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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

The Division of Long-Term Services and Supports Home and Community-Based Services Waiver is due for renewal on July 1, 2026, with an anticipated effective date of October 1, 2026 through September 30, 2031. The changes that have been included in the waiver renewal application are described below.

General Clean-Up

•Terminology and structure were revised throughout the waiver to improve clarity, remove outdated references, and better align with current rules, practices, and the waiver application template.

Provider Related Updates

•Provider enrollment requirements were updated to eliminate redundancy and to align provider types with Medicaid Provider Enrollment types.
•Structured Family Caregiving (SFC) provider standards were updated to strengthen oversight by requiring a home visit before services begin to visually reassess the home, a follow-up home reassessment at the six-month review, and additional home visits for participants identified as high risk.

Service Clarifications

•Service definitions were updated to specify the assessment tool used to determine need and clarify that authorized services address unmet needs and do not duplicate other available or authorized services.

Performance Measures

•Financial Accountability performance measure for sub assurance B was updated to assure that the approved methodology is applied consistently throughout the waiver cycle.

No changes were made to participant eligibility criteria, available waiver services, or access to care as part of this renewal.

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 section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Home and Community-Based Options and Person Centered Excellence (HOPE) Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: SD.0189
Draft ID: SD.010.08.00

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

Regular Waiver

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

10/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

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

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Division of Long-Term Services and Supports (LTSS) within the Department of Human Services, through a Memorandum of Understanding with the Department of Social Services, operates the HOPE Waiver. Administrative authority remains with the Department of Social Services, the State Medicaid Agency. The Department of Social Services and the Department of Human Services jointly develop policies and procedures and Administrative Rules.

The HOPE Waiver provides services to adults age 65 and older and adults with a qualifying disability 18 years of age and older. Its purpose is to reduce unnecessary nursing facility care by supporting individuals to remain at home or transition to less restrictive community settings, as long as it is safe and their choice. The Division of Long Term Services and Supports through the provision of Home and Community-Based Services strives to: 1) Ensure access to services for participants; 2) Protect participants from abuse, neglect and exploitation; 3) Foster partnerships to leverage resources for participants; 4) Improve outcomes through continuous quality improvement; and 5) Continue to ensure access to Home and Community-Based Services to enable older adults and adults with disabilities, including those from diverse communities, to have access to quality services in order to remain in their private residences and communities.

Participants access waiver services through Dakota at Home, South Dakota's "front door" for Long Term Services and Supports, where the intake process is completed by the LTSS Intake Specialists. Once the intake process is complete, the LTSS Case Management Specialists conduct options planning, complete assessments, determine functional eligibility, and coordinate with the Division of Economic Assistance for financial eligibility. If eligible, LTSS Case Management Specialists use a person-centered planning process to assist individuals in accessing waiver services after exploring natural and community supports. LTSS Case Management Specialists then provide ongoing case management after waiver services are in place.

The HOPE Waiver provides a comprehensive set of services designed to meet the diverse needs of participants, including:
Adult Day
Chore
Homemaker
Personal Care
In-Home Respite
Residential Respite
Specialized Medical Equipment
Specialized Medical Supplies
Adult Companion
Assisted Living
Environmental Accessibility Adaptations
In-Home Nursing
Meals
Nutritional Supplements
Emergency Response Systems (ERS)
Community Transition Supports
Community Transition Coordination
Community Living Home
Structured Family Caregiving

All services are delivered by Medicaid-enrolled providers who meet state qualification requirements.

The LTSS Waiver Team administers the HOPE Waiver and ensures compliance with federal and state requirements. Responsibilities include verifying provider qualifications, maintaining financial integrity, and conducting continuous quality improvement through data collection, analysis, and system improvement.

3. Components of the Waiver Request

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

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

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

care.

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver

participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

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

The State secures stakeholder and public input through several methods. LTSS staff conduct regular outreach statewide, engaging participants, providers, and community organizations to gather feedback on service delivery and quality improvement. Waiver participants provide input through an annual Service Experience Assessment and ongoing communication with LTSS Case Management Specialists. Providers share feedback directly with LTSS staff, and program updates are presented at provider association meetings and conferences.

For each waiver renewal or amendment, the State conducts a formal 30-day public comment period. The waiver and a summary of changes are posted on the Department of Human Services website, distributed through public notices and press releases, and made available upon request. Input is also sought through Tribal consultation, the Medicaid Advisory Committee, and the Advisory Council on Aging. Public forums such as town hall calls may also be convened.

The State follows formal processes for updating requirements. Significant changes are reflected in Administrative Rules of South Dakota, which require a public hearing and opportunity for comment. Policy updates are reviewed by the Waiver Review Committee and internal LTSS Policy Workgroup.

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

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

7. Contact Person(s)

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

Last Name: Ballard

First Name: Matthew

Title: Deputy Director

Agency: Department of Social Services, Division of Medical Services

Address: 700 Governors Drive

Address 2:

City: Pierre

State: **South Dakota**

Zip: 57501-7820

Phone: (605) 773-4197 **Ext:** ☐ **TTY**

Fax: (605) 773-5246

E-mail: matthew.ballard@state.sd.us

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

Last Name: Black Bear

First Name: Misty

Title: Assistant Director

Agency: Department of Human Services, Division of Long Term Services and Supports

Address: 3800 HWY 34

Address 2: n/a

City: Pierre

State: **South Dakota**

Zip: 57501

Phone: (605) 773-3656 **Ext:** ☐ **TTY**

Fax: (605) 773-4085

E-mail: misty.blackbear@state.sd.us

8. Authorizing Signature

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

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

in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Matthew

First Name: Ballard

Title: Deputy Director

Agency: South Dakota Medicaid

Address: 700 Governors Drive

Address 2:

City: Pierre

State: **South Dakota**

Zip: 57501

Phone: (605) 773-3495 **Ext:** ☐ **TTY**

Fax: (605) 394-2699

E-mail: Matthew.Ballard@state.sd.us

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:

No new transition is required at this renewal. The 150% cap was implemented under the amendment effective September 9th, 2024, and is currently operational.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(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 Division of Long Term Services and Supports

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the

methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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

The Department of Human Services (DHS) Division of Long-Term Services and Supports (LTSS) operates the HOPE Waiver. DSS, the Single State Medicaid Agency (SSMA), retains administrative authority. A Memorandum of Understanding (MOU) signed by both agencies outlines responsibilities and is reviewed and updated as needed.

DSS responsibilities include:

•Approving waiver applications and amendments for submission to CMS
•Maintaining the Medicaid State Plan and administrative rules
•Conducting financial management and reporting, including drawdown of federal funds, cost allocation, and audit response
•Determining Medicaid eligibility and conducting hearings
•Coordinating quarterly IWRC meetings and monitoring DHS waiver operations through review of performance measures and reports

DHS responsibilities include:

•Operating the HOPE Waiver in compliance with federal and state rules
•Developing and submitting waiver amendments, renewals, and related policy proposals to DSS for review/approval
•Monitoring providers, maintaining program standards, and reporting performance data
•Ensuring proper expenditure of funds and compliance with audit requirements
•Conducting quality oversight and corrective action where needed

Oversight methods:

DSS reviews DHS waiver performance through:

•Quarterly IWRC meetings with program managers and Medicaid staff, where data, trends, and compliance are reviewed
•Annual review of waiver performance measures and quality reports
•Ongoing collaboration on amendments, renewals, and policy updates
•Fiscal monitoring through federal reporting and cost allocation reviews

Frequency of assessment:

Formal oversight occurs quarterly (IWRC) and annually (performance measure review), with additional ad-hoc collaboration as needed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions

on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

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

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

Appendix A: Waiver Administration and Operation

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

   - ◉ **Not applicable**
   - ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's

methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
The number of contracts received and approved by Medicaid prior to approval for HOPE Waiver services provision. Numerator = Number of contracts received and approved by Medicaid prior to approval for HOPE Waiver services provision. Denominator = Total number of contracts

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of Internal Waiver Review Committee (IWRC) meetings that were represented by the program managers. Numerator = number of IWRC meetings that were represented by the HOPE Waiver Team. Denominator = Total number of IWRC meetings.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
New applicants enrolled by the operating agency according to 67:44:03. Numerator: New applicants enrolled by operating agency per SSMA procedures. Denominator: Total new applicants enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Therap database and MMIS.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of service plans exceeding the cost of nursing facility care that were approved according to the exceptions process. Numerator: The number and percent of service plans exceeding the cost of nursing facility care that were approved according to the exceptions process. Denominator: The number of service plans exceeding the cost of nursing facility care

Data Source (Select one):
Other
If 'Other' is selected, specify:
Excel spreadsheet containing all cases approved through exceptions process, Therap database and MMIS.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The South Dakota Department of Social Services (DSS), the single State Medicaid Agency maintains full administrative authority for the HOPE Waiver. Individual problems impacting waiver participants are identified through ongoing case management activities, critical incident reports, participant complaints, provider monitoring, claims reviews, and other quality management activities conducted by the Division of Long-Term Services and Supports (LTSS).

When an individual problem is identified, LTSS assigns responsibility for remediation based on the nature of the issue (e.g., LTSS internal staff or provider). LTSS requires correction of the identified issue, which may include updating or correcting the participant’s service plan, requiring the provider to complete a corrective action plan, retraining LTSS Case Management

Specialists, or implementing health and safety measures, if needed. LTSS verifies that corrective actions have been completed within established timeframes and that the participant's needs are addressed.

All identified issues, remediations steps, and verification of completion are documented by LTSS staff in the Quality Assurance tracking tools. If patterns emerge or systemic concerns are identified, DSS and LTSS collaborate to implement broader programmatic or policy changes.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☒	Aged	65		☒
	☒	Disabled (Physical)	18	64	
	☒	Disabled (Other)	18	64	
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Participants under age 65 with a qualifying disability who enter the waiver and reach the age limit have the option of continuing services in the "aged" target group. If a participant chooses to remain on waiver services, no transition is necessary. If a participant chooses to leave waiver services at any time, a LTSS Case Management Specialist will assist in transitioning the participant to alternative, community-based services or another waiver program as appropriate to meet the participant's needs.

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

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

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3259
Year 2	3397
Year 3	

Waiver Year	Unduplicated Number of Participants
	3541
Year 4	3691
Year 5	3848

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Waiver applications are made to the Department of Social Services and are processed and reviewed on a first-come, first-serve basis. Waiver applicants must meet all eligibility requirements as clarified in the Administrative Rules of South Dakota (ARSD) 67:44:03. Eligibility requirements to receive waiver services per ARSD 67:44:03:02: An individual is eligible for waiver services if the individual is not receiving services under ARSD 67:54:04 or 67:54:09 and meets the following requirements:

1. The individual is age sixty-five or older, or eighteen or older with a qualifying disability;
2. The individual is receiving Supplemental Security Income (SSI) or has an income level within 300% of the Supplemental Security Income standard benefit amount as provided in ARSD 67:46:04:13 and meets the eligibility criteria established in ARSD 67:46:03 or would be eligible for Medicaid under ARSD 67:46 if residing in a nursing facility;
3. The individual meets the nursing facility level of care as determined by the department according to ARSD 67:45:01;
4. The individual resides or will reside at home or in a HOPE waiver-approved home and community-based setting while receiving HOPE waiver services; and
5. The individual has an individual support plan prepared under the provisions of ARSD 67:44:03:04 and requires one or more of the services provided under this chapter

Additionally, applicable provisions of ARSD 67:46, Eligibility for Medical Services, apply to applicants and recipients of waiver services including administrative rules regarding general provisions; application for long-term care; long-term care eligibility; long-term care income requirements; long-term care resource requirements; community spouses; and long-term care notice requirements.
Per ARSD 67:45:01 The Department of Human Services must determine if the individual requesting long-term care assistance is in need of care. The Level of Care instrument/tool that is employed is the Home Care Assessment (HCA).

All initial evaluations of Level of Care for waiver applicants are conducted by a Department of Human Services Nurse Consultant. The DHS Nurse Consultant performs all initial evaluations and reevaluations of Level of Care determinations. The DHS Nurse Consultant is a nurse licensed to practice in the State of South Dakota.

All waiver applications are submitted for a Level of Care determination and a financial eligibility determination. Both eligibility determinations must be made in the affirmative before services can be authorized.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ◉ **Section 1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

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

- ○ **No**
- ◉ **Yes**

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

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

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

  Select one:

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

  Specify percentage: [ ]

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

  Specify:

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

- ○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver**

group under 42 CFR § 435.217. *Appendix B-5 is not submitted.*

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

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

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

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage: [ ]

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

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

◉ **Other standard included under the state plan**

Specify:

A participant living in his/her private residence and/or receiving Structured Family Caregiving services will be allowed an amount equal to 300% of the SSI Federal Benefit Rate (FBR).

A participant receiving Assisted Living or Community Living Home services will be allowed an amount equal to the SSI standard benefit plus $100. If the applicant/recipient is employed an additional amount of $75 per month or the gross amount earned, whichever is less, may be added to the personal needs allowance.

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

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

Specify:

Only those necessary medical or remedial care services prescribed by a physician that are not covered by Medicaid or any third party and incurred during a period which is no more than three months prior to the month of current application will be allowed as an income deduction.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:
- ◉ **Other**

  Specify:

A participant living in his/her private residence will be allowed an amount equal to 300% of the SSI Federal Benefit Rate (FBR).

A participant living in an Assisted Living or Community Living Home will be allowed an amount equal to the SSI standard benefit plus $100. If the applicant/recipient is employed an additional amount of $75 per month or the gross amount earned, whichever is less, may be added to the personal needs allowance.

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

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

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

is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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:

Per Administrative Rules of South Dakota (ARSD) 67:45:01 all initial evaluations of Level of Care for waiver applicants are conducted by a Department of Human Services Nurse Consultant. The DHS Nurse Consultant is a nurse licensed to practice in the State of South Dakota and performs all initial evaluations and reevaluations of Level of Care determinations.

When determining Level of Care, the DHS Nurse Consultant reviews case documentation, including the Home Care Assessment (HCA). The DHS Nurse Consultants receive training from the HCBS Program Manager and the LTSS Nurse Consultant Program Manager. Training topics include Level of Care and the Level of Care determination process and the HOPE policy and procedures. The HCBS Program Manager and the Nurse Consultant Program Manager also provide technical guidance to the DHS Nurse Consultants. Specific to the Home Care Assessment, all LTSS Case Management Specialists receive instructional training to complete the interRAI Home Care Assessment per the interRAI Homecare Assessment User's Manual and an interRAI Clinical Assessment Protocols (CAPs) Manual. Each LTSS Case Management Specialist retains the interRAI Homecare Assessment User's Manual and an interRAI Clinical Assessment Protocols (CAPs) Manual to utilize while completing the assessment and reassessments.

The Division of Long Term Services and Supports employs Long Term Services and Supports (LTSS) Case Management Specialists based on a combination of education and relevant experience. Qualifications include a bachelor's degree with major coursework in social work, psychology, health, or a related field, and/or demonstrated knowledge of social work principles and practices, as well as cultural, economic, social, physical, and psychological factors affecting older adults and adults with disabilities.

When an individual is identified as potentially meeting waiver eligibility requirements, the LTSS Case Management Specialist is responsible for completing the Home Care Assessment (HCA). The completed assessment is submitted to the DHS Nurse Consultant for review and Level of Care determination in accordance with waiver requirements.

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.

Per Administrative Rules of South Dakota (ARSD) 67:45:01 The Department of Human Services must determine if the individual requesting long-term care assistance is in need of care. The DHS Nurse Consultant may assign an individual to a nursing facility Level of Care classification if the individual requires any of the following services:

1. Continuing direct care services that have been ordered by a physician and can only be provided by or under the supervision of a licensed nurse. These services include daily management, direct observation, monitoring, or performance of complex nursing procedures. Continuing care is the repeated application of the procedures or services at least once every 24 hours, frequent monitoring, and documentation of the individual's condition and response to the procedures or services;
2. The assistance of another person for the performance of any activity of daily living according to an assessment of the individual's needs; or
3. Skilled therapeutic services:
a. Physical therapy, occupational therapy, or speech-language therapy in any combination that is provided at least once a week;
b. Continuing mental health services provided through the CARE (ARSD 67:62:12) or IMPACT (ARSD 67:62:13) program and a documented need for waiver services to prevent nursing facility placement by a staff member who meets the requirements of subdivision 67:62:06:03.

The Level of Care instrument/tool that is employed is the Home Care Assessment (HCA).

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.

InterRAI is a collaboration of clinicians, researchers, and health administrators founded in 1992. InterRAI began development of the Minimum Data Sets – Resident Assessment Instrument (MDS-RAI) and the application of the Resource Utilization Group's (RUGs) case-mix system in long-term residential care. Introduction of the MDS-RAI into nursing home care was associated with measurable improvements in the standard of care, particularly when quality indicators derived from the instrument were introduced. In 1994 the community care version of the MDSRAI, the Resident Assessment Instrument for Home Care (RAI-HC) was introduced as a model for comprehensive assessment in a community setting. In 2001, interRAI began a restructuring initiative to ensure all instruments contained common items and definitions. The major revision of the interRAI Home Care assessment is the interRAI Home Care Assessment (HCA). The interRAI HCA assessment is a MDS screening tool which is one in a suite of assessment tools interRAI maintains to assess and monitor the status of individuals with needs for care.

The reliability of the interRAI Home Care Assessment items have been assessed in multiple studies and multiple countries. The kappa values are predominantly above 0.6. Certain key variables such as Activities of Daily Living (ADL) and cognition are above 0.8. Validity has been assessed for sub-scales relative to similar measures.

South Dakota utilizes the MDS-RAI when determining institutional Level of Care under the State Plan, whereas the Home Care Assessment is utilized to determine Level of Care for the HOPE waiver. When a waiver participant transfers to a nursing facility for a short term stay and subsequently returns to a home and community-based setting and a HOPE waiver level of care determination has been completed within the past eleven months, the LTSS Case Management Specialist will follow the Setting Change policy to determine if the individual continues to meet nursing facility care classification so waiver services can be resumed, or if a new level of care needs to be requested prior to resuming waiver services.

When an individual residing in a nursing facility setting is working with a Home Again (MFP) provider to transition to the community, he/she will receive a preliminary Level of Care.

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:

Level of Care is established by reviewing the participant's medical, nursing, psychosocial functioning, and service needs. Upon a determination that a participant may meet the eligibility requirements for the waiver, a Long Terms Services and Supports (LTSS) Case Management Specialist assigned to the participant's case completes the Home Care Assessment (HCA) and submits it to the DHS Nurse Consultant. The DHS Nurse Consultant reviews the documentation and, when needed, requests additional documentation to make a Level of Care determination based on the Level of Care criteria per Administrative Rules of South Dakota (ARSD) 67:45:01. The same process is utilized for both the initial Level of Care evaluation and re-evaluation. The LTSS Case Management Specialist assigned to manage the participant's case conducts an assessment of the participant at least annually, or when the participant's needs change.

This assessment, utilizing the Home Care Assessment (HCA), takes place in the participant's home whenever possible. Alternatives to a home visit are explored when a home visit may pose a health and/or safety risk to the LTSS Case Management Specialist. The assessment is completed prior to when the Level of Care determination is due. Following the assessment, the LTSS Case Management Specialist compiles all required documentation, just as with the initial determination, and submits the documentation to the DHS Nurse Consultant. The DHS Nurse Consultant conducts a review of the submitted documentation to make the Level of Care determination and reports back to the assigned LTSS Case Management Specialist.

If when completing a reassessment, it is determined that a participant no longer meets Level of Care for the waiver, the participant is notified in writing by the Division of Economic Assistance. The LTSS Case Management Specialist offers the participant Options Planning and assists the participant in transitioning to other available services and supports provided through the Division of Long Term Services and Supports, informal supports and/or community organizations.

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):*

Division Long Term Services and Supports (LTSS) Case Management Specialists provide case management to all waiver participants. As such, a LTSS Case Management Specialist is responsible for the timely Level of Care re-evaluations of their assigned participants. To assist the LTSS Case Management Specialist in completing timely re-evaluations, Therap allows the LTSS Case Management Specialist an option to set a task for themselves which is used to monitor when Level of Care re-determinations are due for each participant. The LTSS Case Management Specialist is able to search the Therap system to see which Level of Care re-evaluations need to be completed. The LTSS Case Management Specialist meets with the participant for the reassessment and Individual Support Plan development and compiles all required documentation for a Level of Care re-evaluation which is provided to the DHS Nurse Consultant.

Additionally, all Level of Care determinations are maintained in a database monitored by the Nurse Consultant Program Manager and LTSS Quality Assurance Coordinators which also indicate when Level of Care determinations are due for a reevaluation.

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:

All documentation of the evaluation and re-evaluation Level of Care determinations is scanned and stored electronically in the State of South Dakota's FileDirector system, a digital document reviewing program.

The records are maintained electronically for a minimum of six years. All Level of Care determinations are maintained in a database monitored by the Division of Long Term Services and Supports Nurse Consultant Program Manager.

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:
Number and percent of new applicants who had a level of care determination prior to receiving services. Numerator = number of new applicants who had a level of care determination prior to receiving services. Denominator = number of new applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FileDirector, a document reviewing system, Therap database and MMIS.

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of LOC determinations and LOC redeterminations made where the assessment instrument was applied appropriately. Numerator = Number of LOC determinations and LOC redeterminations where the assessment instrument was applied appropriately. Denominator = Number of LOC determinations and LOC redeterminations reviewed in sample.

Data Source (Select one):

Other
If 'Other' is selected, specify:
FileDirector, a document reviewing system and Therap database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 91% confidence level with +/- 9% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: The State will review a minimum of 10 level of care determinations each month to ensure the level of care was accurately applied and to meet the required sample size.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent level of care determinations in which the level of care processes described in the waiver are applied appropriately. Numerator = Number of LOC determinations in which the level of care processes described in the waiver are applied appropriately. Denominator = All LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FileDirector, a document reviewing system and Therap database.

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

All Quality Improvement Strategy (QIS) processes are coordinated and managed by the Quality Assurance Coordinators.

The Division of Long Term Services and Supports (LTSS) utilizes Regional Operations Managers who provide supervisory oversight to LTSS Case Management Specialists across the state. Due to their direct supervisory role and programmatic responsibility for ensuring consistent application of policy, Regional Operations Managers are responsible for conducting reviews of Level of Care determinations. Each month, all Level of Care determinations made two months prior are randomly assigned to the Regional Operations Managers for review. These reviews are conducted to ensure that new applicants had an approved Level of Care determination prior to the initiation of waiver services and that the Level of Care determination process was applied appropriately and in accordance with waiver requirements.

The Nurse Consultant Program Manager reviews a minimum of 10 Level of Care determinations each month to ensure the Level of Care instrument was accurately applied and to meet the required sample size. The results of the review are recorded in an Excel spreadsheet maintained by the Quality Assurance Coordinators. The margin of error of the representative sample for this measure will be +/- 9% with a confidence level of 91%. The margin of error has been increased on this sample because Performance Measure 2 in Sub-assurance C is being reviewed at 100%. The State increased the frequency of review for performance measure C1 to occur on a monthly basis due to reviewing a smaller sample size.

Level of Care reviews are discussed at quarterly Waiver Review Committee meetings. The Committee includes LTSS leadership, program management staff, quality assurance personnel, and regional operations representatives. The committee reviews trends and makes recommendations for quality improvement.

b. Methods for Remediation/Fixing Individual Problems

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

If it is identified that a Level of Care determination is made without the required documentation, the LTSS Case Management Specialist is responsible for obtaining the missing documentation and submitting all required documentation to the DHS Nurse Consultant for review. If it is discovered the participant did not meet Level of Care at the time of the determination, the participant will be unenrolled from waiver services and transitioned to another program, if eligible. Any payment paid to a provider for services during the time when the participant did not meet Level of Care will be recalled and the services will be paid for through alternative funding.

When a participant is working with the Home Again (MFP) program and has a plan to transition to the community, a Preliminary Level of Care will be requested to determine whether the participant is expected to meet the eligibility requirements for waiver once transitioned. If the participant is determined to be ineligible for waiver once they have transitioned to the community, waiver will reimburse Home Again for all transition services up to and including the transition date; given a preliminary NF LOC for the HOPE waiver had been determined.

Monthly, the Nurse Consultant Program Manager reviews a random sample of the Level of Care determinations to ensure Level of Care criteria were accurately applied. Individual problems identified may result in the participant being removed from the waiver program. If additional information is received and the Level of Care determination cannot be supported, the Level of Care determination will be revised, and a process of retraining will be initiated with staff involved in the erroneous determination. Before removal of the participant from the waiver, documentation will be recollected and resubmitted to the DHS Nurse Consultant for a reevaluation as the participant’s health status may have changed. Any payment paid to a provider for services during the time when the participant did not meet Level of Care will be recalled and the services will be paid for through alternative funding. If it is determined a participant was eligible for waiver services, but the Level of Care criteria was not accurately applied, the participant will immediately be re-evaluated for financial and Level of Care eligibility and, if still eligible, placed on waiver services. Trends are identified to determine if an individual LTSS staff is not correctly applying the Level of Care criteria, or if there is a systemic issue. Training opportunities for the DHS Nurse Consultant are planned and conducted accordingly.

Statewide data analysis conducted by the LTSS Quality Assurance Coordinators and reviewed quarterly by the Waiver Review Committee will allow for identification of trends. The Waiver Review Committee examines trends to determine if improvements need to be made to the waiver design.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

When a participant's Level of Care determination indicates nursing facility Level of Care, the LTSS Case Management Specialist, throughout the assessment and person-centered Individual Support Planning process, discusses the HOPE waiver services that are available to meet the participant's needs at home or in a HOPE waiver residential setting (Assisted Living or Community Living Home).

As part of the participant's initial HOPE waiver eligibility determination and annually thereafter, the LTSS Case Management Specialist develops an Individual Support Plan with the participant and/or the authorized representative. The Individual Support Plan includes a questionnaire which states the following: "The HOPE Waiver offers services in homes or apartments, Community Living Homes, Adult Day Centers, and Assisted Livings with both shared and private rooms. You may also be eligible to receive services in a Nursing Facility if you wish. Are you interested in learning more about these options for you to receive your services?" Additionally, when the Individual Support Plan is signed by the participant or authorized representative, the following statement is acknowledged; "I have been provided information on home and community-based services and understand the service options that are available to me. I understand I have the right to choose between receiving services in my home and community and receiving services in a nursing facility".

Participants are offered informational brochures outlining the various services that are available. The Individual Support Plan also contains the following statement: "I have been offered the choice of all providers of services contained in this plan." A standardized procedure per the HOPE Waiver Policy instructs the LTSS Case Management Specialist to provide the participant or his/her authorized representative with a list of providers available within the participant's community that offer provision of the home and community-based services contained within the participant's Individual Support Plan.

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

The Individual Support Plan, through the participant's or his/her authorized representative's signature, documents that the participant or authorized representative was informed of a choice in the provision of care available in a nursing facility or through the waiver and was provided a choice of all providers of services contained in the Individual Support Plan. All Individual Support Plans are contained electronically in Therap for a minimum of six years.

Appendix B: Participant Access and Eligibility

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

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

The Department of Human Services provides interpreter services free of charge 24 hours a day 7 days to individuals with Limited English proficiency applying for, receiving, or seeking information about services through the Division of Long-Term Services and Supports. Interpreters are available to individuals calling in to Dakota at Home for information and referral and to conduct all case management activities with individuals who are Limited English Proficient. Interpreter may also be accessed 24/7 for interactions between contracted provider agency staff and participants when interpreter services are necessary for service provision. Interpreter services are available on-demand or may be scheduled if preferred. In addition, the State translates vital documents into prevalent languages, provides notices of language assistance, trains staff and providers on LEP requirements, and monitors interpreter service quality and timeliness to ensure compliance and continuous improvement.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Services**		

Service Type	Service		
Statutory Service	In-Home Respite Care		
Extended State Plan Service	Homemaker		
Extended State Plan Service	In-Home Nursing Services		
Extended State Plan Service	Personal Care		
Extended State Plan Service	Specialized Medical Equipment		
Extended State Plan Service	Specialized Medical Supplies		
Other Service	Adult Companion Services		
Other Service	Assisted Living		
Other Service	Chore Services		
Other Service	Community Living Home		
Other Service	Community Transition Coordination		
Other Service	Community Transition Supports		
Other Service	Emergency Response System (ERS)		
Other Service	Environmental Accessibility Adaptations		
Other Service	Meals		
Other Service	Nutritional Supplements		
Other Service	Residential Respite Care		
Other Service	Structured Family Caregiving		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

04 Day Services

Sub-Category 2:

04050 adult day health

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Adult Day services provide regularly scheduled care, supervision and structured social activities in a non-institutional, community-based setting for less than 24 hours per day. Adult day services support the participant's functioning, engagement, and well-being, and may be provided to participants residing in their private residence, an Assisted Living Center, or a Community Living Home.

Core services include supervision, structured group activities, and general health monitoring appropriate to an Adult Day setting. Health-related tasks such as blood pressure checks, medication reminders, or general observation of the participant's condition may be provided as incidental support based on assessed need. Skilled nursing services, if offered by the provider, must comply with state requirements and are not included with the Adult Day reimbursement.

When meals are provided in an Adult Day setting, they are authorized and billed as a separate service.

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

Bathing may be authorized under Personal Care services when needed; bathing is not included in the Adult Day service rate.

Services are authorized based on assessed need as identified through the Home Care Assessment and documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services over this threshold are subject to an exceptions process.

Participants residing in Assisted Living Centers, Community Living Homes, or receiving Structured Family Caregiving services may pursue Adult Day services only when the Case Management Specialist determines there is a documented assessed need that is not otherwise met by the participant's residential setting or available supports, as evidenced by the Home Care Assessment and the person-centered Individual Support Plan. In these circumstances, limited Adult Day services may be authorized.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Adult Day Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. Adult Day Providers must also complete a HCBS Settings Adult Day Assessment. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

A review is conducted every third year following initial enrollment, which includes assurance that standards are met and a HCBS Settings review.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and every third year thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In-Home Respite Care

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

Respite care provides short-term relief to an unpaid caregiver by delivering supervision and assistance to a participant who cannot be left unattended. Services support the participant's health, safety, and daily needs during the caregiver's temporary absence or need for relief. Respite care is provided in the participant's residence and is limited to periods of less than 30 consecutive days per occurrence.

Respite services include tasks that are necessary to ensure safety during the respite period (e.g., cueing, supervision, stand-by assistance). Respite does not include medical or skilled nursing services and does not replace ongoing personal care, or routine supports that the caregiver generally provides.

Room and board are not covered and may not be billed under this service in any private residence.

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

Services are authorized based on assessed need as identified through the Home Care Assessment and documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services over this threshold are subject to an exceptions process.

Respite is intended for participants who reside with an unpaid caregiver. In-Home Respite is not available to participants residing in an Assisted Living Center, Community Living Home, or to participants receiving Structured Family Caregiving services, as these services provide 24-hour supervision by paid caregivers. Participants in these settings may receive Residential Respite as described in the corresponding service definition.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Care Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In-Home Respite Care

Provider Category:

Agency

Provider Type:

Respite Care Providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. In-Home Respite Care providers must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, and gifting. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and at least every third year thereafter, LTSS reviews all In-Home Respite Care providers to ensure they are compliant with the following requirements:
• The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
• The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
• The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list
• The provider must ensure that all staff receive a minimum of six hours of training prior to entering the homes of participants and annually thereafter.

The State conducts additional onsite or desk reviews as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance to ensure ongoing provider oversight between scheduled review cycles.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and at least every third year thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Homemaker

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Homemaker services provide assistance with general household and instrumental activities of daily living necessary to maintain a safe and sanitary living environment when the participant is unable to perform such tasks independently (e.g., meal preparation, light housekeeping, routine cleaning). Services are limited to activities directly related to maintaining the participant's health and safety in the home.

Homemaker services may be authorized if the Case Management Specialist determines there is an assessed need for the service based on the Home Care Assessment and an evaluation of the informal supports available to the participant. When there are other people residing in the home, the Case Management Specialist will evaluate the shared household tasks. Tasks that fall within normal household functioning may be considered met through informal supports unless the participant's needs exceed typical household expectations.

Homemaker services are included within personal care services in South Dakota's Medicaid State Plan. Homemaker services within this waiver are those services that are provided when homemaker services furnished under the approved State Plan limits are exhausted, and do not differ in scope and nature of these services from homemaker services furnished under the State Plan.

Children will receive Homemaker services under the State Plan as EPSDT.

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

Services are authorized based on assessed need as identified through the Home Care Assessment and documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services over this threshold are subject to an exceptions process.

The concurrent provision of Homemaker services as a distinct additional service is prohibited for participants residing in Assisted Living Centers, Community Living Homes, or for participants receiving Structured Family Caregiving services, as Homemaker would duplicate services that must be provided in these settings.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	In-Home Supportive Care Providers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

In-Home Supportive Care Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. In-Home Supportive Care providers must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, and gifting. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and at least every third year thereafter, LTSS reviews all In-Home Supportive Care providers to ensure they are compliant with the following requirements:
• The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
• The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
• The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list
• The provider must ensure that all staff receive a minimum of six hours of training prior to entering the homes of participants and annually thereafter.

The State conducts additional onsite or desk reviews as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance to ensure ongoing provider oversight between scheduled review cycles.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports

Frequency of Verification:

Upon enrollment and at least every third year thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

In-Home Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
05 Nursing	05010 private duty nursing
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Nursing services provide nursing care necessary to maintain the participant's health and safety when such services cannot be safely or effectively performed by the participant or informal supports. Nursing services must be performed by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) practicing within the scope of licensure and in accordance with state nursing practice requirements. Certain nursing tasks may not be delegated pursuant to ARSD 20:48:04.01:07. Providers are responsible for ensuring that only appropriately licensed and qualified individuals perform authorized nursing tasks.

In-Home Nursing services may be authorized when the Case Management Specialist determines there is an assessed need

for skilled nursing based on the Home Care Assessment and an evaluation of available informal supports. Services are provided under the direction of a physician and are documented in the person-centered Individual Support Plan.

In-Home Nursing services are included within personal care services in South Dakota's Medicaid State Plan. Nursing services under this waiver are those services that are provided when nursing services furnished under the approved State Plan limits are exhausted and do not differ in scope or nature from nursing services furnished under the State Plan. Provider qualifications specified in the State Plan apply.

Children will receive in-home nursing services under the State Plan as EPSDT.

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

Services are authorized based on assessed need as identified through the Home Care Assessment and documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services over this threshold are subject to an exceptions process.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	In-Home Supportive Care Providers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: In-Home Nursing Services

Provider Category:

Agency

Provider Type:

In-Home Supportive Care Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. In-Home Supportive Care providers must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, gifting, and medication

administration. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and at least every third year thereafter, LTSS reviews all In-Home Supportive Care providers to ensure they are compliant with the following requirements:
• The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
• The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
• The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list

The State conducts additional onsite or desk reviews as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance to ensure ongoing provider oversight between scheduled review cycles.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and at least every third year thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Personal Care

HCBS Taxonomy:

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

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

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal care services provide assistance with activities of daily living necessary for the participant to maintain health and safety when the participant is unable to perform such activities independently (e.g., bathing, dressing, transferring). Personal care services are provided in the participant's home and are documented in the person-centered Individual Support Plan.

Personal Cares may be authorized when the Case Management Specialist determines there is an assessed need for assistance with activities of daily living based on the Home Care Assessment and an evaluation of available informal supports.

Personal care services are included within South Dakota Medicaid's State Plan. Personal care services under this waiver are those services that are provided when personal care furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State Plan. Provider qualifications specified in the State Plan apply.

Children will receive this service under the State Plan as EPSDT.

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

Services are authorized based on assessed need as identified through the Home Care Assessment and documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services over this threshold are subject to an exceptions process.

Personal Care services may not be authorized for participants residing in Assisted Living Centers or Community Living Homes. In these settings, assistance with activities of daily living and related personal care supports are included within the scope of services that the setting is required to furnish.

Personal Care services may not be authorized for participants receiving Structured Family Caregiving (SFC) when the requested supports are included within, or would duplicate, the responsibilities of the principal caregiver under the SFC service definition. Authorization of Personal Care services in conjunction with SFC may only occur in limited circumstances where the participant has a documented need that exceeds the support capacity complemented under the SFC model, such as a medically necessary two-person assist for transfers or other activities of daily living. In such cases, the need must be clearly documented in the Home Care Assessment and Individual Support Plan, and services must not supplant the core caregiving responsibilities required under SFC.

Personal Care may be authorized on a limited basis for participants attending Adult Day. In these instances, personal care services are limited to assistance with a shower and may only be authorized when an assessed need exists.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	In-Home Supportive Care Providers
Agency	Adult Day Providers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

In-Home Supportive Care Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. In-Home Supportive Care providers must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, gifting, and medication administration (if applicable). Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and at least every third year thereafter, LTSS reviews all In-Home Supportive Care providers to ensure they are compliant with the following requirements:
• The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
• The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
• The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list
• The provider must ensure that all staff receive a minimum of six hours of training prior to entering the homes of participants and annually thereafter.

The State conducts additional onsite or desk reviews as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance to ensure ongoing provider oversight between scheduled review cycles.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and at least every third year thereafter.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Adult Day Providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Adult Day Care providers authorized to furnish limited personal care services in and Adult Day setting must meet all provider qualifications and enrollment requirements applicable to Adult Day services, including compliance with HCBS Setting requirements.

In addition, Adult Day Care providers furnishing personal care services must ensure that personal care assistance provided is limited to assistance with a shower and does not include other activities of daily living. Documentation of service delivery must be maintained in accordance with waiver and EVV requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports

Frequency of Verification:

Upon enrollment and every third year thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*

Specialized Medical Equipment consists of devices, controls, or appliances specified in the person-centered Individual Support Plan that enable the participant to increase or maintain the ability to perform activities of daily living and to remain living safely in the home. Services may include the purchase, lease, installation, and maintenance of assistive technology equipment or other devices that increase, maintain, or improve functional capabilities.

Specialized Medical Equipment authorized under the HOPE Waiver is provided in addition to any medical equipment available under South Dakota's Medicaid State Plan and does not differ in scope or nature from equipment furnished under the State Plan. Waiver funds are used only when State Plan coverage limits are exhausted or when the equipment is not otherwise available through the State Plan. Items that are not of direct medical or remedial benefit to the participant are excluded.

Specialized Medical Equipment must be documented in the person-centered Individual Support Plan. Equipment is authorized based on assessed need and consideration of alternative funding sources and less costly alternatives, when appropriate.

Children will receive this service under the State Plan as EPSDT.

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

Services are authorized based on assessed need as documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	ERS and Assistive Technology Providers
Agency	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Providers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

ERS and Assistive Technology Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Upon Revalidation

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All DMEPOS providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider enrollment application, possession of a valid CMS DME Supplier number, and execution of a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete. Providers must comply with all applicable

federal and state requirements related to the provision of medical equipment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Ongoing Monitoring

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Specialized Medical Supplies are disposable items specified in the person-centered Individual Support Plan that are necessary to maintain the participant's health, manage a medical or physical condition, improve functioning, or support independence. Supplies authorized under this service must be of direct medical or remedial benefit to the participant.

Specialized Medical Supplies reimbursed under the HOPE Waiver are provided in addition to any medical supplies available under South Dakota's Medicaid State Plan and do not differ in scope or nature from supplies furnished under the State Plan.

Waiver funds are used only when State Plan coverage limits are exhausted or when supplies are not otherwise available through the State Plan. Items that are primarily for convenience, comfort, or general household use are excluded.

Specialized Medical Supplies must be documented in the person-centered Individual Support Plan. Authorization is based on assessed need and consideration of alternate funding sources and less costly alternatives, when appropriate.

Children will receive specialized medical supplies under the State Plan as EPSDT.

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

Services are authorized based on assessed need as documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Providers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All DMEPOS providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider enrollment application, possession of a valid CMS DME Supplier number, and execution of a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete. Providers must comply with all applicable federal and state requirements related to the provision of medical supplies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Ongoing Monitoring

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Companion Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Adult Companion Services provide non-medical care, supervision, and social support to a participant living in a private residence or Assisted Living, or Community Living Home. Adult Companion Services are intended to support participant safety, engagement, and well-being through supervision, cueing, and social interaction consistent with the participant's assessed needs and preferences.

Adult Companion services provide support that is incidental to supervision and socialization and do not replace or duplicate services authorized under homemaker, personal care, chore, nursing, or other waiver services. When a participant has an

assessed need for assistance with activities of daily living or instrumental activities of daily living, those services must be authorized separately and provided as distinct, non-duplicative services.

Adult Companion Services are authorized to address needs related to supervision, safety monitoring, social engagement, or structured support as identified through assessment and documented in the Individual Support Plan.
When determining the need for Adult Companion services, the Case Management Specialist evaluates the informal supports available to meet the participant's assessed supervision, safety, or engagement needs. Adult Companion services are authorized when identified needs are not otherwise met through unpaid supports or other waiver services and are necessary to support the participant's health, safety, or community integration.

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

Services are authorized based on assessed need as identified through the Home Care Assessment and documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services over this threshold are subject to an exceptions process.

The concurrent provision of Adult Companion Services as a distinct additional service is limited for participants residing in Assisted Living Centers or Community Living Homes. In these settings, supervision and routine oversight are included within the scope of services that must be provided by the setting and, therefore, Adult Companion services may not be authorized to duplicate supervision, safety monitoring, or oversight responsibilities of the setting.

Adult Companion services may be authorized for participants residing in Assisted Living Centers or Community Living Homes when the service is necessary to support participant-identified goals related to community integration, social engagement, or participation in activities outside of the residential setting, and when such needs are not otherwise met through the setting or available informal supports. The assessed need and corresponding goals and strategies must be clearly documented in the Individual Support Plan.

Adult Companion services may not be authorized when they would duplicate services required to be provided by the residential setting or through Structured Family Caregiving, including supervision, routine oversight, or support that is inherent to the caregiver's role.

For participants receiving Structured Family Caregiving services, Adult Companion may be authorized only when there is a clearly identified, assessed need that cannot be met by the Structured Family Caregiver principal caregiver and when the service supports a distinct goal identified in the Individual Support Plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	In-Home Supportive Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

In-Home Supportive Care Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. In-Home Supportive Care providers must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, and gifting. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and at least every third year thereafter, LTSS reviews all In-Home Supportive Care providers to ensure they are compliant with the following requirements:

- The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
- The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
- The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list
- The provider must ensure that all staff receive a minimum of six hours of training prior to entering the homes of participants and annually thereafter.

The State conducts additional onsite or desk reviews as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance to ensure ongoing provider oversight between scheduled review cycles.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and at least every third year thereafter.

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:

Assisted Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Assisted Living services are provided to participants who reside in a homelike, non-institutional residential setting that offers 24-hour onsite response capability to meet scheduled and unscheduled needs and to provide supervision, safety, and security.

Assisted Living services include homemaker, personal care, chore, and meal preparation services provided as part of the residential setting. Assisted Living centers also provide social and recreational programming and medication assistance, to the extent permitted under State law. Services furnished by third-party providers must be coordinated with the Assisted Living center to ensure continuity of care and avoid duplication of services.

Nursing and skilled therapy services are incidental rather than integral to Assisted Living services. Payment is not made for 24-hour skilled nursing care. Federal financial participation is not available for room and board, items of comfort or convenience, or costs associated with facility maintenance, upkeep, or improvement. The methodology for excluding room and board costs from Assisted Living payments is described in Appendix I-5.

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

Assisted Living services are authorized based on assessed need as identified through the Home Care Assessment and documented in the participant's person-centered Individual Support Plan, with a threshold equal to the average cost of nursing facility care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

The concurrent provision of the following services as distinct additional waiver services is prohibited for participants residing in an Assisted Living center, as these services are included within the scope of the residential setting:
• Homemaker
• Personal Care
• Chore
• Meals
• Emergency Response Systems
• In-Home Respite Care
• Environmental Accessibility Adaptations

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Livings

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Livings

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application, verification of current, valid licensure, and execution of a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and the provider completes a HCBS Settings Assisted Living Assessment. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

A review is conducted every third year following initial enrollment, which includes assurance that standards are met and a HCBS Settings review.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment, LTSS

Frequency of Verification:

Medicaid Provider Enrollment verifies licensure annually

LTSS completes a review upon enrollment and every third year thereafter

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:

Chore Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Chore services are provided to maintain the participant's home in a healthy and safe environment when the participant is unable to perform these tasks due to assessed physical, functional, or health-related limitations.

Covered activities include lawn mowing, snow and ice removal from sidewalks and driveways, or other activities necessary to meet city or county ordinance requirements. Chore services are intended to address intermittent or seasonal needs and are not provided on a routine or ongoing basis.

Chore services do not include routine homemaking services, home repairs, home renovations, or general property maintenance. When other individuals reside in the home, the Case Management Specialist will assess whether exterior or seasonal household tasks are reasonably available through informal supports. Chore services are authorized only when the participant's assessed physical, functional, or health-related limitations prevent the task from being completed and informal supports are not available or sufficient to meet the need.

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

Services are authorized based on assessed need as identified through the Home Care Assessment and documented in the person-centered Individual Support Plan, with a threshold equal to the average cost of nursing home care, which is updated annually. Services over this threshold are subject to an exceptions process.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	In-Home Supportive Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

In-Home Supportive Care Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. In-Home Supportive Care providers must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, and gifting. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and at least every third year thereafter, LTSS reviews all In-Home Supportive Care providers to ensure they are compliant with the following requirements:
• The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
• The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
• The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list
• The provider must ensure that all staff receive a minimum of six hours of training prior to entering the homes of participants and annually thereafter.

The State conducts additional onsite or desk reviews as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance to ensure ongoing provider oversight between scheduled review cycles.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and at least every third year thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Home

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community Living Homes are residential settings that offer waiver participants an opportunity to receive services and supports in a small, licensed home. The purpose of this service is to provide necessary care and supervision for the

participant and to provide opportunity for the participant to remain in the community in the most integrated setting. Participant needs are addressed in a manner that supports and enables the participant to maximize abilities to function at the highest level of independence possible. The service is designed to provide an alternative long-term care option for participants meeting Nursing Facility level of care whose needs can be met in a Community Living Home setting.

The Community Living Home residence may be owned, leased or rented by the Community Living Home provider and must be licensed by the South Dakota Department of Health, consistent with ARSD 44:82. The Community Living Home provider must ensure the basic health and safety needs of the waiver participant are met 24 hours per day, 7 days per week. The maximum number of participants receiving Community Living Home services in any one residence may not exceed four people.

Routine intermittent personal care, supervision, cueing, meals, homemaker services, chore services, medication management (to the extent permitted under State law), and other instrumental activities of daily living (e.g. transportation for necessary appointments and community activities, shopping, managing finances, and phone use) and other appropriate activities as described in the individual's person-centered Individual Support Plan are included activities in Community Living Home services.

For waiver participants receiving Community Living Home services, consistent with their assessed needs and as reflected in the person-centered Individual Support Plan, separate payment for other waiver services provided by a third party Medicaid provider may be authorized by the Division of Long Term Services and Supports including Community Transition Supports, Community Transition Coordination, limited Adult Companion services, limited Adult Day services, In-Home Nursing services, Specialized Medical Equipment, Specialized Medical Supplies, and Nutritional Supplements. Consistent with a participant's assessed needs and as reflected in the person-centered Individual Support Plan, extraordinary personal care needs that exceed intermittent daily assistance may also be authorized for separate payment. For example, when the participant requires more than one person assist to complete activities of daily living. Individuals living in a licensed Community Living Home setting who are not authorized by the Division of Long Term Services and Supports to receive Medicaid-funded Community Living Home services may not receive other waiver funded services.

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

Separate payment for Meals, Homemaker services, Chore services, Emergency Response Systems, and Environmental Accessibility Adaptations will not be provided on behalf of participants receiving Community Living Home services as these activities are integral to and inherent in the provision of Community Living Home services. Payments made for Community Living Home services are not made for room and board, items of comfort or convenience, or the costs of home maintenance, upkeep and improvement.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Living Homes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Home

Provider Category:

Agency

Provider Type:

Community Living Homes

Provider Qualifications

License *(specify):*

Community Living Homes are licensed by the South Dakota Department of Health as per ARSD 44:82:01:02.

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application, verification of current, valid licensure, and execution of a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. Community Living Homes must also complete a HCBS Settings Community Living Home Assessment. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

A review is conducted every third year following initial enrollment, which includes assurance that standards are met and a HCBS Settings review.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically, Medicaid Provider Enrollment and/or the Division of Long Term Service and Supports.

Frequency of Verification:

Medicaid Provider Enrollment verifies licensure annually

LTSS completes a review upon enrollment and every third year thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management

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

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

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

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

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

Service Definition *(Scope):*

Community Transition Coordination is a service that assists eligible individuals who are transitioning to a less restrictive setting in identifying, selecting, and obtaining both paid and unpaid services as well as integrated community housing options, to enhance the person's independence, community integration, and productivity, as specified in the transition care plan. To be eligible for Community Transition Coordination, the individual must:
• Meet the level of care criteria for the HOPE waiver according to an assessment;
• Be eligible for Medicaid funding for at least one full day of institutional services or waiver services in a more restrictive setting than where the individual wishes to transition;
• Have the desire to transition from an institution (e.g., nursing facility, hospital) or another provider-operated living arrangement (e.g., assisted living, community living home) into a less restrictive setting.

For eligible individuals living in a nursing facility/institution, community transition coordination is available for up to 180 consecutive days prior to an individual's date of waiver enrollment and transition to the community. The date the person leaves the institutional setting and is enrolled in the waiver shall be the date of service for billing purposes.

For individuals already enrolled in the HOPE waiver and living in a provider-controlled residential setting, community transition coordination is available for up to 180 consecutive days prior to an individual's move to a more integrated residential setting.

Community Transition Coordination shall be person-centered and include:
• Initial and the ongoing evaluation of the individual's strengths and needs;
• Transition plan development, evaluation and revision;
• Assistance to access service providers;
• Assistance in identifying and securing integrated community housing;
• Assistance in identifying and securing Community Transition Supports to establish a basic household;
• Information and education on the HOPE waiver service options, including the individual's rights and responsibilities; and
• Ongoing monitoring of the transition care plan implementation.

The frequency of face-to-face contacts with the individual shall be based on the individual's needs as identified in the transition plan but will occur, at a minimum, once per week for 90 days post-transition.
Transition coordination supports are complimentary to, and do not duplicate, administrative case management services.

If for an unforeseen reason the person does not enroll in the waiver (e.g., due to death, significant change in condition, etc.), the transition service that was being provided may be covered through Medicaid administrative funding.

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

Community Transition Coordination service limitations:
• Must be reasonable and necessary;
• Must be clearly specified in the person-centered Transition Plan;
• Limited to one time per waiver enrollment;
• Limited to 180 consecutive days prior to transition

• Limited to 90 days post transition

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Social Service Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Coordination

Provider Category:

Agency

Provider Type:

Social Service Providers

Provider Qualifications

License *(specify):*

Not applicable

Certificate *(specify):*

Be accredited or engaged in becoming accredited by the CQL-The Council on Quality and Leadership pursuant to Administrative Rules of South Dakota (ARSD) Article 46:11.

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. Social Service Providers providing Community Transition Coordination must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, and gifting. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and annually thereafter, LTSS reviews all Social Service providers to ensure they are compliant with the following requirements:
• The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
• The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
• The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list
• The provider must ensure that all staff receive a minimum of six hours of training prior to entering the homes of

participants and annually thereafter.

Qualified providers must employ transition case managers with a degree in the field of human services, social work, sociology, psychology, gerontology or related degree or related field experience; and have the ability to complete the tasks as described in the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports

Frequency of Verification:

Upon enrollment and every third year thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community Transition Supports are non-recurring, one-time expenses to provide essential household items and/or services to eligible individuals. To be eligible for Community Transition Supports, the individual must meet the level of care criteria for the HOPE waiver according to an assessment; be eligible for Medicaid funding for at least one full day of institutional services or waiver services (in a more restrictive setting than where the individual wishes to transition); and have the desire to transition from an institution (e.g., nursing facility, hospital) or another provider-controlled living arrangement (e.g., assisted living, community living home) into a less restrictive setting.

Community Transition Supports are available to individuals transitioning to a living arrangement in a private residence or home and community-based setting where the person is directly responsible for his or her own living expenses.

For eligible individuals living in a nursing facility/institution, Community Transition Supports are available for up to 180 consecutive days prior to an individual's date of waiver enrollment and transition to the community. The date the person leaves the institutional setting and is enrolled in the waiver shall be the date of service for billing purposes.

If determined necessary for a successful transition, Environmental Accessibility Adaptations (prohibited if individual transitions to a setting in which another party is responsible for such adaptations) and Specialized Medical Equipment are available to individuals transitioning from an institutional setting for up to 60 consecutive days prior to the transition date.

For individuals already enrolled in the HOPE waiver and living in a provider-controlled residential setting, Community Transition Supports are available for up to 180 consecutive days prior to an individual's move to a more integrated residential setting. If determined necessary for a successful transition, all waiver services are available unless otherwise prohibited by individual service limitations.

Community Transition Supports enable an individual to establish a basic household and may include a security deposit required to obtain a rental lease for an apartment or house; moving expenses required to occupy and use the residence; one-time non-refundable deposits or installation fees to establish utility and other essential service access; one-time residential cleaning or pest extermination costs required for the individual to occupy the residence; non-medical transportation and essential household items necessary for a successful transition as determined by a needs assessment. The Community Transition Specialist will accompany the individual to purchase essential household items.

If for an unforeseen reason the individual does not enroll in the waiver (e.g., due to death, significant change in condition, etc.), the transition service that was being provided may be covered through Medicaid administrative funding.

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

Community Transition Supports service limitations:
• Must be reasonable and necessary;
• Must be clearly specified in the person-centered Transition Plan;
• Limited to one time per waiver enrollment;
• Limited to goods and services not available to individuals through other means;
• Not available to individuals accessing transition services through the Money Follows the Person (Home Again) Demonstration Grant;
• Not available to pay for furnished living arrangements that are owned or leased by a waiver provider where the essential household items and services are already included in the provider's provision of service;
• Limited to goods and services purchased within 60 days of the date of transition;
• The total cost of all items/services purchased shall not exceed $5,000.00;
• When the total cost to maintain a participant's health and safety needs upon transition exceed $5,000.00, any additional costs must be approved through an exceptions process.

Community Transition Supports do not include the following expenses:
• Household items (water heater, furnace/heater, furnished furniture, air conditioner) that are the responsibility of the landlord or property owner to provide, replace, or repair;
• Payment for room and board;
• Monthly rent or mortgage expense;
• Food (with the exception of one-time/initial set up of groceries)
• Regular or ongoing utility fees/charges;
• Items intended for recreational purposes, i.e., televisions, cable TV access, VCRs, DVD/Blue-ray players.

The total cost of the essential household items must not exceed $500.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Social Service Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Supports

Provider Category:

Agency

Provider Type:

Social Service Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. Social Service Providers providing Community Transition Coordination must have written policies on the following topics: abuse and neglect reporting, staff training, intake and admission, discharge, participant confidentiality, participant rights and responsibilities, documentation, incident reporting, emergency response, health and safety, quality assurance, participant grievances, and gifting. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Upon enrollment and annually thereafter, LTSS reviews all Social Service providers to ensure they are compliant with the following requirements:
• The provider must conduct a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all employees hired to work in the homes of participants
• The provider must check the Office of Inspector General (OIG) List of Excluded Individuals and Entities on a monthly basis to ensure employees are not on the exclusion list
• The provider must check the System for Award Management (SAM) database on a monthly basis to ensure employees are not on the exclusion list
• The provider must ensure that all staff receive a minimum of six hours of training prior to entering the homes of participants and annually thereafter.

Qualified providers must employ transition case managers with a degree in the field of human services, social work, sociology, psychology, gerontology or related degree or related field experience; and have the ability to complete the tasks

as described in the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or Division of Long Term Service and Supports

Frequency of Verification:

Upon enrollment and every third year thereafter

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:

Emergency Response System (ERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Emergency Response System (ERS) services provide participants living in a private residence with access to an electronic device that enables the participant to secure help in the event of an emergency. The system is activated by the participant and signals a response center or designated responder when assistance is needed. ERS devices may include wearable or portable components that allow the participant to access emergency assistance while moving within or immediately around

the home.

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

ERS services are authorized based on assessed need as identified through the Home Care Assessment and documented in the participant's person-centered Individual Support Plan, with a threshold equal to the average cost of nursing facility care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

The concurrent provision of ERS as a distinct additional service is prohibited for participants residing in Assisted Living Centers or Community Living Homes, as 24-hour response capability and supervision are inherent in these settings.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	ERS and Assistive Technology Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Emergency Response System (ERS)

Provider Category:

Agency

Provider Type:

ERS and Assistive Technology Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Upon Revalidation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Environmental Accessibility Adaptations are physical modifications to a participant's private residence, or the residence of the participant's family, that are required by the participant's Individual Support Plan and are necessary to ensure the health, welfare, and safety of the participant or to enable the participant to function with greater independence in the home.

Environmental Accessibility Adaptations are authorized to address functional limitations or safety risks identified through assessment and documented in the Individual Support Plan. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical or plumbing systems necessary to accommodate medical equipment or supplies required for the participant's health and welfare.

Excluded are adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations or improvements that add to the total square footage of the home are excluded from this service, except when necessary to complete an approved adaptation (e.g., to improve entrance or egress to the residence or to widen the bathroom door to accommodate a wheelchair). This service does not include general repair or maintenance of the residence, which is considered standard housing obligations of the homeowner or tenant.

Environmental Accessibility Adaptations must be provided in compliance with applicable state and local building codes and

requirements.

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

Environmental Accessibility Adaptations are authorized based on assessed need as identified through the Home Care Assessment and documented in the participant's person-centered Individual Support Plan. Authorization is subject to a threshold equal to the average cost of nursing facility care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

The concurrent provision of Environmental Accessibility Adaptations as a distinct additional service is prohibited for participants residing in Assisted Living Centers or Community Living Homes, as environmental accessibility and structural modifications are inherent responsibilities of those settings.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptations Providers

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:

Environmental Accessibility Adaptations Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts an onsite review and evaluates provider policies and procedures. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and every third year thereafter

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:

Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Meal services provide nutritious meals to participants who reside in a private residence and require assistance to maintain adequate nutrition due to assessed functional, health, or nutritional needs. Meals are provided to supplement the participant's diet and support health and well-being and may include breakfast, lunch, and/or dinner, as identified through assessment and documented in the person-centered Individual Support Plan.

Meals must be consistent with applicable federal dietary guidelines and tailored, when appropriate, to address participant-specific dietary needs or medical conditions.

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

Meal services are authorized based on assessed need as identified through the Home Care Assessment and documented in

the participant's person-centered Individual Support Plan, with a threshold equal to the average cost of nursing facility care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

The concurrent provision of meals as a distinct additional service is prohibited for participants residing in Assisted Living Centers or Community Living Homes, and for participants receiving Structured Family Caregiving services, when meal preparation and provision are inherent in the residential setting or caregiving arrangement.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Organizations
Agency	Senior Meals providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meals

Provider Category:

Agency

Provider Type:

Community-Based Organizations

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Upon Revalidation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meals

Provider Category:

Agency

Provider Type:

Senior Meals providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Upon Revalidation

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:

Nutritional Supplements

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies

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

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

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

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

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

Service Definition *(Scope):*

Nutritional Supplements are provided to participants who have an assessed nutritional need related to being below medically recommended body weight, nutritional deficiency or malnutrition, wound healing, or management of health condition(s). Nutritional Supplements are authorized under the direction of a physician or other qualified medical professional and are intended to supplement, not replace, regular meals.

The need for Nutritional Supplements must be documented in the participant's person-centered Individual Support Plan.

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

Nutritional Supplements are authorized based on assessed need as identified through the Home Care Assessment and documented in the participant's person-centered Individual Support Plan, with a threshold equal to the average cost of nursing facility care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nutritional Supplements Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Supplements

Provider Category:

Agency

Provider Type:

Nutritional Supplements Providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application and signing a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Upon Revalidation

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:

Residential Respite Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Residential Respite provides short-term, temporary care in a licensed residential setting for participants who are unable to care for themselves due to the temporary absence of, or need for relief by a caregiver. Residential Respite is available to eligible participants who ordinarily reside with a caregiver and is intended to support caregiver sustainability while ensuring participant health and safety.

Residential Respite is provided for a limited duration and does not replace permanent residential placement.

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

Residential Respite services are authorized based on assessed need as identified through the Home Care Assessment and documented in the participant's person-centered Individual Support Plan, with a threshold equal to the average cost of nursing facility care, which is updated annually. Services exceeding this threshold are subject to an exceptions process.

Residential Respite is limited to short-term use and may not exceed 30 consecutive days per episode. The concurrent provision of Residential Respite as a distinct additional service is prohibited for participants residing in Assisted Living Centers.

Residential Respite services are not available in Adult Day settings or Community Living Homes.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Long-Term Care Facilities
Agency	Assisted Livings
Agency	Community Living Homes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Respite Care

Provider Category:

Agency

Provider Type:

Long-Term Care Facilities

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must be enrolled as Medicaid waiver providers. Enrollment requires completion of the Medicaid provider application, verification of current, valid licensure, and execution of a standard Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency; specifically Medicaid Provider Enrollment.

Frequency of Verification:

Medicaid Provider Enrollment verifies licensure annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Respite Care

Provider Category:

Agency

Provider Type:

Assisted Livings

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

Assisted Living providers authorized to furnish Residential Respite services in the Assisted Living setting must meet all provider qualifications and enrollment requirements applicable to Assisted Living services, including compliance with HCBS Setting requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency; specifically Medicaid Provider Enrollment, LTSS.

Frequency of Verification:

Medicaid Provider Enrollment verifies licensure annually

LTSS completes a review upon enrollment and every third year thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Respite Care

Provider Category:

Agency

Provider Type:

Community Living Homes

Provider Qualifications

License *(specify):*

Community Living Homes are licensed by the South Dakota Department of Health.

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

Community Living Home providers authorized to furnish Residential Respite services in the Community Living Home setting must meet all provider qualifications and enrollment requirements applicable to Community Living Home services, including compliance with HCBS Setting requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency; specifically Medicaid Provider Enrollment, LTSS.

Frequency of Verification:

Medicaid Provider Enrollment verifies licensure annually

LTSS completes a review upon enrollment and every third year thereafter

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:

Structured Family Caregiving

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02023 shared living, other

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

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

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

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

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

Service Definition *(Scope):*

Structured Family Caregiving (SFC) services offer waiver participants an opportunity to reside with a principal caregiver in the participant's own private home or in the private home of the principal caregiver. The goal of the service is to provide necessary care and supervision for the participant and to support the participant to remain in the community in the most integrated setting. This is accomplished through a cooperative relationship between the participant, the principal caregiver, the participant's LTSS Case Management Specialist, and the Medicaid Enrolled Oversight Agency.

Participant needs are addressed in a manner that supports and enables the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide an alternative long-term care option for individuals who meet Nursing Facility Level of Care and whose needs can be met in a Structured Family Caregiving home setting.

The Structured Family Caregiving home must be the primary residence of both the principal caregiver and waiver participant. The home must be owned, leased, or rented by either the principal caregiver, the waiver participant, or the waiver participant's relative or non-relative fictive kin. The Medicaid Enrolled Oversight Agency may not own, lease, or rent the residence. The Structured Family Caregiving home setting is assessed by the provider agency to ensure the home is safe, accessible, and allows for comfort and privacy for participants receiving care before services begin. The number of participants receiving Structured Family Caregiving services in any one private home may not exceed two participants.

The principal caregiver may be a related family member or non-relative fictive kin. Non-relative fictive kin is defined as an individual who is not related by birth, adoption, or marriage but who has an emotionally significant relationship with the participant. If the principal caregiver is not a related family member or fictive kin, the principal caregiver must be licensed by the South Dakota Department of Health as a Community Living Home, as defined in ARSD 44:82.

Daily routine intermittent personal care, supervision, cueing, meals, homemaker services, chore services, medication management (to the extent permitted under State Law), and other instrumental activities of daily living (e.g., transportation for necessary appointments and community activities, shopping, managing finances, phone use), and other appropriate activities as described in the participant's person-centered Individual Support Plan are included as components of the Structured Family Caregiving service and may not be authorized for separate payment.

Consistent with a participant's assessed needs and as reflected in the person-centered Individual Support Plan, separate payment for other waiver services provided by a third-party Medicaid provider may be authorized by the Division of Long Term Services and Supports. These services may include Community Transition Supports, Community Transition Coordination, Adult Companion, Adult Day, Residential Respite Care, Emergency Response Systems, In-Home Nursing, Specialized Medical Equipment, Specialized Medical Supplies, Environmental Accessibility Adaptations, and Nutritional Supplements. Consistent with assessed need and as documented in the Individual Support Plan, extraordinary personal care needs that exceed routine intermittent daily assistance may also be authorized for separate payment, such as when a participant requires more than one-person assistance to complete activities of daily living.

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

Services are based on assessed need as identified in the person-centered Individual Support Plan with a threshold equal to

the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

Separate payment for meals, homemaker services, and/or chore services will not be authorized for participants receiving Structured Family Caregiving services, as these activities are integral to and inherent in the provision of Structured Family Caregiving. Payments made for Structured Family Caregiving do not include room and board, items of comfort or convenience, or the costs of home maintenance, upkeep, or improvement.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid Enrolled SFC Oversight Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Structured Family Caregiving

Provider Category:

Agency

Provider Type:

Medicaid Enrolled SFC Oversight Agencies

Provider Qualifications

License *(specify):*

If the principal caregiver is not a related family member or fictive kin, the home must also be licensed by the Department of Health as Community Living Home as defined in ARSD 44:82.

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

The Medicaid-enrolled provider agency for Structured Family Caregiving is enrolled as the Medicaid provider; the principal caregiver does not enroll as a Medicaid provider. Enrollment requires completion of the Medicaid provider application and signing a standard SD Medicaid Provider Agreement.

In addition to Medicaid enrollment, LTSS conducts a review and evaluates provider policies and procedures. Structured Family Caregiving providers must have policies on the following topics: statewide coverage, intake and admissions, discharge and service termination, documentation standards, abuse, neglect, and exploitation, incident reporting, emergency response, health and safety, confidentiality, participant rights, quality assurance, participant grievance, and gifting. Once all LTSS enrollment requirements are met, the Department issues a contract. Providers may not begin furnishing waiver services until the contract is fully executed and the Medicaid enrollment process is complete.

The Medicaid-enrolled provider agency is responsible for assessing and approving the home setting to ensure it is safe, accessible, and allows for comfort and privacy for the participant receiving care. The assessment of the home must be conducted before the initiation of HOPE Waiver Structured Family Caregiving services. The provider agency must complete

a home visit to visually assess the home setting and confirm these standards are met.

The Medicaid-enrolled SFC oversight agency is also responsible for assessing the principal caregiver. Caregiver assessments must be comprehensive and establish a plan for educating, coaching, and supporting the caregiver. Educational resources, coaching, and support are designed to ensure caregivers have the competencies necessary to provide daily care and to identify changes in participant health status or other indicators that may lead to unplanned hospitalizations or preventable adverse events.

The Medicaid-enrolled SFC oversight agency must establish a mechanism to collect and review regular caregiver notes, completed electronically when feasible, and with sufficient frequency to support monitoring of participant health and caregiver support needs. Documentation must be made available to LTSS Case Management Specialists and the State upon request. The Division of Long Term Services and Supports monitors and authorizes individuals receiving Structured Family Caregiving services.

The Medicaid-enrolled SFC oversight agency must be accessible during normal business hours and provide coaching to principal caregivers to manage urgent and emergency situations in the home. In coordination with the principal caregiver and the LTSS Case Management Specialist, the oversight agency must establish an emergency back-up plan for instances when the caregiver is unable to provide care.

The oversight agency must conduct a care conference with the participant and principal caregiver on a monthly basis, either on-site or virtually. A monthly telephone conference may be utilized as an alternative due to travel or internet connectivity barriers. At the six-month review, the oversight agency must visually reassess the home setting to confirm that the environment continues to be safe, accessible, and appropriate for the participant. This reassessment may be conducted through an onsite or virtual visit. When done virtually, the visit must include a live video walkthrough of the home.

At least one care conference per year must be conducted as an on-site, face-to-face visit. The frequency of additional on-site visits must be based on the needs of the participant and the principal caregiver. Additional on-site visits may be necessary for participants who the provider has identified as high-risk.

Upon enrollment, LTSS ensures that the provider has compliant policies on the following topics prior to approval: statewide coverage, intake and admissions, discharge and service termination, documentation standards, abuse, neglect, and exploitation, incident reporting, emergency response, health and safety, confidentiality, participant rights, quality assurance, participant grievance, and gifting. Upon enrollment and every third year thereafter, LTSS reviews all Medicaid Enrolled Oversight Agencies to ensure the following:

• The provider conducts a state fingerprint background check (or other alternative state-approved background check) to screen for abuse, neglect, and exploitation for all SFC caregivers.
• The provider ensures that all staff receive a minimum of six hours of training prior to provision of HOPE waiver services and annually thereafter.

A targeted policy review may be conducted during the monitoring reviews. Focus is based on complaints received, new policy requirements, and trends identified during oversight.

Medicaid-enrolled Oversight Agencies are expected to comply with all applicable State and Federal employment laws and regulations, including Fair Labor Standards Act (FLSA) minimum wage and overtime requirements, when applicable. The Medicaid-enrolled provider agency must provide statewide oversight of Structured Family Caregiving services.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and/or the Division of Long Term Services and Supports.

Frequency of Verification:

Upon enrollment and every third year thereafter

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The Division of Long Term Services and Supports (operating division) provides case management services to all waiver participants. Case management services are an essential component of waiver coordination and include assessment, person-centered Individual Support Plan development, service authorization and monitoring, follow-up and documentation. Long Term Services and Supports Case Management Specialists function as case managers for a caseload of waiver and non-waiver participants. The operating division is the same entity providing case management. There is no conflict of interest because all Waiver services are provided by agencies outside of the operating division. Training regarding the HCBS Settings Rule and person-centered planning is provided internally by the HOPE Waiver Team.

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

No services selected for remote delivery

Appendix C: Participant Services

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

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

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

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

All Medicaid-enrolled providers are required, through their provider contract, to ensure that individuals who provide direct services to waiver participants complete a criminal history and/or background investigation prior to delivering services.

Individuals Subject to Background Investigations

Background investigations are required for individuals who provide direct care or services to waiver participants, including;
• In-home service provider employees delivering services in a participant's home;
• Employees of Assisted Living Centers;
• Employees of Adult Day Centers;
• Individuals providing services in Community Living Homes;
• Structured Family Caregiving staff and principal caregivers;
• Community Transition Coordination and Community Transition Supports provider staff who deliver services in a participant's home.

Scope of Background Investigations

Providers must conduct a State fingerprint-based background check, or another State-approved alternative background check, to screen for abuse, neglect, and exploitation. Background investigations must meet all applicable state requirements and be completed prior to service delivery.

Age Requirements

• Individuals subject to background investigations must be 16 years of age or older.
• Structured Family Caregiving principal caregivers must be 18 years of age or older, consistent with the responsibilities and nature of the service.

Verification and Monitoring

The Division of Long Term Services and Supports (LTSS) verifies compliance with background investigation requirements through provider monitoring activities. During provider reviews, LTSS conducts random sample reviews of personnel records to confirm that required background investigations were completed for applicable staff, including those hired on or after June 1, 2015.
If a provider is found to be out of compliance, corrective action is required, including completion of any missing background investigations.

Alternative Background Check Approval

Providers seeking to use an alternative background check in place of the State fingerprint-based background check must obtain State approval. To be approved, the alternative background check must verify that the individual meets State fitness determination standards, and results must be readily accessible to the State upon request.

Fitness Determination Criteria

Automatic Disqualification

The following criminal history findings automatically preclude an individual from being hired or contracted:
• A crime of violence as defined by SDCL 22-1-2 or a similar statute from another state;
• A sex crime pursuant to SDCL chapters 22-22 or 22-24A or SDCL 22-22A-3 or similar statutes from another state;

• Class A and/or B felony convictions.

Discretionary Disqualification

The following findings may preclude employment or contracting at the discretion of the provider:
• Other felonies not described in 3.a.iii.

• Misdemeanor convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
• Any convictions, including any form of suspended sentence, which are determined to be detrimental to the best interests of SD Medicaid. This includes convictions related to a person's character such as perjury and fraud related charges as individuals determined to be dishonest with any party should not be assumed to be honest with SD Medicaid;
• Conviction related to obstruction of a criminal investigation.

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

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

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

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

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

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

are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Due to the frontier and rural nature of much of South Dakota, it can be difficult to find in home supportive care workers, and in many instances, the legally responsible person has been caring for the participant long term and is most familiar with the participant's needs and preferences.

Legally responsible individuals (spouse, parent of and adult participant, legal guardian, or adult son or daughter) can be paid for the provision of homemaker, personal care, chore, and adult companion but must be employed by a provider agency and meet all of the qualifications and training requirements for the services being provided.

For a legally responsible person to be paid for the provision of HOPE Waiver services, all of the following authorization criteria and monitoring provisions must be met. The service must:
• Meet the definition of homemaker, personal care, chore, and adult companion as defined in the federally approved waiver;
• Be necessary to avoid institutionalization;
• Be a service that is specified in the Individual Support Plan;
• Be provided by a spouse, parent of an adult participant, legal guardian, or an adult son or daughter, who meets the qualifications and training standards specified in the waiver for that service;
• Meet the definition of extraordinary care, which is defined as an activity that the family member would not ordinarily perform or is responsible to perform.

The Provider is responsible for the oversight of staff (including legally responsible individuals) in the completion of their assigned tasks. The review process must include unannounced visits to the assigned workplace of each employee. Documentation of the staff monitoring visits must be available for review.

To ensure billed services have been rendered, waiver participants are surveyed at the six-month review to confirm they have received the services. Any discrepancies in the reported rendered services and services billed are further investigated.

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

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

Any Medicaid enrolled waiver provider who is enrolled to provide homemaker, personal care, chore, and adult companion has the authority to hire relatives/legal guardians to provide these services including spouse, parent of an adult participant, legal guardian, or son or daughter. Any relatives/legal guardians hired must meet all of the qualifications and training requirements for employees of the in-home provider and must adhere to the participant's approved Individual Support Plan.

The Provider is responsible for the oversight of staff (including relatives/legal guardians) in the completion of their assigned tasks. The review process must include unannounced visits to the assigned workplace of each employee. Documentation of the staff monitoring visits must be available for review.

To ensure billed services have been rendered, waiver participants are surveyed at the six-month review to confirm they have received the services. Any discrepancies in the reported rendered services and services billed are further investigated.

○ **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:

All willing and qualified providers have the opportunity to enroll as HOPE Waiver service providers in accordance with 42 CFR §431.51. Enrollment for HOPE Waiver services is conducted through an open, statewide process that does not limit the number of qualified providers who may enroll, provided all applicable requirements are met. Although enrollment is open to all willing and qualified providers, approval is contingent upon the successful completion of all required screening, verification, and qualification standards.

The State applies uniform enrollment criteria to ensure provider integrity, protect participants, and safeguard Medicaid funds. Providers that do not meet enrollment requirements, including verification of licensure (when applicable), established business operations, compliance history, or required documentation, will not be approved.

All providers must complete both the LTSS HCBS enrollment process and the South Dakota Medicaid provider enrollment process. Providers begin by submitting an LTSS HCBS Provider Enrollment Request through the online system and completing the LTSS enrollment process as outlined in the LTSS HCBS Enrollment Manual. During this process, providers identify the services they intend to deliver, verify licensure when applicable, and submit all required documentation.

An onsite review is conducted to confirm compliance with business standards. Providers must demonstrate the existence of a legitimate business location suitable for daily operations, confidentiality, and administrative functions and have visible signage identifying the business. Locations used solely for enrollment or review purposes do not meet these requirements.

In addition to the general enrollment requirements, providers of Assisted Living, Community Living Home, Adult Day Centers, Structured Family Caregiving, In-Home Services, Environmental Accessibility Adaptations (EAA), and Community Transitions and Supports must submit their policies and procedures for review and approval. Any identified deficiencies will be communicated to the provider, who will be given the opportunity to correct them. All deficiencies must be resolved within established timeframes to receive approval.

Furthermore, Assisted Livings, Community Living Homes, and Adult Day Centers must comply with the HCBS Settings Final Rule. Compliance is verified through completion of an HCBS Settings Assessment, submission of supporting documentation, and observations conducted during the onsite review. Providers are afforded the opportunity to remediate identified deficiencies; however, all deficiencies must be corrected prior to enrollment approval.

Once all LTSS enrollment requirements have been satisfied, providers are issued a purchase-of-services agreement (contract) with the Department of Human Services (DHS). Providers must complete the Medicaid Provider Enrollment process administered by the Department of Social Services (DSS). SD Medicaid enrollment cannot be finalized without an executed DHS contract. Although the LTSS provider enrollment and the SD Medicaid provider enrollment processes are distinct, they are coordinated, and both must be completed before services may be delivered to HOPE Waiver participants.

Enrolled providers are responsible for maintaining accurate enrollment information and submitting updates when changes occur to either DHS LTSS or DSS Medicaid provider enrollment records. LTSS and/or Medicaid staff may initiate outreach if discrepancies or potential changes are identified. Contracts are reviewed and updated periodically to reflect current requirements, including compliance with HCBS and service-specific standards.

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

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and % of licensed/certified providers that continue to meet required licensure/certification standards and adhere to other standards Numerator = number of providers that continue to meet required licensure/certification standards and adhere to other standards Denominator = licensed/certified waiver service providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted vendor's monitoring report and list of enrolled providers supplied by Medicaid Provider Enrollment.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of new licensed/certified providers that initially meet required licensure/certification standards prior to furnishing services. Numerator = number of new licensed/certified providers that initially meet required licensure/certification standards prior to furnishing services. Denominator = number of new licensed/certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted vendor's validation report and list of enrolled providers supplied by Medicaid Provider Enrollment.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 new non-licensed/non-certified providers by provider type who met initial provider qualifications prior to furnishing services. Numerator= Number of new non-licensed/non-certified providers by type who met provider

qualifications prior to furnishing waiver services. Denominator= Number of new non-licensed/non-certified provides by provider type.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
List of enrolled providers supplied by Medicaid Provider Enrollment.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
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 reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data obtained from the Medicaid Management Information System (MMIS)

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

	Specify:	

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
For in-home providers of homemaker, personal care, companion care and nursing services, data will be collected from the Provider Quality Management Self-Assessment.

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

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

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

Data Aggregation and Analysis:

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

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

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:
Number and percent of providers, by provider type, who meet provider training requirements. Numerator = Number of providers meeting provider training requirements. Denominator = All waiver service providers reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

To identify/discover issues related to provider qualifications, the State employs the activities described in Appendix C1-Provider Standards. Verification that standards were met initially and at the frequencies specified in Appendix C-1 are conducted by quality assurance staff. The strategies employed include provider reviews, verification of enrollment requirements, contract verification, and review of SD Medicaid Provider enrollment records.

For all HOPE Waiver providers, an onsite review is conducted prior to initial enrollment and at least once every three years thereafter to verify continued compliance with waiver provider requirements. Providers who are issued a corrective action plan as a result of an onsite review are subject to follow-up review in the subsequent year to ensure required corrective actions have been implemented. In addition, the State conducts additional onsite or desk reviews as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance to ensure ongoing provider oversight between scheduled review cycles.

Compliance with provider training requirements is monitored through review of documentation submitted during required provider reviews. Providers subject to training requirements according to Appendix C-1 – Provider Standards are required to submit documentation that verifies 6 hours of training were completed for a sample of staff. Qualify Assurance staff review submitted documentation to verify that training requirements have been met and to identify instances of noncompliance for follow-up and remediation when necessary.

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems identified through Appendix C quality improvement activities are addressed in accordance with established provider enrollment and oversight procedures to ensure compliance with waiver requirements.

When issues are identified related to provider enrollment, qualifications, licensure, or required documentation, the Division of Long Term Services and Supports (LTSS) determines and implements appropriate remediation actions. Remediation actions may include:

• Requiring submission or correction of missing or deficient provider documentation
• Verification or re-verification of provider qualifications or licensure
• Issuance of corrective action requirements with defined completion timeframes
• Suspension of authorization to provide waiver services until deficiencies are resolved
• Termination of DHS contract and provider enrollment when compliance cannot be achieved

LTSS verifies completion of required corrective actions prior to continued authorization of waiver services, as applicable. All remediation actions and verification activities are documented in accordance with waiver policies and provider oversight procedures.

Information from individual remediation activities is aggregated and reviewed to identify patterns or systemic issues related to provider compliance. When trends are identified, LTSS implements broader corrective strategies, which may include clarification of enrollment requirements, updates to provider guidance, changes to oversight processes, or other programmatic actions to prevent recurrence.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

The State imposes a limit on the maximum total dollar amount of waiver services authorized for an individual participant under the HOPE Waiver.

The cost limit applies to the combined total of all HOPE Waiver services authorized in a participant's person-centered Individual Support Plan.

The total cost of a participant's person-centered Individual Support Plan is limited to an amount equal to 100 percent of the average cost of nursing facility care in South Dakota. This limit is based on historical utilization and expenditure patterns and is intended to ensure compliance with federal cost neutrality requirements. The average cost of nursing facility care is determined by South Dakota Department of Human Services on an annual basis and is used as the benchmark for establishing the Individual Support Plan cost threshold.

The percentage limit remains constant throughout the waiver period. The dollar value of the limit is updated annually to reflect changes in the statewide average cost of nursing facility care.

When the cost of services necessary to ensure a participant's health and welfare exceeds 100 percent of the average cost of nursing facility care, and exception may be requested. Approved exceptions allow the total cost of waiver services to be authorized up to 150 percent of the average cost of nursing facility care, in accordance with Administrative Rules of South Dakota 67:44:03:16. Exceptions are reviewed and approved by the HCBS Program Manager based on documented health and welfare needs.

If the services required to ensure a participant's health and welfare exceeds the 150 percent threshold, the LTSS Case Management Specialist works with the participant to explore alternative strategies to mitigate risk while respecting participant choice. These strategies may include:

• Identification of informal supports
• Use of community resources
• Transition to another Medicaid program or waiver, if appropriate
• Individual risk agreements when a participant chooses to assume responsibility for identified risks.

Health and welfare protections remain paramount in all planning decisions.

Information regarding Individual Support Plan limits is discussed with participants during intake, referral, and the person-centered planning process. Participants receive information about the estimated cost of services included in their Individual Support Plan and are informed when an exception is requested or approved.

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

South Dakota attests that settings in which HOPE Waiver services are delivered comply with the federal HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance at the time of submission and will maintain compliance ongoing.

HOPE Waiver services are provided in the following settings:

Residential Settings

• Participant-owned or participant-rented private homes
• Assisted Living Centers (provider-owned or provider-controlled)
• Community Living Homes (provider-owned or provider-controlled)

Non-Residential Settings

• Adult Day Centers

Each setting type is evaluated against applicable HCBS settings criteria to ensure participants have full access to community living, autonomy, privacy, dignity, respect, and choice.

A. Private Homes (Participant-Owned or Rented)

Participants may receive waiver services in their own private home or in the home of family members, friends, or roommates. These settings are not provider-owned or provider-controlled and are presumed to meet HCBS settings requirements in accordance with federal guidance.

B. Provider-Owned or Provider-Controlled Residential Settings

HOPE Waiver participants may reside in Assisted Living Centers and Community Living Homes.

These settings must meet:
1. The core HCBS settings criteria at 42 CFR 441.301(c)(4), and
2. The additional residential requirements at 42 CFR 441.301(c)(4)(vi), including:
o Legally enforceable lease or residency agreement
o Privacy in sleeping or living units, including lockable doors
o Choice of roommate, when applicable
o Freedom to furnish and decorate units
o Control of daily schedules and access to food at any time
o Ability to have visitors at any time
o Physical accessibility

C. Provider-Owned or Provider-Controlled Non-Residential Settings

HOPE Waiver participants may receive services in Adult Day Centers.

These settings must meet the core HCBS settings criteria, including:

• Integration and access to the greater community
• Opportunities for employment or volunteer activities
• Access to all areas of the setting
• Access to personal resources
• Choice of setting, including non-disability-specific settings
• Privacy, dignity, and respect, and freedom from coercion and restraint
• Autonomy in daily activities and schedules
• Choice in service provision

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the*

state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)

South Dakota uses multiple overlapping methods to ensure that all HCBS settings meet federal HCBS Settings requirements at the time of submission and on an ongoing basis. These processes are designed to assess both initial compliance and continued adherence to HCBS requirements across all residential and non-residential settings.

A. Provider Enrollment and Initial Compliance

For provider-owned or provider-controlled settings (Assisted Living Centers, Community Living Homes, and Adult Day Centers):

• Providers must demonstrate compliance with HCBS settings requirements prior to Medicaid enrollment.
• The state reviews provider policies, procedures, and setting characteristics to verify alignment with federal requirements.

B. Routine Monitoring and Ongoing Reviews

The state conducts ongoing monitoring of provider-owned and provider-controlled settings to ensure continued compliance:

• Onsite HCBS settings reviews are conducted at least every three years, or more frequently if concerns are identified.
• Reviews utilize the state's HCBS Settings Final Rule Evidence and Onsite Review Assessment tool, which evaluates:

• Community integration
• Participant rights
• Living arrangements
• Implementation of provider policies

Reviews include:

• Provider self-assessment and attestation
• Document review (policies, handbooks, lease/residency agreements)
• Onsite observation
• Staff interviews
• Participant interviews

When non-compliance is identified, the state requires a Corrective Action Plan (CAP) with defined timelines. The state verifies completion of corrective actions before determining the setting is compliant.

C. Person-Centered Planning and Individual-Level Monitoring

Compliance with HCBS settings requirements is also monitored through the person-centered planning process:

• Individual Support Plans (ISPs) are completed at enrollment and reviewed at least annually, or more frequently as needed.
• LTSS Case Management Specialists conduct in-person contacts at regular intervals to assess participant experience and service delivery.
• The ISP documents any modifications to HCBS rights, ensuring all required federal elements are met, including:

• Assessed need
• Prior less restrictive interventions
• Proportionality
• Data collection and review
• Periodic reassessment
• Informed consent
• Assurance of no harm

Blanket or setting-wide restrictions are prohibited. Any modification must be individualized and documented through the ISP process.

D. Participant Experience and Feedback

The state gathers direct participant feedback to assess whether settings operate in compliance with HCBS requirements:

• Participant feedback is collected through routine case management contacts and structured reviews.
• Surveys and interviews assess participant experiences related to:

• Choice and autonomy
• Privacy and dignity
• Community integration
• Access to food, visitors, and daily activities

Identified concerns are addressed through follow-up actions, including additional monitoring or provider review.

E. Complaints, Incidents, and Targeted Reviews

Additional monitoring occurs through complaint and incident processes:

• Participants may report concerns through their Case Management Specialist, formal complaint processes, or the Ombudsman Program.
• Reported concerns are investigated in accordance with state procedures.
• When issues indicate potential non-compliance with HCBS settings requirements, the state may:

• Conduct targeted onsite reviews
• Require additional documentation
• Implement corrective actions

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

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

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

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

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

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

☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the**

same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

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

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Support Plan

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

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

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

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

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

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

☐ **Social Worker**
Specify qualifications:

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

The Division of Long Term Services and Supports employs Case Management Specialists who are responsible for Individual Support Plan development and ongoing case management for individuals receiving home and community-based services. LTSS Case Management Specialists assess individual needs, determine eligibility for LTSS services, coordinate services, and monitor outcomes to support individuals at risk of nursing facility placement in remaining safely in their homes and communities.

All LTSS Case Management Specialists must successfully complete a background investigation in accordance with South Dakota Codified Law (SDCL) 1-36-36.
Minimum Qualifications:

The Division hires LTSS Specialists based on a combination of education and relevant experience. Qualified applicants must meet one or more of the following criteria:
• A bachelor's degree with major coursework in social work, psychology, health, human services, or a related field; or
• Equivalent education and/or work experience demonstrating knowledge of social work principles and practices and experience working with older adults or adults with disabilities.

Required Knowledge, Skills, and Abilities

Upon hire, LTSS Case Management Specialists must demonstrate the knowledge, skills, and abilities necessary to perform person-centered case management functions, including:

Knowledge of:
• Person-centered planning and options counseling principles;
• Federal and state laws, regulations, and policies governing long-term services and supports, including home and community-based services;
• Social, cultural, economic, physical, and psychological factors affecting older adults and adults with disabilities;
• Participant rights, confidentiality requirements, and professional ethics;
• Basic social work assessment and intervention methods.

Skills and Abilities to:
• Conduct interviews, actively listen, and gather accurate and relevant information;
• Translate participant preferences and assessed needs into individualized support plans;
• Monitor progress toward Individual Support Plan goals and adjust services as needed;
• Communicate effectively and professionally, both verbally and in writing;
• Maintain accurate, timely, and complete documentation;
• Use computerized data systems to support case management activities;
• Exercise sound judgment, analyze information, and solve problems independently;
• Establish and maintain effective working relationships with participants, families, providers, and community partners.

Core Functions

LTSS Case Management Specialists perform the following functions in support of home and community-based services:
• Arrange and coordinate in-home and community services to prevent premature or unnecessary nursing facility placement;
• Accept and manage referrals, conduct comprehensive assessments, and evaluate activities of daily living, health status, social supports, and environmental factors;
• Determine the need for LTSS services and coordinate financial eligibility with appropriate agency staff;
• Providing ongoing case management, including service coordination and monitoring;
• Conduct home visits to assess participant progress and adherence to Individual Support Plans, with alternatives used when visits pose a health or safety risk;
• Assess individuals at risk of nursing facility placement or transitioning from institutional settings;
• Obtain and coordinate medical documentation, including physician orders when applicable;
• Provide information and referral regarding available long-term services and supports across the continuum of care;
• Conduct follow-up contacts after hospital or nursing facility discharges to ensure services are in place to support

safe community living.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The participant has full authority over the Individual Support Plan development process and leads the person-centered planning process where possible. The participant chooses where and when the visit to develop the Individual Support Plan will take place, and who the participant wants to participate in the meeting. The Division of Long Term Services and Supports Case Management Specialist typically meets with the participant in his/her home and includes others, e.g., authorized representative, family and/or friends whom the participant wants to include in the person-centered care planning development process. During the Individual Support Plan meeting, the LTSS Case Management Specialist provides information about the waiver, service options, and service provider options that are available to provide waiver services to the participant. The participant is informed of their choice between waiver services and institutional care and of their right to choose their providers. In the early stages of Individual Support Plan development and thereafter as needed, the participant is informed about all of the choices that are available to enable him/her to make informed decisions throughout the care planning process, i.e., choice in services (waiver and non-waiver, paid and unpaid), choice in providers.

The LTSS Case Management Specialist is available to the participant and his/her authorized representatives to answer questions, provide information, and offer support throughout the care planning process. The Regional Operations Managers, the Administrator of HCBS Operations and the HCBS Program Manager are also available to provide information and support to the participant and his/her family.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

When an individual, a member of an individual's family, an authorized representative, or other interested party makes a referral for services through LTSS by contacting (e.g., email, fax, telephone, online referral) the LTSS Dakota at Home Intake line, a standardized intake assessment is completed. The Intake Assessment includes items which are completed by the Intake Specialist under the following sections: living arrangement, health status, activities of daily living (ADLs), instrumental activities of daily living (IADLs), continence, communication, cognition, and behavior. The Intake Assessment provides information on the individual's capacities, health status, and risk factors culminating in a score of the individual's ADL and IADL deficiencies. Within the Intake Assessment, there are specific questions with prompts that note "if answered affirmatively and other criteria are met, the individual may be a candidate for HOPE waiver", for example.

Should an applicant initially present to Intake as a strong candidate for HOPE waiver by meeting the below criteria, completion of the Intake Assessment is not required. The Intake Specialist will document the specific criteria met in the intake notes. This is intended to streamline the process, reduce redundancy, and respect the individual's time.
• Confirmation of Medicaid eligibility including QMB/SLMB eligible, and
• Confirmation that the individual is receiving or is expected to receive:

o Hands-on ADL assistance from another person (or supervision/cueing with an ADL due to cognitive impairment), and/or
o Weekly Skilled Therapies (OT, PT, ST), and/or
o Mental Health Services through the CARE or IMPACT programs and/or
o Daily nursing

If the individual may be a candidate for HOPE waiver, the Intake Specialist will request to have the Department of Social Services mail a Long Term Care (LTC) Medicaid Application to the individual. Within 10-14 days of the Department of Social Services receiving the completed LTC Application back from the individual and notifying LTSS, the LTSS Case Management Specialist conducts an in-home visit to complete the Home Care Assessment (HCA), a standardized assessment tool utilized for all initial assessments and reassessments. The individual chooses if and when he/she would like to complete the assessment, and if he/she would like others to be present. The Home Care Assessment includes the individual's expressed goal of care and outcomes that the individual hopes to achieve as a result of receiving services. The HCA includes items completed by the LTSS Case Management Specialist under the following sections: living arrangement and residential history, cognition, communication and vision, mood, psychosocial wellbeing, functional status, activities of daily living, continence, disease diagnoses, health conditions, nutritional status, medications, treatments and procedures, social supports, and environmental assessment.

Algorithms embedded in the HCA trigger Clinical Assessment Protocols (CAPs). The Clinical Assessment Protocols triggers link the information gathered in the assessment to the basic need(s) referenced by a CAP. The CAPs focus on an individual's function and quality of life, including the individual's needs, strengths, and preferences in the following four broad areas:
• Functional Performance;
• Cognition and Mental Health;
• Social Life; and
• Clinical Issues.

Within these areas, one or more of the following CAPs may be triggered: Physical Activities, Instrumental Activities of Daily Living, Activities of Daily Living, Home Environment, Institutional Risk, Physical Restraints, Cognitive Loss, Delirium, Communication, Mood, Behavior, Abusive Relationship, Informal Support, Social Relationship, Falls, Pain, Pressure Ulcer, Cardio Respiratory, Undernutrition, Dehydration, Feeding Tube, Prevention, Appropriate Medications, Tobacco and Alcohol Use, Urinary Incontinence and Bowel Conditions. The triggered CAPs assist in identifying areas of improvement to be addressed in the development of the Individual Support Plan. When needs are identified, the individual and/or authorized representative of the individual indicate how each need is addressed or not addressed through paid services and unpaid supports, i.e., informal supports or other services available in the community. Each CAP that is triggered is addressed, unless the participant chooses not to address a triggered CAP CAPs that are addressed through service provision are indicated in the Individual Support Plan. Once the HCA is completed and all unmet needs are identified, the LTSS Case Management Specialist shares with the participant the type(s) of services he/she may be eligible for through the Division of Long Term Services and Supports.

When it is determined through the assessment process that an individual has an assessed need for at least one waiver

service and the individual wishes to pursue services through the waiver, the LTSS Case Management Specialist schedules a meeting with the individual to develop the Individual Support Plan within two weeks of completion of the Home Care Assessment. The LTSS Case Management Specialist asks the individual if he/she wants others, e.g., family, friends included in the person-centered Individual Support Plan development process.

Development of the person-centered Individual Support Plan includes assisting the individual in identifying his/her needs, preferences, strengths, capacities, and desired outcomes. Information gathered from the HCA and the CAPs assist in identifying these needs, preferences, and strengths of the individual, resulting in the type(s) of services needed to support the individual to continue living at home in the community.

The Individual Support Plan addresses both paid and unpaid services and supports which the individual will receive. The LTSS Case Management Specialist discusses available options for addressing unmet needs with the individual and his/her representative. The LTSS Case Management Specialist reviews the type, scope, amount, duration, and frequency of services for which the individual has an assessed need and provides the individual with an estimated cost(s) of each service contained in the Individual Support Plan. In addition to the CAPs, information on how needs are or are not addressed, the strategy to address unmet needs, and the estimated cost of services, the Individual Support Plan encompasses the individual's personal goals, emergency/disaster preparedness plan and critical service back-up plan. The individual and his/her authorized representative can choose to decline portions of or the entire Individual Support Plan. If an individual initially declines an identified service to meet an assessed need, he or she can decide at a later time to add the service(s) if the assessed need continues to be unmet.

The Individual Support Plan is signed by the individual and/or authorized representative and the Case Management Specialist. By signing the Individual Support Plan, the individual and/or authorized representative acknowledges agreement with the Individual Support Plan and the following statements:
• I have been offered the choice of all providers of services contained in this plan.
• I understand I have the right to be free from abuse and neglect and exploitation.
• I have been provided with an informational brochure on preventative health care.
• I have been provided information on home and community-based services and understand the service options that are available to me.
• I understand I have the right to choose between receiving services in my home and community and receiving services in a nursing facility.
• I understand I have the choice and the right to accept, or to refuse all or part of the services contained in this plan.
• I understand it is my responsibility to notify The Division of Long Term Services and Supports, who is responsible for monitoring my plan, of any change in my living, medical, or financial status.
• I understand I may have a financial responsibility for the services I receive.

The LTSS Case Management Specialist is responsible for ensuring the provision of services identified in the Individual Support Plan and monitoring the Individual Support Plan. Each waiver participant's Individual Support Plan is revised at least annually, or when the participant's needs change. The LTSS Case Management Specialist is responsible for amending the Individual Support Plan when the participant's needs change. A participant's change in need(s) can be identified through quarterly contacts, the six-month review, the annual review, or communication with the LTSS Case Management Specialist by the participant, his/her family or authorized representative, or service provider. The Individual Support Plan is a standardized form utilized across all Division of Long Term Services and Supports programs and services. To ensure coordination of services for the participant, paid and unpaid services and informal supports are addressed in the Individual Support Plan. The Individual Support Plan is finalized when the provider receives and acknowledges the service authorization in Therap, LTSS's Case Management System. The acknowledgment of the service authorization in Therap serves as an electronic signature.

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

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

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

☒ **A specific and individualized assessed need for the modification.**

☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**

☒ **Less intrusive methods of meeting the need that have been tried but did not work.**

☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**

☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**

☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

☒ **Informed consent of the individual.**

☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the participant are identified and assessed during the Individual Support Plan development process through the completion of the Home Care Assessment and ongoing person-centered planning activities. Identified risks and corresponding mitigation strategies are incorporated into the Individual Support Plan in a manner that reflects the participant's assessed needs, preferences, and strengths. The service planning process also includes the development of backup plans for critical services, as applicable.

Information gathered through the Home Care Assessment, including responses associated with Clinical Assessment Protocols (CAPs), assist the LTSS Case Management Specialist in identifying areas of need and potential risk. CAP triggers link assessment responses to potential problem areas and support the LTSS Case Management Specialist in identifying participants who may be at risk of decline or who may benefit from targeted interventions. CAPs are used as a clinical decision-support tool and inform, but do not replace, professional judgment. When a CAP is triggered, the LTSS Case Management Specialist discusses the identified concern with the participant and incorporates appropriate risk mitigation strategies into the Individual Support Plan. These strategies may address functional performance, cognition and mental health, social supports, and clinical considerations, as applicable.

Through the person-centered planning process, the LTSS Case Management Specialist assists the participant in identifying their strengths, preferences, and needs related to identified risks. The participant's preferences and priorities guide the development of the service plan and the selection of services, supports, and mitigation strategies. The service plan includes an Emergency and Disaster Preparedness Plan that addresses the participant's ability to prepare for and respond to emergencies such as fire, severe weather, power outages, or other natural disasters. The plan documents emergency planning information reviewed with the participant, including evacuation planning, sheltering options, access to emergency supplies, and communication strategies. The LTSS Case Management Specialist works with the participant to identify any devices, supports, or services needed during an emergency and coordinates those supports through waiver services, informal supports, or community resources, as appropriate.

Participants may also be identified as requiring a critical service back-up plan when assessed needs indicate that the absence or interruption of essential services could pose an immediate risk to health or safety. This may include participants who require ongoing supervision, services provided on a continuous or daily basis, or services without which the participant's health would be expected to decline. When a critical service back-up plan is required, the LTSS Case Management Specialist works with the participant and provider(s) to document alternative arrangements to ensure continuity of services when the primary provider is unavailable. Backup planning may include identification of alternative providers, informal supports, or other arrangements appropriate to the participant's needs and preferences.

As part of service plan development and ongoing case management, participants with identified critical service needs are informed that service delivery may be disrupted during inclement weather or other emergencies. The LTSS Case Management Specialist assists the participant in identifying individuals who may be contacted to check on the participant or respond in an emergency situation when services are delayed or unavailable.

In circumstances where a home visit cannot be safely conducted due to known risks to worker safety, the LTSS Case Management Specialist may conduct the assessment or service planning activities in an alternative setting, consistent with the participant's preferences and the requirements of person-centered planning. When an alternative setting is used, the location is selected to ensure accessibility and privacy sufficient to support meaningful participation.

When in-person visits are not feasible, the LTSS Case Management Specialist may utilize alternative methods to support ongoing monitoring of the participant's health and safety, based on individual circumstances and available resources. These methods may include remote contacts using technology, coordination with other involved professionals, scheduled check-ins, and communication with identified contacts. The use of alternative methods does not replace required in-person contacts but may be used to supplement monitoring efforts when necessary. LTSS remains committed to ensure participant health and safety and will adapt monitoring strategies as appropriate to individual needs.

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.

When a participant's needs are identified and an Individual Support Plan is developed, the participant is offered a choice of qualified service providers for the delivery of waiver services. As part of the participant's initial HOPE Waiver eligibility determination and at least annually thereafter, the LTSS Case Management Specialist develops the Individual Support Plan with the participant and/or the authorized representative through a person-centered planning process.

The Individual Support Plan includes documentation confirming that the participant has been informed of available service settings and options, including home and community-based services and the option to receive services in a nursing facility. The participant or authorized representative acknowledges, through signature of the Individual Support Plan, that information regarding service options has been provided and that the participant understands their right to choose among available settings and providers.

Participants are offered informational materials describing the services available through the HOPE Waiver. In accordance with standardized HOPE Waiver policy and procedures, the LTSS Case Management Specialist provides the participant or authorized representative with a list of qualified waiver service providers available within the participant's community for each service included in the Individual Support Plan. Provider lists include available contact information to allow the participant to independently contact providers and make informed decisions.

The LTSS Case Management Specialist may assist the participant in understanding provider options and answering general questions related to service delivery but does not select providers on the participant's behalf. Participants are encouraged to take the time necessary to choose providers that best meet their needs and preferences. The LTSS Case Management Specialist follows up with the participant as needed to support the provider selection process.

When a participant resides in an area with limited provider availability, the LTSS Case Management Specialist documents the lack of available providers and communicates this information through established channels. The Provider Operations Manager, HCBS Program Manager, and LTSS leadership may engage in provider outreach and recruitment efforts or request expansion of provider service areas, when feasible. In circumstances where waiver providers are not available, the LTSS Case Management Specialist works with the participant to identify alternative resources, including unpaid and natural supports, to address unmet needs while preserving participant choice.

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):

As described in Appendix A, DHSS/LTSS (operating agency) and DSS (Single State Medicaid Agency) have a MOU, signed by the Cabinet Secretary of each department, defining the responsibilities of each. The MOU indicates that DSS shall monitor DHS/LTSS operation of the HOPE waiver program through review of DHS/LTSS Service Plan Review and review and approve/deny all administrative rule changes related participant Individual Support Plan development.

Each quarter, LTSS provides the SSMA with a report containing the results of a review of a representative random sample of participant Individual Support Plans.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

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

☐ **Medicaid agency**

☒ **Operating agency**

☐ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Entity Responsible for Monitoring:

The Division of Long Term Services and Supports (LTSS) employs Long Term Services and Supports (LTSS) Case Management Specialists who are responsible for monitoring implementation of the Individual Support Plan and the participant's health and welfare. Monitoring activities are conducted through ongoing person-centered case management and coordination with service providers.

Monitoring Methods:

As part of the initial development of the Individual Support Plan and at least annually thereafter, the LTSS Case Management Specialist meets with the participant and/or authorized representative to review assessed needs, services, goals, and risk mitigation strategies. The Individual Support Plan documents participant acknowledgment of information regarding service options, provider choice, participant rights, and freedom from abuse, neglect, and exploitation.

The LTSS Case Management Specialist provides participants with information related to health and welfare, including abuse, neglect, and exploitation prevention and reporting, and documents acknowledgment of receipt of this information in the Individual Support Plan. Participants are informed of their right to report concerns without jeopardizing services. Services are authorized to providers following development or review of the Individual Support Plan and specify the type, scope, amount, duration, and frequency of authorized services. Providers are required to acknowledge all service authorizations prior to initiating services, in accordance with LTSS procedures.

The LTSS Case Management Specialist maintains ongoing communication with participants and providers to monitor service delivery, participant satisfaction, and changes in needs. Providers are required to notify LTSS of significant changes in participant condition, service concerns, or incidents, and to submit required incident reports consistent with contract and policy requirements.
Frequency of Monitoring:

For each waiver participant, monitoring occurs at a minimum of four times per year and includes:
• Quarterly contacts at three and nine months;
• An in-person visit at six months; and
• An in-person annual review.

In-person visits are required at the six-month and annual reviews unless an alternative location is necessary due to documented safety concerns. When an in-home visit cannot be conducted, an alternative setting is selected based on participant preference and privacy requirements.

Additional contacts occur as needed based on changes in participant condition, service delivery concerns, reported incidents, or participant requests. When a significant change in needs is identified or suspected, the LTSS Case Management Specialist conducts follow-up to determine whether reassessment or amendment of the Individual Support Plan is required.

When in-person visits are not feasible, the LTSS Case Management Specialist may utilize alternative methods to support ongoing monitoring of the participant's health and safety, based on individual circumstances and available resources. These methods may include remote contacts using technology, coordination with other involved professionals, scheduled check-ins, and communication with identified contacts. The use of alternative methods does not replace required in-person contacts but may be used to supplement monitoring efforts when necessary. LTSS remains committed to ensure participant health and safety and will adapt monitoring strategies as appropriate to individual needs.

Monitoring Health and Welfare

LTSS Case Management Specialists are mandatory reporters under South Dakota law and follow Adult Protective Services policies when abuse, neglect, or exploitation is suspected or reported. Providers are also mandated reporters and are required by contract to maintain policies and training consistent with mandatory reporting laws and to notify LTSS of incidents, concerns, or changes affecting participant health and welfare.

When contact with a participant cannot be established and there is concern for health or safety, the LTSS Case Management Specialist initiates appropriate follow-up actions, which may include requesting a welfare check consistent

with policy and local procedures.

Service Plan Updates and Amendments

The Individual Support Plan is reviewed at least annually and updated as needed based on participant request, reassessment findings, or changes in circumstances. Amendments to the plan are documented when services, goals, or strategies are added, modified, or discontinued prior to the annual review. Participant involvement and consent are documented for all plan changes.

System-Level Safeguards

While LTSS Case Management Specialists conduct direct monitoring of Individual Support Plan implementation and participant health and welfare, additional safeguards are in place to support system-wide oversight. Identified concerns and trends are reviewed through established quality assurance and incident review processes. These safeguards and quality improvement activities are described in Appendix G.

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant Individual Support Plans that address personal goals. Numerator = Number of Individual Support Plans that address personal goals. Denominator = Number of Individual Support Plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant Individual Support Plans that address health and safety risk factors. Numerator = Number of Individual Support Plans that address assessed health and safety risk factors. Denominator = Number of Individual Support Plans reviewed.

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

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participant Individual Support Plans that address all assessed needs. Numerator = Number of Individual Support Plans that address all assessed needs. Denominator = Number of Individual Support Plans reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of participant Individual Support Plans updated/revised when the participant's needs change. Numerator = Number of Individual Support Plans updated/revised when the participant's needs change. Denominator = Number of Individual Support Plans reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant Individual Support Plans updated/revised at least annually. Numerator = Number of Individual Support Plans updated/revised at least annually. Denominator = Number of Individual Support Plans reviewed.

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

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

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants who received services in the amount, duration, and frequency specified in the Individual Support Plan. Numerator = Number of participants who received services in the amount, duration, and frequency specified in the Individual Support Plan. Denominator = Number of participants reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants who received services of the type and scope specified in the Individual Support Plan. Numerator = Number of participants who received services of the type and scope specified in the Individual Support Plan. Denominator = Number of participants reviewed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants who are offered choice of waiver services. Numerator= Number of participants offered choice of waiver services. Denominator= Number of participants reviewed.

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

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

		Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participants who are offered choice of waiver providers.
Numerator= Number of participants offered choice of waiver providers.
Denominator= Number of participants reviewed.

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

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

Data Aggregation and Analysis:

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

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

The state employs and integrated quality improvement strategy to identify problems and issues within the HOPE Waiver program. Strategies for identifying issues include routine monitoring activities, performance measure reviews, targeted oversight based on identified risks, and analysis of trends across multiple data sources. These activities are designed to identify individual instances of noncompliance as well as systemic issues that may affect participant health, welfare, or access to services.

Quality improvement activities related to service planning are coordinated by the Division of Long Term Services and Supports (LTSS) through its Quality Assurance (QA) Coordinators, in collaboration with LTSS Case Management Specialists, Regional Operations Managers, and program management staff, as applicable.

Performance Measure Reviews

Issues related to Individual Support Plan development and implementation are identified through the performance measures associated with the Service Plan Assurance. QA Coordinators conduct quarterly reviews of a statistically valid random sample of participant Individual Support Plans (ISPs). These reviews evaluate compliance with waiver requirements and state policies, including:
• Inclusion of assessed needs and health and safety risk factors;
• Documentation of participant goals and preferences;
• Alignment of authorized services with assessed needs;
• Evidence of participant involvement in service planning; and
• Timeliness of service plan development and updates.

Additionally, as part of quarterly performance measure reviews, QA Coordinators review paid claims and compare them to participant Individual Support Plans to verify that services were provided according to the type, scope, duration, and frequency specified in the approved plan.

The state monitors service plan development in accordance with its policies and procedures through the review activities conducted under related Service Plan Assurance performance measures.

Record Reviews and System Monitoring

Individual Support Plans and related documentation are maintained electronically, allowing QA Coordinators to conduct reviews using established systems. When performance measures require comparison across documents or data sources, reviewers correlate assessments, service plans, and authorizations to determine compliance. Targeted or enhanced reviews may be conducted when potential issues are identified through routine monitoring, complaints, incidents, or other oversight activities.

Documentation and Tracking

Findings from performance measure reviews and other monitoring activities are documented using standardized internal tracking tools to support consistency, aggregation, and analysis. Review results identify whether applicable performance measures were met and whether follow-up or remediation is required.

Trend Analysis and Escalation

Data from completed reviews are aggregated and analyzed over time to identify trends, recurring issues, or areas of heightened risk. Trend analysis is conducted on a quarterly basis and includes review of statewide findings across multiple review cycles. Identified trends are presented to appropriate oversight bodies for consideration, including determination of whether system-level actions, policy clarification, or additional staff training may be warranted.

Continuous Quality Improvement

The identification of issues through these strategies informs the state’s continuous quality improvement efforts. Information gathered through discovery activities supports both individual-level corrective action and broader evaluation of waiver operations to ensure ongoing compliance with federal requirements and the effective delivery of services to participants.

b. Methods for Remediation/Fixing Individual Problems

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

When individual problems are identified through performance measure reviews, routine monitoring, complaints, incidents, or other oversight activities, the state takes timely action to remediate the issue and protect participant health and welfare. Remediation activities are proportional to the nature and severity of the issue identified and are designed to address both individual-level noncompliance and potential systemic deficiencies.

Remediation activities related to service planning and service delivery are coordinated by the Division of Long Term Services and Supports (LTSS) Quality Assurance (QA) Coordinators. LTSS Case Management Specialists, Regional Operations Managers, and program management staff have defined roles in remediation, oversight, and follow-up, depending on the nature of the issue identified.

Individual-Level Remediation

When issues are identified related to Individual Support Plan (ISP) development or implementation, remediation is initiated promptly by the LTSS Case Management Specialist, with oversight as appropriate.

Examples of individual-level remediation include:

ISP Content and Timeliness:
o When an ISP does not adequately address assessed needs, health and safety risk factors, or participant goals, the LTSS

Case Management Specialist revises or amends the ISP to bring it into compliance with waiver requirements and state policies. ISPs are updated based on the level and urgency of the identified issue.

Health and Welfare Concerns:
o If an identified issue presents an immediate risk to participant health or safety, the LTSS Case Management Specialist takes immediate action to ensure the participant's safety. Actions may include increased monitoring, coordination with providers or other entities, or assisting the participant in exploring alternative service or living arrangements consistent with participant choice and policy requirements.

Informed Choice of Services and Providers:
o When it is identified that a participant was not adequately informed of choices among waiver services or providers, the LTSS Case Management Specialist reviews available options with the participant and documents informed choice. If the participant elects to change providers, authorizations and service documentation are updated accordingly.

Service Delivery Variances:
o When services are not delivered in accordance with the ISP (including type, scope, amount, duration, or frequency), the LTSS Case Management Specialist reviews the variance with the participant and provider. Remediation may include ISP revision, provider communication, or assistance with transitioning to an alternative provider if services cannot be delivered as authorized.

Participant Availability or Exception Circumstances:
o When ISP development or revision is delayed due to participant unavailability (such as hospitalization), this is documented. The LTSS Case Management Specialist follows up to obtain information on the participant's status and completes ISP updates as soon as feasible upon the participant's return or availability, consistent with waiver policies.

Staff Training and Corrective Action

When individual problems are identified that result from failure to follow established policies or procedures, remediation includes targeted training or technical assistance. If patterns indicate repeated noncompliance by an individual staff member, supervisory review occurs to determine appropriate corrective action in accordance with personnel policies.

Documentation and Tracking

All remediation activities are documented using standardized internal tracking tools. Documentation reflects the issue identified, actions taken, responsible parties, and completion of remediation. This documentation supports follow-up, accountability, and aggregation of data for trend analysis.

Systemic Analysis and Remediation

Information from individual remediation activities is aggregated and analyzed on a quarterly basis to identify trends, recurring issues, or systemic deficiencies. QA Coordinators compile findings and present aggregated data to appropriate oversight bodies for review.

Oversight and Continuous Quality Improvement

Trend data, remediation outcomes, and identified areas of concern are reviewed quarterly by the Waiver Review Committee. Based on this review, the committee may recommend system-level actions such as policy clarification, process improvement, additional staff training, or other quality improvement initiatives. Implementation of approved system improvements is monitored to assess effectiveness and ensure ongoing compliance with federal and state requirements.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

Individuals served under the HOPE Waiver, or their authorized representatives, are informed of their right to request a fair hearing in accordance with 42 CFR Part 431, Subpart E, and applicable provisions of Administrative Rules of South Dakota (ARSD) Title 67.

The Division of Economic Assistance (EA), the agency responsible for Medicaid eligibility determinations, provides written notice of fair hearing rights at the time of initial application and whenever an adverse action is taken. Adverse actions may include denial, reduction, suspension, termination, or failure to act on a request for waiver eligibility or services within required timeframes.
Individuals are notified of these rights through the DSS-EA-266 Notice of Action, which is issued following receipt of an application and whenever waiver services are approved, reduced, discontinued, extended, terminated, or denied for any reason. The DSS-EA-266 explicitly informs the individual of the right to request a fair hearing, the process for doing so, applicable timeframes, and the right to representation.

The Notice of Action includes the following information:
• Right to a Fair Hearing
o Individuals may appeal any action or inaction by the Department with which they disagree.

• How to Request a Fair Hearing
o A fair hearing may be requested by submitting a signed, written request to the Office of Administrative Hearings, located at 700 Governors Drive, Pierre, SD 57501. The request must identify the action being appealed. Individuals may represent themselves or be assisted by a representative or legal counsel at their own expense.

• Timeframes for Requesting a Hearing
o Requests for a fair hearing must be made within 30 days of the date of the Notice of Action, or within 30 days after the date an action should have occurred as required by law or rule.

• Continuation of Benefits Pending Hearing
o If a hearing is requested within 10 days of the date of the Notice of Action, services may continue at the previously authorized level pending the hearing decision. If the Department’s action is upheld, the individual may be required to repay the cost of services received during this period.

Adverse action notices are maintained by the Division of Economic Assistance and are scanned into the Division’s electronic document management system.

As a condition of eligibility for Home and Community-Based Services, individuals must submit a Long-Term Care application to the Division of Economic Assistance. If an individual fails to cooperate with this requirement, a Notice of Action is issued that includes notification of fair hearing rights consistent with federal and state requirements.

Administrative rules governing the fair hearing process include:
• ARSD 67:17:02:01 – Right to hearing
• ARSD 67:17:02:02 – Right to be informed of the hearing process
• ARSD 67:17:02:04 – Time limits for requesting a hearing

Hearings are conducted pursuant to SDCL Chapter 1-26, and final decisions are issued within required federal and state timeframes. Information regarding the fair hearing process, including forms and procedural guidance, is publicly available through the Department’s website.

All individuals receiving an adverse Notice of Action under the HOPE Waiver are afforded the opportunity for a fair hearing consistent with federal Medicaid requirements.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

◉ **No. This Appendix does not apply**

○ **Yes. The state operates an additional dispute resolution process**

• **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

◉ **No. This Appendix does not apply**

○ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Do not complete this item.

• **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).

Do not complete this item.

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).

Adult Protective Services (APS), which operates within the Long Term Services and Supports (LTSS), along with law enforcement and other oversight entities, each have distinct statutory and operational roles in responding to abuse, neglect, exploitation, and other critical incidents involving waiver participants. APS investigations are conducted independently in accordance with South Dakota Codified Law (SDCL) 22-46 and APS policy. LTSS Case Management Specialist responsibilities are limited to mandatory reporting, coordination with appropriate authorities, documentation, and follow-up activities necessary to ensure participation health and welfare. Critical Incident reporting to LTSS does not replace mandatory reporting obligations under SDCL 22-46.

Definitions of Abuse, Neglect, and Exploitation

Per SDCL 22-46, Abuse, Neglect, or Exploitation of Elders or Adults with Disabilities, physical abuse is defined as "physical harm, bodily injury, attempt to cause physical harm or injury, or the infliction of fear of imminent physical harm or bodily injury." Neglect is defined as "harm to the health or welfare of an elder or an adult with a disability, without reasonable medical justification, caused by a caretaker, within the means available for the elder or disabled adult, including the failure to provide adequate food, clothing, shelter, or medical care."

Exploitation is defined in SDCL 22-46 as "the wrongful taking or exercising of control over property of an elder or a disabled adult with intent to defraud the elder or disabled adult." SDCL 22-46-3 further provides that any person who has assumed a duty to provide support and is entrusted with property of an elder or adult with a disability, and who appropriates such property for purposes not in the lawful execution of that trust, is guilty of theft by exploitation. Theft by exploitation is punishable pursuant to SDCL Chapter 22-30A.

Mandatory Reporting Requirements and Timelines

Per SDCL 22-46-9 and 22-46-10, individuals in specified professions and entities with ongoing contact with elders or adults with disabilities are mandatory reporters and must report knowledge or reasonable suspicion of abuse, neglect, or exploitation.

There are two groups of mandatory reporters, and reporting pathways differ by group.

Group One Mandatory Reporters

This group includes physicians, dentists, nurses, paramedics, emergency medical technicians, social workers, psychologists, licensed mental health professionals, counselors engaged in professional counseling, and state, county, or municipal criminal justice employees or law enforcement officers. All employees within the Division of Long Term Services and Supports, including Case Management Specialists and Reginal Operations Managers, are included in this group.

Individuals in this group must make an oral or written report within 24 hours to the Department of Human Services (DHS), law enforcement, or the State's Attorney.

Group Two Mandatory Reporters

This group includes staff of nursing facilities, Assisted Living Centers, Adult Day Centers, community support providers, residential caregivers, homemaker service providers, victim advocates, and hospital personnel involved in admission, examination, care, or treatment of elders or adults with disabilities. This group includes in-home waiver providers.

Individuals in this group must report to the person in charge of the institution or service within 24 hours. The person in charge must then make an oral or written report within 24 hours to DHS, law enforcement, or the State's Attorney. Although SDCL 22-46 allows up to 48 hours for certain institutional reporting, APS policy prioritizes prompt reporting based on risk, and most reports are received within shorter timeframes.

A mandatory reporter who knowingly fails to make a required report is guilty of a Class 1 misdemeanor.

Reasonable Suspicion

When an injury of unknown source or an allegation of a reasonable suspicion of a crime has been reported or discovered

by another individual, reasonable suspicion does not require first-hand knowledge and may be based on observation, prior experience, or reports by participants, family members, or others.

Voluntary Reporting and Reporter Protections

Any person who knows or has reason to suspect that an elder or adult with a disability has been abused, neglected, or exploited may report that information. Persons who, in good faith, make a report of abuse, neglect, or exploitation are immune from civil or criminal liability pursuant to SDCL 22-46-8.

Provider Responsibilities for Reporting Critical Incidents

In accordance with SDCL 22-46, HOPE Waiver providers are mandated reporters of suspected abuse, neglect, or exploitation. All providers must comply with applicable state laws governing mandatory reporting to Adult Protective Services (APS) and law enforcement. Critical incident reporting to LTSS does not replace or supersede mandatory reporting obligations under state law.

To ensure participant health and welfare under the HOPE Waiver, all waiver providers — including In-Home, Assisted Living (AL), Community Living Home (CLH), and Structured Family Caregiving (SFC) providers — must report critical incidents to LTSS.

Providers must submit a critical incident report to the LTSS Case Management Specialist upon discovery of any of the following involving a waiver participant:
• Use of restraint or seclusion
• A missing participant
• A serious injury
• An unexplained or unanticipated death

LTSS reviews reported incidents to determine whether additional action, coordination, or follow-up is necessary to ensure participant health and welfare. These reporting requirements are monitored through provider reviews.

Licensed Provider Reporting Requirements (ALC and CLH)

Assisted Living Centers (ALCs) and Community Living Homes (CLHs) are subject to facility-specific reporting requirements established by administrative rule (ARSD 44:70:01:07 and ARSD 44:82:01:08). Reporting instructions for these providers are maintained by the South Dakota Department of Health (DOH).

Reportable events for ALCs and CLHs include; attempted suicide; cause to suspect abuse or neglect of a resident; death resulting from other than natural causes that originated on facility property; a missing resident; fire in the facility; loss of utilities, emergency generator, fire alarm, sprinklers, or other critical equipment necessary for operation of the facility for more than twenty-four hours; and unsafe drinking water samples or samples from pools or spas.

When a DOH-reportable event occurs under facility licensure requirements, the provider must submit required reports to the State Survey Agency (SSA) through the designated online reporting portal within applicable timeframes. If there is a suspicion of abuse or neglect, reports must also be submitted to law enforcement as required by state law. Investigative findings must be forwarded to the State Survey Agency within required timeframes.

LTSS Oversight and Follow-Up for Licensed Settings

LTSS maintains responsibility for oversight of participant health and welfare under the waiver. LTSS does not duplicate investigations conducted by the Department of Health for licensure-related matters but confirms with the provider that the incident has been reported to the Department of Health in accordance with applicable licensure requirements.

When a LTSS Case Management Specialist receives a report involving a licensed setting, the Specialist confirms compliance with applicable DOH reporting requirements and advises the provider if additional reporting is required.

LTSS documents all reported incidents and coordinates, as appropriate, with APS, law enforcement, DOH, the Long Term Care Ombudsman Program, and other relevant entities.

The LTSS Critical Incident Review Team (CIRT) reviews reported incidents for patterns and trends to identify potential systemic issues and support quality improvement efforts.

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.

During an initial visit to develop the Individual Support Plan, the LTSS Case Management Specialist provides the participant and his or her authorized representative with a brochure which includes information on abuse, neglect and exploitation of elders or adults with disabilities and explains the information contained within the brochure. The brochure includes information on recognizing signs and indicators of abuse, neglect, and exploitation; South Dakota's mandatory reporting law; and how and where to report concerns. Information is provided in a manner appropriate to the participant's communication needs, with accommodations made as necessary to support understanding.

At each Annual Review of the Individual Support Plan, the LTSS Case Management Specialist discusses with the participant and his or her authorized representative the signs of abuse, neglect, and exploitation, emphasizes the participant's right to be free from abuse, neglect, and exploitation, and offers additional copies of the brochure. The participant and/or authorized representative acknowledges receipt of this information through the following statement on the Individual Support Plan: "I understand I have the right to be free from abuse and neglect. I have been provided with an informational brochure which includes information on abuse, neglect, and exploitation."

The Department of Human Services' Adult Protective services (APS) website is publicly accessible and provides information on abuse, neglect, and exploitation, including definitions and indicators, mandatory reporting requirements, and educational materials. Waiver participants and their authorized representatives may access reporting information through the APS website and are directed to the State's online reporting system or other appropriate reporting options.

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.

Per South Dakota Codified Law (SDCL) 22-46-7, a report of abuse, neglect, or exploitation (ANE) may be made to the State's Attorney, the Department of Human Services (DHS), or law enforcement (LE). The State's Attorney or law enforcement shall immediately notify DHS upon receipt of a report. These entities coordinate, as appropriate, to follow up on reports. The Medicaid Fraud Control Unit (MFCU) of South Dakota's Office of the Attorney General works with local, state, and federal partners to investigate and prosecute acts of abuse, neglect, or exploitation perpetrated by providers or against residents of health care facilities that receive federal funding.

Response to Reports Involving Immediate Risk

For reports involving life- or health-threatening conditions or suspected criminal activity, including suspected death due to abuse or neglect; physical abuse resulting in serious injury; domestic or sexual abuse; threats of serious injury or death by a caretaker; suicide risk; or the need for immediate medical attention to prevent irreversible harm, immediate action is required. In these situations, reports are made to law enforcement without delay, and appropriate coordination occurs among DHS, APS, and law enforcement in accordance with SDCL 22-46 and APS policy.

APS response and investigation activities, including collateral contacts and face-to-face contact with the alleged victim, are conducted within 24 hours, in accordance with APS policy and may vary based on the severity and nature of the allegation. In circumstances where law enforcement assumes responsibility for an investigation, APS activities may be coordinated accordingly.

Response to Reports Without Immediate Risk

For reports in which a life- or health-threatening condition does not exist (for example, medical non-compliance without immediate risk, inadequate attention to physical needs, intimidation by a caretaker, exploitation of resources, or serious but non-life-threatening self-neglect), APS initiates and conducts response activities within 48 hours, in accordance with APS policy, and face-to-face contact with the alleged victim occurs within 7 business days. Reports involving exploitation require case initiation within 48 hours of assignment and face-to-face contact with the alleged victim within 10 business days.

Specific APS timelines for case initiation and face-to-face contact are determined by the type and severity of the allegation and are governed by APS policy rather than waiver requirements.

APS Intake and Investigation

All reports of abuse, neglect, or exploitation are entered into the Adult Protective Services (APS) data management system. APS Specialists conduct screening and investigation activities in accordance with SDCL 22-46 and APS policy, which may include collateral contacts, attempts to locate and engage the alleged victim, coordination with law enforcement, and consultation with supervisors prior to case closure.

LTSS Responsibilities and Coordination

Long Term Services and Supports (LTSS) waiver program staff serve as mandatory reporters when abuse, neglect, exploitation, or other critical incidents are identified involving waiver participants. LTSS responsibilities include reporting concerns to APS and/or law enforcement as required, documenting incidents, coordinating with appropriate oversight entities, and following up to ensure participant health and welfare. LTSS waiver program staff do not conduct APS investigations.

When LTSS receives reports of abuse, neglect, exploitation, or other critical incidents involving waiver participants who reside in facilities licensed by the Department of Health (DOH), LTSS coordinates with DOH staff as appropriate. Referrals may also be made to law enforcement, the Medicaid Fraud Control Unit, or the Attorney General's Office when indicated to ensure participant safety.

Reports of suspected scams or financial exploitation may be forwarded to law enforcement and the Attorney General's Office, as appropriate.

Critical Incident Documentation and Follow-Up

DHS receives notification of critical incidents from multiple sources. When an LTSS Case Management Specialist receives a report of unexplained or unanticipated death, missing person, restraint, seclusion, or serious injury involving a waiver participant, the incident is documented in a Critical Incident (CI) case note in the state's designated case management system. In addition to waiver Critical Incident reporting requirements, Assisted Living Centers and Community Living Homes are required to report incidents involving waiver participants in accordance with DOH requirements. LTSS advises providers of applicable reporting requirements when necessary and documents follow-up actions once reports are received.

When a Case Management Specialist becomes aware of a provider that has not reported a required critical incident involving a waiver participant, the Case Management Specialist advises the provider of applicable reporting obligations and documents the follow-up.

Deaths

When an LTSS Case Management Specialist receives a report the death of a waiver participant due to natural causes, the Specialist documents the death and closes the case in accordance with the Case Discontinuation Policy.

When an LTSS Case Management Specialist receives a report of an unexplained or unanticipated death of a waiver participant residing in an Assisted Living Center or Community Living Home, the Specialist confirms with the provider that the death has been reported to the Department of Health in accordance with applicable licensure requirements. If required reporting has not occurred, the Case Management Specialist advises the provider of the reporting obligation. The Case Management Specialist also notifies the Long-Term Care Ombudsman Program, as appropriate.

When a waiver participant dies in any setting and the death is unexplained or unanticipated, the Case Management Specialist documents the death and notifies the Critical Incident Review Team (CIRT). The CIRT consults available data sources (e.g., South Dakota Health Link medical records, APS, complaint data, and prior critical incidents) to determine if additional follow up is necessary and relevant entities are informed as needed (e.g., APS, law enforcement).

Missing Persons

When a Case Management Specialist receives a report of a missing person involving a waiver participant residing in an Assisted Living Center or Community Living Home, the Case Management Specialist determines whether the incident has been reported to the Department of Health and advises the provider of reporting requirements if needed.

When a waiver participant residing in a private home, apartment, or registered residential setting is reported missing, the Case Management Specialist reports the incident to law enforcement immediately, documents the incident, and follows up with law enforcement in accordance with LTSS policy to monitor status and document updates.

Restraint and Seclusion

When restraint and/or seclusion involving a waiver participant is reported, the Case Management Specialist documents the incident and follows up with the participant to obtain additional information. If the information obtained does not give rise to reasonable suspicion of abuse, neglect, or exploitation, the Case Management Specialist may provide education regarding restraints and explore less restrictive alternatives, as appropriate. If abuse, neglect, or exploitation is suspected, the incident is reported to APS. When a report of restraint and/or seclusion involving a waiver participant residing in an Assisted Living Center or Community Living Home is received, additional follow up may also include a report to the Department of Health Complaint Coordinator and/or a referral to the Long-Term Care Ombudsman Program.

Serious Injury

When a Case Management Specialist receives a report of serious injury involving a waiver participant, the Case Management Specialist documents the incident in a Critical Incident (CI) case note in the state's designated case management system and completes appropriate follow-up to determine whether additional services are needed.

Other Critical Incidents

When a Case Management Specialist receives a report of a critical incident other than unexplained or unanticipated death,

missing person, restraint, seclusion, or serious injury involving a waiver participant, the incident is documented and reviewed in accordance with LTSS policy to determine whether additional assessment or services are needed.

If abuse, neglect, or exploitation is suspected in connection with any reported incident, the Case Management Specialist ensures the concern is reported to Adult Protective Services.

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

The Department of Human Services' Division of Long Term Services and Supports (LTSS) is the operating agency for this waiver and is responsible for programmatic oversight of critical incidents and events affecting waiver participants. Oversight is ongoing and includes monitoring reports of alleged abuse, neglect, and exploitation, as well as other critical incidents and events, regardless of how reports are received (e.g., phone, written, or electronic submission). Oversight activities are consistent across reporting methods.

LTSS oversight functions include ensuring that required reports are made, appropriate coordination occurs with Adult Protective Services (APS), law enforcement, the Department of Health, and other oversight entities as applicable, and that documentation and follow-up activities necessary to ensure participant health and welfare are completed. LTSS waiver program staff do not conduct APS investigations. APS investigations are conducted independently in accordance with South Dakota Codified Law (SDCL) 22-46 and APS policy.

Critical Incident Review Team (CIRT)

A Critical Incident Review Team (CIRT), consisting of LTSS State Office program staff and led by the HCBS Program Manager, meets on a monthly basis to review reported critical incidents and events. The CIRT reviews incidents involving unexplained or unanticipated death, missing person, restraint, seclusion, or serious injury that occurred one to two months prior to ensure required reporting, coordination, documentation, and follow-up actions were completed in accordance with Critical Incident Reporting requirements and applicable policies. All critical incident reviews include a screening for potential abuse, neglect, and exploitation (ANE). CIRT confirms with the APS Program Manager that all incidents involving ANE have been reported appropriately. The APS Program Manager is responsible for reviewing all ANE of HOPE wavier participants to ensure follow-up occurs within appropriate timeframes.

Reports generated from the state's designated case management and APS systems are used to monitor incident reporting and follow-up activities, including timeliness. When gaps in reporting, documentation, or follow-up are identified, the responsible LTSS Specialist is notified to ensure participant safety concerns are addressed and required actions are completed and appropriately documented.

In addition to monitoring compliance, the CIRT analyzes incident data to identify patterns and trends and to inform quality improvement strategies aimed at reducing and preventing future incidents.
As part of its responsibilities, the CIRT conducts routine monitoring of unexplained or unanticipated deaths of waiver participants. Available death-related information is reviewed to determine if the death was unexplained or unanticipated. Coordination with Adult Protective Services, law enforcement, the Department of Health, or other oversight entities, will occur as necessary to resolve concerns. The CIRT will review the data for trends that may warrant additional review and follow-up.

Provider Oversight

In accordance with waiver provider contracts, providers are required to maintain written policies for abuse, neglect, and exploitation reporting that comply with mandatory reporting laws and to provide annual training to staff on these requirements. LTSS monitors provider compliance with these requirements through enrollment and provider reviews conducted in accordance with provider oversight processes.

Appendix G: Participant Safeguards

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

3)

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

◉ **The state does not permit or prohibits the use of restraints**

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

The South Dakota Department of Health (DOH), through the Office of Health Facilities Licensure and Certification, is responsible for oversight of the use of restraints in Assisted Living Centers and Community Living Homes. The Office of Health Facilities Licensure and Certification identifies potential unauthorized use of restraints through complaints, unannounced onsite surveys, and record reviews. When concerns are identified, DOH conducts follow-up activities in accordance with licensure and certification requirements to ensure resident rights are protected.

The South Dakota Long-Term Care Ombudsman Program receives and documents complaints related to the use of restraints in Assisted Living Centers and Community Living Homes and makes referrals as appropriate. Ombudsman staff collaborate with DOH to address concerns related to unauthorized restraint use and regularly provide resident rights education to residents and staff. The Long-Term Care Ombudsman Program conducts routine visits to Assisted Living Centers and responds to complaints on behalf of residents in both Assisted Living Centers and Community Living Homes.

Oversight in Home and Community-Based Settings

The Division of Long Term Services and Supports (LTSS) is responsible for monitoring for potential unauthorized use of restraints in home and community-based waiver settings. The use of restraints in these settings is uncommon; however, LTSS Case Management Specialists may identify concerns through direct contact with participants during required visits and periodic monitoring activities.

As part of ongoing assessment and monitoring, LTSS Case Management Specialists complete the Home Care Assessment (HCA) at required intervals. The HCA includes items related to physical restraint use, regardless of stated intent. Information collected through the HCA and participant interactions is used to assess participant needs, safety, and freedom of movement and to inform person-centered planning. During the in-person six-month review, a Service Experience Assessment (SEA) is completed with the participant. The SEA also includes a survey question related to restraint.
When assessment results or observations indicate potential restraint use, LTSS works with the participant and, as appropriate, the authorized representative to address the underlying need in a manner consistent with person-centered planning principles. This includes identifying alternatives to restraint and incorporating appropriate paid and unpaid supports to promote safety while maximizing independence and freedom of movement.

Training and Identification

LTSS Case Management Specialists receive training on identifying potential restraint use, including observational indicators that may limit a participant’s freedom of movement. Training emphasizes recognizing both physical and environmental practices that may function as restraints and reinforces the expectation that participants receiving waiver services have the right to freedom from unnecessary restraint.

Coordination with Adult Protective Services

When LTSS identifies potential unauthorized restraint use that may constitute abuse, neglect, or exploitation, the concern is reported to Adult Protective Services (APS) in accordance with mandatory reporting requirements. APS reviews and investigates such reports in accordance with South Dakota Codified Law (SDCL) 22-46 and APS policy.
In addition to required reporting, LTSS coordinates with the participant and authorized representatives, as appropriate, to support the discontinuation of unauthorized restraints and to address the underlying causes through appropriate services, supports, and environmental modifications.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

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

The South Dakota Department of Health (DOH), through the Office of Health Facilities Licensure and Certification, is responsible for oversight of the use of restrictive interventions in Assisted Living Centers and Community Living Homes. The Office of Health Facilities Licensure and Certification identifies potential unauthorized use of restrictive interventions through complaints, unannounced onsite surveys, and record reviews. When concerns are identified, DOH conducts follow-up activities in accordance with licensure and certification requirements to ensure resident rights are protected.

The South Dakota Long Term Care Ombudsman Program receives and documents complaints related to restrictive interventions in Assisted Living Centers and Community Living Homes and makes referrals as appropriate. Ombudsman staff collaborate with DOH to address concerns related to unauthorized restrictive interventions and regularly provide resident rights education to residents and staff. The Long Term Care Ombudsman Program conducts routine visits to Assisted Living Centers and responds to complaints on behalf of residents in both Assisted Living Centers and Community Living Homes.

Oversight in Home and Community-Based Settings

The Division of Long Term Services and Supports (LTSS) is responsible for monitoring for potential unauthorized use of restrictive interventions in home and community-based waiver settings. Restrictive interventions may include actions that limit a participant's rights, freedom of movement, access to others or activities, use of restraint, or seclusion. The use of restrictive interventions in home settings is uncommon; however, LTSS Case Management Specialists may identify concerns through direct contact with participants during required visits and periodic monitoring activities.

As part of ongoing monitoring, LTSS Case Management Specialists engage participants in discussion regarding their experience with services, including whether they feel restricted, restrained, or secluded. Information gathered through participant interaction and assessment activities is used to evaluate participant safety, autonomy, and compliance with person-centered planning requirements.

Response and Coordination

When potential unauthorized use of restrictive interventions is identified, LTSS works with the participant and, as appropriate, the authorized representative to address the underlying need in a manner consistent with person-centered planning principles. This includes identifying alternatives to restrictive interventions and incorporating appropriate paid and unpaid supports to promote safety while respecting participant rights, autonomy, and freedom of movement.

If information gathered gives rise to reasonable suspicion of abuse, neglect, or exploitation, the concern is reported to Adult Protective Services (APS) in accordance with mandatory reporting requirements. APS reviews and investigates such reports in accordance with South Dakota Codified Law (SDCL) 22-46 and APS policy.

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

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

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

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

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

The South Dakota Department of Health (DOH), through the Office of Health Facilities Licensure and Certification, is responsible for oversight of the use of seclusion in Assisted Living Centers and Community Living Homes. The Office of Health Facilities Licensure and Certification identifies potential unauthorized use of seclusion through complaints, unannounced onsite surveys, and record reviews. When concerns are identified, DOH conducts follow-up activities in accordance with licensure and certification requirements to ensure resident rights are protected.

The South Dakota Long-Term Care Ombudsman Program receives and documents complaints related to seclusion in Assisted Living Centers and Community Living Homes and makes referrals as appropriate. Ombudsman staff collaborate with DOH to address concerns related to unauthorized seclusion and regularly provide resident rights education to residents and staff. The Long-Term Care Ombudsman Program conducts routine visits to Assisted Living Centers and responds to complaints on behalf of residents in both Assisted Living Centers and Community Living Homes.

Oversight in Home and Community-Based Settings

The Division of Long Term Services and Supports (LTSS) is responsible for monitoring for potential unauthorized use of seclusion in home and community-based waiver settings. Seclusion includes actions that isolate a participant or restrict freedom of movement or access to others without consent. The use of seclusion in home settings is uncommon; however, LTSS Case Management Specialists may identify concerns through direct contact with participants during required visits and periodic monitoring activities.

Information gathered through participant interaction and assessment activities is used to evaluate participant safety, autonomy, and compliance with person-centered planning requirements.

Response and Coordination

When potential unauthorized use of seclusion is identified, LTSS works with the participant and, as appropriate, the authorized representative to address the underlying need in a manner consistent with person-centered planning principles. This includes identifying alternatives to seclusion and incorporating appropriate paid and unpaid supports to promote safety while respecting participant rights, autonomy, and freedom of movement.

If information gathered gives rise to reasonable suspicion of abuse, neglect, or exploitation, the concern is reported to Adult Protective Services (APS) in accordance with mandatory reporting requirements. APS reviews and investigates such reports in accordance with South Dakota Codified Law (SDCL) 22-46 and APS policy.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are

available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication management and follow-up requirements under the HOPE Waiver apply only to licensed residential settings in which the provider has round-the-clock responsibility for the health and welfare of residents. These settings include Assisted Living Centers and Community Living Homes.

Assisted Living Centers

Entity Responsible for Monitoring:
Medication management and follow-up for waiver participants residing in Assisted Living Centers is monitored by the South Dakota Department of Health (DOH) through its licensure and regulatory oversight authority, in conjunction with the Assisted Living Center and licensed medical professionals involved in resident care. The Administrative Rules of South Dakota (ARSD) regarding Assisted Living Centers can be found in ARSD 44:70; ARSD 20:48:04:01; South Dakota Codified Law 34-12.

Methods of Monitoring:
Monitoring of participant medication regimens is conducted through:
• DOH licensure surveys and onsite inspections conducted in accordance with state licensing requirements
• Investigation of complaints and critical incidents related to medication administration or management
• Facility-level policies and procedures governing medication administration, storage, documentation, and disposal
• Ongoing clinical oversight by licensed nursing staff, when applicable
• Monthly pharmacist reviews for residents who require medication administration, including review of diagnoses, medication regimens, laboratory findings, and dietary considerations, with documented recommendations provided to the resident's prescribing practitioner and facility administrator

Frequency of Monitoring:
• DOH licensure surveys and complaint investigations are conducted in accordance with state regulatory schedules and as issues are identified
• Pharmacist medication regimen reviews are conducted monthly for residents receiving medication administration
• Licensed nurse reviews of resident care and condition are conducted when required, at intervals specified by state regulation based on facility staffing and approval status
• Evaluation of a resident's continued ability to self-administer medications is conducted at least every three months when applicable

Community Living Homes

Entity Responsible for Monitoring:
Medication management and follow-up for waiver participants residing in Community Living Homes is monitored by the South Dakota Department of Health (DOH) through licensure and regulatory oversight, in coordination with the Community Living Home provider. The Administrative Rules of South Dakota (ARSD) regarding Homes can be found in ARSD 44:82:05 and South Dakota Codified Law 34-12-13.

Methods of Monitoring:
Monitoring of participant medication regimens is conducted through:
• DOH licensure surveys and onsite inspections
• Investigation of complaints and critical incidents
• Review of facility compliance with state requirements related to medication labeling, storage, access control, administration, and disposal
• Verification that medications are administered only by authorized individuals or self-administered in accordance with state rules

Frequency of Monitoring:
• DOH licensure surveys and complaint investigations are conducted in accordance with state regulatory requirements and as issues are identified
• Medication-related practices are reviewed during each applicable licensure inspection and during any investigation involving medication concerns

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.

The State ensures that waiver participant medications are managed appropriately in licensed residential settings through regulatory oversight conducted by the South Dakota Department of Health (DOH), Office of Health Facilities Licensure & Certification. Oversight applies to Assisted Living Centers and Community Living Homes in which the provider has round-the-clock responsibility for participant health and welfare.

(a) Identification of Potentially Harmful Medication Practices
Potentially harmful medication practices are identified through multiple oversight mechanisms, including:
• DOH licensure surveys and onsite inspections, during which medication administration, storage, documentation, and disposal practices are directly observed
• Review of resident records, including medication administration records and related clinical documentation
• Monthly pharmacist reviews of medication regimens for residents receiving medication administration in Assisted Living Centers and Community Living Homes, including identification of contraindicated medications, duplicative therapies, adverse reactions, or other drug therapy irregularities
• Investigation of complaints and critical incidents involving medication errors, adverse drug events, or unsafe practices
• Review of staff credentials and training records for individuals authorized to administer medications

(b) Follow-Up on Potentially Harmful Practices
When potentially harmful medication practices are identified, the State ensures follow-up through:
• Issuance of deficiencies and required plans of correction outlining corrective actions and timelines
• Technical assistance provided by DOH survey staff to address identified deficiencies
• Verification of corrective actions through documentation review, follow-up surveys, or additional onsite inspections as warranted
• Referral to appropriate licensing or regulatory entities, including the South Dakota Board of Nursing or other professional boards, when indicated
• Additional surveys or investigations conducted when complaints or incidents suggest ongoing or unresolved medication-related risks

Assisted Living Centers and Community Living Homes may be surveyed more frequently than the standard licensure cycle when medication-related concerns are identified.

(c) State Agency Responsible for Oversight and Follow-Up
The South Dakota Department of Health, Office of Health Facilities Licensure & Certification, is responsible for oversight and follow-up related to medication management practices in Assisted Living Centers and Community Living Homes. The Department coordinates with other regulatory entities, as appropriate, to address medication-related deficiencies and ensure participant health and welfare.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies

concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State policies governing medication administration and participant self-administration under the HOPE Waiver apply to licensed residential settings in which the provider has round-the-clock responsibility for participant health and welfare, including Assisted Living Centers and Community Living Homes. These policies are established through South Dakota statutes, administrative rules, and licensing requirements, which are available to CMS upon request.

Medication Administration by Waiver Providers

Medication administration may be performed only by individuals who are licensed or authorized under South Dakota law to administer medications. When medication administration is delegated to unlicensed personnel, delegation and supervision must be conducted in accordance with South Dakota Board of Nursing rules governing nursing delegation. A licensed nurse remains responsible for assessing participant needs, determining whether delegation is appropriate, verifying staff competency, and providing ongoing supervision.

Certain medication administration tasks may be delegated to unlicensed staff only under defined conditions and written protocols developed by a registered nurse. Other medication administration tasks may not be delegated and must be performed by licensed nursing personnel. Delegation practices must comply with all applicable state laws and regulations.

Participant Self-Administration of Medications

Assisted Living Centers and Community Living Homes must maintain written policies and procedures governing participant self-administration of medications. A participant may self-administer medications only when a licensed practitioner or supervising nurse has determined that the practice is safe and appropriate.

For participants who self-administer medications:
• The provider must clearly document responsibility for medication storage and administration
• The participant’s ability to self-administer must be periodically reassessed in accordance with state regulatory requirements
• The provider must ensure that self-administration occurs with appropriate oversight to protect participant health and safety

Assisted Living Center Requirements

Assisted Living Centers that provide medication administration services must be approved by the South Dakota Department of Health (DOH) to do so and must comply with state requirements related to:
• Physician or practitioner medication orders
• Medication storage, labeling, and control
• Supervision of self-administration
• Disposal of discontinued or outdated medications
• Training and supervision of staff involved in medication administration

Community Living Home Requirements

In Community Living Homes, medications must be administered only by authorized individuals or self-administered by residents in accordance with state law. Providers must comply with requirements governing:
• Secure storage of medications
• Proper labeling and handling
• Refrigeration of medications, when applicable
• Safe disposal of discontinued or expired medications

- **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:

Providers responsible for medication administration in licensed residential settings, including Assisted Living Centers and Community Living Homes, are required to record medication errors in accordance with state law and licensing requirements. Medication error information is maintained by the provider and made available to the State upon request.

Types of Medication Errors Required to Be Recorded

Medication errors that must be recorded include, but are not limited to:
• Administration of the wrong medication
• Administration of the wrong dose
• Administration at the wrong time
• Omission of a scheduled medication dose
• Administration of a medication to the wrong participant
• Administration of a medication without a valid order
• Improper route of administration
• Failure to document medication administration accurately
• Adverse drug reactions or side effects related to medication administration
• Errors related to storage, labeling, or disposal that could affect participant safety

Reporting and Follow-Up

Medication errors and adverse drug reactions must be documented in the participant's record and reported to the participant's prescribing physician, physician assistant, or nurse practitioner, as required by state regulation.

Medication errors that involve or are suspected to involve abuse, neglect, or exploitation must be reported to the South Dakota Department of Health in accordance with mandatory reporting requirements.

All recorded medication errors are subject to review during licensure surveys, complaint investigations, or upon request by the South Dakota Department of Health, Office of Health Facilities Licensure & Certification.

• **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.

The South Dakota Department of Health (DOH), Office of Health Facilities Licensure & Certification, is responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants residing in licensed residential settings, including Assisted Living Centers and Community Living Homes.

Methods of Monitoring

State oversight of medication administration practices is conducted through:
• Unannounced onsite licensure surveys and inspections
• Observation of medication administration and review of medication storage, documentation, and control practices
• Review of medication administration records and related resident documentation
• Investigation of complaints and allegations involving medication administration, abuse, neglect, or unsafe practices
• Follow-up surveys or investigations when deficiencies or medication-related concerns are identified

Frequency of Monitoring
• Licensure surveys are conducted in accordance with state regulatory requirements and licensure cycles
• Additional onsite surveys, inspections, or investigations are conducted as needed in response to complaints, critical incidents, or identified medication-related risks

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:
Number and percent of incidents of abuse, neglect, and exploitation that were reported appropriately. Numerator = incidents of abuse, neglect, and exploitation that were reported appropriately. Denominator = number of incidents documented in records sampled.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of abuse, neglect and exploitation investigations initiated within specified timeframes. Numerator = Number of abuse, neglect, and exploitation investigations initiated within specified timeframes. Denominator = Total number of abuse, neglect, and exploitation investigations.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Journal entries in SAMS and provider incident reports in File Director

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver participants who receive educational information regarding abuse, neglect, and exploitation. Numerator = Number of participants who received educational information regarding abuse, neglect, and exploitation. Denominator = Number of participants reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of percent of waiver participants who have Individual Support Plans which address back up plans and emergency preparedness as appropriate. Numerator = Number of participants with Individual Support Plans that address back up plans and emergency preparedness as appropriate. Denominator = Number of participants reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents (death, missing person, serious injury) where appropriate follow-up occurred. Numerator = Number of critical incidents (death, missing person, serious injury) where appropriate follow-up occurred. Denominator = All critical incidents.

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

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of complaints regarding providers that were addressed within required timeframes. Numerator = Number of complaints regarding providers that were addressed within required timeframes. Denominator = All complaints regarding providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data will be collected from Ombudsmanager and Therap data bases

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of reported incidents of restraint and seclusion where appropriate follow-up occurred. Numerator = reported incidents of restraint and seclusion where appropriate follow-up occurred. Denominator = All reported incidents of restraint and seclusion.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data will be collected from Therap database where information on critical incident reports received and all follow up is documented.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver participants who reported they were not restrained or secluded while receiving waiver services. Numerator = Number of respondents who reported they were not restrained or secluded while receiving waiver services. Denominator = Number of total respondents.

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who received age appropriate educational information regarding preventative health care. Numerator = Number of participants who received age appropriate educational information regarding preventative health care. Denominator = Number of participants reviewed.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver participants who received age appropriate preventative health care. Numerator = Number of participants who received age appropriate preventative health care. Denominator = Number of participants reviewed.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

The state employs targeted quality improvement strategies to identify issues related to participant health, welfare, and safeguards within the HOPE Waiver program. These strategies focus on the discovery of concerns involving critical incidents, complaints, restrictive practices, and other events that may place participants at risk. The identification of issues through these mechanisms supports timely intervention and informs broader quality improvement activities.

Oversight and issue identification activities described in this appendix are coordinated by the Division of Long Term Services and Supports (LTSS) through designated review teams and program staff, including the Critical Incident Review Team (CIRT), Quality Assurance (QA) Coordinators, and waiver program management, as applicable.

Critical Incident and Event Monitoring

Issues related to participant health and welfare are identified through the review of reported critical incidents and events. Critical incident data are collected through the state's electronic reporting system and reviewed on a monthly basis to ensure that required follow-up actions were completed in accordance with policy and within established timeframes.
Review activities focus on identifying:
• Incidents that were not reported timely or lacked appropriate follow-up;
• Patterns indicating increased risk to participants; and
• Any occurrence of prohibited practices, including restraint or seclusion.

Findings from incident reviews are tracked and analyzed to identify recurring issues or trends that may warrant additional oversight or corrective action.

Complaint Monitoring and Analysis

Issues may also be identified through complaint monitoring processes. Complaint data are obtained from internal systems and reports provided by external oversight entities, including the Ombudsman Program. Complaint reports and supporting documentation are reviewed monthly to verify that complaints were addressed within required timeframes and resolved in accordance with policy.

Complaint data are analyzed to identify trends or patterns that may indicate systemic concerns related to participant rights, provider practices, or compliance with HCBS requirements, including the HCBS Settings Rule.

Participant Safeguards and Prohibited Practices

Participant safeguards, including emergency preparedness and backup planning requirements, are monitored through applicable performance measure reviews and incident reporting processes. Data related to restrictive interventions, including restraint or seclusion, are reviewed through multiple sources, including incident reports and participant survey responses. Any indication of restraint or seclusion is reviewed to ensure appropriate follow-up and compliance with waiver prohibitions. Data from these reviews are aggregated and analyzed to identify potential systemic risks or noncompliance.

Documentation, Tracking, and Trend Analysis

Findings from critical incident reviews, complaint monitoring, and related oversight activities are documented using standardized internal tracking methods to support consistency and analysis. Review results identify whether required actions were completed and whether further follow-up or escalation is necessary.

Data are aggregated and reviewed on a regular basis, including quarterly trend analysis, to identify recurring issues, emerging risks, or areas requiring additional oversight.

Escalation and Continuous Quality Improvement

Identified trends or significant findings related to participant health and welfare are escalated to appropriate waiver oversight bodies for review and determination of next steps. Information gathered through these issue identification activities informs continuous quality improvement efforts, including targeted monitoring, policy clarification, provider outreach, or training activities, as appropriate.

b. Methods for Remediation/Fixing Individual Problems

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

The state employs targeted remediation methods to address individual problems related to participant health, welfare, and safeguards identified through the oversight activities described in Appendix G. Remediation activities focus on ensuring timely follow-up, mitigating risk to participants, and verifying that appropriate corrective actions have been completed.

Remediation activities are coordinated by the Division of Long Term Services and Supports (LTSS) and carried out by

designated staff, including LTSS Case Management Specialists, the Critical Incident Review Team (CIRT), Quality Assurance (QA) Coordinators, and waiver program management, as applicable.

Individual-Level Remediation

When issues are identified through critical incident reviews, complaint monitoring, or other safeguard-related oversight activities, remediation actions are initiated promptly to address the specific concern and ensure participant safety. Individual-level remediation may include:
• Verification that required follow-up actions related to incidents or complaints were completed in accordance with policy;
• Coordination with providers or other responsible parties to ensure corrective actions are implemented;
• Additional participation contact or monitoring to confirm health and welfare concerns have been resolved; and
• Referral to other oversight entities, including Adult Protective Services, when required by policy.

Remediation activities and outcomes are documented to demonstrate that identified risks have been addressed and that appropriate safeguards are in place.

Validation of Corrective Actions

The state verifies completion of required corrective actions through review of documentation, follow-up reporting, or additional oversight activities, as appropriate to the nature of the issue. Verification activities ensure that remediation efforts resulted in meaningful resolution of the identified concern and reduced risk to the participant.

If corrective actions are incomplete, inadequate, or not implemented within required timeframes, additional follow-up actions are initiated until compliance is achieved.

Systemic Issues and Escalation

When recurring issues or trends are identified through aggregation and analysis of incident, complaint, or safeguard-related data, the state evaluates whether broader system-level remediation is necessary. Systemic issues are escalated to appropriate waiver oversight bodies for review and determination of next steps.

System-level remediation may include policy clarification, targeted technical assistance, provider outreach, additional monitoring activities, or staff training, as appropriate. Actions taken to address systemic issues are tracked and monitored to assess effectiveness over time.

Documentation and Continuous Quality Improvement

Remediation actions and outcomes are documented using standardized internal methods to support consistency, tracking, and analysis. Information gathered through remediation activities informs the state's continuous quality improvement efforts and supports ongoing evaluation of participant health and welfare protections within the HOPE Waiver.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

System Improvement Identification and Analysis

Data aggregation, trending, and analysis of discovery and remediation information for the HOPE Waiver are conducted on an ongoing basis by the Quality Assurance (QA) Coordinators, in collaboration with HOPE Waiver program leadership. Information reviewed includes performance measure results, critical incident data, complaint and grievance data, Individual Support Plan reviews, provider monitoring activities, and remediation outcomes.

Trend identification occurs concurrently with data analysis and focuses on identifying recurring issues, patterns of noncompliance, gaps in policy or process, and areas presenting potential risk to participant health and welfare or program integrity.

Review and Oversight

Identified trends, emerging issues, and proposed areas for system improvement are presented quarterly to the Waiver Review Committee. The Waiver Review Committee includes representation from program leadership, field operations, provider operations, quality assurance, and regional management.

The role of the Waiver Review Committee is to:
• Review aggregated data and trend analyses,
• Provide oversight of identified system issues,
• Validate prioritization decisions, and
• Support communication and implementation of system improvements.

The Committee serves as an advisory and oversight body and is not solely responsible for generating improvement initiatives.

Prioritization of System Improvements

System improvement priorities are determined by HOPE Waiver program leadership, informed by data analysis and Waiver Review Committee input. Prioritization considers the following criteria, as applicable:
1. Compliance with federal and state regulatory requirements
2. Risk to participant health and welfare
3. Scope and frequency of the issue (volume)
4. Financial impact on the waiver or Medicaid program
5. Potential impact of the improvement
6. Feasibility of implementation given available resources
7. Likelihood of achieving measurable improvement

Not all criteria must be met for an issue to be prioritized; rather, criteria are applied based on the nature of the issue identified.

Design and Implementation of System Improvements

Once a system improvement need is identified, the design and development of corrective actions or system changes are led by the HCBS Program Manager in coordination with appropriate program staff. Depending on the nature of the improvement, implementation activities may include:
• Revisions to waiver policy or procedures,
• Clarification of existing requirements,
• Development of guidance documents or tools,
• Targeted staff training or technical assistance,
• Provider education or communication, and/or
• Modifications to internal workflows or monitoring processes.

Implementation activities are managed by HOPE Waiver program leadership and may involve QA Coordinators, LTSS Case Management Specialists, Regional Operations staff, and other Division staff as appropriate.

Communication, Training, and Monitoring

System improvements are communicated to staff and stakeholders through a combination of written guidance, policy updates, webinars, meetings, and direct communication, as appropriate. Training is provided when changes impact staff roles, responsibilities, or procedures.

Progress on system improvement initiatives is monitored through ongoing data collection, follow-up reviews, and performance measure monitoring. Updates on system improvement activities and outcomes are reported during quarterly Waiver Review Committee meetings.

Staff Development and Continuous Improvement

When data analysis identifies trends indicating inconsistent application of waiver requirements or policies by staff, targeted staff development or corrective action strategies are implemented. These may include additional training, clarification of expectations, supervisory oversight, or revisions to guidance materials.
Coordination with Internal Waiver Review Committee

The Internal Waiver Review Committee (IWRC), comprised of HCBS Waiver Program Managers, Medicaid Agency representatives, and other departmental stakeholders, also serves as a forum for sharing trend data, discussing cross-waiver issues, and coordinating system improvements. Information related to HOPE Waiver trends, system changes, and improvement initiatives is shared at quarterly IWRC meetings, and meeting minutes are maintained by the Medicaid Agency.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Monitoring and analysis of the effectiveness of system design changes under the HOPE Waiver is an ongoing process embedded within the waiver's quality assurance and quality improvement activities. Quality Assurance (QA) Coordinators conduct routine monitoring through performance measure reviews, discovery activities, remediation tracking, and follow-up analyses to assess whether implemented system design changes are achieving the intended outcomes.

Issues of noncompliance, recurring deficiencies, or emerging risks identified through discovery activities are documented, aggregated, and analyzed by QA Coordinators in collaboration with HOPE Waiver program leadership. Trends indicating potential system-level issues or ineffective system design changes are identified through repeated findings, lack of improvement over time, or evidence of continued risk to participant health and welfare or program integrity.

Identified trends, analyses, and proposed adjustments to system design changes are presented quarterly to the Waiver Review Committee for review and oversight. The Waiver Review Committee reviews aggregated data and evaluates whether implemented changes are resulting in measurable improvement, stabilization, or continued deficiencies. The Committee provides input on whether additional monitoring, time for implementation, or further system adjustments may be warranted.

Decisions regarding modification, continuation, or expansion of system design changes are led by HOPE Waiver program leadership. When additional system changes are needed, corrective actions or design modifications are developed and implemented by program leadership in coordination with QA Coordinators, LTSS Case Management Specialists, Regional Operations staff, and State Office Program staff, as appropriate.

The effectiveness of system design changes is assessed using objective indicators, including:
• Changes in performance measure results,
• Trends in discovery and remediation data,
• Reduction in repeat or systemic findings, and
• Evidence of improved compliance with waiver requirements and protection of participant health and welfare.

Information regarding system design changes, monitoring results, and outcomes is shared quarterly with internal stakeholders through the Waiver Review Committee and the Internal Waiver Review Committee (IWRC). Targeted information related to specific system changes is communicated to providers and other stakeholders with a primary interest in the improvement area, as appropriate.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The quality improvement strategy for the HOPE Waiver is evaluated on an ongoing and periodic basis through structured review of performance data, trend analyses, and system improvement activities. Quality Assurance (QA) Coordinators, in collaboration with HOPE Waiver program leadership, conduct regular analysis of performance measure results, remediation outcomes, and system improvement progress to assess the effectiveness of the quality improvement strategy.

At least quarterly, aggregated data, identified trends, and updates on system improvement initiatives are presented to the Waiver Review Committee for review and oversight. The Waiver Review Committee reviews information from prior quarters, assesses whether identified strategies are resulting in measurable improvement, and provides input on whether adjustments to quality improvement approaches are warranted.

The evaluation process includes:
• Comparison of performance results to establish benchmarks or expected outcomes,
• Analysis of trends indicating improvement, stagnation, or decline,
• Review of remediation activities to identify recurring or systemic issues, and
• Assessment of whether current discovery, remediation, and improvement strategies remain effective and appropriate.

At least annually, HOPE Waiver program leadership completes a formal review of the overall Quality Improvement Strategy to determine whether revisions are needed to performance measures, monitoring approaches, remediation methods, or system improvement processes. Revisions to the Quality Improvement Strategy are made as necessary based on evaluation findings and are implemented through updates to policy, procedures, guidance, and training.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Independent Audits and Oversight

Providers enrolled to furnish HOPE Waiver services are subject to audit requirements consistent with the Single Audit Act, as applicable. Independent audits meeting Single Audit Act requirements are conducted and overseen by the Department of Social Services (DSS) Program Integrity Unit (PIU).

In addition, the South Dakota Department of Legislative Audit conducts an annual independent audit of the DSS Medicaid program, which includes review of waiver services. These audits provide external oversight of financial integrity and compliance with federal and state Medicaid requirements.

Program Integrity Unit (PIU) Responsibilities

Pursuant to 42 C.F.R. Part 456, South Dakota Medicaid maintains a Program Integrity Unit (PIU) responsible for safeguarding against unnecessary or inappropriate utilization of Medicaid services and for identifying and recovering improper payments. The PIU conducts post-payment reviews to monitor provider billing practices and service delivery across Medicaid programs, including the HOPE Waiver.

The PIU has authority to recover overpayments regardless of whether payment errors were caused by provider billing practices or state processing errors. Depending on claim age, PIU may void claims or require repayment. When recoupments occur, the PIU coordinates with the DSS finance division to ensure appropriate federal financial participation (FFP) adjustments.

Financial Audit Methods, Scope, and Frequency

Post-Payment Reviews and Desk Audits

The PIU conducts annual desk audits using statistically valid sampling methodologies. These audits include a random sample of personal care services and at least one additional waiver service annually. Sampling is conducted using RAT-STATS (OIG software) to ensure statistical validity.

In addition, an annual internal post-payment review of waiver provider claims is completed using a random sample of paid claims data. Ten percent of paid claims for each reviewed service are sampled. The following services are reviewed annually:
• Personal Care
• Homemaker
• Chore
• In-home Nursing

Additional waiver services may be selected for review based on emerging trends or identified risk.

Targeted and Risk-Based Reviews

The PIU conducts additional post-payment reviews on an ongoing basis, including:
• Reviews of providers identified through spike reports showing reimbursement increases greater than 125 percent compared to the prior year,
• Reviews focused on billing issues related to specific procedure codes or providers, and
• Reviews of claims submitted by providers suspected of fraud.

PIU audit methods do not differ by waiver service. When fraud is suspected, referrals are made to the Medicaid Fraud Control Unit (MFCU) for investigation.
Corrective action plans are required when systemic issues are identified. PIU follows up to ensure corrective actions are implemented timely and may request policy clarification or revision when appropriate.
Payment Error Rate Measurement (PERM)

South Dakota participates in the federal Payment Error Rate Measurement (PERM) program, which operates on a three-year review cycle. PERM reviews are conducted by federally contracted entities and include:
• Eligibility reviews,
• Data processing and claims reviews, and
• Medical record reviews.

The PERM process is coordinated by the Division of Medical Services and typically spans approximately two years. Providers are contacted to supply documentation as needed. For waiver services, eligibility or medical documentation requests are coordinated with the Division of Long Term Services and Supports, including the HOPE Waiver program.

Provider Enrollment and Contractual Requirements

All waiver providers must execute a standard Medicaid provider agreement as a condition of enrollment. These agreements include extensive financial integrity requirements, including:
• Maintenance and disclosure of complete and accurate fiscal and service records,
• Submission of claims that are true, accurate, complete, and supported by documentation,
• Acceptance of Medicaid reimbursement as payment in full (less authorized cost sharing),
• Compliance with billing instructions, state and federal regulations, and payer-of-last-resort requirements,
• Cooperation with audits, inspections, and investigations by DSS, MFCU, and HHS, and
• Acknowledgement that improper billing or abuse may result in recoupment, termination, and civil or criminal liability.

Providers are required to accept Medicaid payment via electronic funds transfer.

State-Level Quality Assurance Reviews

Quality Assurance staff and Regional Operations Supervisors conduct additional state-level reviews to ensure billing and payment integrity. These reviews include:
• Quarterly analysis of waiver expenditures using data from the Medicaid Management Information System (MMIS),
• Review of a statistically valid sample of waiver claims using a 95% confidence interval with a ±5% margin of error, and
• Onsite provider reviews once every three years, with additional reviews completed as needed based on identified risks, complaints, critical incidents, or patterns of noncompliance.

Onsite reviews apply to providers of homemaker, personal care, in-home nursing, adult companion, in-home respite, and chore services. Reviews verify required billing procedures, confirm services were authorized, and ensure documentation supports billed claims.

When billing errors are identified, providers receive written notice and are required to void or adjust claims within 30 days. Failure to comply results in referral to PIU. Corrective actions are monitored to completion.

Electronic Visit Verification (EVV)

South Dakota implemented Electronic Visit Verification (EVV) effective October 1, 2020, for the following HOPE Waiver services:
• Homemaker
• Personal care
• In-home nursing
• Adult companion
• In-Home Respite
• Chore services

A service authorization is required prior to claim payment, ensuring services were authorized by the state. Providers are unable to bill for units in excess of authorized amounts.
EVV data or approved manual entry is required prior to payment. Providers must maintain EVV compliance at the threshold established in policy for claims payment.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial

accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:
Number and percent of waiver claims that were submitted for approved services.
Numerator = Waiver claims that were submitted for approved services Denominator = Waiver claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data using reports generated from the MMIS system

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

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver claims paid according to the reimbursement methodology specified in the approved waiver. Numerator = The number of sampled waiver claims that are paid according to the reimbursement methodology specified in the approved waiver. Denominator = The total number of waiver claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
claims data from MMIS, provider documentation, authorization for services

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

☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver claims that were submitted for participants that were enrolled in the waiver on the date the service was delivered. Numerator = Number of waiver claims submitted for participants that were enrolled in the waiver on the date the service was delivered. Denominator = Waiver claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data using reports generated from the MMIS system

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of survey respondents who reported they received the services that are authorized. Numerator= Number of survey respondents who reported they received the services authorized. Denominator= Number of survey respondents reviewed.

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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		95% confidence level with +/- 5% margin of error
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percent of rate reviews completed within established LTSS timeframes in accordance with the approved rate methodology. Numerator = Number of rate reviews completed within established LTSS timeframes in accordance with the approved rate methodology Denominator = Number of rate reviews

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Budget and Finance records

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of rates utilizing the State Plan fee schedule and/or usual and customary charges that are consistent with the rate methodology in the approved waiver.
Numerator= number of rates utilizing the State Plan fee schedule and/or usual and customary charges that are consistent with the rate methodology in the approved waiver.
Denominator= Number of rates reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
State Medicaid fee schedule, MMIS claims data, provider usual and customary charge.

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

		Confidence Interval = *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

The State employs multiple, complementary strategies to identify individual billing and payment issues and to analyze data for trends indicating systemic deficiencies. These activities are coordinated by Quality Assurance (QA) staff in collaboration with LTSS program staff and the Department of Social Services Budget and Finance and Program Integrity Units, as appropriate. Findings and corrective actions are documented and tracked to ensure timely resolution and to support broader system improvement efforts.

Claims Monitoring and Sampling

To ensure that waiver service claims are submitted only for approved waiver services and for individuals enrolled in the HOPE Waiver, QA staff generate quarterly reports of all waiver claims from the Medicaid Management Information System (MMIS). The universe consists of all claims paid with waiver funds for the quarter. A representative random sample is selected using the Raosoft sample size calculator. Sampling results and review outcomes are documented and tracked in internal monitoring tools.

Verification of Service Delivery

To verify that billed services were rendered, waiver participants are asked during the six-month participant survey to confirm receipt of authorized services during the month prior to the survey. The universe includes all waiver survey respondents for the quarter, and a representative random sample is selected using Raosoft. If a sampled respondent indicates that authorized services were not received, the associated claims are reviewed to ensure services were not billed in excess of services actually provided. This verification process is applied consistently across all waiver services.

Payment Accuracy and Authorization Review

QA staff review MMIS claims data, provider documentation, and LTSS service authorizations to ensure that waiver claims were billed and paid accurately, for eligible participants, and in accordance with approved authorizations and program rules. A representative random sample of waiver service claims is selected using Raosoft.

Payment accuracy reviews vary by service type, as follows:
• Services reimbursed at usual and customary rates or State Plan fee schedule rates: Claims are reviewed against the applicable fee schedule and/or provider-submitted usual and customary charge information to ensure payments do not exceed allowable limits.
• Services requiring Electronic Visit Verification (EVV): EVV data or approved manual entries are reviewed to verify service delivery and unit accuracy.
• Tiered services: Claims are reviewed to ensure the provider billed the appropriate tier based on the participant's authorized level of need.
• Meals: Claims are reviewed to verify billing at the appropriate authorized meal rate.

Rate Methodology Oversight (Finance Integration)

For services with rates established using standardized cost reports, QA staff verify that payment rates are consistent with the approved rate methodologies described in the waiver. This review is conducted in coordination with Budget and Finance staff by comparing the established fiscal year rate to cost report summaries and rate-setting documentation.

Information is reviewed to ensure that established rates remain aligned with reported average costs of service provision and approved inflationary or legislative adjustments. This process is applied consistently across all services utilizing cost-report-based rate methodologies.

For services reimbursed based on the State Plan fee schedule or provider usual and customary charges, QA staff review MMIS claims data and applicable fee schedules and may request provider documentation to ensure claims were not paid in excess of allowable rates.

Documentation, Trending, and Remediation

All identified issues are documented, tracked, and analyzed to determine whether errors represent isolated incidents or indicate broader trends or systemic deficiencies. When individual billing or payment errors are identified, providers are

required to void or adjust claims in accordance with established timelines. Repeated findings, patterns of noncompliance, or elevated risk indicators are escalated for further review and may result in targeted technical assistance, corrective action plans, or referral to the Program Integrity Unit, as appropriate.

Information from these reviews is aggregated and analyzed to inform quality improvement activities, support system design changes, and strengthen ongoing billing and payment integrity controls.

b. Methods for Remediation/Fixing Individual Problems

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

When individual problems are identified through monitoring, reviews, audits, or other discovery activities, the State implements timely and proportionate remediation actions to correct the issue, recover improper payments when applicable, and prevent recurrence. Remediation activities are documented and tracked to support trend analysis and continuous quality improvement.

LTSS Staff Remediation

If it is determined that an LTSS Case Management Specialist incorrectly authorized waiver services, the authorization is corrected promptly to ensure alignment with assessed need, program rules, and waiver requirements. Targeted technical assistance, retraining, or supervisory oversight is provided as appropriate to address the identified issue. When trends indicate repeated or systemic authorization errors, additional staff development activities or personnel actions may be implemented in accordance with agency policy.

Provider Billing and Authorization Errors

When incorrect claims are identified, the State first reviews the applicable service authorization to determine whether the authorization accurately reflects approved services.

• If an authorization error is identified, the authorization is corrected immediately. Improper payments may be recouped, and services may be reimbursed using appropriate alternate funding sources, if applicable.
• If the authorization is correct and the provider billed inaccurately, remediation actions may include provider education, technical assistance on billing requirements, and required claim voids or adjustments. Payment may be temporarily withheld until improper payments are returned and corrective actions are implemented, as appropriate.
Services Not Rendered

If review activities determine that services were billed but not rendered, the State initiates recovery of the improper payments and conducts follow-up with the provider. Remediation may include provider training, corrective action plans, and enhanced monitoring. Additional enforcement actions may be taken consistent with state policy and referral to the Program Integrity Unit or Medicaid Fraud Control Unit when fraud is suspected.

Rate Methodology and Financial Corrections

When analysis of payment rates and cost report data indicates potential misalignment with approved rate methodologies, the Division of Long Term Services and Supports refers the information to the Provider Rate Workgroup for review and consideration of rate methodology adjustments.

If it is determined that waiver claims were paid in excess of the applicable State Plan fee schedule or the provider’s usual and customary charges, improper payments are recouped and claims are reprocessed at the appropriate rate. System corrections, provider education, and staff training are implemented as necessary to prevent recurrence.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

General Rate-Setting Framework

South Dakota law requires review of Medicaid rate methodologies at least once every five years. The Department of Human Services (DHS) is responsible for establishing provider payment rates for HOPE Waiver services. DHS utilizes a structured, data-driven rate-setting process that incorporates stakeholder input, standardized cost reporting, publicly available benchmarks, and legislative appropriations.

Rate-setting methodologies are developed and reviewed through stakeholder workgroups, both formal and informal, that include representation from providers, provider associations, and DHS fiscal, program, and service delivery staff. This workgroup structure supports a transparent and collaborative approach to rate development.

In addition to periodic methodology reviews, DHS conducts annual reviews of provider cost report data, and rates are adjusted annually based on the final legislative appropriation. Provider reimbursement rates are publicly available on the DHS website.

Service-Specific Rate Determination Methods

Homemaker, Personal Care, In-Home Nursing, In-Home Respite, Adult Companion, Chore Services, Adult Day, and Meals

Rates for these services are established as prospective rates using historical cost data and publicly available benchmarks. A standardized cost report is submitted annually by providers after the close of their fiscal year. Cost reports summarize expenses related to service delivery and associated revenue and include cost components such as wages, benefits, and operating expenses.

DHS aggregates and analyzes cost report data from providers statewide, in combination with publicly available data, to ensure rates reflect the actual cost of providing services.
• If cost report data indicates that rates are sufficient, proposed rates for the upcoming fiscal year are adjusted based on legislatively appropriated inflation.
• If cost report data indicates that the cost of providing services exceeds the modeled rate, the information is used to propose revised rates for a subsequent fiscal year.

The most recent methodology review for these services was completed in 2023.

Residential Respite

Rates for Residential Respite services are based on the average usual and customary charge for nursing facility care in South Dakota. Usual and customary charge data is collected annually from South Dakota nursing facilities and evaluated by DHS Budget and Finance staff.

If the rate is determined to be sufficient, the proposed rate for the upcoming fiscal year is adjusted based on legislatively appropriated inflation. The most recent methodology review was completed in 2021.

Assisted Living, Community Living Home, and Structured Family Caregiving

Rates for these residential services are established using standardized provider cost reports and public benchmarks, including Bureau of Labor Statistics (BLS) wage data. Providers submit annual cost reports to allow analysis of the cost of service provision.
• If rates are sufficient based on cost reports and public benchmarks, proposed rates are adjusted based on legislatively appropriated inflation.
• If cost report data indicates that service costs exceed the current rate, the information is used to propose revised rates for a subsequent fiscal year.

These services utilize a three-tier rate structure based on participant acuity, as determined by the Home Care Assessment (HCA) and associated algorithms. The tiered structure reflects differences in time, staffing, and resources required to meet participant needs.

In 2023, the State worked with the external entity and stakeholder workgroups to refine individual rate components and establish tier-specific rates. Rate calculations include:
• Staff wages for personnel providing daily services
• Benefits and supervision costs
• Administrative and program support overhead
• Staffing ratios by service and tier
• Occupancy adjustment factors, including bed-hold policy considerations
• Calculation of daily per-participant cost by dividing annual cost by 365

Tier increases are based on the percentage increase in care required from the base rate, as reflected through adjusted staffing ratios. The most recent methodology review was completed in 2023.

Community Transition Coordination

The rate for Community Transition Coordination was established using an existing rate for a comparable service within the DHS Division of Developmental Disabilities. Because the service closely aligns with Conflict-Free Case Management (CFCM) under the CHOICES waiver, DHS adopted the same rate methodology.

The CFCM rate was originally derived in October 2015 using Community Support Provider cost report data, including salaries, benefits, taxes, and overhead. South Dakota Department of Labor wage statistics for comparable professions are used to validate the data. Rate comparisons are conducted at least once every five years, and cost report data are reviewed to determine whether rate adjustments are necessary. Annual adjustments are based on legislatively approved inflation.

Medical Equipment and Medical Supplies

When State Plan coverage has been exhausted, rates for LTSS medical equipment and supplies are limited to the lesser of the provider's usual and customary charge or the applicable DSS fee schedule. Fee schedules are developed using Medicare rates and other state Medicaid rates and are established jointly by DHS, LTSS, and DSS' Division of Medical Services.

Emergency Response Systems (ERS), Nutritional Supplements, Environmental Accessibility Adaptations, and Community Transition Supports

For these services, providers bill market retail rates, not to exceed their usual and customary charge to the general public. Rates are evaluated based on provider feedback.

Public Comment and Transparency

Opportunities for public comment on rate methodologies include:
• Participation in stakeholder workgroups and provider associations, including the South Dakota Association of Healthcare Organizations and the South Dakota Health Care Association
• Public hearings during South Dakota's annual legislative session related to budget allocations and rate adjustments
• Legislative review and approval of Administrative Rules of South Dakota, which are subject to public testimony
• Waiver public comment processes, including Tribal Consultation, the Medicaid Advisory Committee, and the Advisory Council on Aging

Additional information regarding public comment opportunities is included in Main Section 6-1 of this waiver.

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:*

Claims for waiver services are submitted directly to the claims unit in the Division of Medical Services, a Division of the State Medicaid Agency, for payment.

Appendix I: Financial Accountability

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

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

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

Select at least one:

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

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

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

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

Appendix I: Financial Accountability

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

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

South Dakota Medicaid employs a layered billing validation process to ensure that claims submitted for federal financial participation meet all eligibility, authorization, and service delivery requirements prior to and following payment.

Pre-Payment Validation

Business rules embedded within the Medicaid Management Information System (MMIS) support automated claim adjudication. MMIS verifies Medicaid eligibility by comparing the individual's eligibility status to the date of service.
• Claims submitted for dates when the individual was eligible for Medicaid waiver services may proceed to payment.
• Claims submitted for dates when the individual was not eligible are denied or suspended for further review.

For services subject to Electronic Visit Verification (EVV), EVV data or approved manual entries must be submitted prior to payment. Providers are unable to bill for units that exceed authorized amounts. A valid authorization must be in place for the service, provider, and date of service for the claim to be eligible for payment. Claims that do not meet authorization requirements are denied or pended for review.

Post-Payment Validation and Oversight

All paid claims are subject to ongoing post-payment validation through multiple oversight mechanisms.

South Dakota participates in the federal Payment Error Rate Measurement (PERM) program, which includes eligibility, claims processing, and medical record reviews conducted by federally contracted entities. PERM activities are coordinated by DSS' Division of Medical Services, with waiver-specific documentation support provided by the Division of Long Term Services and Supports, as needed.

In addition, under 42 CFR Part 456, South Dakota Medicaid maintains a Program Integrity Unit (PIU) responsible for post-payment review activities. The PIU conducts reviews to monitor provider billing practices and service delivery and has authority to recover overpayments regardless of whether the error was caused by the provider or by state processing.

Participant Verification

As an additional safeguard, a sample of Medicaid recipients receives periodic survey letters requesting verification of services billed on their behalf during a prior month. Services are described in non-technical terms, and confidential services are excluded. Responses indicating potential discrepancies are reviewed to determine whether claims were billed appropriately.

State-Level Performance Measure Reviews

To further validate provider billings for waiver services, Quality Assurance (QA) staff generate quarterly waiver expenditure reports from MMIS. Using these reports, statistically valid random samples of claims are selected and reviewed to ensure that:
• Claims that were submitted were for approved waiver services,
• The participant was eligible on the date of service, and
• The service was authorized in the participant's approved Individual Support Plan

Participant surveys are also reviewed each quarter to confirm receipt of authorized services.

Annually, QA staff review a statistically valid random sample of claims paid during the review period to ensure that claims were paid in accordance with the reimbursement methodology specified in the waiver. The review verifies that:
• Claims were paid at the approved daily or per-unit rate established under the applicable reimbursement methodology,
• For services reimbursed at the State Plan fee schedule or usual and customary rate, payment does not exceed the allowable amount and reflects the correct rate,
• Units billed do not exceed total units authorized
• For services requiring Electronic Visit Verification (EVV), EVV data supports that the service was provided as authorized
• For tiered services, providers billed and were paid at the authorized tier rate
Sampling is conducted using a representative sample with a 95 percent confidence interval and a +\-5 percent margin of error, consistent with the Financial Accountability performance measures.

If LTSS becomes aware, through complaints, provider concerns, or onsite provider reviews, that services were not delivered in accordance with the authorized service plan, a targeted claim review is initiated to determine whether improper billing occurred.

Error Resolution and Financial Corrections

When claims are identified as having been paid in error, corrective action is taken promptly.
• If the error resulted from state processing, payment corrections are made using non-Medicaid funds, as appropriate.
• If the error resulted from provider billing errors, services not rendered, or services provided without authorization, the provider is required to reimburse Medicaid for the improper payment.

Recovered funds are adjusted to ensure accurate federal financial participation, and findings are tracked to inform trend analysis and future quality improvement activities.

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:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

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

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

Appendix I: Financial Accountability

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

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

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

○ ***Applicable***

Check each that applies:

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

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

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

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

Appendix I: Financial Accountability

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

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

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

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

Check each that applies:

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

☐ ***Provider-related donations***

☐ ***Federal funds***

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

Appendix I: Financial Accountability

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

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

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

The Department of Human Services (DHS) Budget and Finance establishes reimbursement rates for residential waiver services using methodologies that clearly distinguish between costs reimbursable under the HOPE Waiver and room and board expenses, which are the responsibility of the participant. Medicaid payment under the waiver does not include room and board costs.

Standardized provider cost reports, as described in Appendix I-2, require residential service providers to separately report costs associated with waiver services and costs associated with room and board. This separation ensures that room and board expenses are excluded from rate development and are not included in Medicaid reimbursement for residential services.

When an individual is determined eligible for the HOPE Waiver by the Division of Economic Assistance, the participant retains a standard needs allowance, as described in Appendix B-5. This allowance is intended to be used by the participant to pay for room and board expenses in the residential setting.

For Assisted Living and Community Living Home services, the Department of Social Services issues an annual notification to qualified providers on behalf of each waiver participant. This notification clearly identifies:
• The services reimbursed through the HOPE Waiver, and
• The amount the provider may collect directly from the participant for room and board.

For Structured Family Caregiving services, room and board costs are excluded from Medicaid payment. The amount paid for room and board by a participant residing in the principal caregiver's home is determined through an agreement between the participant and the principal caregiver, consistent with state requirements.

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	19070.32	19647.00	38717.32	74534.00	55309.00	129843.00	91125.68
2	19427.82	22130.00	41557.82	82499.00	64913.00	147412.00	105854.18
3	19818.29	24927.00	44745.29	91315.00	76184.00	167499.00	122753.71
4	20215.98	28078.00	48293.98	101073.00	89412.00	190485.00	142191.02
5	20622.34	31627.00	52249.34	111874.00	104937.00	216811.00	164561.66

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	3259	3259

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 2	3397	3397
Year 3	3541	3541
Year 4	3691	3691
Year 5	3848	3848

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.*

CMS 372 Lag Reports for FY22, FY23, FY24, and FY25 were used as the historical basis for projecting average length of stay. The year-over-year percentage change across this period was calculated to determine the annual growth trend. The average annual percentage change (4.25%) was then applied prospectively to estimate average length of stay for the renewal period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Projections for waiver service utilization and expenditures were developed using historical utilization data and current fee schedule rates. The primary data sources used for projection development were CMS 372 Lag Reports for Years 1-4 of the current waiver cycle, and MMIS claims data. These reports include unduplicated participants, service users, total units, and total expenditures by service.

Projection of Service Users

The number of projected users for each service was estimated using historical trends in service participation. The percent change in service users between Years 3 and 4 of the current waiver cycle was calculated and used to estimate Year 5 service users. This approach was selected to reflect the most recent utilization trends while minimizing the influence of earlier years of the waiver that may have reflected program start-up effects or rapid expansion of new services.

For renewal years, projected service users were trended forward from the Year 5 baseline using the same methodology. Projections were reviewed for reasonableness to ensure they were consistent with anticipated program growth.

For services that cannot be authorized concurrently with Structured Family Caregiving (SFC), including In-Home Respite Care, Homemaker, Personal Care (except in limited two-person assist situations), Chore, Meals, Assisted Living, and Community Living Home, projected service users were evaluated relative to the projected population not receiving SFC services to ensure projections were consistent with program authorization rules.

Projection of Average Units per User

Average units per user were calculated using historical data from the CMS 372 reports and MMIS claims by dividing total units for each service by the number of service users. Because service utilization patterns were relatively stable in the most recent years of the waiver cycle, the average units per user from Years 3 and 4 were used to establish a representative baseline. Average units per user were held constant for projected years.

Cost Per Unit

Services with Fixed Fee Schedule Rates

The cost per unit for each service was based on the established fee schedule in effect during the projection period. For services with fixed fee schedule rates, (Adult Day, In-Home Respite, Homemaker, In-Home Nursing, Personal Care, Adult Companion, Assisted Living, Community Living Home, and Structured Family Caregiving), an estimated inflationary increase of 2% was applied annually during the renewal period to determine projected cost per unit.

For services with tiered rates, including Assisted Living, Community Living Home, and Structured Family Caregiving, projections were calculated using the established rate methodology which distributes the estimated allocation of participants as follows:
• 45% Base Tier
• 45% Tier 1
• 10% Tier 2

Tier-specific rates were applied to the projected number of participants in each tier to determine total expenditures for the service.

When the projected number of participants for a service was very small, exact proportional distribution across tiers was not always mathematically possible. In these cases, participants were allocated across tiers using the closest reasonable approximation to the methodology while also considering current utilization patterns for the service. For example, Community Living Home has historically served a very small number of participants, and current utilization does not include Tier 2 participants. Therefore, projected participants were distributed between Base Tier and Tier 1 in a manner consistent with observed service utilization.

Services Without Fixed Fee Schedule Rates

Certain services in the waiver do not utilize a standard fee schedule rate or have historically variable costs based on the provider's usual and customary charges. For these services, projected costs were derived using historical claims data and recent utilization patterns.

For Specialized Medical Supplies, Nutritional Supplements, Specialized Medical Equipment, and Environmental Accessibility Adaptations, services are authorized using the provider's usual and customary rate. Because costs vary based on the item or modification provided, an average cost per participant was calculated using total expenditures divided by the number of participants receiving the service in Years 3 and 4 of the current waiver cycle. The average cost per participant from these two years was used as the projected cost per participant for Year 5 and renewal years. The number of projected participants for each year was based on the historical relationship between service users and total unduplicated waiver participants.

For Meals, reimbursement rates vary by provider. To estimate projected costs, the average of provider rates in the current fee schedule was used to establish a baseline cost per meal. Beginning in the renewal period, a two percent annual inflationary adjustment was applied to the average rate to reflect anticipated increases in provider reimbursement.

For Emergency Response Systems, rates vary by type of system but have remained relatively stable. The projected cost per unit was derived by averaging claims paid for the service during Years 3 and 4 of the current waiver cycle. Because these rates have historically remained stable, the average rate was held constant throughout the projection period.

Services with Limited or No Historical Utilization

Some services included in the waiver have experienced limited or no utilization during the current waiver cycle. In these cases, projections were developed using reasonable estimates based on program availability and historical authorization patterns.

Community Transition Coordination and Community Transition Supports are currently not utilized because transitions from more restrictive settings are managed through the state's Money Follows the Person (Home Again) program. These services remain available within the waiver should the Money Follows the Person program no longer operate. Therefore, utilization was not assumed in the projections.

Residential Respite has not generated claims during the current waiver cycle. Because the service remains available and may be utilized in the future, projections include a minimal number of participants each year. Costs were calculated using the established fee schedule rate for the service, with the two percent annual inflationary adjustment applied during renewal years.

Projection of Total Service Expenditures

Total projections for the current waiver cycle were calculated using current fee schedule rates. For the renewal period, cost per unit was increased annually by two percent to account for anticipated inflationary adjustments to provider reimbursement rates.

All projections were reviewed for consistency with historical utilization patterns, program eligibility requirements, and anticipated waiver growth. While projections cannot fully predict future utilization, the methodology relies on recent historical trends and established rate structures to produce reasonable estimates of future service demands and expenditures.

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:*

CMS 372 Lag Reports for FY22, FY23, FY24, and FY25 were utilized to identify historical expenditures. The average increase (12.64%) was applied to projections for year 1-5 of this waiver.

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:*

CMS 372 Lag Reports for FY22, FY23, FY24, and FY25 were utilized to identify historical expenditures. The average increase (10.69%) was applied to projections for years 1-5 of this waiver.

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:*

CMS 372 Lag Reports for FY22, FY23, FY24, and FY25 were utilized to identify historical expenditures. The average increase (17.36%) was applied to projections for year 1-5 of this waiver.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Services	
In-Home Respite Care	
Homemaker	
In-Home Nursing Services	
Personal Care	
Specialized Medical Equipment	
Specialized Medical Supplies	
Adult Companion Services	
Assisted Living	
Chore Services	
Community Living Home	
Community Transition Coordination	
Community Transition Supports	
Emergency Response System (ERS)	
Environmental Accessibility Adaptations	
Meals	
Nutritional Supplements	
Residential Respite Care	
Structured Family Caregiving	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**157636.86**
Adult Day Services	15 Minutes	19	2200.71	3.77	**157636.86**	
In-Home Respite Care Total:						**99587.12**
In-Home Respite Care	15 Minutes	25	368.50	10.81	**99587.12**	
Homemaker Total:						**2238210.64**
Homemaker	15 Minutes	204	982.24	11.17	**2238210.64**	
In-Home Nursing Services Total:						**1964575.40**
In-Home Nursing Services	15 Minutes	148	617.69	21.49	**1964575.40**	
Personal Care Total:						**5378097.87**
Personal Care	15 Minutes	218	2208.61	11.17	**5378097.87**	
Specialized Medical Equipment Total:						**97663.23**
Specialized Medical Equipment	Each	287	1.00	340.29	**97663.23**	
Specialized Medical Supplies Total:						**5003.77**
Specialized Medical Supplies	1 Month	15	3.50	95.31	**5003.78**	
Adult Companion Services Total:						**7105128.48**
Adult Companion Services	15 Minutes	664	989.87	10.81	**7105128.48**	
Assisted Living Total:						**28901967.38**
Tier 1	1 Day	536	270.51	93.14	**13504681.55**	
Tier 2	1 Day	119	270.51	108.61	**3496230.84**	
Base	1 Day	536	270.51	82.08	**11901054.99**	
Chore Services Total:						**4509.93**
Chore Services	15 Minutes	10	41.72	10.81	**4509.93**	
Community Living Home Total:						**70551.84**
Tier 1	1 Day	2	311.79	62.86	**39198.24**	
Tier 2	1 Day				**0.00**	

GRAND TOTAL: 62150167.93

Total Estimated Unduplicated Participants: 3259

Factor D (Divide total by number of participants): 19070.32

Average Length of Stay on the Waiver: 292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		0	0.00	70.42		
Base	1 Day	2	311.79	50.28	31353.60	
Community Transition Coordination Total:						0.00
Community Transition Coordination	15 Minutes	0	0.00	22.01	0.00	
Community Transition Supports Total:						0.00
Community Transition Supports	Each	0	0.00	0.01	0.00	
Emergency Response System (ERS) Total:						187767.97
Emergency Response System (ERS)	1 Month	531	8.65	40.88	187767.97	
Environmental Accessibility Adaptations Total:						217786.85
Environmental Accessibility Adaptations	Each	67	1.00	3250.55	217786.85	
Meals Total:						653986.37
Meals	Each	384	186.13	9.15	653986.37	
Nutritional Supplements Total:						282304.92
Nutritional Supplements	1 Month	307	6.00	153.26	282304.92	
Residential Respite Care Total:						2115.12
Residential Respite Care	1 Day	1	7.00	302.16	2115.12	
Structured Family Caregiving Total:						14783274.17
Tier 1	1 Day	269	261.55	102.51	7212290.94	
Base	1 Day	269	261.55	82.00	5769269.90	
Tier 2	1 Day	60	261.55	114.81	1801713.33	

GRAND TOTAL: 62150167.93

Total Estimated Unduplicated Participants: 3259

Factor D (Divide total by number of participants): 19070.32

Average Length of Stay on the Waiver: 292

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*
Adult Day Services Total:						***169454.67***
Adult Day Services	*15 Minutes*	*20*	*2200.71*	*3.85*	***169454.67***	
In-Home Respite Care Total:						***105678.43***
In-Home Respite Care	*15 Minutes*	*26*	*368.50*	*11.03*	***105678.43***	
Homemaker Total:						***2385075.17***
Homemaker	*15 Minutes*	*213*	*982.24*	*11.40*	***2385075.17***	
In-Home Nursing Services Total:						***2085123.78***
In-Home Nursing Services	*15 Minutes*	*154*	*617.69*	*21.92*	***2085123.78***	
Personal Care Total:						***5715440.96***
Personal Care	*15 Minutes*	*227*	*2208.61*	*11.40*	***5715440.96***	
Specialized Medical Equipment Total:						***101746.71***
Specialized Medical Equipment	*each*	*299*	*1.00*	*340.29*	***101746.71***	
Specialized Medical Supplies Total:						***5337.36***
Specialized Medical Supplies	*1 Month*	*16*	*3.50*	*95.31*	***5337.36***	
Adult Companion Services Total:						***7566358.41***
Adult Companion Services	*15 Minutes*	*693*	*989.87*	*11.03*	***7566358.41***	
Assisted Living Total:						***30692735.46***
Tier 1	*1 Day*	*558*	*270.51*	*95.00*	***14339735.10***	
Tier 2	*1 Day*	*124*	*270.51*	*110.78*	***3715920.13***	
Base	*1 Day*	*558*	*270.51*	*83.72*	***12637080.24***	
Chore Services Total:						***4601.72***
Chore Services	*15 Minutes*	*10*	*41.72*	*11.03*	***4601.72***	

GRAND TOTAL: ***65996306.97***

Total Estimated Unduplicated Participants: ***3397***

Factor D (Divide total by number of participants): ***19427.82***

Average Length of Stay on the Waiver: *295*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Home Total:						**71967.37**
Tier 1	1 Day	2	311.79	64.12	**39983.95**	
Tier 2	1 Day	0	0.00	71.83	**0.00**	
Base	1 Day	2	311.79	51.29	**31983.42**	
Community Transition Coordination Total:						**0.00**
Community Transition Coordination	15 Minutes	0	0.00	22.45	**0.00**	
Community Transition Supports Total:						**0.00**
Community Transition Supports	Each	0	0.00	0.01	**0.00**	
Emergency Response System (ERS) Total:						**195901.05**
Emergency Response System (ERS)	1 Month	554	8.65	40.88	**195901.05**	
Environmental Accessibility Adaptations Total:						**224287.95**
Environmental Accessibility Adaptations	Each	69	1.00	3250.55	**224287.95**	
Meals Total:						**694637.16**
Meals	Each	400	186.13	9.33	**694637.16**	
Nutritional Supplements Total:						**294259.20**
Nutritional Supplements	1 Month	320	6.00	153.26	**294259.20**	
Residential Respite Care Total:						**2157.47**
Residential Respite Care	1 Day	1	7.00	308.21	**2157.47**	
Structured Family Caregiving Total:						**15681544.11**
Tier 1	1 Day	280	261.55	104.56	**7657347.04**	
Base	1 Day	280	261.55	83.64	**6125291.76**	
Tier 2	1 Day	62	261.55	117.10	**1898905.31**	

GRAND TOTAL: 65996306.97

Total Estimated Unduplicated Participants: 3397

Factor D (Divide total by number of participants): 19427.82

Average Length of Stay on the Waiver: 295

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**181162.45**
Adult Day Services	15 Minutes	21	2200.71	3.92	**181162.45**	
In-Home Respite Care Total:						**111931.88**
In-Home Respite Care	15 Minutes	27	368.50	11.25	**111931.88**	
Homemaker Total:						**2536006.17**
Homemaker	15 Minutes	222	982.24	11.63	**2536006.17**	
In-Home Nursing Services Total:						**2208859.44**
In-Home Nursing Services	15 Minutes	160	617.69	22.35	**2208859.44**	
Personal Care Total:						**6087613.83**
Personal Care	15 Minutes	237	2208.61	11.63	**6087613.83**	
Specialized Medical Equipment Total:						**105830.19**
Specialized Medical Equipment	Each	311	1.00	340.29	**105830.19**	
Specialized Medical Supplies Total:						**5670.94**
Specialized Medical Supplies	1 Month	17	3.50	95.31	**5670.94**	
Adult Companion Services Total:						**8040219.08**
Adult Companion Services	15 Minutes	722	989.87	11.25	**8040219.08**	
Assisted Living Total:						**32643956.56**
Tier 1	1 Day	582	270.51	96.90	**15255627.86**	
Tier 2	1 Day	129	270.51	113.00	**3943224.27**	
Base					**13445104.43**	

GRAND TOTAL: ***70176563.58***

Total Estimated Unduplicated Participants: ***3541***

Factor D (Divide total by number of participants): ***19818.29***

Average Length of Stay on the Waiver: 298

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 Day	582	270.51	85.40		
Chore Services Total:						**4693.50**
Chore Services	15 Minutes	10	41.72	11.25	**4693.50**	
Community Living Home Total:						**73407.84**
Tier 1	1 Day	2	311.79	65.40	**40782.13**	
Tier 2	1 Day	0	0.00	73.27	**0.00**	
Base	1 Day	2	311.79	52.32	**32625.71**	
Community Transition Coordination Total:						**0.00**
Community Transition Coordination	15 Minutes	0	0.00	22.90	**0.00**	
Community Transition Supports Total:						**0.00**
Community Transition Supports	Each	0	0.00	0.01	**0.00**	
Emergency Response System (ERS) Total:						**204034.12**
Emergency Response System (ERS)	1 Month	577	8.65	40.88	**204034.12**	
Environmental Accessibility Adaptations Total:						**234039.60**
Environmental Accessibility Adaptations	Each	72	1.00	3250.55	**234039.60**	
Meals Total:						**738906.32**
Meals	Each	417	186.13	9.52	**738906.32**	
Nutritional Supplements Total:						**306213.48**
Nutritional Supplements	1 Month	333	6.00	153.26	**306213.48**	
Residential Respite Care Total:						**2200.59**
Residential Respite Care	1 Day	1	7.00	314.37	**2200.59**	
Structured Family Caregiving Total:						**16691817.60**
Tier 1	1 Day	292	261.55	106.65	**8145137.79**	
Base	1 Day	292	261.55	85.32	**6516110.23**	

GRAND TOTAL: 70176563.58

Total Estimated Unduplicated Participants: 3541

Factor D (Divide total by number of participants): 19818.29

Average Length of Stay on the Waiver: 298

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier 2	1 Day	65	261.55	119.44	2030569.58	

GRAND TOTAL: 70176563.58
Total Estimated Unduplicated Participants: 3541
Factor D (Divide total by number of participants): 19818.29
Average Length of Stay on the Waiver: 298

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						193662.48
Adult Day Services	15 Minutes	22	2200.71	4.00	193662.48	
In-Home Respite Care Total:						122574.15
In-Home Respite Care	15 Minutes	29	368.50	11.47	122574.16	
Homemaker Total:						2691003.64
Homemaker	15 Minutes	231	982.24	11.86	2691003.64	
In-Home Nursing Services Total:						2351916.44
In-Home Nursing Services	15 Minutes	167	617.69	22.80	2351916.44	
Personal Care Total:						6469946.31
Personal Care	15 Minutes	247	2208.61	11.86	6469946.31	
Specialized Medical Equipment Total:						110594.25
Specialized Medical Equipment	Each	325	1.00	340.29	110594.25	
Specialized Medical Supplies Total:						5670.94
Specialized Medical Supplies	1 Month	17	3.50	95.31	5670.94	

GRAND TOTAL: 74617186.69
Total Estimated Unduplicated Participants: 3691
Factor D (Divide total by number of participants): 20215.98
Average Length of Stay on the Waiver: 301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Companion Services Total:						**8549418.10**
Adult Companion Services	15 Minutes	753	989.87	11.47	**8549418.10**	
Assisted Living Total:						**34742072.69**
Tier 1	1 Day	607	270.51	98.84	**16229485.50**	
Tier 2	1 Day	135	270.51	115.26	**4209162.65**	
Base	1 Day	607	270.51	87.11	**14303424.54**	
Chore Services Total:						**5263.81**
Chore Services	15 Minutes	11	41.72	11.47	**5263.81**	
Community Living Home Total:						**74873.25**
Tier 1	1 Day	2	311.79	66.71	**41599.02**	
Tier 2	1 Day	0	0.00	74.73	**0.00**	
Base	1 Day	2	311.79	53.36	**33274.23**	
Community Transition Coordination Total:						**0.00**
Community Transition Coordination	15 Minutes	0	0.00	23.36	**0.00**	
Community Transition Supports Total:						**0.00**
Community Transition Supports	Each	0	0.00	0.01	**0.00**	
Emergency Response System (ERS) Total:						**212874.42**
Emergency Response System (ERS)	1 Month	602	8.65	40.88	**212874.42**	
Environmental Accessibility Adaptations Total:						**243791.25**
Environmental Accessibility Adaptations	Each	75	1.00	3250.55	**243791.25**	
Meals Total:						**786185.20**
Meals	Each	435	186.13	9.71	**786185.20**	
Nutritional Supplements Total:						**320006.88**
Nutritional Supplements					**320006.88**	

GRAND TOTAL: 74617186.69

Total Estimated Unduplicated Participants: 3691

Factor D (Divide total by number of participants): 20215.98

Average Length of Stay on the Waiver: 301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 Month	348	6.00	153.26		
Residential Respite Care Total:						**2244.62**
Residential Respite Care	1 Day	1	7.00	320.66	**2244.62**	
Structured Family Caregiving Total:						**17735088.24**
Tier 1	1 Day	304	261.55	108.78	**8649228.34**	
Base	1 Day	304	261.55	87.02	**6919064.62**	
Tier 2	1 Day	68	261.55	121.83	**2166795.28**	

GRAND TOTAL: 74617186.69
Total Estimated Unduplicated Participants: 3691
Factor D (Divide total by number of participants): 20215.98
Average Length of Stay on the Waiver: 301

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**206514.63**
Adult Day Services	15 Minutes	23	2200.71	4.08	**206514.63**	
In-Home Respite Care Total:						**129343.50**
In-Home Respite Care	15 Minutes	30	368.50	11.70	**129343.50**	
Homemaker Total:						**2864310.06**
Homemaker	15 Minutes	241	982.24	12.10	**2864310.06**	
In-Home Nursing Services Total:						**2499939.68**
In-Home Nursing Services	15 Minutes	174	617.69	23.26	**2499939.68**	

GRAND TOTAL: 79354757.16
Total Estimated Unduplicated Participants: 3848
Factor D (Divide total by number of participants): 20622.34
Average Length of Stay on the Waiver: 304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**6894838.70**
Personal Care	15 Minutes	258	2208.61	12.10	**6894838.70**	
Specialized Medical Equipment Total:						**115018.02**
Specialized Medical Equipment	Each	338	1.00	340.29	**115018.02**	
Specialized Medical Supplies Total:						**6004.53**
Specialized Medical Supplies	1 Month	18	3.50	95.31	**6004.53**	
Adult Companion Services Total:						**9091461.02**
Adult Companion Services	15 Minutes	785	989.87	11.70	**9091461.02**	
Assisted Living Total:						**36959981.48**
Tier 1	1 Day	633	270.51	100.81	**17261981.59**	
Tier 2	1 Day	141	270.51	117.56	**4483962.94**	
Base	1 Day	633	270.51	88.85	**15214036.95**	
Chore Services Total:						**5369.36**
Chore Services	15 Minutes	11	41.72	11.70	**5369.36**	
Community Living Home Total:						**100137.59**
Tier 1	1 Day	2	311.79	68.04	**42428.38**	
Tier 2	1 Day	1	311.79	76.23	**23767.75**	
Base	1 Day	2	311.79	54.43	**33941.46**	
Community Transition Coordination Total:						**0.00**
Community Transition Coordination	15 Minutes	0	0.00	23.83	**0.00**	
Community Transition Supports Total:						**0.00**
Community Transition Supports	Each	0	0.00	0.01	**0.00**	
Emergency Response System (ERS) Total:						**221714.72**
Emergency Response System (ERS)	1 Month	627	8.65	40.88	**221714.72**	

GRAND TOTAL: 79354757.16

Total Estimated Unduplicated Participants: 3848

Factor D (Divide total by number of participants): 20622.34

Average Length of Stay on the Waiver: 304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						**256793.45**
Environmental Accessibility Adaptations	Each	79	1.00	3250.55	**256793.45**	
Meals Total:						**834737.21**
Meals	Each	453	186.13	9.90	**834737.21**	
Nutritional Supplements Total:						**332880.72**
Nutritional Supplements	1 Month	362	6.00	153.26	**332880.72**	
Residential Respite Care Total:						**2289.49**
Residential Respite Care	1 Day	1	7.00	327.07	**2289.49**	
Structured Family Caregiving Total:						**18833423.00**
Tier 1	1 Day	317	261.55	110.95	**9199014.28**	
Base	1 Day	317	261.55	88.76	**7359211.43**	
Tier 2	1 Day	70	261.55	124.27	**2275197.30**	

GRAND TOTAL: 79354757.16

Total Estimated Unduplicated Participants: 3848

Factor D (Divide total by number of participants): 20622.34

Average Length of Stay on the Waiver: 304