checkbox"/>
Personal Attendant Care	<input type="checkbox"/>

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

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

Case management is furnished as a Medicaid administrative activity provided by the DRS Service Coordinator. The DRS Service Coordinator is hired as a Dept. of Human Services employee. Time spent on activities allocable to Medicaid administration is captured through a time study process approved by the US Department of Health and Human Services as a component of the Department of Human Services cost allocation plan. The Department of Human Services, Office of Budget and Finance, in cooperation with the Department of Social Services, the State Medicaid Agency, utilizes the quarterly administrative claiming process to request funding for administrative activities.

The DRS Service Coordinator provides support and assistance to the ADLS participant to support participant

direction activities. The DRS Service Coordinator provides training and guidance to the participant on self-direction and the independent living philosophy. To support this, the DRS Service Coordinator provides the participant with information regarding all services available within the waiver, what the service provides, and gives a list of all qualified service providers available in their coverage area. Participants are encouraged to contact providers with any questions prior to making a decision, to assist them in making an informed choice regarding the selection of providers.

The DRS Service Coordinator encourages the participant to invite anyone they want to attend their annual reassessment and service plan meetings. This can include, family, friends, PA's, non-legal representatives who would participate with the best interests of the participant in mind. The participant and DRS Service Coordinator review the services they are receiving and the current providers to ensure they are getting quality services. The DRS Service Coordinator will inform the participant that they can change providers/vendors during the reassessment/service plan meeting, or at any time during the year if they decide to do so. The DRS Service Coordinator provides the participant with a business card, which includes a toll free phone number, at each meeting to ensure they know how to contact the coordinator, who is available to talk with them as the need arises.

The DRS Service Coordinator works very closely with the Consumer Preparation Specialist (CPS) to ensure the participant is trained and is receiving support through the CPS to interview, hire, supervise, approve timecards, and terminate if necessary, their Personal Attendants. The training received by the CPS is an integral part of the success in the participants' ability to hire and retain their own staff. The DRS Service Coordinator discusses with the participant on a regular basis, at least annually, the level of support they are receiving for participant-direction and if the level they are receiving is sufficient to meet their needs. As indicated, the level of participant-direction support can change at any time as needed during the year.

## Appendix E: Participant Direction of Services

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### 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

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### E-1: Overview (11 of 13)

- I. 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:

A participant may demonstrate that they can no longer manage and self-direct their services, or their service provider may have evidence that the participant is not taking full responsibility to manage and self-direct their services. If the participant wishes to stay on the ADLS program, a referral can be made to a qualified provider who maintains a staffing pool for personal attendant care, and who takes responsibility for hiring, scheduling and training the personal attendant staff. If the participant does not want to remain in the ADLS program, other services and supports will be identified by the ADLS Waiver Manager and the DRS Service Coordinator. Other options may include the Home and Community Based Waiver within the DSS/Adult Services and Aging program, remain in home and receive supports from friends and relatives, or possibly enter into a nursing home.

ADLS services will continue until the DRS Service Coordinator can ensure that the transition occurs on a timely basis and does not compromise the health and welfare of the participant to the greatest extent possible.

**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.

When a participant’s cognitive ability has decreased to the extent the participant cannot manage and self-direct services, or if they refuse to manage and self-direct services to the extent that it affects their health, safety and welfare, the participant will be presented with possible service options. One would be to have a family member, friend, or non-legal representative manage and direct their services for them. If the participant does not have someone who wants to assist with management and self-direction, options will be explored by the participant’s DRS Service Coordinator, in consultation with the ADLS Waiver Manager. Other options may include the Home and Community Based Waiver within the DSS/Adult Services and Aging program, or one of two waivers in the Division of Developmental Disabilities, if eligible, or possibly skilled nursing home care.

Regardless of who is managing and self-directing the service, the provider agency and the ADLS Waiver Manager must assure that all health, safety and welfare assurances are being met while on the waiver while transitioning to another more suitable program. Transition of supports will be seamless from one state program to another.

If the participant refuses to consider options for alternative services for management and self-direction, then the ADLS Waiver Program termination process will begin. The provider agency works closely with the ADLS Waiver Manager in these situations to gather all pertinent information and documentation to support the provider’s termination decision. The program provider notifies the participant ten days prior to the termination of services. If there are no other providers willing or able to work with the participant, and they refuse to utilize a more traditional home health agency approach for personal attendant care, then the ADLS Waiver termination process will begin.

A revised level of care is sent to the Department of Social Services, who issues a Notice of Adverse Action. This Notice of Action explains the process for requesting a fair hearing if the participant does not agree with the decision to terminate ADLS waiver services.

**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**

Waiver Year	Employer Authority Only		Budget Authority Only or Budget Authority in Combination with Employer Authority		
	Number of Participants		Number of Participants		
Year 1		130			
Year 2		134			
Year 3		138			
Year 4		138			
Year 5		138			

**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:

Certified as a Center for Independent Living by DHS and the U.S. Department of Health and Human Services.

Certified as a Home Health Agency Program Provider by DHS.

All qualified providers must have a signed Medicaid Provider Agreement.

- 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:

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

Specify:

## Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

## Appendix E: Participant Direction of Services

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

- b. Participant - Budget Authority**

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

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

## Appendix E: Participant Direction of Services

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

- b. Participant - Budget Authority**

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

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

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

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

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

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

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

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

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

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

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice

(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants are informed by the DRS Service Coordinator of the right to a fair hearing verbally and in writing via the Freedom of Choice form at least annually, informing them of their rights and the process to request a fair hearing is outlined in the Freedom of Choice and Rights to a Fair Hearing form, which they sign. A hearing may be requested anytime a participant feels they have been denied a waiver service, denied choice of waiver providers or if waiver services are denied, suspended, reduced or terminated. In addition to the applicant receiving this notice, a copy is also sent to the ADLS Waiver Manager.

Regarding a reduction in services, participants are informed verbally by the DRS Service Coordinator, and in writing via a service plan amendment/modification which includes the right to a fair hearing. A paper copy is maintained by the ADLS Waiver Manager in the participant's file, and a copy is given to the participant.

The participant's DRS Service Coordinator will provide them with resources to assist them to file a request for hearing, if needed. For example, a participant may be referred to a Center for Independent Living or South Dakota Advocacy Services for assistance in requesting and preparing for an administrative hearing.

If the participant appeals a termination decision, efforts will be made to ensure that the participant's health and welfare needs are being met during that time. The ADLS Waiver will continue to provide services during this time as long as the situation is safe for staff to provide those services, and if the participant continues to have personal attendants who want to continue to provide these services. If there are no attendants who want to continue services with this participant, then the DRS Service Coordinator, in collaboration with the ADLS Waiver Manager, will identify other resources to ensure health, welfare and safety standards. This will be accomplished by referring the participant to other alternatives, such as the traditional home health agency option, a skilled nursing facility, another Medicaid waiver that may better meet their needs, or to the care of family members. If the participant remains on the ADLS waiver during this time, an agreement of responsibilities may be put into place between the participant and the provider agency. The participant is informed of all available options, including a referral to Adult Protective services. Waiver services continue pending a fair hearing decision.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

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

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

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

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

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

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

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

Participants are afforded access to a grievance process through the provider agency as outlined in the employee handbook. Participants are informed that the right to Medicaid fair hearing is preserved when a participant elects to make use of this process. All qualified providers who assist with self-direction are required to maintain a grievance/complaint process which contains procedures for grievance, specifying that the participant is informed that the right to a Medicaid fair hearing is preserved when a participant elects to make use of this process. Grievance procedures are reviewed during annual provider certification reviews.

All waiver participants can contact the DRS Service Coordinator or ADLS Waiver Manager to share a grievance or to file a complaint. The ADLS Waiver Manager contacts the provider agency and requests file information related to the grievance or complaint. All grievances or complaints that meet the requirements of Medicaid Fraud reporting are referred to the SD Office of Attorney General for investigation.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The ADLS Waiver Program and qualified provider agencies recognize the professional nature of the relationship between the participant/family and provider. Because of this professional relationship, the participant/family and provider are expected to make every attempt to resolve differences and/or problems. Each provider agency must provide each participant with a grievance procedure for those participants who manage and self-direct their personal attendants as part of their orientation materials.

Should issues arise between the two parties, the following procedure shall be utilized:

- The aggrieved party must bring the grievance to the attention of the other party either verbally or in writing. Both parties will meet to discuss the issue and potential solutions as soon as possible.
- If the issue is not resolved, the aggrieved party shall have the right to submit the complaint, in writing, to the provider agency.
- The written complaint must also detail all previous efforts taken to resolve the issue.

After reviewing the written complaint, the provider agency will attempt to resolve the issue. This will include mediation, either by telephone or in person.

The provider agency, whose decision is final and binding, will report to both parties with a decision within ten (10) working days of mediation attempts.

In the case of adverse action, participants are informed that the right to Medicaid fair hearing is preserved when a participant elects to make use of this process.

## 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).

Mandatory reporting laws:

South Dakota law requires individuals in the medical and mental health professions and employees or entities that have ongoing contact with and exposure to elders and adults with disabilities to report knowledge or reasonable suspicion of abuse or neglect of elders and adults with disabilities. Reports must be made either orally or in writing within 24 hours of suspected abuse or neglect.

To report abuse, neglect or exploitation of an elder or adult with disabilities, entities contact their local law enforcement agency, local state's attorney's office or the local office of the Department of Social Services.

In addition to mandatory reporting, people can make reports on a voluntary basis. Any person who knows or has reason to suspect that an elder or adult who has a disability has been abused or neglected may report that information. Persons who, in good faith, make a report of abuse or neglect of an elder or disabled adult are immune from liability.

A mandatory reporter who knowingly fails to make the required report is guilty of a Class 1 misdemeanor.

DRS ANE Critical Incident Reporting Policy:

Providers of services to ADLS waiver participants are required to report critical incidents, which include death, abuse, neglect or exploitation. Providers are expected to report critical incidents immediately after they become aware of them.

The ADLS Waiver Program has an approved policy (DRS/ADLS 07-01) for the reporting of abuse, neglect and exploitation. Provider agencies must report alleged incidents of abuse, neglect and exploitation immediately by calling the nearest Department of Social Services/Office of Adult Protective Services, as well as the local law enforcement agency for any criminal activity. Providers must also notify by telephone call, fax or mail the ADLS Waiver Manager and DRS Service Coordinator within 48 hours of the incident or the next working day, whichever comes first. Following notification, an incident report (DRS/ADLS -101) must be submitted by the provider agency within 7 calendar days following the incident, including steps taken to ensure they followed mandatory reporting procedures as identified in SDCL 22-46. The written report must contain an account of the incident and specify what happened, when and where it happened, the participant's current status, and actions taken by the qualified provider.

Upon receipt of a report of any critical incident concerning the health, welfare and safety of the participant, the DRS Service Coordinator will make sure a plan is in place that addresses the concern within 48 hours of the incident.

The ADLS Waiver Manager will communicate with the DRS Service Coordinator and follow up on all reports to ensure that systems are in place to remediate all incidents of abuse, neglect or exploitation. During annual file review, the ADLS Waiver Manager will review services and supports for all participants involved in an incident of abuse, neglect or exploitation.

- 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.

The DRS Service Coordinator meets initially and at least annually thereafter with the ADLS Waiver participant, as well as any family members or legal representatives during the annual assessment. During that time, the DRS Service Coordinator provides training to the participant about abuse, neglect and exploitation. They also provide information about who to contact if they should experience abuse, neglect or exploitation, and how to report it.

The DRS Service Coordinator has a discussion with them to determine if it is a concern for the participant, and provides them with a brochure from Department of Social Services, Adult Protective Services with contact information provided. The DRS Service Coordinator also provides the participant with their contact information, which includes a toll free number if they should have any concerns.

The ADLS Waiver Manager ensures that DRS Service Coordinators and qualified providers have opportunity for mandatory reporting training on a regular basis.

- 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.

Upon receipt of the initial report (within 48 hours) the ADLS Waiver Manager will consult with the qualified provider who submitted the report to ensure the participant's immediate safety, ensure appropriate report to DSS Adult Protective Services, in the case of suspected criminal activity, ensure appropriate notification to law enforcement, ensure appropriate medical examination/treatment, and alert Medicaid fraud as indicated by the Memorandum of Understanding with the Attorney General. The Waiver Manager will work closely with the DRS Service Coordinator to provide any other technical assistance appropriate for the situation.

Upon receipt of the written report (within 7 days), the ADLS Waiver Manager will review the report to ensure appropriate reporting/notification as described above, will forward the report to Medicaid Fraud Control Unit, if applicable, conduct follow up with collaborating agencies (DSS Adult Protective Services, law enforcement), assess the current situation to ensure health, welfare and safety of the recipient, assess the action of the qualified provider to ensure compliance with the approved policy on abuse, neglect and exploitation, and conduct further review of the incident if determined that the qualified provider is not compliant with the provision of certification.

DRS may impose probation, not to exceed one year, if a qualified provider has deficiencies which seriously affect the health, safety, welfare or rights of the participant. The qualified provider must complete, in a time period approved by DRS, but not to exceed one year, a plan of corrective action approved by DRS. All relevant parties are notified in writing of the results of the investigation within 15 days of the completion of an investigation.

A qualified provider's certification may be revoked if they are found to be permitting, aiding or abetting the commission of an unlawful act, conduct of their practices is detrimental to the welfare of participants served, failure to comply with all licensing and other standards required by federal, state, county, city, or tribal statute, rule or ordinance that result in practices with are detrimental to the welfare of the participant, or failure to comply with a probationary plan of corrective action.

The Internal Waiver Review Committee is comprised of all HCBS Waiver Managers, as well as representation from the DSS Medicaid Office as Administrative Authority of all HCBS Waivers in South Dakota, and the DHS Office of Budget and Finance. The Internal Waiver Review Committee conducts an external review of critical incidents to identify trends and areas of concern and provide recommendations to DRS.

- 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.

Reports of alleged abuse, neglect and exploitation are made to the local office of DSS Adult Protective Services, the local law enforcement, or the local state's attorney. The three entities work together to follow up on reports and determine next steps.

DRS Waiver Manager is responsible for oversight of critical incidents and events that affect waiver participants. The oversight is ongoing as reports of alleged abuse, neglect and exploitation, and reports of other critical incidents and events are received in the DRS office at the State level.

The ADLS Waiver Manager provides support to DRS Service Coordinators to ensure health, safety and welfare of ADLS participants. Each DRS Service Coordinator provides continued follow up to ensure health, safety and welfare of participants, and ensures participants are training in abuse, neglect and exploitation, how to report, and who to report incidents to.

## 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:

Use of restraints is not applicable as participants live in their own homes and they self-direct their own care. DRS is responsible for detecting unauthorized use of restraints through incident reports received, annual reviews conducted by the ADLS Waiver Manager, and assessment of health, safety and welfare by the DRS Service Coordinator. The DRS Service Coordinator provides at least quarterly contacts with participants providing ongoing regular monitoring of participant health and welfare, and meets face to face with the participant at least annually, reviewing with ADLS participants information regarding abuse and neglect, as well as information on how to report it.

The ADLS Waiver Manager performs annual reviews, which include a representative, random sample of service plans. The statistically valid sample size is based upon historical data from the previous annual review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results. For the purpose of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review results will provide the response distribution percentage. The unauthorized use of restraints would be detected during these reviews.

The ADLS Waiver Manager performs annual reviews of provider agencies and Service Coordinators to ensure that any problems, changes, complaints, observations, concerns or other participant issues are documented in the participants file and reported according to policy. All incidents will be investigated by the ADLS Waiver Manager, and when applicable, will be reported to Medicaid Fraud through the SD Office of Attorney General.

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

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

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

## Appendix G: Participant Safeguards

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

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

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

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

Use of restrictive interventions are not applicable as participants live in their own homes and they self-direct their own care. DRS is responsible for detecting unauthorized use of restrictive interventions through incident reports received, annual reviews conducted by the ADLS Waiver Manager, and assessment of health, safety and welfare by the DRS Service Coordinator. The DRS Service Coordinator provides at least quarterly contacts with participants providing ongoing regular monitoring of participant health and welfare, and meets face to face with the participant at least annually, reviewing with ADLS participants information regarding abuse and neglect, as well as information on how to report it.

The ADLS Waiver Manager performs annual reviews, which include a representative, random sample of service plans. The statistically valid sample size is based upon historical data from the previous annual review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results. For the purpose of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review results will provide the response distribution percentage. The unauthorized use of restrictive interventions would be detected during these reviews.

The ADLS Waiver Manager performs annual reviews of provider agencies and Service Coordinators to ensure that any problems, changes, complaints, observations, concerns or other participant issues are documented in the participants file and reported according to policy. All incidents will be investigated by the ADLS Waiver Manager, and when applicable, will be reported to Medicaid Fraud through the SD Office of Attorney General.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

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

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

## Appendix G: Participant Safeguards

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

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

Use of seclusion is not applicable as participants live in their own homes and they self-direct their own care. DRS is responsible for detecting unauthorized use of restrictive interventions through incident reports received, annual reviews conducted by the ADLS Waiver Manager, and assessment of health, safety and welfare by the DRS Service Coordinator. The DRS Service Coordinator provides at least quarterly contacts with participants providing ongoing regular monitoring of participant health and welfare, and meets face to face with the participant at least annually, reviewing with ADLS participants information regarding abuse and neglect, as well as information on how to report it.

The ADLS Waiver Manager performs annual reviews, which include a representative, random sample of service plans. The statistically valid sample size is based upon historical data from the previous annual review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results. For the purpose of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review results will provide the response distribution percentage. The unauthorized use of seclusion would be detected during these reviews.

The ADLS Waiver Manager performs annual reviews of provider agencies and Service Coordinators to ensure that any problems, changes, complaints, observations, concerns or other participant issues are documented in the participants file and reported according to policy. All incidents will be investigated by the ADLS Waiver Manager, and when applicable, will be reported to Medicaid Fraud through the SD Office of Attorney General.

- 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).

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v

- 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:

^  
v

## Appendix G: Participant Safeguards

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

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

- a. Applicability.** Select one:

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

- b. Medication Management and Follow-Up**

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

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v

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

## Appendix G: Participant Safeguards

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

#### c. Medication Administration by Waiver Providers

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

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

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

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

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

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

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

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

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

**Appendix G: Participant Safeguards**

**Quality Improvement: Health and Welfare**

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

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

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

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

**Performance Measure:**

**Percentage of reports of abuse, neglect and exploitation (ANE) which were reported timely. Numerator -Number of reports reported to DRS within 48 hours of becoming aware of the incident/Denominator - Total number of participant reports reported.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percentage of participants who received training on reporting ANE. Numerator - Number of participant files reviewed in which the participant received training on ANE reporting/Denominator - total number of participant files reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data</b>	<b>Sampling Approach (check each that applies):</b>
-----------------------------------	---

<b>collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/- 5
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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.*

- 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.*

- 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.*

- 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.

Using a comprehensive review tool, ADLS Waiver Manager selects a valid sample of participants to include a review of participant files and claims, with result being aggregated for quarterly and annual information for the Internal Waiver Review Committee. Their findings and recommendations are reported to DRS and SSMA for remediation. All qualified providers and the Service Coordinator are required to report critical incidents to DRS. Incidents are reviewed by the ADLS Waiver Manager to ensure proper procedure is followed.

Participant Surveys: DRS ADLS Waiver Manger conducts annual participant surveys. Data is aggregated and can be used to complete focused file review if the data would indicate a need for that. This data is also shared quarterly, if available, with the Internal Waiver Review Committee.

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

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
The primary discovery activities that have the potential to reveal individual issues include complaint referrals to DRS, annual provider reviews, participant surveys, participant file reviews and grievance and complaint reports.

When an individual problem is discovered, the ADLS Waiver Manager may take immediate action to assess, and if necessary, ensure the safety of the participant. The DRS Service Coordinator will meet with the participant to gather information critical to resolving issues and problems. As merited by the situation, DRS may request additional information from the provider. As appropriate, if there is suspicion of abuse or neglect, DRS will immediately contact Adult Protective Services, Adult Services and Aging, Law Enforcement, and/or the Medicaid Fraud Control Unit as per the SDCL 22-46 mandatory reporting law. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions, to include a plan of correction, probationary status and decertification.

The problem would be individually documented and systemically remediated through the discovery activity that revealed the problem. Additional information may be documented in the participant's file maintained by DRS.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify:  Internal Waiver Review Committee	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

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

- No**
- Yes**

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

**Appendix H: Quality Improvement Strategy (1 of 2)**

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare,

financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### **Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the 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;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 2)**

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### **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.

DHS DRS, the operating agency, is responsible for data analysis and remediation information from the quality improvement system. The operating agency is also responsible for trending the data and providing

information to the Medicaid agency. Together the operating agency and Medicaid agency determine system improvements or changes that may be needed. This communication facilitates ongoing discovery and remediation. The Waiver Manger is responsible for implementation of system improvements and changes. This includes updates to both internal and external stakeholders, tracking systems changes, and potentially amending the Waiver with changes to, or addition of, performance measures.

In addition to the Medicaid agency, the operating agency also utilizes other waiver partners for assistance with data analysis, review of trended information, and development of potential system improvements. These partners include the Statewide Independent Living Council, the Internal Waiver Review Committee, and Budget and Finance Analysts. If necessary, the operating agency may also bring together additional groups of stakeholders if significant issues are identified within the waiver operation.

Data related to the operation of the waiver is received, documented, and maintained by the Waiver Manager. Data sources currently include ADLS Waiver tracking systems, SMART system, annual review of qualified providers, and ANE reports. The data collected is then recorded in the appropriate databases and spreadsheets for analysis and trending. If necessary, any immediate remediation is completed. The analyzed/trended data, and any remediation completed, is reviewed by the operating agency and SSMA to identify any additional areas that may need attention. The Statewide Independent Living Council and Internal Waiver Review Committee are also utilized to review the data analysis, completed remediation, and recommendations for further enhancements. Once further enhancement plans are developed, these will be shared with internal and external stakeholders through issuance of DRS Policy Memorandums approved by the SSMA.

The State continually reviews the QIS to determine if the design remains functional or if changes and improvements to the QIS are required.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Internal Waiver Review Committee, Statewide Independent Living Council	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**b. System Design Changes**

- i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The responsibility for monitoring the effectiveness of the waiver quality improvement strategies is continuous and ongoing. The initial steps to ensure quality begin with the DRS Service Coordinator properly implementing ARSD and waiver assurances. The next steps are a quality review of waiver participant files by DRS staff to ensure compliance with ARSD and waiver assurances. The final step in the quality assurance process is the Waiver Manager who has the primary responsibility of the waiver. The Waiver Manager is responsible for the administration of the waiver, implementation of the quality improvement strategies, and assessment of their effectiveness. The Waiver Manager provides this information to the SSMA agency and other partners for assistance with remediation and potential changes to the quality improvement strategies. The DRS Director is very important in the overall waiver operations to ensure the quality improvement strategies function as necessary to meet waiver participants' needs as well as CMS and other regulatory standards. If changes are determined necessary, the operating agency and SSMA will design the changes. The

Waiver Manager will implement the changes and collect and analyze the data to determine if the system changes were successful. Effectiveness of the changes will be determined by data indicating a positive or negative change in the overall discovery data. The analysis will be presented to the DRS administration, the Internal Waiver Review Committee and the Statewide Independent Living Council for continued trending.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Information vital to the success of the waiver is gathered through many forms, SMART system, critical incident reporting, annual provider reviews, and waiver tracking systems. This information is directly related to the waiver's quality improvement system. The quality improvement system is evaluated at each juncture of the continuous quality improvement cycle:

Discovery;  
Remediation;  
Implementation/Improvement.

This continuous cycle will provide the avenue necessary to determine the effectiveness of the quality system. If the quality system is not effective this will be apparent through repeated issues and problems. These will be the indicators of the necessity for changes to the quality system. The DRS administration, State Independent Living Council, Internal Waiver Review Committee, and other stakeholders will play a vital role in the development of improvements to the quality strategy. At a minimum all aspects of the quality improvement system will be reviewed annually to review the collected and analyzed data.

## 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).

As part of the State's Quality Assurance Strategy, qualified providers, according to the contractual arrangement, are required to undergo and submit an annual, entity-wide audit conducted by an independent, third party audit firm in accordance with generally accepted accounting principles. These audits are received, reviewed and analyzed by DHS fiscal staff. Issues/concerns are reported to DRS for follow-up.

Qualified providers are required to:  
Conduct and submit an annual audit;  
Undergo a representative random sample review of all claims; and  
Submit to monitoring conducted by DHS as a component of the Payment Error Rate Measurement (PERM).

Qualified providers are required to participate in a billing review process conducted by a DHS analyst, in which a review is conducted on a representative random sample of participants' claims to ensure and validate the accuracy of record keeping, supporting documentation, and the resulting claims submitted for payment. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution. The response distribution is calculated each cycle, using the previous review cycle results.

For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent review cycle's population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

Findings are compiled, reviewed by the ADLS Waiver Manager, if appropriate, addressed in a plan of correction, and summarized in a report issued to the provider, the DRS Director and SSMA.

Financial transactions and claims submissions are also monitored as a component of the PERM process. Waiver claims are included in the sample population for PERM and are reviewed for accuracy as part of this process.

All claims adjudicated through the MMIS fall under the authority of the DSS Surveillance and Utilization Review System (SURS). The SURS unit is staffed with investigators who seek and review paid claims to find inappropriate or incorrect payments to providers, and then implement any needed corrective actions.

The Department of Legislative Audit (DLA) conducts the State of South Dakota's annual independent audit, ensuring that it complies with the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). DLA is under the Legislative Branch of state government, therefore independent of the Executive Branch. DLA audits are conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. In accordance with Government Auditing Standards, DLA also reviews internal controls over financial reporting and tests compliance with certain provisions of laws, regulations, contracts, and grant agreements.

Upon completion of the Single State Audit, DLA submits copies to each department secretary and Director of Budget and Finance. The DHS' Office of Budget & Finance is responsible for coordinating all responses to the Single State Audit and gathers all pertinent information for any necessary response.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

#### a. Methods for Discovery: Financial Accountability

***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

##### i. Sub-Assurances:

- a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

#### Performance Measures

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

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

#### Performance Measure:

**Percentage of claims paid accurately for an approved service for eligible waiver participants. Numerator - Number of correct sampled claims/Denominator - Total number of sampled claims.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data</b>		<b>Sampling Approach</b> (check each that applies):
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<b>collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Proportionate sample; 95% +/- 5.
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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.*

- 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.

A DHS management analyst performs a review of payments for waiver services to ensure each claim billed meets waiver qualifications. All claims billed in the sampling period are susceptible for review. The provider is informed of the review dates(s) and the sampled claims. The analyst reviews documentation of services and if necessary, requests clarification or additional information from the provider. The analyst reviews all documentation to ensure payment was correct according to processing and payment methodologies and to ensure the claim was billed and paid according to the services authorized by the program rules.

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

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

Claims Reviews serve as the primary discovery activity for individual problems related to financial accountability. Claims review findings are summarized in a report issued to the provider, the DRS Director, the ADLS Waiver Manager, and DSS. An error rate is calculated based on the total dollars found in error versus the total dollars reviewed. The provider is required to complete individual claims adjustments within 60 days of the date they receive the report of findings from the review. If a provider is found to have an error rate greater than five percent, this results in a follow-up review approximately four months later. The DHS management analyst tracks each incorrect claim to ensure an appropriate adjustment is made. The DHS management analyst follows up with the provider if the adjustment is not made.

- ii. **Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Internal Waiver Review Committee	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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

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### 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).

Rate setting and payment amounts for ADLS waiver services are based on the fee schedule that is utilized by the Home and Community Based Waiver within DSS, Adult Services and Aging Division and DHS ADLS Waiver program. Provider rates are determined by the DSS Office of Provider Reimbursement and Audits and DHS Office of Budget and Finance. Rates are determined using a standard cost report submitted by providers after the close of the fiscal year. The cost reports summarize expenses associated with provision of waiver services and corresponding revenue. Aggregation and analysis of data submitted in cost reports by providers from across the state allows the DSS and DHS to establish rates reflective of actual costs. DSS and DHS utilize a financial workgroup to develop rate-setting methodologies. The workgroup includes representation from providers and agencies, fiscal, program and service delivery. The purpose of the workgroup is for providers to provide input on the rate-setting methodology. Rates identified within the fee schedules include: consumer preparation, personal attendant services, skilled nursing services, respite services, and emergency response services.

Supplies/vendor services for incontinence supplies, specialized medical equipment and supplies, environmental accessibility adaptations and vehicle modifications are provided at market/retail rates. Therefore, fee-for-service rates are not established for these services.

Rates and public input concerning rate setting for Medicaid providers are reviewed annually by DSS. Services listed above are inflated each year by an amount as appropriated by the South Dakota Legislature. Typically this inflation rate is based on the current Consumer Price Index (CPI) and is relayed by DSS and DHS through the Governor's Bureau of Finance and Management.

- 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:

The ADLS waiver program funding is from the South Dakota Legislature via the appropriations process. The waiver will be operated by DHS, a separate Executive Branch agency from DSS, which is the designated SSMA. A Memorandum of Understanding (MOU) signed by the Secretary of each department sets forth the responsibilities of each department. DSS exercises administrative authority in the administration and supervision of the waiver and authorizes and pays all waiver claims through the DSS MMIS. Approval of state funding and federal funds expenditure authority is given to DHS. DHS provides assurances to the DSS supporting appropriate expenditures of Title XIX funds.

DRS contracts with service providers or provider agencies that in turn provide HCBS services to waiver participants. Claims are entered into a clearinghouse type system and submitted and submitted electronically to DSS.

## Appendix I: Financial Accountability

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## 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:

- a) When an applicant / participant does not meet the waiver level of care, the DSS Benefits Specialist updates the MMIS reflecting the appropriate period of eligibility/ineligibility. The MMIS will only pay those waiver claims submitted for a participant with a date of service within level of care eligibility timeframes.
- b) Providers may only enter time cards or other billing requests for services in the internet application for approved services/providers as designated by the service plan.
- c) All personal attendant time cards are approved weekly by the program participant they were providing waiver services for. Compliance with this is monitored during annual on-site file reviews.
- d) A management analyst within DHS performs an internal review of payments for waiver services. The analyst selects a random sample of claims from each provider and reviews the associated services billed during a specified time period. The provider is informed of the review date and the sampled participants. The analyst reviews documentation of services (service plan, case notes, etc.) and if necessary, requests clarification or additional information from the provider. The analyst reviews all documentation to ensure payment was correct according to processing and payment methodologies and to ensure the claim was billed and paid according to the services authorized by the program rules. The review findings are summarized in a report issued to the provider, the DRS Director and the SSMA. Identified errors are addressed and corrected.

- 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:

- 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:

## 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:*

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

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- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

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### 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

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### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

**Appendix I: Financial Accountability****I-4: Non-Federal Matching Funds (1 of 3)**

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of waiver costs are appropriated by the South Dakota Legislature to the DHS DRS.

The DSS MMIS reimburses claims utilizing DHS DRS accounting coding. As payments are made, the expenses for both the Federal & non-federal share are posted to the applicable DHS budget centers. DSS reimburses DHS the Federal share after they draw the Federal cash. DHS verifies/certifies expenditures on a quarterly basis by providing an accounting report to DSS. In turn, DSS prepares the Federal CMS 64 report.

**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

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### 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

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

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

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

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

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

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

## Appendix I: Financial Accountability

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

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

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings: **Do not complete this item.**

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- Nominal deductible**  
 **Coinsurance**  
 **Co-Payment**  
 **Other charge**

*Specify:*

### **Appendix I: Financial Accountability**

#### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

### **Appendix I: Financial Accountability**

#### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

### **Appendix I: Financial Accountability**

#### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

### **Appendix I: Financial Accountability**

#### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1		16998.00	16998.00	51965.00	24997.00	76962.00	59964.00
2		17508.00	17508.00	53524.00	25746.00	79270.00	61762.00
3		18033.00	18033.00	55130.00	26519.00	81649.00	63616.00
4		18574.00	18574.00	56784.00	27314.00	84098.00	65524.00
5	33797.03	19132.00	52929.03	58487.00	28134.00	86621.00	33691.97

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	130		130
Year 2	134		134
Year 3	138		138
Year 4	138		138
Year 5	138		138

**Appendix J: Cost Neutrality Demonstration**

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

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

The average length of stay is calculated by using the unduplicated count of consumers on the waiver divided by the total days of waiver coverage. The length of stay from the current waiver is being utilized. The number will be adjusted based on actual data for future 372 reports and renewals.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

A multifaceted approach was utilized to project the estimated annual average per capita Medicaid cost for home and community based services for individuals in the waiver program. Historical data was analyzed and trended forward to project utilization and expenditures for existing services. Participant surveys and average costs for similar home and community based services were utilized to develop utilization and expenditures projections for new services.

- 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 estimated annual average per capita Medicaid cost for state plan services provided to individuals in the waiver program for FY2013 was projected using historic data and then adjusted for a 3% annual increase for inflation.

- 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 estimated annual average per capita Medicaid cost for nursing facility care in FY2013 (that would be incurred for individuals served in the waiver, were the waiver not granted) adjusted for a 3% annual increase for inflation.

- 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 estimated annual average per capita Medicaid costs in FY2013 for state plan services (other than those included in Factor G for individuals served in the waiver were the waiver not granted) adjusted for a 3% annual increase for inflation.

## 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	
Personal Attendant Care	
Respite	
Incontinence Supplies	
Consumer Preparation Services	
Environmental Accessibility Adaptations	
In Home Nursing	

<b>Waiver Services</b>	
<b>Personal Emergency Response (PERS)</b>	
<b>Specialized Medical Equipment and Supplies</b>	
<b>Vehicle Modifications</b>	

### 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
<b>Personal Attendant Care Total:</b>						<b>3611862.80</b>
Personal Attendant Care	15 minutes	130	5924.00	4.69	3611862.80	
<b>Respite Total:</b>						
Respite						
<b>Incontinence Supplies Total:</b>						<b>49348.00</b>
Incontinence Supplies	unit	73	13.00	52.00	49348.00	
<b>Consumer Preparation Services Total:</b>						<b>42025.72</b>
Consumer Preparation Services	15 minutes	121	38.00	9.14	42025.72	
<b>Environmental Accessibility Adaptations Total:</b>						
Environmental Accessibility Adaptations						
<b>In Home Nursing Total:</b>						<b>32625.25</b>
In Home Nursing	15 minutes	35	103.00	9.05	32625.25	
<b>Personal Emergency Response (PERS) Total:</b>						<b>3220.00</b>
Personal Emergency Response (PERS)	month	10	14.00	23.00	3220.00	
<b>Specialized Medical Equipment and Supplies Total:</b>						
Specialized Medical Equipment and Supplies						
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						130
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Vehicle Modifications Total:</b>						
Vehicle Modifications						
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						130
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**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
<b>Personal Attendant Care Total:</b>						3834131.28
Personal Attendant Care	15 minutes	134	5924.00	4.83	3834131.28	
<b>Respite Total:</b>						
Respite						
<b>Incontinence Supplies Total:</b>						52917.28
Incontinence Supplies	units	76	13.00	53.56	52917.28	
<b>Consumer Preparation Services Total:</b>						44339.92
Consumer Preparation Services	15 minutes	124	38.00	9.41	44339.92	
<b>Environmental Accessibility Adaptations Total:</b>						
Environmental Accessibility Adaptations						
<b>In Home Nursing Total:</b>						34595.64
In Home Nursing	15 minutes	36	103.00	9.33	34595.64	
<b>Personal Emergency Response (PERS) Total:</b>						3316.60
Personal Emergency Response (PERS)	month	10	14.00	23.69	3316.60	
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						134
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Specialized Medical Equipment and Supplies Total:</b>						
Specialized Medical Equipment and Supplies						
<b>Vehicle Modifications Total:</b>						
Vehicle Modifications						
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						134
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**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
<b>Personal Attendant Care Total:</b>						4063034.64
Personal Attendant Care	15 minutes	138	5924.00	4.97	4063034.64	
<b>Respite Total:</b>						
Respite						
<b>Incontinence Supplies Total:</b>						55942.38
Incontinence Supplies	unit	78	13.00	55.17	55942.38	
<b>Consumer Preparation Services Total:</b>						47132.16
Consumer Preparation Services	15 minutes	128	38.00	9.69	47132.16	
<b>Environmental Accessibility Adaptations Total:</b>						
Environmental Accessibility Adaptations						
<b>In Home Nursing Total:</b>						36623.71
In Home Nursing	15 minutes	37	103.00	9.61	36623.71	
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						138
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Emergency Response (PERS) Total:</b>						3416.00
Personal Emergency Response (PERS)	month	10	14.00	24.40	3416.00	
<b>Specialized Medical Equipment and Supplies Total:</b>						
Specialized Medical Equipment and Supplies						
<b>Vehicle Modifications Total:</b>						
Vehicle Modifications						
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						138
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**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
<b>Personal Attendant Care Total:</b>						4185661.44
Personal Attendant Care	15 minutes	138	5924.00	5.12	4185661.44	
<b>Respite Total:</b>						
Respite						
<b>Incontinence Supplies Total:</b>						57625.62
Incontinence Supplies	unit	78	13.00	56.83	57625.62	
<b>Consumer Preparation Services Total:</b>						48542.72
Consumer Preparation Services	15 minutes	128	38.00	9.98	48542.72	
<b>Environmental Accessibility Adaptations Total:</b>						
Environmental Accessibility Adaptations						
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						138
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>In Home Nursing Total:</b>						37728.90
In Home Nursing	15 minutes	37	103.00	9.90	37728.90	
<b>Personal Emergency Response (PERS) Total:</b>						3166.38
Personal Emergency Response (PERS)	month	9	14.00	25.13	3166.38	
<b>Specialized Medical Equipment and Supplies Total:</b>						
Specialized Medical Equipment and Supplies						
<b>Vehicle Modifications Total:</b>						
Vehicle Modifications						
<b>GRAND TOTAL:</b>						
Total Estimated Unduplicated Participants:						138
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						330

**Appendix J: Cost Neutrality Demonstration**

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

**d. Estimate of Factor D.**

**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
<b>Personal Attendant Care Total:</b>						4308288.24
Personal Attendant Care	15 minutes	138	5924.00	5.27	4308288.24	
<b>Respite Total:</b>						109032.84
Respite	15 minutes	21	883.00	5.88	109032.84	
<b>Incontinence Supplies Total:</b>						59349.42
Incontinence Supplies	unit	78	13.00	58.53	59349.42	
<b>Consumer Preparation Services Total:</b>						50001.92
Consumer Preparation Services	15 minutes				50001.92	
<b>GRAND TOTAL:</b>						4663990.22
Total Estimated Unduplicated Participants:						138
Factor D (Divide total by number of participants):						33797.03
Average Length of Stay on the Waiver:						330

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		128	38.00	10.28		
<b>Environmental Accessibility Adaptations Total:</b>						<b>54600.00</b>
Environmental Accessibility Adaptations	each	26	2.00	1050.00	<b>54600.00</b>	
<b>In Home Nursing Total:</b>						<b>38872.20</b>
In Home Nursing	15 minutes	37	103.00	10.20	<b>38872.20</b>	
<b>Personal Emergency Response (PERS) Total:</b>						<b>3260.88</b>
Personal Emergency Response (PERS)	month	9	14.00	25.88	<b>3260.88</b>	
<b>Specialized Medical Equipment and Supplies Total:</b>						<b>6984.72</b>
Specialized Medical Equipment and Supplies	each	36	2.00	97.01	<b>6984.72</b>	
<b>Vehicle Modifications Total:</b>						<b>33600.00</b>
Vehicle Modifications	each	4	1.00	8400.00	<b>33600.00</b>	
<b>GRAND TOTAL:</b>						<b>466390.22</b>
Total Estimated Unduplicated Participants:						<b>138</b>
Factor D (Divide total by number of participants):						<b>33797.03</b>
Average Length of Stay on the Waiver:						<b>330</b>