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 §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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:
Home and Community-Based Options and Person Centered Excellence (HOPE) Waiver

C. Waiver Number:SD.0189
Original Base Waiver Number: SD.0189.

D. Amendment Number:SD.0189.R06.04

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

10/01/20

Approved Effective Date: 10/01/20
Approved Effective Date of Waiver being Amended: 10/01/16

2. Purpose(s) of Amendment

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

In March 2017, SD Senate Bill 147 was passed. This bill requires The Department of Social Services and the Department of Human Services to jointly establish a rate-setting methodology for services delivered by home and community-based service providers. The bill requires each category of service to undergo a comprehensive rate modeling analysis at least every five years. The Assisted Living Rate methodology workgroup was held, as required by SB 147, and as a result an updated tiered Rate Methodology was recommended. The tiered methodology, along with funding to support it, was approved during the FY20 Legislative Session. The primary purpose of this amendment is to secure approval for the approved tiered rate methodology.

South Dakota is committed to rebalancing Medicaid expenditures through several initiatives led by the Division of Long-Term Services and Supports (LTSS) to ensure South Dakotans can live and receive services in the most integrated setting according the individuals preferences and needs. This amendment also includes updates that will allow for continued progress toward LTSS' initiative to expand and enhance home and community-based services for individuals eligible for the HOPE Waiver. These enhancements include the addition of adult day centers as a provider type for personal care and respite care to ensure the most integrated access to service; modifications to projections to increase the number of participants that South Dakota can support through the HOPE waiver; and addition of language to ensure HOPE waiver consumers participate in the most appropriate service available to them.

Finally, a correction to required background checks from "FBI Background Checks" to "State Fingerprint Background Check/State Approved Alternative Background Check" as well as an update to the frequency of onsite reviews for in home services provider from once a year to once every third year.

In summary, the following amendments are being requested to the HOPE Waiver:

1. Update the Assisted Living rate methodology to include rate tiers as proposed by the Assisted Living Rate Methodology Workgroup
2. Addition of adult day as a provider type for personal care and respite care to ensure HOPE waiver participants are able to access services in the most integrated setting available to them.
3. Addition of language to ensure consumers participate in the most appropriate service. The most appropriate service is determined based on the service definitions in the waiver, the individual's level of need, and a care plan that includes services that can meet the individual's needs in the most cost effective manner.
4. Update HOPE waiver projections to include new assisted living rate methodology, and increased participants and increased expenditures
5. Update background check requirement from "FBI Background Checks" to "State Fingerprint Background Check/State Approved Alternative Background Check."
6. Update to the frequency of onsite visits for in home service providers.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A Waiver Administration and Operation**	
☐ **Appendix B Participant Access and Eligibility**	
☐ **Appendix C Participant Services**	
☐ **Appendix D**	

Component of the Approved Waiver	Subsection(s)
Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

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

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☒ **Revise service specifications**
- ☒ **Revise provider qualifications**
- ☒ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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

1. Request Information (1 of 3)

A. The **State** of **South Dakota** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: SD.0189
Waiver Number:SD.0189.R06.04
Draft ID: SD.010.06.04

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/16
Approved Effective Date of Waiver being Amended: 10/01/16

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 in42 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 §1915(a)(1)(a) of the Act and described in Appendix I**

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

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

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual 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. The 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 primary goal of the HOPE Waiver is to provide services to adults, age 65 and older and adults with a qualifying disability over the age of 18 in their homes or the least restrictive community environment available to them. The goal of the HOPE Waiver is to reduce unnecessary nursing facility care by providing individuals with community-based services to remain at home and/or to transition to a less restrictive setting in their communities as long as they remain safe and/or choose to live there. 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 consumers; 2) Protect consumers from abuse, neglect and exploitation; 3) Foster partnerships to leverage resources for consumers; 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 own homes and communities.

Consumers access home and community-based waiver services by contacting the Division of Long Term Services and Supports which employs Specialists (57 FTE), in 24 LTSS offices located throughout the state. In South Dakota, the Aging and Disability Resource Connections (ADRC) functions as the 'front door' to access long term services and supports. Five of the LTSS offices, are regional ADRC Call Centers with separate 1-800 toll free telephone numbers and designated counties allowing statewide coverage. The ADRC Call Centers are marketed to the general public as the single point of entry to access the long-term services and supports system in South Dakota. The 24 LTSS offices also function as a 'No Wrong Door' connecting individuals to Home and Community-Based Services.

LTSS Specialists perform intake and referral, options planning, assessment, and person centered care planning in addition to case management and follow-up. LTSS Specialists determine functional eligibility for the Medicaid State Plan and Home and Community-Based Services Waiver and are co-located in offices with Division of Economic Assistance staff who determine financial eligibility and track individual eligibility status throughout the eligibility determination process. If the individual applicant is deemed eligible, the LTSS Specialist after exploring all available resources, including natural supports, assists the individual to access waiver services through a person centered planning process.

The HOPE Waiver provides a wide range of services with the goal of meeting the individual needs of each waiver consumer, realizing that needs vary greatly across the spectrum of health issues and disabilities the waiver participants face. Waiver services include: Adult Day Services, Chore, Homemaker, Personal Care, Respite Care, Specialized Medical Equipment, Specialized Medical Supplies, Adult Companion Services, Assisted Living, Environmental Accessibility Adaptations, In-Home Nursing Services, Meals, Nutritional Supplements, Emergency Response System (ERS),Community Transition Supports, Community Transition Coordination, Community Living and Structured Family Caregiving. Waiver services are delivered by providers that have successfully enrolled with SD Medicaid (or through a Medicaid Enrolled oversight agency for Structured Family Caregiving and Community Living as applicable)and met all qualification requirements.

The Division of Long Term Services and Supports ensures the providers authorized to provide services are qualified and that financial integrity is maintained. LTSS conducts all continuous quality improvement activities, including data collection, aggregation, analysis, trend identification, and design changes and implementation.

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

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

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

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §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 §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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

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

The State secures stakeholder and public input through several methods. Regular community outreach allows the public and stakeholders to provide feedback on service delivery and quality improvement. LTSS staff conduct outreach throughout the state, speaking with consumers and non-consumers at community events and health fairs, community organizations, hospitals and health clinics, Senior Centers and nutrition sites, Medicare open-enrollment events and during facility visits. Feedback about service delivery regarding waiver services is forwarded to the HCBS Program Manager who assures follow-up is completed as appropriate. Waiver consumers have an annual opportunity to provide feedback through a Quality of Life survey and at any time to the LTSS Specialist. Waiver service providers directly communicate with LTSS staff. Additionally, the HCBS Program Manager and other Program Specialists present changes and program information at provider association meetings and conferences.

The thirty day formal public comment period was held from 5/8/2020 through 6/7/2020. The waiver amendment along with a summary of changes was made available to the public, consumers, providers, stakeholders, and LTSS staff through the DSS and DHS websites. Hard copies of the waiver amendment and corresponding summary of changes were also made available upon request through email, mail or phone. A public hearing was held on May 14, 2020 to provide an opportunity to ask questions and/or make a comment.

Assisted Living Centers were given a waiver amendment public comment poster, summary of changes and instructions on how to comment through email, mail, and phone or via the public hearing. Providers were asked to display the poster for consumers to see. The poster included a summary of changes and information on how to comment. The poster included the following language "View the Waiver Amendment online at https://dss.sd.gov/keyresources/hearings.aspx or at http://dhs.sd.gov/ltss/titlexix.aspx or contact the Division of Long Term Services and Supports at 605-773-3656 to request a copy."

Notice of the Waiver Amendment was sent to tribes and to the Medicaid Advisory Committee on 5/8/2020.

There is a formal process for updating and changing requirements associated with the HOPE waiver. Administrative Rules of South Dakota must be revised to reflect significant changes in waiver design and processes, including the addition of services. Revisions to Administrative Rules require a public hearing allowing for public comment. LTSS policies are revised when updates to the waiver are made. Waiver related policy updates are reviewed with the Waiver Review Committee as well as an internal LTSS Policy Workgroup regarding revisions to policy and procedure.

Due to character constraints, comments received during the public notice period for this amendment and the state's responses are available online at https://dhs.sd.gov/ltss/titlexix.aspx.

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:

Hynes

First Name:

Samantha

Title:

Policy Strategy Manager

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) 773-3040 **Ext:** ☐ **TTY**

Fax:

(605) 773-5246

E-mail:

samantha.hynes@state.sd.us

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

Last Name:

n/a

First Name:

n/a

Title:

n/a

Agency:

n/a

Address:

n/a

Address 2:

n/a

City:

n/a

State: **South Dakota**

Zip:

57501

Phone:

(605) 773-3495 **Ext:** ☐ **TTY**

Fax: (605) 773-5246

E-mail: n/a

8. Authorizing Signature

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

Signature: Samantha Hynes

State Medicaid Director or Designee

Submission Date: Sep 22, 2020

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

Last Name: Aker

First Name: Sarah

Title: Deputy Division Director

Agency: Division of Medical Services

Address: 700 Governors Drive

Address 2:

City: Pierre

State: **South Dakota**

Zip: 57501

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

Fax: (605) 773-5246

E-mail:
sarah.aker@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:

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

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

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

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

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

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

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan."
SD prepared a specific assessment for Adult Day settings utilizing the HCBS Non-Residential Exploratory Questions in the CMS HCBS Toolkit. Assessments were performed by ASA staff. SD determined these settings meet the intent of the federal regulations and do not require further action to be compliant. SD will require each enrolled setting to sign a supplemental agreement attesting to compliance with the requirements of the federal regulations.

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 operates the HOPE Waiver. The Department of Human Services/Division of Long Term Service and Supports is a separate executive branch agency from the Department of Social Services (DSS), which is the designated Single State Medicaid Agency (SSMA). A Memorandum of Understanding (MOU) signed by the Cabinet Secretary of each department sets forth the responsibilities of each department.

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

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

•Preparation and submission of quarterly projections of Title XIX expenditures for future quarters to the federal government;
•Preparation and submission of federally mandated reports of actual Title XIX expenditures to the federal

government;
•Explanation of variances between projected and actual Title XIX expenditures to the federal government;
•Drawdown of all Federal Title XIX cash for the state;
•Review of cost allocation plans involving Title XIX funding prior to submission to the federal government; and
•Review of responses to federal reviews and audits involving Title XIX prior to submission to the federal government.

DHS, to exercise operational authority and supervision of the waiver, will have the responsibility:
•To develop regulations for new or revised DHS program objectives; to present and defend Medicaid regulations proposed by DHS to the Legislative Research Council and the Interim Rules Review Committee;
•To notify the State Medicaid Director (SMD) and seek review and comment from the SMD or designee on new or proposed changes to Title XIX Medicaid Waiver Programs and changes in regulations or standards of existing programs so DSS may assess the administrative and financial impact on the Medicaid budget;
•To develop proposed Medicaid State Plan and Waiver amendments as required for DHS Title XIX programs and services and to submit such proposals, along with summary information on proposed changes, to DSS for review, approval and submission to CMS;
•To provide documentation and assurances to DSS supporting appropriate expenditures and related nonfederal match (including that provided by local school districts) of Title XIX funds as a provision of accepting those funds;
•To meet sub-recipient audit requirements of the Single Audit Act and associated OMB Circular A-133;
•To maintain program standards and to monitor the provision of services to individuals age 65 or older or individuals age 18 or older with a qualify disability
•To conduct financial recoveries necessitated by erroneous, fraudulent or abusive practices by DHS providers and to work with DSS on proper handling of these recoveries;
•To accept total responsibility for that portion of the state's federally-established quality control error rate resulting from DHS errors, including any financial penalties and development of appropriate corrective action;
•To accept total responsibility should there be federal audit exceptions related to DHS' involvement with Title XIX Medicaid funding;
•To assist in the resolution of pended and denied claims;
•To cooperate with DSS and the SMD in the administration of the Medicaid Program; to comply with all rules and regulations governing the Medicaid Program; to provide information necessary for DSS to function effectively as the SSMA;
•To operate all approved DHS HCBS waiver programs in compliance with all federal and state statutes, rules, and regulations, and provide reports detailing program implementation, participants served, and other performance measures specified by DSS;
•To work cooperatively with DSS as the administrative authority when implementing HCBS waiver changes, amendments and renewals initiated by DHS as the operating agency; and
•To review all proposed hearing decisions regarding non-financial eligibility issues for the Title XIX Medicaid Waiver Programs administered by DHS and submit any comments or recommendations within seven days of receipt of the proposed decision. If compliance with timeframes set in rules regarding issuance of a final order require a quicker response time, DHS will comply with the necessary response time upon receipt of notice of such from DSS.
•DHS calculates waiver payment amounts and/or rates in preparation for waiver application/renewal and submission of the 372 report to CMS. This information is then sent to the SSMA for review and approval/denial.

Quarterly Internal Waiver Review Committee meetings are held between the State Medicaid Agency and all State of South Dakota HCBS Waiver Program Managers. The Internal Waiver Review Committee (IWRC) is comprised of the HCBS Wavier Program Managers of each of the four HCBS waivers in South Dakota, a representative from the Division of Medical
Services (the Medicaid Agency) and other representatives from the DSS and the DHS. At quarterly IWRC meetings, HCBS Waiver Program Managers present information about trends in data, renewal application or amendment progress, and areas of concern. The IWRC quarterly meeting minutes are maintained by the Medicaid Agency.

During the period prior to waiver application/renewal, DSS and DHS meet jointly to collaborate in completing each of the appendices of the new waiver template. DHS is responsible for drafting and forwarding each appendix to DSS, to include the state Medicaid Director (SMD), Director of Economic Assistance, and the Chief

Financial Officer, for review and approval/denial.

Appendix A: Waiver Administration and Operation

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:

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:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☒
Level of care 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 States quality improvement strategy, provide information in the following fields to detail the States 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:
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:
FileDirector, a document reviewing system, SAMS 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**	☐ **Other**

	Ongoing	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 times the designated agency (DHS) maintained program participants within approved waiver limits. Numerator: The total number of times when the designated agency (DHS) maintained program participation within approved waiver limits. Denominator: The total number of times.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of times the designated agency (DHS) maintained program expenditures within approved waiver limits. Numerator: The total number of times the designated agency maintained program expenditures within approved waiver limits. Denominator: The total number of times.

Data Source (Select one):
Other
If 'Other' is selected, specify:
372 report, Claims data from 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:

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, SAMS 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 States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The South Dakota Department of Social Services (DSS), the single State Medicaid Agency retains ultimate administrative authority and responsibility for the entire operation of the HOPE Waiver. If individual problems are identified in the administration of this waiver or within Long Term Services and Supports, performance of specific delegated waiver functions, identified problems will be remediated between the State Medicaid Agency and the Division of Long Term Services and Supports. A meeting(s) to address and reach a resolution to identified problems will be held which may also generate changes to the design of the waiver and methods of implementation. If the problems identified are the result of the ineffectiveness of one individual LTSS staff member, said staff member will receive additional training and/or have personnel action initiated depending on the scope of the identified problem(s).

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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - General					
	☒	Aged	65		☒
	☒	Disabled (Physical)	18	64	
	☒	Disabled (Other)	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:

Consumers 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 consumer chooses to remain on waiver services, no transition would be necessary. If a consumer chooses to leave waiver services at any time, an LTSS Specialist will assist in transitioning the consumer to alternative, community-based services or as appropriate to meet the consumer's needs, to another waiver program.

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	

Waiver Year	Unduplicated Number of Participants
	1827
Year 2	2065
Year 3	2295
Year 4	2527
Year 5	2782

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. Waiver applications 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 in order 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 65 or older or is over the age of 18 with a qualifying disability;
(2) The individual is receiving Supplemental Security Income 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 institutionalized;
(3) The medical review team has determined according to ARSD 67:45:01 that the individual meets the nursing facility level of care; and
(4) The individual will reside at home or in a home and community-based residential setting, while receiving waiver services.

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 a Medical Review Team 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 Community Health Assessment (CHA)/Functional Supplement to the CHA.

All initial evaluations of Level of Care for waiver applicants are conducted by a Medical Review Team. The Medical Review Team performs all initial evaluations and reevaluations of Level of Care determinations and is comprised of a Division of Long Term Services and Supports Nurse Consultant, a Registered Nurse licensed to practice in the State of South Dakota, and a Division of Long Term Services and Supports Specialist. When the LTSS Specialist who sits on the Medical Review Team is the one who completes the Community Health Assessment in the case under review, an alternate LTSS Specialist is assigned to assure the Level of Care determination does not include the LTSS Specialist who completed the consumer's assessment.

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)*:

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

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

- ( ) **No**
- (●) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **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: [ ]

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

  Specify:

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

○ **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, 2019 (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 §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

A consumer living in his/her own home and/or receiving a structured family caregiving services will be allowed an amount equal to 300% of the SSI Federal Benefit Rate (FBR).

A consumer receiving Assisted Living or community living home services will be allowed an amount equal to the SSI standard benefit plus $20. 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 §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 periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ◉ **Other**

  Specify:

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

A consumer living in an Assisted Living will be allowed an amount equal to the SSI standard benefit plus $20. 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:

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate 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 five-year period beginning January 1, 2014.

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

Answers provided in Appendix B-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 five-year period beginning January 1, 2014.

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

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

Answers provided in Appendix B-5-a indicate 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 a government agency 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 Medical Review Team. The Medical Review Team performs all initial evaluations and reevaluations of Level of Care determinations and is comprised of a Division of Long Term Services and Supports (LTSS) Nurse Consultant, a Registered Nurse licensed to practice in the State of South Dakota, and an LTSS Specialist. When the LTSS Specialist who sits on the Medical Review Team is the one who completes the Community Health Assessment in the case under review, an alternate LTSS Specialist is assigned to assure the Level of Care determination does not include the LTSS Specialist who completed the consumer's assessment.

When determining Level of Care, the Medical Review Team reviews case documentation including the Community Health Assessment (CHA). Medical Review Team members receive training from the Home and Community-Based Services (HCBS) Program Manager and the LTSS Nurse Consultant Program Manager, a Registered Nurse. Training topics include Level of Care and the Level of Care determination process and the Home and Community-Based Services Waiver policy and procedures. The HCBS Program Manager and the Nurse Consultant Program Manager also provide technical guidance to the Medical Review Team. Specific to the Community Health Assessment, all LTSS Specialists receive instructional training to complete the interRAI Community Health Assessment/Functional Supplement to the CHA per the interRAI Community Health Assessment/Functional Supplement User's Manual and an interRAI Clinical Assessment Protocols (CAPs) Manual. Each LTSS Specialist retains the interRAI Community Health Assessment/Functional Supplement User's Manual and an interRAI Clinical Assessment Protocols (CAPs) Manual to utilize in completing the assessment and reassessments.

The Division of Long Term Services and Supports hires individuals for the position of LTSS Specialist based on education and experience to include a Bachelor's Degree with major work in social work, psychology, health or related field and/or knowledge of social work principles and practices; and cultural, economic, social, physical and psychological factors that influence the elderly population and adults with disabilities.

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 a Medical Review Team must determine if the individual requesting long-term care assistance is in need of care. The Medical Review Team 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 which have been ordered by a physician and can only be provided by or under the supervision of a professional nurse. 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) In need of skilled mental health services or skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once a week.

The Level of Care instrument/tool that is employed is the Community Health Assessment(CHA)/Functional Supplement to the CHA.

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 MDS-RAI, 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 Community Health Assessment (CHA). The interRAI CHA 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 Community Health 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 Community Health Assessment is utilized to determine Level of Care for the HOPE waiver. When a waiver consumer transfers to a nursing facility for a short term stay and subsequently returns to a home and community-based setting and resumes waiver services, the MDS-RAI and the physician admit and/or discharge order are utilized by the Medical Review Team to make the appropriate Level of Care determination for each setting in which the consumer resides.

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 consumer's medical, nursing, psychosocial functioning and service needs. Upon a determination that a consumer may meet the eligibility requirements for the waiver, a Long Terms Services and Supports (LTSS) Specialist assigned to the consumer's case completes the Community Health Assessment (CHA), and submits it to the the Medical Review Team. The Medical Review Team 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 Specialist assigned to manage the consumer's case conducts an in-home reassessment of the consumer at least annually, or when the consumer's needs change. This reassessment, using the Community Health Assessment (CHA), takes place prior to when the Level of Care determination is due. Following a home visit, the LTSS Specialist compiles all required documentation, just as with the initial determination, and submits the documentation to the Medical Review Team. The Medical Review Team conducts a review of the submitted documentation to make the Level of Care determination and reports back to the assigned LTSS Specialist. If when completing a reassessment, it is determined a consumer no longer meets Level of Care for the waiver, the consumer is notified in writing by the Division of Economic Assistance. The LTSS Specialist offers the consumer Options Planning and assists the consumer to transition to other available services and supports provided through the Division of Long Term Services and Supports, natural 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) Specialists provide case management to all waiver consumers. As such, an LTSS Specialist is responsible for the timely Level of Care re-evaluations of their assigned consumers. To assist the Specialist in completing timely re-evaluations, the Social Assistance Management System (SAMS) dashboard is used in monitoring when Level of Care re-determinations are due for each consumer. A notification indicates to the Specialist when the consumer requires a reassessment and Level of Care re-evaluation. The Specialist meets with the consumer for the reassessment and Care Plan development and compiles all required documentation for a Level of Care re-evaluation which is provided to the Medical Review Team. When a Specialist who completes the reassessment also serves on the Medical Review Team, an alternate Specialist sits on the Medical Review Team for said determination to maintain objectivity of the case being re-evaluated.

Additionally, all Level of Care determinations are maintained in a database monitored by the Nurse Consultant Program Manager and LTSS Regional Managers 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 States quality improvement strategy, provide information in the following fields to detail the States 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, SAMS 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 consumers whose level of care determination included the required documentation. Numerator = Number of LOC determinations with correct documentation. Denominator = All LOC determinations.

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

FileDirector, a document reviewing system and SAMS 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**

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 LOC determinations (initial and annual) made where the LOC criteria was accurately applied. Numerator = Number of LOC determinations where criteria was accurately applied. Denominator = Number of LOC determinations reviewed in sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FileDirector, a document reviewing system and SAMS 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%, +/-9%
☐ **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:

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 Home and Community-Based Services (HCBS) Program Manager.

The Division of Long Term Services and Supports has ten Regional Supervisors who supervise Specialists located in 24 offices around the state. Each month all Level of Care determinations made the previous month are randomly assigned to the Regional Supervisors for review. The Regional Supervisors are responsible for reviewing the Level of Care determinations to ensure new applicants had a Level of Care determination prior to receiving services and that the Level of Care determination included the required documentation.

The Nurse Consultant Program Manager reviews a random sample of the Level of Care determinations based on the projected number of waiver participants for the year to ensure the Level of Care criteria was accurately applied. The universe for the random sample for the first three quarters of the year is the projected number of waiver consumers for that year. The projected number of waiver consumers is entered into the Raosoft sample calculator to determine a sample size. For the last quarter of the year, the universe is updated to reflect the actual number of waiver consumers for the year and the sample size is updated based on the actual number of waiver consumers for the year as well. The random sample is created using Microsoft Excel random number and sorting functions. The results of the review are recorded in an Excel spreadsheet maintained by the HCBS Program Manager. The margin of error of the representative sample for this measure will be +/- 9%. We have increased the margin of error on this sample because Performance Measure 1 in Sub-assurance C is being reviewed at 100%. The State will increase the frequency of review for performance measure C2 to occur on a monthly basis due to reviewing a smaller sample size. 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.

Level of Care reviews are discussed at quarterly Waiver Review Committee meetings and recommendations for improvement are made when trends are identified. The Waiver LTSS Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, LTSS Training Coordinator, LTSS Regional Managers, two LTSS Regional Supervisors, and two LTSS Specialists.

b. Methods for Remediation/Fixing Individual Problems

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

100% of the Level of Care determinations are reviewed by the Division of Long Term Service and Supports Regional Supervisors on a monthly basis, allowing them to identify individual problems.

If it is determined that an individual has received waiver services prior to the Level of Care determination and the services have already been reimbursed by Medicaid, the payment will be recalled and services provided will be paid for through alternative funding. Additionally, Level of Care processes and procedures are reviewed and recommendations for improvement are made if trends are identified.

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

Quarterly, 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 consumer being removed from the waiver program. If, through a process of additional information retrieval, 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 consumer from the waiver, documentation will be recollected and resubmitted to the Medical Review Team for a re-evaluation as the consumer's health status may have changed. Any payment paid to a provider for services during the time when the consumer did not meet Level of Care will be recalled and the services will be paid for through alternative funding. If it is determined a consumer was eligible for waiver services, but Level of Care criteria was not accurately applied, the consumer 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 Medical Review Team are planned and conducted accordingly.

Statewide data analysis conducted by the Home and Community-Based Services (HCBS) Program Manager 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. The Waiver Review Committee is led by the HCBS Program Manager and includes the following additional members: Division Long Term Services and Supports Director and Deputy Division Director, LTSS Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, LTSS Training Coordinator, LTSS Regional Managers, two LTSS Regional Supervisors, and two LTSS Specialists.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 consumer's Level of Care determination indicates nursing facility Level of Care, the Specialist throughout the assessment and person centered care planning process discusses the HOPE Waiver Services that are available to meet the consumer's needs at home or in a HOPE waiver residential setting (Assisted Living, Structured Family Caregiving Home, Community Living Home). The Specialist also discusses the provision of long term care services provided in a nursing facility with the consumer or his/her authorized representative. The Care Plan is signed by the consumer or authorized representative and includes the following statement, "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." Various informational brochures, i.e., "Assisted Living in South Dakota, "Aging & Disability Resource Connections", "Home and Community-Based Services Waiver" explaining available long term services including HOPE Waiver Services an are offered to the consumer or his/her authorized representative. The Care Plan form 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 Specialist to provide the consumer or his/her authorized representative a list of providers, available within the consumer's community, that offer provision of the home and community-based services contained in the consumer's Care 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 Care Plan, through the consumer's or his/her authorized representative's signature, documents that the consumer 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 Care Plan. All Care Plans are scanned and stored electronically in the State of South Dakota's FileDirector system, a digital document reviewing program, 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 (DHS) employs several methods to provide Limited English Proficient persons access to services. Formal agreements with community organizations and individual interpreters who provide interpreter services and bilingual DHS staff are utilized to arrange for Interpreters to accompany the LTSS Specialists on initial and follow-up home visits and during assessment and the care planning processes with consumers who are Limited English Proficient. Consumers are offered free interpreters such as through InterpreTalk, an unscheduled telephone interpretation service that allows for interpretation of 170 languages, 24 hours a day, 7 days a week. Individual interpreters may also be available depending on the consumer's culture, i.e., Lakota and are utilized in addition to family members or other natural supports who serve as the consumer's interpreter. Department of Human Services offices located across the state maintain a document entitled, "Procedures for Communicating Information to Persons With Sensory Impairments and Limited English Proficiency" which includes a list of community organizations, individual interpreters and bilingual DHS staff that provide interpreter services to the Department of Human Services for persons with Limited English Proficiency. The Department of Social Services Application for Long Term Care or Related Medical Assistance and a handbook describing the Division of Long Term Services and Supports Programs are available in Spanish and can be accessed by individuals who are Limited English Proficient at Department of Human Services offices located across South Dakota and by direct access through the Department's online website.

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**		
Statutory Service	**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**		

Service Type	Service		
Other Service	Nutritional Supplements		
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: **Sub-Category 1:**

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

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

Service Definition *(Scope)*:

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

Adult day services provide regular care, supervision and structured activities in a non-institutional community-based setting. Adult day services include both health and social services needed to ensure the optimal functioning of the consumer for a period of less than 24 hours per day. Adult day services are provided to a consumer who lives at home. Nutritious meals/snacks are available but are billed as a separate service. Adult day services are integrated in the community. Although not required, nursing services are provided based on assessed need and include health screenings, blood pressure checks, medication management, and a general assessment of the consumer's condition.

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 care plan with a threshold equal to the average cost of nursing home care. 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**

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	Senior Center
Agency	Free-standing Adult Day Centers

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:

Senior Center

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Agreement and completing a HCBS Settings Adult Day Assessment.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:

Free-standing Adult Day Centers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Agreement and completing a HCBS Settings Adult Day Assessment.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:

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

Respite care will be provided short-term (less than 30 consecutive days) for an individual who is unable to care for him or herself in the absence of or for the relief of the caregiver. Respite care is available to eligible individuals who reside with unpaid caregivers.

Room and board will not be reimbursed in any private residence including individual's place of residence and private residence of the respite care provider.

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 care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

The concurrent provision of respite care as a distinct additional service is prohibited for a consumer who resides in an assisted living center.

When respite services are provided in and adult day setting, respite is limited to non adult-day business hours.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care
Agency	Private and hospital-based in-home service providers
Agency	Long-term care facility
Agency	Assisted Living Centers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify)*:

N/A

Certificate *(specify)*:

N/A

Other Standard *(specify)*:

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Agreement and completing a HCBS Settings Adult Day Assessment.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify)*:

Not Applicable

Other Standard *(specify)*:

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Provider Agreement, and completing a Provider Quality Management Self-Assessment.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Long-term care facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

Long-term care facilities must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, providing verification of current, valid licensure and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically Medicaid Provider Enrollment.

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Assisted Living Centers

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 Centers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, providing verification of current, valid licensure and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically Medicaid Provider Enrollment.

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope):*

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

In-home services consist of the performance of general household tasks provided by a homemaker, when the consumer is unable to manage the home and care for him or herself or others in the home. 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. The scope and nature of these services do not differ from homemaker services furnished under the State Plan. The provider qualifications specified in the State Plan apply. The additional amount of services that may be provided through the waiver is the provision of additional homemaker services over and above the amount allowed in the State Plan.

HOPE waiver participants must be referred to a Structured Family Caregiving provider for assessment when a primary caregiver resides in the home and is being paid to provide routine intermittent personal care, supervision, cueing, meals, homemaker, chore services, medication management and/or other instrumental activities of daily living.

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 based on assessed need as identified in the person centered care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

The concurrent provision of homemaker services as a distinct additional service is prohibited for a consumer who resides in an assisted living center. Homemaker services are included in the scope of services provided to a consumer living in an assisted living center.

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

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

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify)*:

Not Applicable

Other Standard *(specify):*

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Provider Agreement, and completing a Provider Quality Management Self-Assessment.

The Supplemental Agreement requires that the provider have policies on the following:
- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake/Admission
- Discharge
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy
- Medication Administration

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:
- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters a consumer's home unsupervised. The Provider will ensure that each in-home aide receives a minimum of 6 hours of training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope)*:

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

Care provided by a licensed nurse within the scope of State of South Dakota Codified Law. In-home nursing services are provided under the waiver when nursing services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from nursing services furnished under the State Plan. The provider qualifications specified in the State Plan apply. Services are under the direction of a physician.

Services are based on assessed need as identified in the person centered care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process

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 based on assessed need as identified in the person centered care plan with a threshold equal to the average cost of nursing home care. 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**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Provider Agreement, and completing a Provider Quality Management Self-Assessment.

The Supplemental Agreement requires that the provider have policies on the following.

- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake/Admission
- Discharge
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy
- Medication Administration

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters a consumer's home unsupervised.

The Provider must verify, through the South Dakota Board of Nursing, RN or LPN licensure for each newly employed nursing staff who will be providing services to LTSS consumers. The Provider must have a Staffing Policy that specifies the processes for conducting this verification.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope):*

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

Personal care includes assistance provided to a consumer living at home to perform his or her activities of daily living. In-home personal care services are those services provided when personal care furnished under the approved State Plan limits are exhausted. The additional amount of services that may be provided through the waiver is the provision of additional personal care services over and above the amount allowed in the State Plan. The scope and nature of these services do not differ from personal care services furnished under the State Plan. The provider qualifications specified in the State Plan apply.

HOPE waiver participants must be referred to a Structured Family Caregiving provider for assessment when a primary caregiver resides in the home and is being paid to provide routine intermittent personal care, supervision, cueing, meals, homemaker, chore services, medication management and/or other instrumental activities of daily living.

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:

The concurrent provision of personal care services as a distinct additional service is prohibited for a consumer who resides in an assisted living center. Personal care services are included in the scope of services provided to a consumer living in an assisted living center.

Services are based on assessed need as identified in the person centered care plan with a threshold equal to the average cost of nursing home care. 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**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

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:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Provider Agreement, and completing a Provider Quality Management Self-Assessment.

The Supplemental Agreement requires that the provider have policies on the following:
- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake/Admission
- Discharge
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy
- Medication Administration

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:
- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters a consumer's home unsupervised. The Provider will ensure that each in-home aide receives a minimum of 6 hours of training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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 Care

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

All personal care providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Provider Agreement, and completing a Provider Quality Management Self-Assessment.

The Supplemental Agreement requires that the provider have policies on the following:
- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake/Admission
- Discharge
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy
- Medication Administration

Additionally, the Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:
- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee completes personal care tasks unsupervised. The Provider will ensure that staff member receives a minimum of 6 hours of training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope):*

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

Specialized medical equipment are devices, controls, or appliances, specified in the plan of care, that enable consumers to increase their ability to perform activities of daily living and assist the consumer to remain living safely at home. Services consist of assistive technology equipment, installation and monitoring, purchasing, leasing or otherwise providing devices, controls, sensors or appliances to be used to increase, maintain, or improve functional capabilities of consumers. Specialized medical equipment reimbursed with waiver funds is in addition to any specialized medical equipment furnished under the State Plan and excludes those items that are not of direct medical or remedial benefit to the consumer.

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 based on assessed need as identified in the person centered care plan with a threshold equal to the average cost of nursing home care. 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**

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

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

Provider Specifications:

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

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:

Private businesses

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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 supplier

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement. Providers of Specialized Medical equipment must also have a CMS Supplier number.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically Medicaid Provider Enrollment.

Frequency of Verification:

Ongoing monitoring.

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:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacies are licensed by the South Dakota Board of Pharmacy.

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

Pharmacies must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, providing verification of current, valid licensure and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically 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:**

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

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

Service Definition *(Scope)*:

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

Specialized medical supplies are disposable supplies which are necessary to maintain a consumer's health, manage a medical or physical condition, improve functioning, or enhance independence as specified in the Care Plan. Medical supplies reimbursed with waiver funds are in addition to any medical supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the consumer.

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 based on assessed need as identified in the person centered care plan with a threshold equal to the average cost of nursing home care. 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**

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

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

Provider Specifications:

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

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:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify)*:

Not Applicable

Other Standard *(specify):*

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacies are licensed by the South Dakota Board of Pharmacy.

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

Pharmacies must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, providing verification of current, valid licensure and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically Medicaid Provider Enrollment.

Frequency of Verification:

Ongoing monitoring.

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 suppliers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically 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:**

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

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

Service Definition *(Scope)*:

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

Non-medical care, assistance, supervision or socialization provided to a consumer living at home or in an Assisted Living Center. Companions perform tasks that are incidental to the care and supervision of the consumer as opposed to completing the tasks for the consumer. Completion of homemaker, personal care and chore services will be authorized and provided as distinct, unduplicated services as assessed and specified in the Care Plan.

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 care plan with a threshold equal to the average cost of nursing home care. 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**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify)*:

Not Applicable

Other Standard *(specify)*:

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Provider Agreement, and completing a Provider Quality Management Self-Assessment. In addition, when authorized to provide adult companion services, these provider agencies are responsible for liability and maintaining proof of insurance and proof of a valid driver's license for any employee transporting consumers.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope):*

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

Assisted living centers offer homemaker, personal care, chore, and meal preparation to consumers who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable consumer needs and to provide supervision, safety and security. The assisted living location promotes the health, treatment, comfort, safety, and well-being of residents, with easy accessibility for visitors and others.

Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5.

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 care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

The concurrent provision of homemaker, personal care, chore services, emergency response systems, respite care, meals, and environmental accessibility adaptations as distinct additional services is prohibited for a consumer who resides in an assisted living center.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Centers

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 Living Centers

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 Centers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, providing verification of current, valid licensure, signing a standard Provider Agreement and a Provider Addendum.

The Supplemental Agreement requires the Provider to 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 homes of consumers. In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:
• The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
• The alternative background check identifies the criminal history of the individual hired
• The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically Medicaid Provider Enrollment.

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope)*:

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

Chore services needed to maintain the consumer's home in a healthy and safe environment. Chore services are lawn mowing, snow and ice removal from sidewalks and driveways, or other services which the home owner is required to complete by city or county ordinance.

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 care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

The concurrent provision of chore services as a distinct additional service is prohibited for a consumer who resides in an assisted living center.

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

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

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

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

Provider Specifications:

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

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:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify)*:

Not Applicable

Other Standard *(specify):*

All private and hospital-based in-home service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, signing a Supplemental Provider Agreement, and completing a Provider Quality Management Self-Assessment.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:

Community-based organizations

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope):*

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

Community living home residential services 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 shall be addressed in a manner that support and enable 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 to persons who meet Nursing Facility level of care and 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 service 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 care 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, adult companion services, 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 care plan, respite care may also be authorized for separate payment when the community living home is the full time residence of the owner/operator who is providing direct care services. Consistent with a participant's assessed needs and as reflected in the person-centered care 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**

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):*

Community living providers must either enroll as a Medicaid waiver provider or enroll through a Medicaid enrolled oversight agency. The enrollment process includes completing an enrollment application, providing verification of current, valid licensure, signing a standard Provider Agreement, and a Provider Addendum.

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

Additionally, any person over the age of 18 residing in a community living home must also have a State fingerprint (or other approved) background check.

The Provider must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

Providers must establish a mechanism for daily documentation of services. Documentation must be readily available at the State's request.

When a community living provider enrolls through a Medicaid enrolled oversight agency, the oversight Agency must provide telephonic support and emergency back-up as needed, 24 hours a day, 7 days a week. The Medicaid enrolled oversight agency must conduct a minimum of one visit (telephonic, on-site, or virtual) per month with the participant and principal caregiver. At least one visit per quarter must be an on-site face to face visit.

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:

Annual

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:**

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

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

Service Definition *(Scope):*

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

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 includes:

- 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**

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 organization
Agency	Private business

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:

Community-based organization

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 community transition providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, and signing a Provider Addendum.

The Provider Addendum requires that the provider have policies on the following:

- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake process for new referrals
- Termination of services
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:
- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters a consumer's home unsupervised.

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:

Once every two years

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:

Private business

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 community transition providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, and signing a Provider Addendum.

The Provider Addendum requires that the provider have policies on the following:

- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake process for new referrals
- Termination of services
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters a consumer's home unsupervised.

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:

Once every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Supports

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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 consumer 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 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 consumer'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, 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**

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	Private Businesses

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:

Community-Based Organizations

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All community transition providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, and signing a Provider Addendum.

The Provider Addendum requires that the provider have policies on the following:

- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake process for new referrals
- Termination of services
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters a consumer's home unsupervised.

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 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:

Once every two years

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:

Private Businesses

Provider Qualifications

License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

All community transition providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement, and signing a Provider Addendum.

The Provider Addendum requires that the provider have policies on the following:

- Abuse and Neglect Reporting
- Staffing
- Staff Training
- Intake process for new referrals
- Termination of services
- Consumer Confidentiality
- Consumer Rights and Responsibilities
- Documentation
- Incident Reporting
- Emergency Response
- Health and Safety
- Quality Assurance
- Consumer Grievances
- Gifting Policy

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:
- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Provider must routinely check the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not on the excluded list.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters a consumer's home unsupervised.

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 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:

Once every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Emergency Response System (ERS)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

An Emergency Response System is an electronic device that enables a consumer who lives in his or her home to secure help in an emergency. The consumer may also wear a portable "help" button to allow for mobility. The system is connected to a consumer's phone and programmed to signal a response center once a "help" button is activated.

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 care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

The concurrent provision of the emergency response service as a distinct additional service is prohibited for a consumer who resides in an assisted living center.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Utility companies
Agency	Telephone cooperatives
Agency	Private and hospital-based in-home service providers
Agency	Durable Medical Equipment supplier
Agency	Private businesses

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:

Utility companies

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically 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: Emergency Response System (ERS)

Provider Category:

Agency

Provider Type:

Telephone cooperatives

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically 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: Emergency Response System (ERS)

Provider Category:

Agency

Provider Type:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All private and hospital-based in-home service providers must enroll as waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically 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: Emergency Response System (ERS)

Provider Category:

Agency

Provider Type:

Durable Medical Equipment supplier

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically 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: Emergency Response System (ERS)

Provider Category:

Agency

Provider Type:

Private businesses

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope):*

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

Those physical adaptations to the private residence of the consumer, or the consumer's family, required by the consumer's care plan, that are necessary to ensure the health, welfare, and safety of the consumer or that enable the consumer to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the consumer.

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

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 care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

The concurrent provision of environmental accessibility adaptations as a distinct additional service is prohibited for a consumer who resides in an assisted living center.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private businesses
Agency	Community-based organizations

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:

Private businesses

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify)*:

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement and signing a Supplemental Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:

Community-based organizations

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement and signing a Supplemental Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope)*:

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

Nutritious meals, provided to a consumer who lives at home, which follow federal dietary guidelines and can be provided for breakfast, lunch and dinner to enhance a consumer's diet.

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 care plan with a threshold equal to the average cost of nursing home care. Services over this threshold are subject to an exceptions process.

The concurrent provision of meals as a distinct additional service is prohibited for a consumer who resides in an assisted living center.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Senior Meals providers
Agency	Community-based organizations

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 enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically 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:

Community-based organizations

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:**

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

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

Service Definition *(Scope):*

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

Nutritional supplements provided to a consumer who is below his or her medically recommended body weight; nutritionally deficient or malnourished; to promote wound healing, or to manage other health conditions. Services are under the direction of a physician.

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 care plan with a threshold equal to the average cost of nursing home care. 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**

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

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

Provider Specifications:

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

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:

Private and hospital-based in-home service providers

Provider Qualifications

License *(specify)*:

Not Applicable

Certificate *(specify)*:

Not Applicable

Other Standard *(specify)*:

All waiver providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacies are licensed by the South Dakota Board of Pharmacy.

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

Pharmacies must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application, providing verification of current, valid licensure and signing a standard Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically Medicaid Provider Enrollment.

Frequency of Verification:

Ongoing monitoring.

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:

Community-based organizations

Provider Qualifications

License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

All service providers must enroll as Medicaid waiver providers. The enrollment process includes completing an enrollment application and signing a standard Provider Agreement.

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 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:

Structured Family Caregiving

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

The structured family caregiving service offers 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 this service is to provide necessary care and supervision for the participant, and to provide an opportunity for 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 HOPE Waiver case manager, and the Medicaid enrolled structured family caregiving provider agency.

Participant needs shall be 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 to 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 the 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 structured family caregiving provider agency may not own, lease or rent the residence. The structured family caregiving home setting is assessed by the provider agency to ensure that the home setting is safe, accessible and allows for comfort and privacy for the participants receiving care. The number of participants receiving the structured family caregiving service in any one private home may not exceed two participants.

The principal caregiver may be a related family member or a non-relative fictive kin. A 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 also be licensed by the South Dakota Department of Health as a community living home as defined in ARSD 44:82.

Routine intermittent personal care, supervision, cueing, meals, homemaker, 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 participant's person-centered service plan are included activities in structured family caregiving.

Consistent with a participant's assessed needs and as reflected in the person-centered care 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, adult companion services, adult day services, respite care, emergency response systems, in-home nursing services, specialized medical equipment, specialized medical supplies, environmental accessibility adaptations, and nutritional supplements. Consistent with a participant's assessed needs and as reflected in the person-centered care 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.

HOPE waiver participants must be referred to a Structured Family Caregiving provider for assessment when a primary caregiver resides in the home and is being paid to provide routine intermittent personal care, supervision, cueing, meals, homemaker, chore services, medication management and/or other instrumental activities of daily living.

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

Separate payment for meals, homemaker services and/or chore services will not be provided on behalf of 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 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**

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 Oversight Agency

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 Oversight Agency

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). The enrollment process an enrollment application and signing a standard Provider Agreement and Provider Addendum. The Medicaid enrolled provider agency is responsible for assessing and approving the home setting to ensure the home is safe, accessible and allows for comfort and privacy of the participant receiving care. Provider agencies are 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 provide each caregiver with the competencies necessary to provide daily care to a participant and help the caregiver identify health status changes and other signs that could lead to unplanned hospitalizations or preventable events. Provider agencies must establish a mechanism to collect and review regular caregiver notes that are completed electronically, if possible, and in sufficient frequency such that the agency provider can use the information collected to monitor participant health and caregiver support needs. The agency provider must make such notes available to waiver case managers and the State upon request. The Division of Long Term Services and Supports monitors and authorizes individuals utilizing structured family caregiving services.

The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider.

Additionally, provider agencies must assess and document the roles and responsibilities of other individuals living in the home. The Medicaid enrolled provider agency must check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure the principal caregiver is not on the excluded list.

The Medicaid enrolled provider agency must be accessible during normal business hours and coach a caregiver to manage urgent and emergency situations in the home and, in conjunction with the principal caregiver and the waiver case manager, establish an emergency back-up plan for instances when the caregiver is unable to provide care. The Medicaid enrolled provider agency must conduct a care conference (on-site or virtual) on a monthly basis with the participant and principal caregiver. At least one care conference must be conducted as an on-site face to face visit on an annual basis with the participant and principal caregiver. The provider must establish the frequency of on-site face to face care conferences throughout the year based on the assessed needs of the participant and family. The provider agency must establish a mechanism for documentation of services. Documentation must be readily available at the State's request. Medicaid enrolled provider agencies are expected to fully comply with all State and Federal employment laws and regulations, including the Fair Labor Standards Act (FLSA) minimum wage and overtime requirements when applicable.

The Medicaid enrolled oversight agency must provide statewide oversight of structured family caregiving.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☒ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

The Division of Long Term Services and Supports(operating division) provides case management services to all waiver consumers. Case management services are an essential component of waiver coordination and include assessment, person centered Care Plan development, service authorization and monitoring, follow-up and documentation. Long Term Services and Supports Specialists function as case managers for a caseload of waiver and non-waiver consumers. 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.

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):

The Supplemental Agreement requires the Provider to 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 consumers.

During provider reviews the Division of Long Term Services and Supports staff reviewer conducts a random sample review of employee records to ensure provider employees had a background check completed (if hired after June 1, 2015). When it is identified that a provider did not complete a background check(s) as required, the provider is instructed to complete the missing background check(s).

The Assisted Living Provider Addendum to the South Dakota Medicaid Provider Agreement requires all employees of assisted living centers to have a State fingerprint background check. The Supplemental Agreement requires the Provider to conduct a State fingerprint background check (or other alternative State approved background check) to screen for abuse, neglect, and exploitation for all employees.

The Provider Addendums for Community Living Homes, and Structured Family Caregiving Homes require individuals providing direct care to consumers to have a State fingerprint background check (or other alternative State approved background check) to screen for abuse, neglect and exploitation. Additionally, any person over the age of 18 residing in a community living home and/or structured family caregiving home must also have a State fingerprint background check (or other alternative State approved background check) to screen for abuse, neglect, and exploitation.

The Provider Addendum for Community Transition Coordination and Community Transition Supports requires providers of these services to conduct State fingerprint background checks (or other alternative State approved background check) to screen for abuse, neglect and exploitation for all employees hired to work in the homes of consumers.

The Provider Addendum for Community Interpreter Services requires providers of these services to conduct The Supplemental Agreement requires the Provider to 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 homes of consumers.

In order to receive the State's approval for an alternative background check, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

The Department of Human Services conducts State fingerprint background checks on each person hired in the following employment positions with the Division of Long Term Services and Supports: Home Health Aides, LTSS Specialists, LTSS Supervisors and LTSS Regional Managers per South Dakota Codified Law 1-36-36.

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

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

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

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 care plan;
•Be provided by a spouse, parent of an adult participant,legal guardian, or and 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 work place of each employee. Documentation of the staff monitoring visits must be available for review.
To ensure billed services have been rendered, waiver consumers are surveyed at the 6 month review to confirm they have received the services. Any discrepancies in the reported rendered services and services billed are further investigated.

☐ **Self-directed**

☒ **Agency-operated**

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

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

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 consumer's approved Care 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 work place of each employee. Documentation of the staff monitoring visits must be available for review.
To ensure billed services have been rendered, waiver consumers are surveyed at the 6 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:

Information about enrolling as a Medicaid provider can be accessed by potential providers on the Department of Social Services' website. Potential waiver providers may also access information about provider enrollment and/or how to apply as a Medicaid provider by contacting any of the Division of Long Term Services and Supports Regional Offices or the Home and Community-Based Services (HCBS) Program Manager at the Department of Human Services' State Office. The Division of Long Term Services and Supports providers requesting information on enrolling to be a waiver provider to the HCBS Program Manager.

All willing and qualified providers can enroll as waiver service providers. Providers must complete an online enrollment application to apply through the Division of Medical Services which manages provider enrollment. Licensed providers must provide verification of current, valid licensure and all providers must sign a standard South Dakota Medicaid Provider Agreement and pass mandatory provider enrollment screening and credentialing criteria.

In addition to the standard Medicaid requirements, providers of homemaker, personal care, adult companion and nursing services (in-home providers) must also sign a Supplemental Provider Agreement, complete and sign a Provider Quality Management Self-Assessment and complete any recommendations from an onsite review as part of the enrollment process.

In addition to the standard Medicaid requirements, providers of Adult Day Services must be determined compliant with Home and Community-Based Settings Final Rule. The Division of Long Term Services and Supports Regional Supervisors complete a Home and Community-Based (HCB) Settings Assessment to confirm compliance. Any areas of non-compliance with the HCB Settings Final Rule are addressed prior to approval.

In addition to the standard Medicaid requirements, Assisted Living providers must sign and complete a Supplemental Agreement and complete a HCB Settings Self-Assessment to ensure they are in compliance with the HCB Settings Final Rule. Additionally, LTSS Regional Supervisors complete a Home and Community-Based (HCB) Settings LTSS Assessment to validate the Assisted Living's HCB Settings Self-Assessment and to confirm compliance with the HCB Settings Final Rule. Any areas of non-compliance with the HCB Settings Final Rule are addressed prior to approval.

Medicaid Provider Enrollment and the HCBS Program Manager work together to ensure that all of the requirements are in place before a provider is approved to deliver waiver services. Once all required components are in place and Medicaid enrollment is complete, the HCBS Program Manager is notified that a new provider has enrolled to provide waiver services and in turn the HCBS Program Manager informs the appropriate Division of Long Term Services and Supports Regional Office that the provider is an enrolled waiver provider. The Division of Long Term Services and Supports Office then adds the provider to the provider list which is given to consumers. Consumers may choose from any provider on the provider list to deliver the authorized waiver services.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 percent of new licensed and/or certified providers that initially meet state licensing standards. Numerator = number of new providers initially meeting licensing standards. Denominator = number of new licensed 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:

Performance Measure:
Number and percent of licensed and/or certified providers, by type, that continually meet state licensing standards. Numerator = number of providers meeting licensing standards. Denominator = all licensed waiver service providers.

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 *(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 non-licensed/non-certified providers, by provider type who continue to meet waiver provider qualifications. Numerator = number of non-licensed/non-certified in-home providers of homemaker, personal care, nursing, and companion care, who continue to meet waiver provider qualifications. Denominator = number of non-licensed/non-certified providers.

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):

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):
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 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 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 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**
	☐ **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.

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:

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

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

Adherence to waiver requirements is determined upon initial enrollment and annually after enrollment. Providers must submit an enrollment application through an on-line enrollment system. During enrollment, providers must identify all services they intend to render by notation of specialties/subspecialties and submit a signed South Dakota Medicaid Provider Agreement. Enrollment applications will not be approved without a signed Provider Agreement. Enrolled providers are responsible for reviewing and updating their enrollment information when changes are necessary. Outreach to providers requesting updates or validation of information are also made by enrollment staff when potential changes are identified outside of provider notification.

Provider types requiring licensure in South Dakota are licensed by the Department of Health (DOH). Upon initial enrollment as a Medicaid provider, licensed providers must submit a copy of their current, valid license. SD Medicaid provider enrollment applications of licensed providers are not approved without verification of current licensure.

SD has a vendor contract in place to complete licensure validation as part of the provider enrollment screening and credentialing process. Licensure status is verified by the contracted vendor prior to Medicaid Provider Enrollment approving the application. If any issues are identified, the provider will not be approved as a waiver provider. The Home and Community-Based Services (HCBS) Program Manager obtains data from Medicaid Provider Enrollment each quarter to confirm that each licensed provider was submitted for validation prior to their approval.

Likewise, the contracted vendor monitors licensed providers on an ongoing basis to ensure providers continually remain licensed and in good standing. Medicaid Provider Enrollment reviews the monitoring reports for any provider risks or issues identified. The provider is terminated if they are no longer licensed. In addition, Medicaid Provider Enrollment staff has a working relationship with the Department of Health licensing staff and are notified per the DOH notification list should a licensed provider have a change of ownership or licensure status. The HCBS Program Manager obtains data from Medicaid Provider Enrollment staff annually to compare enrolled licensed providers to the contractors monitoring list. This ensures that all enrolled licensed providers are being monitored as per the contract.

There are waiver provider qualifications beyond provider enrollment and the SD Medicaid Provider Agreement for providers of homemaker, personal care, adult companion and nursing services (in-home providers). Upon initial enrollment and annually thereafter, the in-home providers submit two additional components – the current year's Supplemental Provider Agreement and the current year's Provider Quality Management Self-Assessment. The Supplemental Provider Agreement outlines the responsibilities of in-home providers. Providers must sign and date the Supplemental Provider Agreement indicating they have received the agreement and the requirements have been executed. The Provider Quality Management Self-Assessment instructs the provider to indicate if they do or do not have each required component in place. The HCBS Program Manager is responsible for creation, distribution, and collection of the signed Supplemental Provider Agreements and completed Provider Quality Management Self-Assessments and tracks the return of required documentation.

An on-site review is conducted for each in-home provider prior to initial enrollment every 3 years thereafter unless more frequent on-site visits are deemed necessary. On-site reviews are performed by LTSS Regional Supervisors and Regional Managers, or the HCBS Program Manager and follow a standard on-site review protocol. The on-site reviews include review of consumer records and visit documentation, personnel records, policies and procedures. The reviewer ensures all required components are in place and completes a Provider Review Report, a copy of which is given to the provider who has 60 days to respond to the determination of the initial findings of the annual on-site review. If components are not in place the provider must respond with a plan to address how to meet required components.

The Supplemental Provider Agreement and Provider Quality Management Self-Assessment outline the provider training requirements. Training requirements are reviewed annually either at the on-site review or a desk review. A random sample of the provider's personnel records is reviewed to determine if the training components are being met. The reviewer completes a Provider Review Report, a copy of which is given to the provider who has 60 days to respond to the determination of the initial findings of the annual on-site review. Providers must respond to how the required training components will be met and are asked to provide a description of training topics. The HCBS Program Manager collects and tracks this data, noting on the master list of waiver providers

that a provider has met provider training requirements.

Data aggregation and analysis for all Qualified Providers Performance Measures is conducted by the HCBS Program Manager and presented to the Division Long Term Services and Supports Waiver Review Committee. The Waiver Review Committee is led by the HCBS Program Manager and includes LTSS staff: Director and Deputy Division Director, Nurse Consultant Program Manager, SAMS Program Manager, Regional Managers, Regional Supervisors, and LTSS Specialists. The Waiver Review Committee meets quarterly to discuss consumer and provider issues and to set priorities for system-wide quality improvement. As a result of an analysis of the discovery and remediation information presented to the Waiver Review Committee, system improvements are identified and design changes are made.

b. Methods for Remediation/Fixing Individual Problems

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

To ensure that licensed providers initially meet licensing standards, Medicaid Provider Enrollment does not enroll the provider without a copy of their current, valid licensure from the Department of Health. The provider cannot be authorized to provide waiver services until the enrollment process is complete. No waiver services are authorized until Medicaid Provider Enrollment completes the enrollment process. If the provider fails to submit verification or fails the enrollment screening or credentialing process, the provider is not approved to enroll or provide services. If it is determined a licensed provider was enrolled and authorized to provide waiver services without proof of licensure, the Provider Enrollment Supervisor will be notified for retraining or disciplinary action of the Provider Enrollment Worker who enrolled the provider outside of the enrollment expectations. Notification is made to the Medicaid Payment Control Officer so payment for ineligible services provided is made using alternative, non-Medicaid funds. The HCBS Program Manager works with the Provider Enrollment Supervisor to determine how the provider was enrolled without verification of licensure. Together, the HCBS Program Manager and Provider Enrollment Supervisor may recommend changes to the provider enrollment process in an effort to alleviate the concern.

If an inactive or terminated license is identified through the ongoing monitoring processes, the information is reported to Medicaid Provider Enrollment. Medicaid Provider Enrollment will determine provider licensure status (ex: confirm licensure data accurate and not due to source delay) and take appropriate actions. If a provider failed to renew license or the license was terminated, the provider will be terminated with notification to the provider and the HCBS Program Manager. Medicaid Provider Enrollment will review claims to determine if any dates of service after licensure were paid. If it is determined that payments were made to a non-licensed provider, a referral to the Payment Control Officer within Surveillance and Utilization Review System (SURS) and inclusion of the HCBS Program Manager will be made so these payments can be recouped with subsequent payment for services provided using alternative, non-Medicaid funds.

Waiver consumers served by a provider whose license has been terminated are asked to choose an enrolled provider who has continuously met state licensing standards. Consumers are then assisted in transitioning to the provider of their choice.

The HCBS Program Manager and Medicaid Enrollment Team work together closely to ensure that non-licensed providers of homemaker, personal care, adult companion and nursing services initially meet provider requirements. Medicaid Enrollment protocol states that these providers will not be Medicaid approved until the HCBS Program Manager has confirmed that the Supplemental Agreement and the Quality Management Self-Assessment have been submitted and all recommendations from the onsite review have been completed. LTSS does not authorize services by a provider until the HCBS Program Manager has confirmed the provider is an enrolled waiver provider. If a new provider is erroneously authorized to provide services prior to their enrollment, the Specialist who authorized the services is retrained. Payment for services provided will be made using alternative, non-Medicaid funds.

In-home providers of homemaker, personal care, adult companion and nursing services are required to submit the Supplemental Agreement and Provider Quality Management Self-Assessment initially and annually thereafter. An onsite review is completed prior to enrollment and every third year to confirm that all requirements are met. If a provider fails to submit the required documents or fails to comply with the onsite review, the provider will not be approved and/or will be terminated as a waiver provider. In addition, a desk audit is completed annually (if an onsite is not scheduled). If it is determined during a review that the provider does not comply with all requirements, the HCBS Program Manager works closely with the provider to establish a plan and timeline for implementing the required components. If the provider does not implement the required elements within set timelines, all consumers served by said provider will be asked to choose a provider who initially met and continually meets waiver provider qualifications. Consumers will be assisted in transitioning to the provider of their choice by the LTSS Specialist. Providers who fail to submit the required documentation, or fail to meet the standards, are not utilized to provide services to consumers of the HCBS waiver.

If during the onsite or desk review, it is determined a provider does not have the required training components in place, the HCBS Program Manager works closely with the provider to establish a plan and timeline for implementing the required components. If the provider does not implement the required training in a jointly determined period of time, all consumers served by said provider are asked to choose a provider that meets waiver provider qualifications, including training requirements, and are assisted in transitioning to the provider of their choice.

Documentation of all remediation activities in the Qualified Providers assurance will be maintained by the HCBS Program Manager, primarily in the master list of waiver providers. Data aggregation and analysis on provider quality will be compiled and presented at the quarterly Waiver Review Committee meetings. When trends are identified, the Waiver Review Committee will recommend changes to reduce individual waiver problems and improve waiver quality.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix

C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Refer to Attachment #2.

Community living homes are limited to 4 participants at any given time. The smaller size of the community living home provides a small homelike atmosphere that is integrated in and supports full access to the community. Providers are required to ensure waiver participants access community activities. A provider assessment and staff assessment will be completed for each community living home prior to approval as a waiver setting to ensure compliance with the Rule. An Addendum will also be signed by each community living home provider requiring them to attest to compliance. Onsite reviews and participant surveys will also be completed to ensure ongoing compliance with the Rule.

Structured family caregiving homes are limited to 2 participants at any given time. This small home setting in which the participant resides with family/fictive kin is a family home that is integrated and supports full access to the community. A provider and staff assessment will be completed prior to approval as a waiver setting to ensure compliance with the Rule. The State conducts Participant surveys with HOPE waiver participants on an annual basis. The State will conduct onsite reviews of community living homes every three years, or more frequently if deemed necessary based on participant surveys and/or other stakeholder feedback to ensure ongoing compliance with the Rule.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Care Plan

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

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☒ **Other**
  Specify the individuals and their qualifications:

The Division of Long Term Services and Supports employs Long Term Services and Supports Specialists who are responsible for Care Plan development and case management. Successful applicants are required to undergo a background investigation per South Dakota Codified Law (SDCL) 1-36-36. The purpose of the Specialist position is to assess and determine eligibility for a wide range of services that would benefit individuals at risk of having to leave their own homes; investigates allegations of abuse, neglect and exploitation and works for safe resolutions; provides information and referral services to the public and family members about aging and community resources.

The Division of Long Term Services and Supports hires individuals based on education and experience. A Bachelor's Degree with major work in social work, psychology, health or related field and/or knowledge of social work principles and practices; cultural, economic, social, physical and psychological factors that influence the elderly population and adults with disabilities; and ability to:

- Establish and maintain effective and collaborative working relationships and demonstrate compassion, respect, courtesy, and tact when interacting with others;
- Actively listen, elicit needed information and communicate information effectively and accurately, both orally and in writing;
- Utilize computerized data systems (Microsoft Word preferred but not required);
- Prepare clear and concise documentation, reports, and correspondence that reflect relevant facts;
- Effectively plan and organize work activities, adjust to multiple demands, and prioritize tasks to complete assignments and meet schedules and deadlines;
- Gather and analyze data; reason logically and accurately; and solve problems using common sense, reasoning and resourcefulness;
- Assume initiative with minimal supervision; and
- Observe and correctly assess situations.

LTSS Specialists must demonstrate, upon hire, the following Knowledge, Skills, Abilities and Functions:

Knowledge of:

- Principles and methods of person centered focused options counseling including availability and use of local and state resources;
- Cultural, economic, physical, social, and psychological factors that influence family dynamics and interpersonal relationships;
- Federal and state legislation, policies, and regulations governing social services programs;
- Basic theories, principles, and methods of social work and methods of assessment, and intervention;
- Concepts related to consumers' rights, confidentiality, and professional ethics;
- Principles and techniques of conducting interviews and acquiring information from individuals who are in need of services.

Skills:

- Strong organizational and computer skills;
- Good interpersonal skills;
- Excellent active listening and interviewing skills.

Ability to:

- Transfer consumers' personal goals to a care plan;
- Monitor progress toward identified care plan goals;
- Work with computerized data systems;
- Maintain consumer records and documentation;
- Prepare reports and compose correspondence;
- Gather and analyze data, reason logically and accurately, and draw valid conclusions;
- Organize and express information concisely and effectively, both orally and in writing;
- Communicate information clearly and concisely with a variety of individuals, professionals and the public;
- Exercise good judgment in evaluating situations and in making decisions;
- Summarize data, prepare reports and make recommendations based on findings which

contribute to solving problems;
- Establish and maintain effective working relationships with consumers, their families, representatives of other services agencies, public officials, and the public.

Functions:
Arranges for in-home services and coordinates resources for elderly people and adults with disabilities to prevent premature or unnecessary institutional placement.
a. Accepts assignment of referrals, interviews consumers and conducts multi-faceted assessments of consumers and their situations including activities of daily living, finances, personal adjustment, social resources, home environment, physical health and nutritional status.
b. Makes collateral contacts to collect information, coordinate services, and advocates for consumers
c. Determines need for services provided by the agency and coordinates financial eligibility for these services with other agency staff
d. Provides case management services by assessing needs of consumers and coordinating services provided by Long Term Services and Supports and other community resources
e. Makes home visits to assess consumer's progress and adherence to care plans.

Assesses individuals at risk of placement or intended placement in a nursing facility.
a. Completes multi-faceted assessments including activities of daily living, finances, personal adjustment, social resources, home environment, nutritional status, physical health, and physicians' reports.
b. Provides information on long term services and supports to meet individuals' needs in the most integrated and least restrictive community setting along a continuum of natural supports, in-home services, and HOPE Waiver residential services.
c. Obtains physician's orders for authorization of in-home services as necessary.
d. Conducts follow-up contacts with individuals discharged from hospitals and nursing facilities to determine the home and community-based services that are needed to enable them to remain in a safe, integrated setting.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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 consumer has full authority over the Care Plan development process and leads the person centered planning process where possible. The consumer chooses where and when the home visit to develop the Care Plan will take place, and who the consumer wants to participate in the Care Plan meeting. The Division of Long Term Services and Supports Specialist typically meets with the consumer in his/her home, and with others, e.g., authorized representative, family and/or friends whom the consumer wants to include in the person centered care planning process. During the Care Plan meeting the Specialist provides information about the Waiver, service options, and service provider options that are available to provide waiver services to the consumer. The consumer is informed of the choice between waiver services and institutional care and choice of providers. In the early stages of Care Plan development and thereafter as needed, the consumer 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 Specialist is available to the consumer and his/her authorized representatives to answer questions, provide information, and offer support throughout the care planning process. The LTSS Regional Supervisor and Home and Community-Based Services (HCBS) Program Manager are also available to provide information and support to the consumer and his/her family.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

When a consumer, his/her family, authorized representative, or other interested parties make a referral by contacting (e.g., email, fax, telephone, walk-in) the Division of Long Term Services and Supports for long-term services and supports, a standardized intake screen, SD Choices, is completed with the consumer. Responses to the intake screen questions result in one of five service levels to assist the LTSS Specialist in objectively identifying the scope of services which the consumer may need. Consumers at a SD Choices service level 1 generally may only need information and/or a referral to a provider of the consumer's choice for basic services, e.g., emergency response system, medical equipment, medical supplies, nutritional supplements, meals and/or need assistance to access basic services. Consumers at a service level 2 (in addition to having a need for information and/or a referral to a provider of the consumer's choice for basic services and/or assistance to access basic services) are offered an in-home visit to assess their need for homemaker services.

Potential waiver consumers, based on their higher level of need typically fall into service levels 3, 4 or 5. All consumers at a service level 3, 4, or 5 are offered an in-home visit to complete an assessment (e.g., personal care, nursing services). Because the service level outcome of the SD Choices is based on an individual consumer's responses, if the Specialist believes the consumer under-estimated (or over-estimated) his/her needs, the Specialist will offer an in-home visit to the consumer to further assess, utilizing the Community Health Assessment, and ascertain his/her need for community-based services and supports. The SD Choices intake screen includes items which are completed by the Specialist under the following sections: living arrangement, health status, activities of daily living, instrumental activities of daily living, communication, cognition, and behavior. The SD Choices provides information on the consumer's capacities, health status and risk factors culminating in an outcome of the consumer's level of service need.

Within 7 to 10 days from completing the consumer's intake, the Specialist conducts a home visit to complete the Community Health Assessment (CHA), a standardized assessment tool utilized for all initial assessments and reassessments. The consumer chooses if and when he/she would like to complete the assessment, and if he/she would like another person to be present.

The Community Health Assessment includes the consumer's expressed goal of care or outcomes that the person hopes to achieve as a result of receiving services. The CHA includes items completed by the Specialist under the following sections: living arrangement and residential history, cognition, communication and vision, mood, psychosocial well-being, functional status, activities of daily living, continence, disease diagnoses, health conditions, nutritional status, medications, treatments and procedures, social supports, and environmental assessment.

A Functional Supplement to the Community Health Assessment is completed when algorithms embedded in the CHA are triggered based on a consumer's increased needs. Algorithms embedded in the CHA and/or the Functional Supplement 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 a person's function and quality of life, including the person's needs, strengths, and preferences in the following four broad areas: 1) Functional Performance; 2) Cognition and Mental Health; 3) Social Life; and 4) 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 CAPs triggered assist to identify needs to include in the development of the Care Plan. When needs are identified, the consumer and/or authorized representative of the consumer, indicate how each need is addressed or not addressed through paid services and unpaid services, i.e., natural supports or other services available in the community. Each CAP that is triggered is addressed. The consumer can choose to not address a triggered CAP; however, if a waiver service is currently or will be provided to meet the consumer's needs, the triggered CAP must have a corresponding goal/strategy in the Care Plan.

Once the CHA is completed and all unmet needs are identified, the Specialist shares with the consumer the type of services he/she may be eligible forthrough the Division of Long Term Services and Supports. When waiver services may be able to meet the needs of the consumer, information on the Waiver and assistance on applying for financial eligibility are provided to the consumer. The Specialist gathers and reviews all relevant documentation (i.e., completed SD Choices and Community Health Assessment) and information obtained during intake. The Specialist schedules a meeting with the consumer in his/her home to develop the Care Plan within thirty days of the intake. The Specialist asks the consumer if he/she wants others, e.g., family, friends included in the care planning process.

Development of the person centered Care Plan is a collaborative process with the consumer, the consumer's family,

friends, authorized representative, and the Specialist. Care Plan development includes assisting the consumer to identify his/her needs, preferences, strengths, capacities and desired outcomes. Information gathered from the CHA and the CAPs also assist in identifying the needs, preferences, and strengths of the consumer, resulting in the type of services needed to support the consumer to continue living at home in the community. The Care Plan addresses both paid and unpaid services and supports which the consumer receives. The Specialist discusses available options with the consumer and his/her representative for addressing unmet needs. The Specialist reviews the type, scope, amount, duration, and frequency of services recommended and provides the consumer with an estimated cost(s) of each service contained in the Care 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 Care Plan encompasses the consumer's personal goals, emergency/disaster preparedness plan and critical service back-up plan.

The consumer and his/her authorized representative can choose to decline portions of or the entire Care Plan. If a consumer 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 Care Plan is signed by the consumer and/or authorized representative and the Specialist. By signing the Care Plan, the consumer and/or authorized representative acknowledges agreement with the Care 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. I have been provided with an informational brochure on abuse, 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 Specialist is responsible for ensuring the provision of services identified in the Care Plan and monitoring the Care Plan. Each waiver consumer's Care Plan is revised at least annually, or when the consumer's needs change. The Specialist is responsible for amending the Care Plan when the consumer's needs change. A consumer's change in need(s) can be identified through quarterly contacts, six month review, annual review, and communication with the Specialist by the consumer, his/her family or authorized representative, or service provider. The Care 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 consumer, paid and unpaid services and natural supports are addressed in the Care Plan.

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.

Algorithms in the Community Health Assessment and the Functional Supplement trigger Clinical Assessment Protocols (CAPs) which assist the Long Term Services and Supports Specialist to objectively identify the consumer's needs and assess possible risks. CAP triggers embedded in the assessment link the information gathered in the assessment to the basic problem referenced by a CAP. The CAP triggers seeks to identify two types of consumers. First are consumers who have a higher than expected likelihood of declining and second, are consumers who have an increased likelihood of improving including those declining due to a recent acute problem and whose symptoms will be alleviated when the problem is addressed. For each CAP triggered the Specialist discusses the problem with the consumer, who then assists in developing appropriate strategies to address underlying issues. CAPS guide the Care Plan development to resolve problems, reduce the risk of decline, or increase the potential for improvement in four broad areas: Functional Performance, Cognition and Mental Health, Social Life, and Clinical Issues.

The Specialist assists the consumer to identify their strengths, preferences, and needs in addressing the consumer's triggered problem areas. The preferences and priorities of the consumer guide the person centered care planning process by addressing the specific needs of the consumer. In addition, the Care Plan contains an Emergency/Disaster Preparedness Plan to address the consumer's preparedness plans for fire, tornado, blizzard, and power outage. The plan also describes the information provided by the Specialist to the consumer on evacuation plans for fire (e.g., smoke detector, fire extinguisher), emergency shelter plan for tornado (e.g., weather alert, interior room plan) and a plan for blizzard/power outage (e.g., food and water supply, power/heat alternative source). The Specialist assists the consumer to identify any devices or services the consumer may require during an emergency and arranges for those services as part of Care Plan development, either through waiver services or an alternate resource or community service or support. For example, each fall Specialists distribute "heater meals" to those consumers who may be impacted by severe winter weather conditions, i.e. blizzard. "Heater meals" can be prepared without electricity enabling the consumer to have a warm, nutritious meal if there is a power outage or the consumer is stranded in their home and unable to obtain food. Additional informational emergency preparedness tools are provided and explained including an emergency telephone list, medication list, and an emergency readiness checklist.

A consumer may also be identified as needing a critical service back-up plan. The Specialist and consumer develop a back-up plan when the consumer has needs that prevent him/her from being left alone for extended periods of time, requires a service provided 24/7 or without the service (e.g., oxygen, injection, medication, wound care, therapy, etc.) the consumer's health would immediately decline, and the consumer has few, if any, natural supports. When a consumer is identified as needing a critical service back-up plan, the Specialist will communicate the need to the provider(s) and work with the consumer and the provider(s) to coordinate service provision when the usual caregiver(s) is not available to provide services, i.e., personal care, nursing services to the consumer.

Additionally, as part of Care Plan development, the Specialist reminds consumers with identified critical service needs that during inclement weather providers may not be able to deliver scheduled services. The Specialist assists these consumers in identifying an emergency back-up person, (family, friend or neighbor), who can be contacted to check on the consumer and respond in an emergency situation, e.g., blizzard, power outage.

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 consumer's needs are identified and a Care Plan is developed, the consumer is offered a choice of service providers to utilize for their service delivery. Consumers must choose the service provider, and the Long Term Services and Supports Specialist can help the consumer obtain information about the qualified providers of the waiver services in the Care Plan. The Specialist provides the consumer with a list of all waiver providers for the services contained in the Care Plan. The list includes contact information, e.g. phone numbers, address, and website. The consumer can review the list and contact providers to make inquiries. The Specialist also offers the consumer a "Consumer Decision Tool" which contains a list of questions for the consumer to ask in-home providers to assist in determining which provider may best meet their needs. Consumers can take their time choosing a provider. The Specialist will follow-up with the consumer, offering additional encouragement, until the consumer has made a choice of provider. When a consumer with unmet needs resides in an area of the state (rural area) where there is a lack of provider coverage, the Specialist communicates this to the Regional Supervisor and the HCBS Program Manager who work to recruit additional providers in that area of the state. When there is a lack of a provider in a remote or sparsely populated area of the state (frontier area), the HCBS Program Manager makes every effort to recruit new providers and/or request a provider expand their coverage area to include the remote area where the consumer resides. The Specialist also works with the consumer to identify unpaid and natural supports to meet the consumer's unmet need(s).

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 Care Plan development.

Each quarter LTSS provides the SSMA with a report, which contains the results of a review of a representative random sample of participant Care 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 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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Division of Long Term Supports and Services (LTSS) employs LTSS Specialists who are responsible for monitoring the implementation of consumer Care Plans and consumer health and welfare. During the initial and annual person centered care planning process, the Specialist discusses the importance of preventative health care, the preventative health care available and if the consumer chooses, includes a preventative health care goal on the consumer's Care Plan. The Specialist provides the consumer with information on preventative health care which may include informational handouts or brochures on free or low cost healthcare services including vaccinations and screenings, taking an active role in their health care, the benefits of exercise, questions to ask about their medication, and a variety of other topics of specific interest or directly related to a consumer's health condition, i.e., diabetes, heart disease, hearing loss, high blood pressure, smoking, alcohol use, pain, etc. The Specialist also provides information on abuse, neglect and exploitation including the signs of possible abuse, neglect and exploitation and how and where to report. During an initial home visit to develop the Care Plan, the Specialist provides the consumer and his/her authorized representative with a brochure titled, "Abuse, Neglect & Exploitation of Elders or Adults with Disabilities" on abuse, neglect, and exploitation and explains the information contained in the brochure. The brochure provides information about abuse, neglect and exploitation including information regarding South Dakota's mandatory reporting law, recognizing signs of possible abuse, neglect or exploitation, and also provides contact information regarding where and how to report. Thereafter, at each annual review of the Care Plan, the Specialist discusses with the consumer the signs of abuse, neglect, and exploitation stressing that he/she has the right to be free from abuse, neglect and exploitation and offers the consumer additional copies of the brochure. The consumer and/or authorized representative acknowledge receipt of information on abuse, neglect, and exploitation through the following statement on the Care Plan, "I understand I have the right to be free from abuse and neglect. I have been provided with an informational brochure on abuse, neglect and exploitation." and acknowledgement of receipt of information on preventative health care through the following statement, "I have been provided with an informational brochure on preventative health care".

The Specialist is always aware of the potential need for Adult Protective Services (APS), even if the information does not clearly identify there is an 'adult protection' situation. Consumers may be reporting a situation that needs immediate APS follow-up without stating specific details or providing an immediate cause for action. These may include but are not limited to the following:

- Medical noncompliance (i.e., refusal to follow medical advice that may result in need for immediate medical intervention);
- Inadequate attention to physical needs (i.e., not enough food, lack of access to medical care or medication, lack of heat or cooling in the home, no one checking in on the individual who is not mobile or is bed ridden);
- Serious, but not life threatening self-neglect (i.e., hoarding, deterioration due to not eating or bathing, not taking medication or seeking medical attention);
- Intimidation by a caregiver (i.e., threatens to harm, to withdraw care or a threat resulting in mental anguish); or
- Other situations that indicate a need for face to face follow-up.

Upon receipt of a report of abuse, neglect, or exploitation the Specialist as a mandatory reporter per South Dakota Codified Law 22-46 follows the Adult Protective Services Policy. Additionally, the Specialist ensures a "welfare check" is completed when a contact with a consumer has been attempted but failed due to the lack of a consumer's response. The Specialist may contact law enforcement to perform a "welfare check" or to accompany the Specialist on a "welfare check".

In accordance with South Dakota Codified Law (SDCL) 22-46 providers are mandated to report any suspected abuse or neglect of a consumer. A Supplemental Provider Agreement requires providers to have a policy on Abuse and Neglect Reporting which conforms to the mandatory reporting laws and to provide annual training on the mandatory reporting laws to provider staff.

Additionally, per the Supplemental Provider Agreement, providers must notify the Division of Long Term Services and Supports of any consumer-related concerns, incidents and occurrences, including possible exploitation, that are not consistent with routine care. Providers must also submit an incident report to the Specialist documenting the circumstances of any incident that involves serious injury, missing person, restraint, seclusion, or death. Providers are directed to alert Specialists of changes in the consumer's needs (i.e., if authorized services need to be increased or decreased).

During the annual review when the Care Plan is signed by the consumer, the Specialist authorizes services by provider(s)

using the Authorization for Services form. The Authorization for Services form specifies the type, scope, amount, duration, and frequency of services to be provided by the provider. The provider(s) must sign and return the Authorization for Services form within seven days of receipt. The Specialist tracks the return of the Authorization for Services form to ensure the form has been received by the provider and the provider has agreed to provide the service(s). If the signed Authorization for Services form is not received within seven days, the Specialist contacts the provider to follow up. Once the signed Authorization for Services form has been returned, the provider has seven days to initiate service delivery.

The Specialist has regular communication with the service provider(s) who report changes in the consumer's needs, i.e., health and welfare and whether there is a need to increase or decrease services or add additional services. The Specialist also contacts the consumer by telephone within two weeks following authorization of services to inquire as to whether services started and if yes, how services have been going and if the consumer has any questions or concerns regarding services. The Specialist will conduct follow up with provider(s) when the consumer is not satisfied with services or services have not begun.

A consumer's change in need(s) is identified by the Specialist in regular communication, i.e., quarterly contacts, six month review, annual review, and communication with the Specialist by the consumer, his/her family or authorized representative, or service provider. Through these opportunities the Specialists seeks to assure the consumer's needs continue to be met through the provision of waiver and/or non-waiver services. The Specialist meets with the consumer in his/her home twice per year, at the six month review and again at the annual review. The Specialist communicates with the consumer through quarterly contacts inquiring about services and whether there is a need for changes, questions or concerns regarding services. When a significant change, i.e., decline in health, improvement in health, change in informal supports, change in living environment is reported or suspected in the consumer's needs, the will schedule a home visit to ascertain whether a reassessment needs to be completed and/or changes to the Care Plan are warranted. When changes are made the Care Plan is amended prior to the Annual Review.

A request for a change in goals or strategies from the consumer or his/her authorized representative or a change in the consumer's needs are reflected on the Care Plan by modifying goals or strategies; implementing new goals or strategies; or discontinuing goals or strategies. Changes made to the Care Plan prior to the Annual Review are documented on the Care Plan addendum. When an annual Community Health Assessment has previously been completed and there is a need to revise the Care Plan prior to the six month review, discussion is held with the consumer to add a goal and strategy which is documented on the Care Plan addendum. At the six month review during a home visit with the consumer, the Care Plan is reviewed with the consumer and his/her authorized representative including goals and strategies. The Specialist and the consumer discuss progress towards achieving goals; whether the goals and strategies continue to be appropriate and whether any changes to the Care Plan are needed. The Specialist visits with the consumer about his/her satisfaction with services and the service provider(s). All changes made prior to and during the Six Month Review (i.e., goal/strategy changed, added or discontinued due to changes in services or at the request of the consumer) are documented on the Care Plan Addendum and the consumer's signature is obtained.

Consumers receiving in-home waiver services are advised in writing "If you have a concern about the services you receive, call the Specialist or the agency provider immediately. Services will not be jeopardized if you report a concern." When a consumer reports dissatisfaction with a service provider's provision of services, the Specialist conducts follow-up with the service provider to address the dissatisfaction. The consumer may request a change in waiver service providers and choose another service provider from a list provided by the Specialist of qualified waiver service providers.

Through these processes, the Care Plan may be amended based on the consumer's need for increased services or decreased services or additional services or discontinuation of services. While the Specialist conducts all direct monitoring of the consumer's Care Plan and health and welfare, other safeguards are in place to assure that the health and welfare of all consumers is protected. The HCBS Program Manager and the Critical Incident Review Team review each region's information and identify individual problems that require remediation. The identified individual problems are forwarded to the LTSS Regional Supervisor who works with the specific Specialist to assure remediation. Additional safeguards are explained in more detail in the Quality Improvement section of Appendix G.

b. Monitoring Safeguards. *Select one:*

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

participant health and welfare may provide other direct waiver services to the participant.

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 consumer Care Plans that address health and safety risk factors. Numerator = Number of Care Plans that address assessed risk. Denominator = Number of Care 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%, +/-5%
☐ **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 consumer Care Plans that address all assessed needs. Numerator = Number of Care Plans that address all assessed needs. Denominator = Number of Care 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%, +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of consumer Care Plans that address personal goals. Numerator = Number of Care Plans that address personal goals. Denominator = Number of Care 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%, +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	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 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.

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

Performance Measures

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

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

Performance Measure:
Number and percent of consumer Care Plans updated/revised at least annually. Numerator = Number of Care Plans updated/revised at least annually. Denominator = Number of Care 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%, +/-5%
☐ **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 consumer Care Plans updated/revised when the consumer's needs change. Numerator = Number of Care Plans updated/revised when the consumer's needs change. Denominator = Number of Care 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%, +/-5%
☐ **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: 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 consumers who received services of the type and scope specified in the Care Plan. Numerator = Number of consumers who received services of the type and scope specified in the Care Plan. Denominator = Number of consumers 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%, +/-5%
☐ **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 consumers who received services in the amount, duration, and frequency specified in the Care Plan. Numerator = Number of consumers who received services in the amount, duration, and frequency specified in the Care Plan. Denominator = Number of consumers 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%, +/-5%
☐ **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:

e. ***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 consumers who are offered choice of waiver services. Numerator= Number of consumers offered choice of waiver services. Denominator= Number of consumers 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%, +/-5%
☐ **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 consumers who are offered choice of waiver providers. Numerator= Number of consumers offered choice of waiver providers. Denominator= Number of consumers 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%, +/-5%
☐ **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 continuous quality improvement activities for the Care Plan sub-assurances are conducted primarily by the Division of Long Term Services and Supports Regional Supervisors, Regional Managers and the Home and Community-Based Services (HCBS) Program Manager. The Regional Supervisors are responsible for the quarterly on-site record review process for all Performance Measures in the Care Plan assurance.

Quarterly, the HCBS Program Manager provides the LTSS Regional Supervisors a random sample of waiver consumers for whom Care Plans must be reviewed. The HCBS Program Manager utilizes a random sample selection process to make the consumer assignments by LTSS Regional Office coverage area. The universe for the random sample for the first three quarters of the year is the projected number of waiver consumers for that year. The projected number of waiver consumers is entered into the Raosoft sample calculator to determine a sample size. For the last quarter of the year, the universe is updated to reflect the actual number of waiver consumers for the year and the sample size is updated based on the actual number of waiver consumers for the year as well.

Once the sample size is determined, the universe for the quarter is limited to waiver consumers due for an annual review. This ensures any reviews that were not completed timely are immediately identified and remediated. This also ensures the consumer's assessed needs and/or health and welfare risk factors that previously were not addressed, will be met as soon as possible in the Care Plan implementation.

Regional Supervisors are randomly assigned Care Plans to review from another region in the state and therefore do not review Care Plans which were developed within their assigned regional office coverage area. This assignment changes quarterly to ensure objectivity within the review process. All Care Plans are stored electronically in the State of South Dakota's FileDirector system, a digital document reviewing program, which allows the LTSS Regional Supervisors to review consumer Care Plans remotely on their office computers. To ensure Performance Measures are being met, the LTSS Regional Supervisors review a consumer's current Care Plan. When a Performance Measure requires a comparison of current consumer assessment with the current Care Plan, the reviewer correlates the assessment to the Care Plan to determine if all assessed needs are addressed in the Care Plan.

When a Performance Measure requires review of the previous Care Plan as well as the current Care Plan, the reviewer compares the dates that the consumer signed the Care Plans to determine if the current Care Plan was completed within one year of the previous Care Plan. Other Performance Measures that require a comparison of the current Care Plan with paid claims to verify services were provided in accordance with the Care Plan are reviewed by the LTSS Regional Managers.

The HCBS Program Manager maintains and provides Excel Spreadsheets to the LTSS Regional Supervisors and LTSS Regional Managers for tracking data gathered, listing every consumer to be reviewed, and the Performance Measures to be reviewed. This process specifies notations to be made for Performance Measures met by the Care Plan and Performance Measures that require remediation.

Upon completion of the quarterly review, the completed Excel Spreadsheets are returned to the HCBS Program Manager for data aggregation and analysis. The HCBS Program Manager identifies trends by looking at completed statewide reviews over a series of quarters. Data analysis and trends are presented to the Waiver Review Committee quarterly. The Waiver Review Committee will determine how statewide trends can be remediated and how additional staff training or changes to the waiver design could result in quality improvements.

b. Methods for Remediation/Fixing Individual Problems

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

Division of Long Term Services and Supports (LTSS) Regional Supervisors conduct quarterly reviews of all consumer Care Plans to identify and document individual problems that require remediation. Where possible, the Regional Supervisors are asked to identify why a Performance Measure was not met.

When individual problems are identified in Care Plans that do not address all of a consumer's assessed needs and personal goals, the Specialist remediates the problem by revising or amending the Care Plan to bring it into compliance. If at any time a consumer is in harm's way, the Specialist takes immediate action to assure the consumer is safe. Actions taken may include immediately assisting the consumer to leave the setting where he/she resides, locate an alternative housing option, and work towards an immediate resolution to the identified problem.

When it is identified that a consumer is not afforded choice between institutional care, waiver services, and/or providers, the Specialist contacts the consumer by telephone or makes a home visit to discuss these choices. The consumer may request a change in waiver providers and can choose from a list of qualified waiver providers provided by the Specialist. When the result is a change from one provider to another provider for the same service, the process may only require the change to be reflected on the Authorization for Services form. The Authorization for Services form specifies the type, scope, amount, duration, and frequency of services to be provided by the provider.

When it is identified that a Care Plan is not revised/amended at least annually or when warranted due to changes in a consumer's needs, these individual problems may be explained by a consumer's unavailability at the time of the scheduled annual review. In this situation, the LTSS Regional Supervisor may note that the consumer was hospitalized at the time the Care Plan was scheduled to be developed. In those cases where the consumer remains unavailable, the Specialist must obtain information on the consumer's whereabouts and plans to return to his/her home. If the consumer still cannot be available for the annual review, he/she is removed from the waiver program. Should the consumer return home and want to reenroll in the waiver program, he/she is given the opportunity to reenroll and receive waiver services. If the consumer was available, but the Specialist did not develop the Care Plan in a timely manner, the Specialist will promptly meet with the consumer to develop the Care Plan. Consumers served under the waiver can request a fair hearing per Administrative Rules of South Dakota (ARSD) 67:17:02. Consumers are informed of this right following their initial application for waiver services and in the Notice of Action they receive from the Division of Economic Assistance. Consumers are notified through the DSS-EA-266 form which is provided to the consumer following receipt of the application and thereafter when waiver services are approved, reduced, discontinued, extended, terminated or denied for any reason.

Individual problems that are identified when the Care Plan is not revised/amended when the consumer's needs change are remediated by immediately developing a new or revised Care Plan based on the level of change in the consumer's needs. If the Specialist did not complete the Care Plan or did not revise the Care Plan in a timely manner when the consumer's needs changed, the Specialist will be retrained on waiver processes and procedures and Care Plan development.

When individual problems are identified due to services not being delivered in accordance with the Care Plan, (including the type, scope, amount, duration and frequency specified in the Care Plan), the Care Plan is immediately revised to accurately reflect the services provided. If it is determined the services in the Care Plan adequately meet the consumer's needs, but are not being delivered by the provider, remediation includes communication with the provider and the consumer to determine the cause of the variance in services identified in the Care Plan versus the services delivered. If the provider cannot deliver the necessary services, the consumer is asked to choose a provider who offers provision of the identified services. The Specialist assists the consumer in transitioning to the service provider(s) of his/her choice.

Whenever it is identified that Care Plan development is not being implemented in accordance with policies and procedures, the Specialist is retrained on the Division of Long Term Services and Supports policies and procedures including waiver processes and Care Plan development. Trends are identified to determine if individual Specialists are consistently not following the Division's policies and procedures in the development of Care Plans, or if the problems are not Specialist specific. If identified problems are Specialist specific, a Regional Supervisor will determine the appropriate personnel action that may be required.

Quarterly the HCBS Program Manager provides a report to the Waiver Review Committee which includes trends

identified through data aggregation and analysis including individual problems and remediation activities. The Waiver Review Committee is led by the HCBS Program Manager and includes the following additional members: LTSS Director and Deputy Division Director, Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, Training Coordinator, Regional Managers, Regional Supervisors, and two LTSS Specialists. The LTSS Waiver Review Committee meets quarterly to discuss consumer and provider issues and to set priorities for system-wide quality improvement. As a result of an analysis of the discovery and remediation information presented to the Waiver Review Committee, system improvements are identified and design changes are made.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget

or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

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.

Consumers served under the waiver can request a fair hearing per Administrative Rules of South Dakota (ARSD). Consumers are made aware of this right following their initial application for waiver services and in the Notice of Action they receive from the Division of Economic Assistance. Consumers are notified via the DSS-EA-266 form which is sent following receipt of the application and thereafter when waiver services are approved, reduced, discontinued, extended, terminated or denied for any reason. This notice (DSS-EA-266) states that the individual has a right to fair hearing as follows:

Right to hearing - If your application for assistance is denied or you do not agree with the action the Department has taken, you may appeal such action.

How to request a hearing - You may begin the hearing procedure by filing a signed, written request for a hearing to the Office of Administrative Hearings, 700 Governors Drive, Pierre, SD 57501-2291, Fax (605) 773-6873. The request must state the action that is being appealed. At both the conference and the fair hearing, you can present your case by yourself or with assistance of other's including legal counsel. The cost of legal counsel will not, however, be the responsibility of the Department.

Thirty Day Limitation - You may request a fair hearing within (30) days after notice of the proposed action, or thirty (30) days after action should have been taken as provided by law or rule.

Status of payments during hearing process - If you want to ensure that your payments remain the same pending the hearing decision, you must request within ten (10) days after the notice of the proposed change. If the action of the Department is upheld, you may have to repay the amount of money you received during the hearing process. If you have any questions about hearings or time limits, contact your Benefits Specialist. You may request your Benefits Specialist to assist you in your request for a hearing.

In order to be eligible for Home and Community-Based Waiver services, the individual must file a Long-Term Care Application with the Division of Economic Assistance. If the individual fails to cooperate with this requirement, a Notice of Action is sent to the individual by the Long Term Services and Supports Specialist which states in part:

Notice of Right to Fair Hearing:
You have the right to appeal decisions that adversely affect you. You have the right to a fair hearing. You have the right to appear in person at the time of the hearing, or be assisted at the hearing by a representative or lawyer at your own cost, and to withdraw or abandon the hearing at any time. If the appeal is on behalf of a corporation, the corporation must be represented by an attorney at all stages of the appeal. Your request for a hearing must be in writing. Please address all appeals to the Office of Administrative Hearings, 700 Governors Drive, Pierre, SD 57501-6851 or Fax to 605-773-6873. The request must be made within 30 days after the date of this notice and as provided by law or rule.

Administrative Rules regarding the Right to a Fair Hearing include:

67:17:02:01. Right to hearing. An individual or entity that is aggrieved by the department's action or inaction taken under the provisions of Administrative Rules of South Dakota (ARSD) Title 67 may request a hearing. A hearing is conducted under the provisions of this chapter and South Dakota Codified Law (SDCL) Chapter 1-26. A hearing is not allowed if either state or federal law requires automatic grant adjustments unless the reason for the hearing is an incorrect computation.

67:17:02:02. Right to be informed of hearing process. The department shall inform each applicant and recipient of the right to request a hearing. The department shall print this information on all applications for public assistance and on all formal notices issued by the department concerning an action taken.

67:17:02:03. Hearing Requests. To appeal a department action or inaction made under the food stamp program, the individual must clearly express to the department an intent to appeal. The request for an appeal may be made either orally or in writing.

67:17:02:04. Time limits for requesting hearing. A request for a fair hearing must be made within one of the following time limits: (6) Thirty days after notice of the action complained of or of the conference decision or 30 days after action should have been taken by the department as provided by law or rule.

For all other department programs, to appeal a department action or inaction the individual or an individual representing the entity affected must submit a written and signed request for a hearing to the Department of Social Services, Office of Administrative Hearings. A person assisting an individual such as a relative, friend, or attorney may request a hearing on the individual's behalf.

67:17:02:27. Final decision by secretary. Based on the transcript or recording of testimony, the exhibits, and the proposed

decision, the secretary or a designee shall enter a final decision accepting, rejecting, or modifying the proposed decision. If the hearing involves a food stamp issue, the decision must be mailed to the parties involved within 60 days after the request for the hearing. For all other hearings, the decision must be mailed to the parties involved within 90 days from the date of the request for the hearing. If a continuance of a hearing is requested and the parties to the action stipulate to the continuance, the time allowed for mailing the final decision is extended for the same number of days for which the continuance is granted.

When making a request for a hearing, the individual requesting the appeal must indicate what department action is being appealed. If the reason for the appeal is unclear, any party involved in the action may request the Office of Administrative Hearings to further clarify the issue.

Steps for requesting a fair hearing are available to the public on the Department's website. Additionally, forms and publications available online to the public include the "Administrative Hearings Brochure," Guide to Administrative Hearings Procedure" and "Request for Administrative Hearing."

If the entity requesting a hearing is a corporation, the corporation must be represented throughout the hearing process by its attorney.

Pursuant to South Dakota Codified Law (SDCL) 1-26-18.23 Any individual in a contested case exceeding $250.00 may request that a hearing be held by the Office of Hearing Examiners which is an entity separate and apart from the Department of Social Services. Additionally, SDCL 1-26-30.2 states that an appeal shall be allowed in the circuit court to any party in a contested case from a final decision, ruling, or action of an agency.

Thus, an individual who receives an adverse Notice of Action is entitled to a fair hearing from the Department. If it is in excess of $250.00, they may request a hearing from an independent branch of state government and all adverse decisions are appealable to the Circuit Court which would likewise be appealable to the Supreme Court. In sum, there is a process which would allow an individual who receives an adverse Notice of Action to appeal that decision all the way to the State Supreme Court.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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).

Per South Dakota Codified Law (SDCL) 22-46, Abuse, Neglect, or Exploitation of Elders or Adults with Disabilities, abuse is defined as "physical harm, bodily injury, or attempt to cause physical harm or injury, or the infliction of fear of imminent physical harm or bodily injury on an elder or a disabled adult" and neglect is defined as "harm to an elder's or a disabled adult's health or welfare, without reasonable medical justification, caused by the conduct of a person responsible for the elder's or disabled adult's health or welfare, 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 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" and 22-46-3 states "Any person who, having assumed the duty by written contract, by receipt of payment for care, or by order of a court to provide for the support of an elder or a disabled adult, and having been entrusted with the property of that elder or disabled adult, with intent to defraud, appropriates such property to a use or purpose not in the due and lawful execution of that person's trust, is guilty of theft by exploitation. Theft by exploitation is punishable as theft pursuant to chapter 22-30A.".

In addition to the types of critical events or incidents listed above, the Division of Long Term Services and Supports (LTSS) requires In Home, Community Living Home (CLH), Structured Family Caregiving Home (SFCH)and Assisted Living Center (ALC) waiver providers to report incidents involving death, missing person, restraint, seclusion or serious injury of waiver consumers to LTSS.

Individuals and/or entities that are required to report such events and incidents and the timelines for reporting:

Per SDCL 22-46-9 and 22-46-10 (Mandatory Reporting), individuals in the medical and mental health professions and employees or entities with ongoing contact with and exposure to elders and adults with disabilities, are required to report knowledge or reasonable suspicion of abuse or neglect of elders and adults with disabilities. There are two groups of mandatory reporters and the process for reporting is different for each group.

The first group of mandatory reporters includes physicians, dentists, doctors of osteopathy, chiropractors, optometrists, podiatrists, religious healing practitioners, hospital interns or residents, nurses, paramedics, emergency medical technicians, social workers (including LTSS Specialists, Supervisors) or any health care professionals; psychologists, licensed mental health professionals or counselors engaged in professional counseling; or any state, county or municipal criminal justice employee or law enforcement officer. All employees within the Division of Long Term Services and Supports, specifically Specialists, Supervisors are included in this group. These individuals must make an oral or written report within 24 hours to the Department of Human Services, law enforcement or the state's attorney.

The second group of mandatory reporters includes any staff member of a nursing facility, Assisted Living Center (ALC), adult day care center or community support provider; or any residential caregiver, individual providing homemaker services, victim advocate; or hospital personnel engaged in the admission, examination, care or treatment of elders or adults with disabilities. This group includes in-home waiver providers. Any individual in this group must report to the person in charge of the institution where the elder or adult with disabilities resides or is present, or the person in charge of providing the services within 24 hours. The person in charge must also make an oral or written report within 24 hours to the Department of Human Services, law enforcement or the state's attorney. Although the law states this group has up to 48 hours to report, current practice is that most reports are received much sooner than the 48 hour limit.

In addition to mandatory reporting, people can make reports on a voluntary basis. Any person who knows or has reason to suspect that an elder or adult who is disabled has been abused or neglected may report that information. Persons who in good faith make a report of abuse, neglect, or exploitation of an elder or adult with disabilities are immune from civil or criminal liability per SDCL 22-46-8.

Facilities or programs that are licensed or regulated by the Department of Health or Department of Human Services follow department procedures in place for reporting.

A mandatory reporter who knowingly fails to make the required report is guilty of a Class 1 misdemeanor.

In accordance SDCL 22-46, in-home and Structured Family Caregiving Home waiver providers or are mandated to report any suspected abuse or neglect of a consumer. These waiver providers are reminded of this requirement in the Supplemental Agreement which is signed by all in-home and Structured Family Caregiving Home waiver providers each year. These providers must immediately, following receipt of information, notify LTSS of any consumer-related

concerns, incidents and occurrences, including possible exploitation, that are not consistent with routine care. In addition, these providers must submit an incident report to the Specialist documenting the circumstances of any incident that involves death, missing person, restraint, seclusion or serious injury.

The Department of Health provides reporting instructions to providers, including Assisted Living and Community Living Home Providers, in the "Reporting of Injuries of Unknown Source and Reasonable Suspicion of a Crime" reporting instructions. The policy states in part:

When an injury of unknown source or an allegation of a reasonable suspicion of a crime* has been reported or discovered by staff or another individual, a reasonable suspicion does not have to be first-hand knowledge. Attorneys define reasonable suspicion as: a legal standard of proof that is more than a hunch but less than probable cause. A reasonable suspicion would include observation, previous experience, and reports by residents and family members. In the event an injury of unknown source or an allegation of a reasonable suspicion of a crime has been reported or discovered; take immediate and necessary actions to provide appropriate medical care and appropriate interventions for the resident(s).

The seriousness of the event that leads to reasonable suspicion establishes two time limits for reporting:
1. Serious Bodily Injury* - 2 hour limit
2. All Others* - Within 24 hours

The reporting timeline is based on clock time, not business hours. After business hours, on weekends and holidays, the report continues to be forwarded to the state survey agency (SSA) fax 1.866.539.3886. The report must go to both the SSA and local law enforcement. An individual (facility employee) may report per policy a reasonable suspicion of a crime to the facility administrator (provided an individual has clear assurance the administrator is reporting it), who will then coordinate reporting to the SSA and local law enforcement as required. The facility may not retaliate against any individual that reports a crime. Either of the above timelines also requires a thorough investigation and the investigative findings forwarded in a report to the SSA within 5 working days.

Definitions in the "Reporting of Injuries of Unknown Source and Reasonable Suspicion of a Crime" reporting instructions are as follows:

Crime: Section 1150B (b)(1) of the Affordable Care Act provides that a "crime" is defined by law of the applicable political subdivision where a LTC facility is located. Applicable facilities must coordinate with their local law enforcement entities to determine what actions are considered crimes within their political subdivision. Political subdivisions would be a city, county, township or village, or any local unit of government created by or pursuant to State law.

Serious Bodily Injury: Section 2011 (19)(A) of the Affordable Care Act provides that "serious bodily injury" is defined as an injury with: extreme physical pain; with the possibility of loss or impairment of a bodily member, mental faculty, or organ; a risk of death; or that may require surgery, hospitalization, or rehabilitation. When in doubt, with regard to whether an injury qualifies as "serious bodily injury", report using the earlier timeline.

Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This included deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

Physical Abuse: Hitting, slapping, pinching, and kicking. Also includes controlling behavior through corporal punishment. (per 42 CFR 483.13(b)(c)

Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (per 42 CFR 483.13(b)(c)

Misappropriation of resident property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. (per Administrative Rules of South Dakota (ARSD).

Other per ARSD include: any death resulting from other than natural causes originating on facility property such as accidents, abuse, negligence, or suicide; any missing resident – individual away from facility without staff knowledge of

department or exit time and destination; any fire with structural damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for the operation of the facility for more than 24 hours.

Administrative Rules of South Dakota (ARSD) 44:70:01:07 requires each Assisted Living Center to submit to the Department of Health, the pertinent data necessary to comply with the requirements of South Dakota Codified Law (SDCL) Chapter 34-12 and ARSD 44:70.

Administrative Rules of South Dakota (ARSD) 44:82:01:08 requires each Community Living Home to submit to the Department of Health, the pertinent data necessary to comply with the requirements of South Dakota Codified Law (SDCL) Chapter 34-12 and ARSD 44:82.

When a Specialist receives a report of death, missing person, restraint, seclusion or serious injury in an Assisted Living Center or Community Living Home, the Specialist determines if the provider has reported the critical incident to the Department of Health. If the provider has not reported the critical incident to the Department of Health, the Specialist directs the provider to report the incident to Department of Health to ensure Department of Health is aware of incidents and appropriate protocols are being followed. Department of Human Services is working with Department of Health to further improve and formalize the process for identifying trends and patterns of critical incidents to ensure the health and safety of consumers.

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 home visit to develop the Care Plan, the Specialist provides the consumer and his/her authorized representative with a brochure titled, “Abuse, Neglect & Exploitation of Elders or Adults with Disabilities” on abuse, neglect, and exploitation and explains the information contained in the brochure. The brochure provides information about abuse, neglect and exploitation including information regarding South Dakota’s mandatory reporting law, recognizing signs of possible abuse, neglect or exploitation, and provides contact information regarding where to report abuse, neglect and exploitation. Thereafter at each Annual Review of the Care Plan, the Specialist discusses with the consumer and his/her authorized representative the signs of abuse, neglect, and exploitation stressing that he/she has the right to be free from abuse, neglect and exploitation and offers the consumer additional copies of the brochure. The consumer and/or authorized representative acknowledges receipt of information on abuse, neglect, and exploitation through the following statement on the Care Plan, “I understand I have the right to be free from abuse and neglect. I have been provided with an informational brochure on abuse, neglect and exploitation.”

The Department of Human Services' website on Adult Protective Services is available for access by the general public and contains the following information on abuse, neglect and exploitation: definitions and indicators, mandatory reporting of abuse and neglect, presentations, a video and a printable copy of the brochure titled, “Abuse, Neglect & Exploitation of Elders or Adults with Disabilities”. A waiver consumer and his/her authorized representative can access information on abuse, neglect and exploitation from the website 24/7 and how to report including access to submit a report of abuse, neglect or exploitation via email to the Division of Long Term Services and Supports from the website.

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 SDCL 22-46-7, a report of abuse, neglect, or exploitation may be made to the State's Attorney, the Department of Human Services (DHS), or Law Enforcement. The State's Attorney or Law Enforcement shall immediately notify DHS. The entities work together to follow-up on reports.

The Medicaid Fraud Control Unit of the South Dakota Office of Attorney General works with local, state, and federal partners to investigate and prosecute acts of abuse, neglect, or exploitation perpetrated by providers or upon any resident in a health care facility that receives federal funding.

For reports of life or health threatening conditions or criminal activity including reports of suspected death of an alleged victim due to suspected abuse or neglect; physical abuse (fractures, burns, other injuries); domestic abuse; sexual abuse; an individual who is a danger to himself or others; threat of serious injury or death by a caretaker; threat of suicide; need for immediate medical attention to prevent irreversible physical damage (unconsciousness, acute pain, severe respiratory distress) immediate action and immediate notification to a Law Enforcement is required. Collateral contacts and face to face contact with the individual are made within 24 hours unless Law Enforcement assumes total responsibility for investigation.

A report in which a life or health threatening condition does not exist (medical non-compliance which does not include a life-threatening condition, inadequate attention to physical needs, intimidation by a caretaker, exploitation of resources, serious, but not life threatening self-neglect) requires collateral contacts within 72 hours and face to face contact with the alleged victim within 7 business days. If the result of collateral calls is a referral to Law Enforcement, a face to face visit may not be necessary and a case may not be opened.

Long Term Services and Supports (LTSS) receive reports of abuse, neglect and exploitation perpetrated against adults with developmental disabilities. When an incident occurs while the alleged victim is receiving services from a Community Support Provider, a critical incident report is made to the Department of Human Services' Division of Development Disabilities following the protocol outlined in number 1 and 2 above. Depending on the severity of the report, the Specialist may also direct the referring party to report the incident to Law Enforcement and will also follow up with Law Enforcement and DHS to ensure the report was received.

When LTSS receive reports of abuse, neglect, exploitation, or other critical incidents concerning individuals who reside in facilities licensed by the Department of Health (DOH), investigations are coordinated with DOH staff. A referral may also be made to other entities such as Law Enforcement and the Medicaid Fraud Control Unit to ensure the health and safety of the resident.

The case may be referred to the State's Attorney, Law Enforcement, or Attorney General's Office of Consumer Protection. Reports of scams are forwarded to Law Enforcement and the Attorney General's Office of Consumer Protection. Collateral contacts are made within 72 hours and face to face contact with the alleged victim is made within 7 business days.

Any time there is a SAMS call with an ADRC outcome indicating a "Referral for Adult Protective Services" there must be a corresponding APS Investigation in SAMS. This may include collateral contacts and not necessarily a face to face with the alleged victim. The LTSS Specialist may make collateral contacts (people or agencies that have knowledge of the situation but are not directly involved in the referral such as other caregivers or relatives, landlords, neighbors, physicians, home health agencies, mental health providers, Community Support Providers, etc.) to obtain further information regarding the alleged abuse, neglect, exploitation, self-abuse or self-neglect. In most cases and especially when the eligible adult's decision making is in question the LTSS Specialist should complete a Mini-Mental Status Exam (MMSE) or contact the individual's physician to see if one was recently completed.

With the consent of an adult who has the capacity to consent, or with the consent of the adult's guardian, or in accordance with DHS policy, DHS may refer and purchase services of a nurse or physician for the purpose of medical examination, diagnosis, or treatment. This may include a nutritional assessment and/or medication review.

The perpetrator assessment must be completed during the intake if there is a perpetrator and if the information is known by the reporter. The Specialist will not contact the alleged perpetrator if the victim does not want contact to be initiated with the alleged perpetrator, or if contacting the alleged perpetrator places the individual in jeopardy.

When an alleged victim cannot be located, the Specialist must leave two messages for the alleged victim/family to

contact the Specialist; make at least 2 visits to the home until the Specialist has either interviewed and seen the alleged victim or until the Specialist has completed the following steps:1) contacted Law Enforcement to do a welfare check on the individual; 2) used all available information sources to find the alleged victim.

A Law Enforcement agency must be notified if the Specialist believes that a criminal act has occurred. The Specialist may use Law Enforcement investigative reports or a record of criminal conviction to substantiate the abuse, neglect or exploitation of an individual. The goal is to protect the individual from any further abuse, neglect or exploitation.

Specialists receive notification of critical incidents, including death, missing person, restraint, seclusion or serious injury from a variety of sources including providers, family members, consumers, obituaries, etc. When a Specialist receives these reports, the information must be documented in SAMS as a critical incident.

Assisted Living Centers (ALC) and Community Living Homes (CLH) are required to report incidents of death, missing person, serious injury, restraint and/or seclusion of waiver consumers to DOH. When a consumer chooses an ALC or CLH to receive services, a partnership between LTSS and the ALC/CLH is developed to ensure the health, safety, and welfare of the individual. If a Specialist discovers a provider is not reporting incidents involving LTSS consumers as required, he/she informs the provider of their responsibility to report such incidents. In the event a report is not made to LTSS at the time of the critical incident, documentation and appropriate follow up is completed by the Specialist once the report is received.

When a Specialist receives a report of critical incident/death resulting from natural causes that occurred in an ALC or CLH, the Specialist documents the death in SAMS. When a Specialist receives a report of critical incident/death resulting from other than natural causes that occurred in an ALC or CLH, the Specialist directs the provider to report the incident to DOH to ensure DOH is aware of the death and appropriate protocol was followed.

When a Specialist receives a report of critical incident/missing person or serious injury (i.e. fractures, concussion, laceration requiring sutures, severe burn, dislocation of a major limb, internal injury) involving a consumer who lives in an ALC or CLH, the Specialist directs the provider to report the incident to DOH to ensure DOH is aware of incidents and appropriate protocols are being followed.

When a Specialist receives a report of critical incident/restraint or seclusion involving a LTSS consumer who lives in an ALC or CLH, the Specialist must document the critical incident/restraint in the SAMS Journal and report the restraint to the DOH Complaint Coordinator.

The Specialist may also make a referral to the Long Term Care Ombudsman Program if a consumer residing in an ALC or CLH needs assistance with resident rights advocacy related to a critical incident.
When a Specialist learns a consumer died in a setting other than an ALC or CLH, the Specialist must follow up and document the critical incident/death in SAMS based on the source of notification.
•Obituary: Specialist documents the critical incident in SAMS.
•Provider: Specialist documents the critical incident in SAMS, requests the critical incident report from the provider; documents the receipt of the critical incident report in SAMS; scans the critical incident report in FileDirector.
•Other: Specialist documents the critical incident in SAMS and locates the obituary within one week of the report to confirm the death and document confirmation. If the Specialist is unable to confirm the death, he/she reports the death to the county coroner or local law enforcement.

When a Specialist receives a report of critical incident/missing person involving a LTSS consumer who lives in a home/apartment, a Structured Family Caregiving Home or in a registered residential setting, the Specialist must report the incident to law enforcement immediately and document the critical incident/ missing person in the SAMS Journal.

The Specialist must follow up with Law Enforcement regarding the status of the missing person within 48 hours and narrate a “critical incident/follow-up” in SAMS. If the individual is still missing after 48 hours, the Specialist follows up with Law Enforcement within 1 week. If after 30 days, the Specialist has not received any additional information from Law Enforcement and the whereabouts of the individual remain unknown, the Specialist documents this information in SAMS.

When a Specialist receives a report of critical incident/restraint or seclusion involving a LTSS consumer who lives in a home/apartment, a Structured Family Caregiving Home or in a registered residential setting, the Specialist must

document the critical incident/restraint or seclusion in the SAMS Journal and follow up with the consumer to obtain more information about the restraint or seclusion being reported. If the consumer's response does not give the Specialist reasonable suspicion of abuse or neglect, the Specialist may need to follow up with education to the consumer, provider, and/or caregiver about restraints/seclusion and potentially provide suggestions for other, less restrictive solutions.

When a Specialist receives a report of critical incident/serious injury involving a consumer who lives in a home/apartment, a Structured Family Caregiving Home or in a registered residential setting, the Specialist documents the critical incident/serious injury in SAMS and refers to the Assessment Policy to determine if additional services are needed.
If a provider reports a critical incident involving a LTSS consumer who lives in a home/apartment, a Structured Family Caregiving Home or in a registered residential setting, the Specialist must also:
•Request a critical incident report from the provider (681 LTSS Critical Incident Report)
•Document the receipt of the critical incident report in the SAMS Journal
•Scan the critical incident report in File Director/Correspondence

When a Specialist receives a report of a critical incident and abuse, neglect or exploitation is suspected, the Specialist must refer to Adult Protection Services Policy.

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 of this waiver and is responsible for oversight of critical incidents and events that affect waiver consumers. Oversight is ongoing as reports of alleged abuse, neglect and exploitation, and reports of other critical incidents and events are received in the regional offices or at the state level. Reports may be filed by phone, in written form, or through email. The process followed is the same regardless of how the report is received. The Home and Community-Based Services Program Manager and the Adult Protective Services Program Specialist provide support to LTSS Regional Offices as they conduct investigations and coordinate with law enforcement.

A Critical Incident Review Team (CIRT) consisting of LTSS State Office Program staff and led by the Home and Community-Based Services Program Manager, meet on a monthly basis to ensure that all instances of abuse, neglect, exploitation, death, missing person, restraint, seclusion or serious injury that occurred the previous month were responded to according to Critical Incident Reporting and Adult Protective Services policies. Reports created from SAMS are utilized to obtain information regarding reports received and follow-up completed, including the timeframes in which follow up occurred. If the response to reports of Critical Incidents was not completed according to Critical Incident Reporting and Adult Protective Services Policies, the Specialist is immediately notified to ensure the consumer is safe and out of harm's way and then to complete the required follow up and/or document the follow up that was completed. In addition to reviewing for appropriate response, the CIRT analyzes data to monitor trends and to develop strategies for reducing and preventing incidents.

Per the Supplemental Agreement, the provider must have a policy for Abuse and Neglect Reporting which conforms to the mandatory reporting laws and must provide training on mandatory reporting laws to provider staff on an annual basis. Provider compliance with this requirement is monitored on an annual basis during the onsite or desk review.

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, Office of Health Facilities Licensure & Certification is responsible for detecting the unauthorized use of restrictive interventions in Assisted Living Centers and Community Living Homes. The Office of Health Facilities Licensure & Certification receives information about the unauthorized use of restraints through complaints. The Office of Health Facilities Licensure & Certification conducts on-site reviews at Assisted Living Centers and Community Living Homes and through these unannounced surveys and on-site record reviews identify incidents of unauthorized use of restraints. Surveyors may make unannounced visits and on-site record reviews in follow up to complaints received. Also, when reports are received regarding Assisted Living Centers and Community Living Homes by the State or Local Long-Term Care Ombudsmen, the Ombudsman documents the report in the Ombudsman Program database and makes appropriate referrals. The Ombudsman and the Office of Health Facilities Licensure & Certification staff collaborate to follow-up on unauthorized use of restraints to ensure residents' rights are being protected. The State and Local Long-Term Care Ombudsmen regularly visit Assisted Living Centers, provide training on resident rights to residents and Assisted Living Center staff and respond to complaints from or on behalf of residents in Assisted Living Centers. The South Dakota Long Term Care Ombudsman Policy specifies that Assisted Living Centers will be visited at a minimum on a quarterly basis. In addition, the South Dakota Long Term Care Ombudsman Program will respond to complaints from or on behalf of residents in Community Living Homes and will provide training on resident rights to residents and Community Living Home staff.

The Division of Long Term Services and Supports (LTSS) is responsible for detecting the unauthorized use of restraints in a consumer's home. The use of restraints in the home setting is uncommon, however the Specialist by direct contact with the consumer during home visits (initial, six months, and annual) and through quarterly telephone calls may detect the unauthorized use of restraints occurring in the consumer's home. At the six month review the Specialist directly asks the consumer as part of the Quality of Life Survey if he/she is being restrained (e.g., holds, drugs used as restraints, mechanical restraints). During the initial home visit and at least annually thereafter Specialists complete the Community Health Assessment (CHA) for each consumer. The CHA contains the following question: "Indicate whether the person was physically restrained in the last 3 days, regardless of stated intent of restraint." Instructions to code a response of "No" or "Yes" to this item include: For example, the person's limbs were restrained, the person used bed rails; or the person was restrained to the chair when sitting." Clinical Assessment Protocols triggers link the information gathered in the CHA to the basic need(s) referenced by a CAP. The CAPs focus on a person's function and quality of life, including the person's needs, strengths, and preferences in the following four broad areas: 1) Functional Performance; 2) Cognition and Mental Health; 3) Social Life; and 4) Clinical Issues. Within these areas several CAPs may be triggered and one of those CAPs is Physical Restraints. The CAPs triggered assist to identify needs to include in the development of the Care Plan. As needs are identified, the consumer and/or a representative of the consumer, can indicate if and how each need can be addressed or not addressed through paid services and unpaid services, i.e., natural supports or other services available in the community. As part of this process, if the Physical Restraint CAP is triggered, the Specialist will work with the consumer and/or authorized representative and family members to remove the physical restraint and address the reason for the restraint by meeting the consumer's needs with paid and unpaid services and supports.

During the initial training on how to complete the CHA Assessment, Specialists are trained to make observations and question whether the person has freedom of movement. Observations made of the consumer and the home setting include but is not limited to the following: use of gait belts, being belted or tied to a bed or chair, held in a chair by a non-removable tray or by keeping the foot rest up preventing the consumer from moving out of the chair. Training includes discussion that a restraint is also removing the battery from an electric wheelchair, locking the breaks on the wheelchair, putting chairs around a bed and use of bed rails, which prevent the consumer from freedom of movement.

The Specialist will, upon detecting the unauthorized use of restraints in the home setting, gather additional information to determine if an APS case needs to be opened to address the unauthorized use of restraints in the home setting. When an APS case is opened the Specialist will follow the Adult Protective Services Policy. Additionally the Specialist will work with the consumer and/or authorized representative and family members to discontinue the use of the restraint and address the reason for the restraint by meeting the consumer's needs with paid and unpaid services and supports.

○ **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, Office of Health Facilities Licensure & Certification is responsible for detecting the unauthorized use of restrictive interventions in Assisted Living Centers and Community Living Homes. The Office of Health Facilities Licensure & Certification receives information about the unauthorized use of restraints through complaints. The Office of Health Facilities Licensure & Certification conducts on-site reviews at Assisted Living Centers and Community Living Homes and through these unannounced surveys and on-site record reviews identify incidents of unauthorized use of restraints. Surveyors may make unannounced visits and on-site record reviews in follow up to complaints received. Also, when reports are received regarding Assisted Living Centers and Community Living Homes by the State or Local Long-Term Care Ombudsmen, the Ombudsman documents the report in the Ombudsman Program database and makes appropriate referrals. The Ombudsman and the Office of Health Facilities Licensure & Certification staff collaborate to follow-up on unauthorized use of restraints to ensure residents' rights are being protected. The State and Local Long-Term Care Ombudsmen regularly visit Assisted Living Centers, provide training on resident rights to residents and Assisted Living Center staff and respond to complaints from or on behalf of residents in Assisted Living Centers. The South Dakota Long Term Care Ombudsman Policy specifies that Assisted Living Centers will be visited at a minimum on a quarterly basis. In addition, the South Dakota Long Term Care Ombudsman Program will respond to complaints from or on behalf of residents in Community Living Homes and will provide training on resident rights to residents and Community Living Home staff.

The Division of Long Term Services and Supports (LTSS) is responsible for detecting the unauthorized use of restrictive interventions in a consumer's home including, but not limited to restricting a consumer's rights, access to others or activities, restraints, restriction of movement, and/or seclusion.. The use of restrictive interventions in the home setting is uncommon, however the Specialist by direct contact with the consumer during home visits (initial, six months, and annual) and through quarterly telephone calls may detect the unauthorized use of restrictive interventions occurring in a consumer's home. At the six month review the Specialist will directly ask the consumer as part of the Quality of Life Survey if he/she is being restrained or secluded (e.g., holds, drugs used as restraints, mechanical restraints, locked in a room, told to remain in).

The Specialist will upon detecting the unauthorized use of restrictive interventions in the home setting gather additional information to determine if an APS case needs to be opened to address the unauthorized use of restrictive interventions in the home setting. When an APS case is opened the Specialist will follow the Adult Protective Services Policy. Additionally the Specialist will work with the consumer and/or authorized representative and family members to discontinue the use of restrictive interventions and address the reason for the restrictive intervention by meeting the consumer's needs with paid and unpaid services and supports.

○ **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, Office of Health Facilities Licensure & Certification is responsible for detecting the unauthorized use of restrictive interventions in Assisted Living Centers and Community Living Homes. The Office of Health Facilities Licensure & Certification receives information about the unauthorized use of restraints through complaints. The Office of Health Facilities Licensure & Certification conducts on-site reviews at Assisted Living Centers and Community Living Homes and through these unannounced surveys and on-site record reviews identify incidents of unauthorized use of restraints. Surveyors may make unannounced visits and on-site record reviews in follow up to complaints received. Also, when reports are received regarding Assisted Living Centers and Community Living Homes by the State or Local Long-Term Care Ombudsmen, the Ombudsman documents the report in the Ombudsman Program database and makes appropriate referrals. The Ombudsman and the Office of Health Facilities Licensure & Certification staff collaborate to follow-up on unauthorized use of restraints to ensure residents' rights are being protected. The State and Local Long-Term Care Ombudsmen regularly visit Assisted Living Centers, provide training on resident rights to residents and Assisted Living Center staff and respond to complaints from or on behalf of residents in Assisted Living Centers. The South Dakota Long Term Care Ombudsman Policy specifies that Assisted Living Centers will be visited at a minimum on a quarterly basis. In addition, the South Dakota Long Term Care Ombudsman Program will respond to complaints from or on behalf of residents in Community Living Homes and will provide training on resident rights to residents and Community Living Home staff.

The Division of Long Term Services and Supports (LTSS) is responsible for detecting the unauthorized use of seclusion in a consumer's home. The use of seclusion in the home setting is uncommon, however the Specialist by direct contact with the consumer during home visits (initial, six months, and annual) and through quarterly telephone calls may detect the unauthorized use of seclusion occurring in the consumer's home. The Specialist will upon detecting the unauthorized use of seclusion in the home setting gather additional information to determine if an APS case needs to be opened to address the unauthorized use of restrictive interventions in the home setting. When an APS case is opened the Specialist will follow the Adult Protective Services Policy. Additionally, the Specialist will work with the consumer and/or authorized representative and family members to discontinue the use of seclusion and address the reason for the seclusion by meeting the consumer's needs with paid and unpaid services and supports.

○ **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)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication management is dependent on the setting in which the waiver participant resides:

Assisted Living
The South Dakota Department of Health (DOH) is responsible for licensure of all Assisted Living Centers where consumers served under the waiver may reside. DOH follows a number of Administrative Rules to guide the ongoing monitoring of consumer medication regimens. Monitoring is conducted by on-site reviews, as well as responding to complaints and critical incidents. 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 (SDCL) 36-9-4

Assisted Living Centers must meet several requirements, one of which specifies the Assisted Living Center be approved for medication administration by the Department of Health (DOH). If an Assisted Living Center does not have a licensed nurse to administer medications, to supervise resident care at all times, and to admit or retain residents who require administration of medications, the Assisted Living must employ or contract with a licensed nurse who reviews and documents resident care and condition at least weekly. An Assisted Living that employs a licensed nurse who is on the premises at least 40 hours per week is not required to review and document resident care and condition weekly, but must document resident's identified needs. A registered nurse must provide medication administration training to unlicensed staff who will be administering medications. Each licensed practical nurse who reviews resident care and condition must be in compliance with requirements for supervision. Each Assisted Living Center staff is required to attend specific in-service training within one month after employment. Unlicensed staff must receive ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the Assisted Living Center.

Assisted Living Centers must have policies and procedures in place outlining care provided to residents including policies on diagnostic and therapeutic orders; administration and control of medications; nursing care; infection control; and resident safety. Assisted Living Centers must establish and practice methods and procedures for medication control that include the following requirements to: 1) Ensure the resident’s physician, physician assistant, or nurse practitioner provide electronic or written orders for medications taken by the resident; 2) Have proper storage of medications including separate storage of poisons, topical medications, and oral medications. Each resident’s medication must be stored in the container in which it was originally received and not transferred to another container. A medication prescribed for one resident is not to be administered to any other resident. 3) Have procedures in place to ensure self-administration of medications is supervised. When a resident self-administers a medication, a description of the responsibilities of the resident, the resident’s family members, and the Assisted Living Center’s staff is provided to the resident along with the rights and responsibilities associated with medication self-administration. 4) Have procedures for disposal of medications that are discontinued or outdated.

In an Assisted Living Center with approval for medication administration, the pharmacist completes a monthly review of each resident’s medications (residents who need medications administered to them). The pharmacist completes a review of the resident’s diagnosis, drug regimen, laboratory findings and dietary considerations. The pharmacist reports potential drug therapy irregularities and makes recommendations to the resident’s physician, physician assistant, or nurse practitioner and the administrator in a monthly report which is retained by the administrator of the Assisted Living Center. Medications brought from home may be used when the medication is ordered by the resident’s physician, physician assistant, or nurse practitioner. Medications prescribed for one resident may not be administered to another resident. Residents can keep medications with them or in their room with a physician’s order for medication self-administration.

If a resident of the Assisted Living Center cannot assume responsibility for medication self-administration or self-directed assistance with medication administration or if the Assisted Living Center is approved to provide services to cognitively impaired residents, the Assisted Living Center shall also be approved by the DOH to provide medication administration. When medication administration is provided, there are various ARSD rules that must be complied with as well as requirements for training and supervision. The supervising nurse is responsible to provide an orientation to the unlicensed staff who will administer medications. The orientation must be specific to the Assisted Living Center and relevant to the residents receiving the medication. If a resident self-administers medications, the Assisted Living Center’s policies and procedures related to self-administered medications includes a description of the responsibilities of the resident, the resident’s family members, and the Assisted Living Center’s staff. The Assisted Living Center provides written educational materials to the resident and the

resident's family explaining the resident's rights and responsibilities for self-administration. Additionally, in an Assisted Living Center approved for medication administration, a resident with the cognitive ability to understand may self-administer medications. At least every three months, the supervising nurse or the physician shall evaluate and record the continued appropriateness of the residents' ability to self-administer medications.

Community Living Home
The South Dakota Department of Health (DOH) is responsible for licensure of all Community Living Homes where consumers served under the waiver may reside. DOH follows a number of Administrative Rules to guide the ongoing monitoring of consumer medication regimens. Monitoring is conducted by on-site reviews, as well as responding to complaints and critical incidents. The Administrative Rules of South Dakota (ARSD) regarding Community Living Homes can be found in ARSD 44:82:05 and South Dakota Codified Law (SDCL) 34-12-13 (9).

The requirements for medications in community living homes include the following:
(1) Medications and biologicals kept in the premises shall be labeled with the drug name, strength, and expiration date;
(2) Medications shall be kept in a secure location or in the resident's room to prevent unauthorized access;
(3) Medications requiring refrigeration may be stored in a refrigerator used for food storage if the drugs are stored in a sealed container and placed on the top rack or tray;
(4) Medications shall be self-administered only by residents and family members, or by qualified personnel or care providers licensed or authorized to administer drugs (ARSD 20:48); and
(5) Outdated or discontinued medication shall be properly destroyed or disposed.

Structured Family Caregiving Home/In Home Nursing

For Structured Family Caregiving Homes, the Medicaid enrolled provider is responsible for second-line monitoring of participant medication regimens. If medication administration is going to be delegated to unlicensed personnel, the qualified provider is required to provide a minimum of 20 hours of medication administration training to its employees, including academic instruction and practical application per ARSD 20:48. This training must be conducted under the supervision of a licensed registered nurse. The content of the training for medication administration must address these areas:

1) General information relevant to the administration of medications including governmental regulations and legalities, ethical issues, terminology, forms of medication, procedures and routes of medication administration, and medication references;
2) An overview of major categories of medications as related to body systems and basic principles of drug therapy;
3) Additional instruction, including those categories of medications related to the specific needs of the consumers that the staff will be assisting;
4) Limitations of the staff administering medications;
5) Legal responsibilities to the consumers, the nurse, and the qualified provider;
6) Reporting observations for the well-being of the consumer, including potential side effects and adverse reactions to medications;
7) The Medicaid enrolled provider's policy and procedures regarding its medication system, including storage;
8) Assistance with safe and accurate self-administration or administration of medications; and
9) Reporting of medication administration errors.

The training may also include the areas of first aid, cardiopulmonary resuscitation, infection control, and communicable diseases. Each qualified provider shall have employees demonstrate proficiency in medication administration before administering medication or assisting with self-administration of medication. The required level of proficiency in medication administration is obtaining a score of at least 85 percent through a written examination and demonstrating clinical proficiency on a performance checklist. Each qualified provider shall maintain documentation of an employee's training and proficiency level in the employee's personnel file. Employees completing the medication administration training are subject at least annually to a proficiency review supervised by a licensed registered nurse. The qualified provider shall maintain documentation of annual evaluations of an employee's proficiency in the employee's personnel file.

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.

Assisted Living/Community Living Home
The survey team leader reviews documentation including a copy of deficiencies and plan of correction from the prior survey; copy of any complaint surveys since the last survey; copy of the provider's current license; information about relevant operational changes (i.e. changes in administrator, manager, or ownership); and floor plans. The life safety code surveyor reviews documentation including the Life Safety Code form appropriate for the size of Assisted Living Center (small<16 beds; large>16 beds)/Community Living Home (4 beds); the Exit Interview form; copy of deficiencies and Life Safety Code form from the prior survey; and floor plans. The team leader completes pre-survey tasks including contacting the complaint coordinator and the local long term care ombudsman to inquire if there are identified concerns at the Assisted Living Center/Community Living Home prior to entering.

SURVEY PROCEDURES
An Entrance Conference is held by the DOH survey team with the Assisted Living Center/Community Living Home to explain the reason they have entered the premises and the survey process required to determine compliance with applicable regulations. The survey team tours the Assisted Living Center/Community Living Home to meet the residents, obtain an overall picture of the environment, and identify focus areas. A comparison is conducted of the optional services approved on the provider's license to the actual needs of the residents.

A random sample of residents is selected to target potential concerns based on offsite preparation and tour observations. Residents who may be over Level of Care for the Assisted Living Center/Community Living Home are included as are residents who have been admitted since the prior survey. For providers with over 35 beds a 10% of the current resident census is reviewed. Additionally for all Assisted Living Center/Community Living Home surveys, at least one closed record is reviewed. A minimum of three residents (up to 5% of the provider's current census) are interviewed.

The survey team conducts information gathering including: 1)Observations, interviews, and review of the sampled residents' care records determine compliance with sufficient personal care services and staffing, activities program, privacy and confidentiality, and quality of life; 2)a closed resident care record is reviewed, specifically documentation on the care records notes or progress reports for a month or two prior to discharge to identify any potential quality of care or quality of life concerns; and 3)Residents are observed evacuating during the fire drill to determine compliance with physical impairment or self-preservation requirements.

During the onsite survey medication administration and storage is observed to ensure compliance with specific medication control regulations. For providers approved for medication administration, compliance with the following is determined: 1) the credentials and South Dakota Board of Nursing approval for the nurse/pharmacist conducting the medication training; 2)medication control and disposal procedures; 3)the staff schedule to ensure there are qualified unlicensed staff available 24/7; 4)the personnel files of the unlicensed staff administering medications.

The Department of Health holds an Exit Conference with the Assisted Living Center/Community Living Home describing how the requirements and findings are not in compliance and technical assistance is provided to the Assisted Living as needed.

Assisted Living Centers/Community Living Homes are surveyed more than once each year if warranted; for example, when complaints are received that include potentially harmful medication administration practices. The Office of Health Facilities Licensure & Certification also requests Assisted Living Centers/Community Living Homes to provide documentation as needed.

Structured Family Caregiving Home/In Home Nursing Services
Providers of Structured Family Caregiving and In Home Nursing services are required to have a policy in place regarding medication administration, which includes recording and tracking of medication errors and appropriate physician follow up. During annual on-site reviews of the in-home providers, Division of Long Term Services and Supports staff reviewers will assure the in-home providers are in compliance with the provider's policy on medication administration. In addition, during the provider review process, individual employee files are reviewed for compliance with the provider agreement. If the employee being reviewed is a licensed nurse, the record is reviewed to ensure the provider verified the Nursing Licensure through the SD Board of Nursing. If the employee being reviewed is not a licensed nurse but is providing medication administration under the direct supervision of a

licensed nurse, the record is reviewed to ensure the provider conducted the appropriate curriculum as outlined in ARSD 20:48.

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)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

General Administrative Rules regarding nursing:
Per Administrative Rules of South Dakota (ARSD) 20:48:04.01:02, the licensed nurse provides supervision of all nursing tasks delegated to unlicensed staff in accordance with the following conditions: 1) The licensed nurse determines the degree of supervision required after considering the stability of the resident's condition, the competency of the unlicensed person to whom the nursing task is delegated, the nature of the nursing task being delegated, and the proximity and availability of the licensed nurse to the unlicensed person when the nursing task will be performed. 2) The delegating licensed nurse or another licensed nurse is readily available either in person or by telecommunication; and 3) If the unlicensed person is providing care in the home, the time interval between supervisory visits and whether the visit is conducted in person or via telecommunication is determined by the licensed nurse in accordance with ARSD 20:48:04.01:01. The visit shall occur no less than once every 60 days to assure client safety.

ARSD 20:48:04.01:11, provides for medication administration tasks that may not be routinely delegated and require written protocol. Medication administration tasks that may be delegated to unlicensed staff only in accordance with ARSD 20:48:04.01:01 include the following: 1) Administration of the initial dose of a medication that has not been previously administered to the resident; 2) Administration of medications on an as-needed basis, including schedule II controlled substances listed in SDCL 34-20B-16 and 34-20B-17 as provided in ARSD 20:48:04.01:10(3); and 3) Administration of insulin by the subcutaneous route in accordance with ARSD 20:48:04.01:16 and ARSD 20:48:04.01:17. A RN is responsible for developing written protocol for the instruction and training of unlicensed staff and maintaining the protocol on file.

In accordance with ARSD 20:48:04.01:12, the licensed nurse may not delegate the following tasks of medication administration: 1) Administration of schedule II controlled substances listed in SDCL 34-20B-16 and 34-20B-17 from a locked stock supply; 2) Administration of medications by subcutaneous, intramuscular, intradermal, or intravenous route except as authorized in ARSD 20:48:04.01:11; 3) Administration of medications by way of a tube inserted in a cavity of the body; 4) Administration of medications via inhalation route in a complex nursing situation as defined in ARSD 20:48:01:01; and 5) Calculation of any medication dose.

According to ARSD 20:48:04.01:01, the RN is responsible for the nature and quality of nursing care that a resident of an ALC and a consumer living at home receives under the nurse's direction. To achieve full utilization of the services of a RN or a LPN, the licensed nurse may delegate selected nursing tasks to unlicensed staff. Unlicensed staff may complement the licensed nurse in the performance of nursing functions but may not substitute for the licensed nurse. Unlicensed staff may not re-delegate a delegated act. A licensed nurse is accountable to practice in accordance with the scope of practice as defined in South Dakota Codified Law (SDCL) 36-9. The delegating nurse is accountable for assessing a situation and making the final decision to delegate. The delegation of nursing tasks to unlicensed staff must comply with the following criteria: 1) The nursing task is one that a reasonable and prudent licensed nurse would find within the scope of sound nursing judgment to delegate; 2) The nursing task is one that, in the opinion of the delegating licensed nurse, can be properly and safely performed by unlicensed staff without jeopardizing the client's welfare; 3) The nursing task does not require unlicensed staff to exercise nursing judgment; 4) The licensed nurse evaluates the resident's nursing care needs before delegating the nursing task; 5) The licensed nurse verifies that the unlicensed person is competent to perform the nursing task; and 6) The licensed nurse supervises the performance of the delegated nursing task in accordance with the requirements of ARSD 20:48:04.01:02.

ARSD specific to nursing in Assisted Living Centers:
The SD Department of Health (DOH) Office of Health Facilities Licensure & Certification oversees all medication administration activities, including self-administration activities, in health care facilities. Per ARSD 44:70:07:07, if any resident of the Assisted Living Center (ALC) cannot assume responsibility for medication self-administration or self-directed assistance with medication administration or if the ALC is approved to provide services to cognitively impaired residents per ARSD 44:70:04:14(3), the ALC must also be approved by the DOH to provide medication administration. If medication administration is provided, there are rules that must be complied with as well as requirements for training and supervision. The supervising nurse is responsible to provide an orientation to the unlicensed staff who will administer medications. The orientation must be specific to the ALC and relevant to the residents receiving the medication. If any resident is permitted to self-administer medications, the ALC's policies and procedures related to self-administered drugs must include a description of the responsibilities of the resident, the resident's family members, and the ALC's staff.

In an ALC approved for medication administration, a resident may self-administer drugs if the physician, RN, PA, or nurse practitioner has determined the practice to be safe and, at least every three months, the supervising nurse or the physician shall evaluate and record the continued appropriateness of the residents' ability to self-administer medications. Additionally, in an ALC approved for medication administration, a resident with the cognitive ability to understand may self-administer medications and according to ARSD 44:70:09:13, the determination shall state whether the resident or the nursing staff is responsible for storage of the drug and documentation of its administration in accordance with the provisions of ARSD 44:70:07.

Per ARSD 44:70:07:01, it is the responsibility of each ALC to establish and practice methods and procedures for medication control that include the following: 1) A requirement of the ALC to ensure that each resident's prescribing physician, physician assistant, or nurse practitioner provide to the center electronic or written signed orders for any medications taken by the resident; authorization for medications or drugs kept on the person or in the room of the resident; and release of medications. 2) The ALC is also required to have provisions for proper storage of prescribed medications so that the medications are inaccessible to residents or visitors including requirements for separate storage of poisons, topical medications, and oral medications. Each resident's medication must be stored in the container in which it was originally received and not transferred to another container. A medication prescribed for one resident is not to be administered to any other resident. 3) Each ALC must have procedures in place to ensure that self-administration of a medication is accomplished with the supervision of a designated employee of the center. When a resident self-administers a medication, a description of the responsibilities of the resident, the resident's family members, and the Assisted Living Center's staff is provided to the resident along with the resident's rights and responsibilities associated with the self-administration. 4) The ALC must also have procedures in place to ensure the proper disposition of medicines that are discontinued because of the discharge or death of the resident, because the drug is outdated, or because the prescription is no longer appropriate to the care of the resident.

ARSD specific to nursing in Community Living Home:
The South Dakota Department of Health (DOH) is responsible for licensure of all Community Living Homes where consumers served under the waiver may reside. DOH follows a number of Administrative Rules to guide the ongoing monitoring of consumer medication regimens. Monitoring is conducted by on-site reviews, as well as responding to complaints and critical incidents. The Administrative Rules of South Dakota (ARSD) regarding Community Living Homes can be found in ARSD 44:82:05 and South Dakota Codified Law (SDCL) 34-12-13 (9).

The requirements for medications in community living homes include the following:
(1) Medications and biologicals kept in the premises shall be labeled with the drug name, strength, and expiration date;
(2) Medications shall be kept in a secure location or in the resident's room to prevent unauthorized access;
(3) Medications requiring refrigeration may be stored in a refrigerator used for food storage if the drugs are stored in a sealed container and placed on the top rack or tray;
(4) Medications shall be self-administered only by residents and family members, or by qualified personnel or care providers licensed or authorized to administer drugs; and
(5) Outdated or discontinued medication shall be properly destroyed or disposed.

ARSD specific to nursing in a Structured Family Caregiving Home/In Home Nursing:
In-home nursing services must be performed by a RN or a LPN according to the Supplemental Provider Agreement signed by in-home providers of nursing services. The in-home nursing services are monitored by the in-home provider who hires licensed nurses to provide nursing services. Nursing services are provided to consumers who live at home and need assistance to manage and/or administer medication. Through provision of nursing services, licensed nurses administer medication by giving injections when the consumer is unable to inject him/herself and set up medications and monitor self-administration of medication, when the consumer is unable to self-administer medications him/herself. In addition, licensed nurses provide supervision of all nursing tasks delegated to unlicensed in-home waiver provider staff and of principal caregivers in Structured Family Caregiving Homes per ARSD 20:48:04.01:01 and ARSD 20:48:04.01:02. Per the South Dakota Board of Nursing Declaratory Ruling 92-1, homemakers employed by in-home providers may provide assistance with the self-administration of medications to consumers who are mentally capable of self-directing their care and who reside in their own home, provided they are under the supervision of a licensed professional nurse. Assistance with medication administration by a homemaker is limited to reminding the consumer to take a medication at a prescribed time,

opening and closing a medication container, and returning a medication container to the proper storage area.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Assisted Living
In Assisted Living Centers when a medication administration error is the result of suspected abuse or neglect, the error must be reported to the Department of Health. Other medication errors are not required to be reported, but must be recorded and available upon request by the South Dakota Department of Health Office of Health Facilities Licensure & Certification. In Assisted Living Centers medication administration records and medication administration observations are reviewed during unannounced Department of Health surveys and should reflect all records of medication administration including medication errors.

In Assisted Living Centers, pursuant to Administrative Rules of South Dakota (ARSD) 44:70:07:08, medication administration records are used and regularly checked against the physician, physician assistant, or nurse practitioner's orders. Each medication administered is recorded in the resident's medical record and signed by the individual responsible. Medication errors and drug reactions are reported to the resident's physician, physician assistant, or nurse practitioner and an entry is made in the resident's medical record. Orders involving abbreviations and chemical symbols may be carried out only if the Assisted Living Center has a standard list of abbreviations and symbols and the list is available to the nursing staff. A person may not administer medications that have been prepared by another person.

Community Living Home
In Community Living Homes, pursuant to Administrative Rules of South Dakota (ARSD) 44:82:05:02, the owner or operator shall ensure confidentiality and safeguarding of resident records. Records for each resident shall be maintained while the resident is residing in the home and for an appropriate amount of time thereafter. The home may arrange storage or transfer of resident records with another licensed home, or at the request of the resident, relinquish records to the resident or the resident's legal representative, or arrange storage of remaining medical records with a third party vendor who undertakes such a storage activity. At least 30 days before closure, the owner or operator shall notify the department in writing indicating the provisions for the safe preservation of resident records and their location. If ownership of the community living home is transferred, the new owner shall maintain the resident records as if there was not a change in ownership. Resident records at a minimum shall include the following:
(1) Current basic health information including a list of medications, allergies, diet requirements, and daily health needs;
(2) The name and contact information of the resident's physician and other health care professionals involved with the resident's care;
(3) The name and contact information of the resident's preferred emergency contacts, immediate family members, and health care representative or power of attorney;
(4) An evaluation of the resident's individualized and independent residential community living support needs completed within the past year, or upon a significant change in the resident's condition requiring notification pursuant to § 44:82:06:04, that is recorded on a form approved by the department;
(5) A current plan of care, as agreed to by the resident or the resident's legal representative and the owner or operator, updated at least annually;
(6) Any reports of suspicion of abuse or neglect reported to the department;
(7) Disposition of medications that were outdated or disposed; and
(8) Discharge information including disposition of medications.

Structured Family Caregiving Home/In Home Nursing
Providers of Structured Family Caregiving Homes and In-Home Nursing are required to have a policy in place regarding medication administration, which includes recording and tracking of medication errors. During annual on-site reviews of the in-home providers, Division of Long Term Services and Supports staff reviewers will assure the in-home providers are in compliance with the provider's policy on medication administration. This includes reviewing the recorded medication errors and ensuring appropriate physician notification and follow up was conducted.

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Assisted Living/Community Living Home
The Department of Health Office of Health Care Facilities Licensure & Certification has oversight responsibility for monitoring the performance of waiver providers in the administration of medications to waiver consumers residing in Assisted Living Centers/Community Living Homes. Monitoring is conducted through on-site, unscheduled surveys. Additionally, the Office of Health Care Facilities Licensure & Certification will perform additional surveys or investigations if they receive complaints or allegations of abuse and neglect.

The Department of Health will investigate if there is a pattern of medication errors or other medication administration errors with a specific individual residing in an Assisted Living Center/Community Living Home.

Structured Family Caregiving Home/In Home Nursing
The Department of Human Services, Division of Long Term Services and Supports (LTSS) conduct on-site reviews for each provider of Structured Family Caregiving Homes and In-Home Nursing prior to initial enrollment and annually thereafter. On-site reviews are performed by LTSS Regional Managers and Supervisors, the HCBS Program Manager, or other LTSS designees and follow a standard on-site review protocol. The on-site review includes review of consumer records and visit documentation, personnel records, policies and procedures to include medication administration policies, procedures and provider records of medication errors. The reviewer ensures all required components are in place and completes a Provider Review Report, a copy of which is given to the provider who has 60 days to respond to the determination of the initial findings of the annual on-site review. If components are not in place the provider must respond with a plan to address how to meet required components.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of waiver consumers who receive educational information regarding abuse, neglect, and exploitation. Numerator = Number of consumers who received information. Denominator = Number of consumers 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%, +/-5%
☐ **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 abuse, neglect and exploitation investigations initiated within specified timeframes. Numerator = Number of investigations initiated within specified timeframes. Denominator = Total number of 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**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of percent of waiver consumers who have Care Plans which address back up plans and emergency preparedness as appropriate. Numerator = Number of consumers with Care Plans that address back up plans and emergency preparedness as appropriate. Denominator = Number of consumers 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, +/-5%
☐ **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 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%, +/-5%
☐ **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 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 complaints regarding providers that were addressed within required timeframes. Numerator = Number of complaints 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 Social Assistance Management System (SAMS) 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**

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 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:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver consumers 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**	☒ **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:

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 Social Assistance Management System (SAMS) 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**
	☐ **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 consumers who received age appropriate educational information regarding preventative health care. Numerator = Number of consumers who received educational information regarding preventative health care. Denominator = Number of consumers 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%,+/5%
☐ **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**

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

Performance Measure:
Number and percent of waiver consumers who received age appropriate preventative health care. Numerator = Number of consumers who received age appropriate preventative health care. Denominator = Number of consumers 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%, +/5%
☐ **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.

Health and welfare assurances that are contained in the Care Plan are reviewed on a quarterly basis and are reviewed by LTSS Regional Supervisors during quarterly Care Plan reviews using the same random sample utilized for the Care Plan assurances. At the end of the quarter, each Regional Supervisor receives a list of waiver consumers for whom Care Plans must be reviewed. Review assignments are made by the Home and Community-Based Services (HCBS) Program Manager. Care Plans are stored electronically in FileDirector, a digital document reviewing program, which allows Regional Supervisors to review consumer Care Plans remotely. Regional Supervisors record the results of each performance measure in the SAMS database. This process notates which Performance Measures were met for each consumer reviewed and which Performance Measures require remediation. The data is aggregated and analyzed by the HCBS Program Manager and Program Specialists.

Abuse, neglect and exploitation reports made to LTSS on behalf of elders and adults with disabilities are assigned to a Specialist. The Specialist follows the policies and procedures for investigating reports and documenting all pertinent information in the Social Assistance Management System (SAMS) consumer database. The Critical Incident Review Team (CIRT) reviews Adult Protective Services (APS) cases involving consumers monthly to ensure cases were initiated according to timeframes specified in policy. Data for APS cases involving consumers is collected from a report generated from SAMS. The data is reviewed to ensure waiver consumers receive educational information regarding abuse, neglect and exploitation is contained in the Care Plans. This performance measure is reviewed quarterly by the Regional Supervisors as part of Care Plan Reviews utilizing the Care Plan assurances random sample. During the quarterly review of Care Plans, Regional Supervisors review the same random sample of consumers and their records to identify signs of abuse, neglect and exploitation that occurred during the review period. If there were signs of abuse, neglect and exploitation, consumer records are further reviewed to ensure incidents of abuse, neglect and exploitation were followed up according to the Adult Protective Services (APS) Policy.

Data to ensure waiver consumers have back up plans and emergency preparedness as appropriate is contained in the Care Plans. This performance measure is reviewed by the Regional Supervisors quarterly as part of Care Plan Reviews utilizing the Care Plan assurances random sample.

The data to ensure complaints regarding waiver providers are addressed within required timeframes is collected from reports generated in the Ombudsman Program database and SAMS. The reports, and relevant documentation, are reviewed by the CIRT monthly to ensure each complaint was addressed within timeframes required by policy. The HCBS Program Manager tracks the complaints, noting the total number of complaints per month that were addressed in the required timeframes.

The data for critical incidents resulting in death, missing person, restraint, serious injury or seclusion of waiver consumers is collected from a SAMS generated report. The report, and relevant documentation in SAMS, is reviewed by the CIRT each month to ensure appropriate follow up of each critical incident occurred. The HCBS Program Manager tracks the critical incidents, noting the total number of incidents per month that were not appropriately followed-up and the total number of incidents reported. Restrictive interventions including restraints and seclusion are prohibited in this waiver. Data on restraints and seclusion is also collected from responses provided by consumers on the Quality of Life Survey. Additionally, restraints and seclusion are recorded and followed up on as critical incidents. Responses to the survey and critical incidents involving restraint or seclusion are reviewed monthly by the CIRT and reports of restraint and seclusion become an APS case opened for investigation if required by APS policy. Survey responses and critical incident data are collected, compiled, and analyzed for trends.

Data to ensure consumers receive educational information regarding preventative health care is contained in the Care Plans. This performance measure is reviewed by Regional Supervisors during quarterly Care Plan reviews using the same random sample utilized for Care Plan assurances. To determine if consumers received appropriate preventative health care, Regional Supervisors utilize the same random sample to complete Care Plan reviews. Specifically, the Community Health Assessment, which has questions involving appropriate preventative health care the consumer received, is reviewed. Regional Supervisors review the answers to these questions to determine if age appropriate preventative health care has been received by the consumer.

For the performance measures reviewed by the CIRT, reports are pulled and reviewed monthly and results are recorded on Excel Spreadsheets. This process notates which Performance Measures were met (for each

occurrence of abuse, neglect, exploitation, restraint, seclusion, death, missing person, serious injury and complaint) and which require remediation. Those requiring remediation are forwarded to the Regional Supervisors to work with the Specialists to remediate and ensure the health and welfare of consumers. Trends are identified by looking at completed statewide reviews over a series of quarters. Data analysis and trends are presented to the Waiver Review Committee quarterly. The Waiver Review Committee determines how statewide trends can be remediated and how additional staff training or changes to the waiver design could result in quality improvements.

b. Methods for Remediation/Fixing Individual Problems

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

When it is determined that investigations of abuse, neglect and exploitation are not initiated within specified time frames, it is first determined why the investigation was not initiated within the specified timeframes. If the investigation has still not been initiated at the time of review, the investigation begins immediately, following proper protocol and timeframes from that point forward. Immediate action is taken to protect the health and welfare of the consumer.

When identified that a consumer has not received educational information regarding abuse, neglect and exploitation, the Specialist remediates the problem by providing the educational materials to the consumer immediately.

When it is identified that a consumer does not have a back-up plan and/or emergency preparedness plan as required by policy or the plan is not appropriate, remediation consists of contacting the consumer, and revising the Care Plan to include an appropriate back-up and emergency preparedness plan. The Care Plan will be revised within 30 days.

When individual problems are identified with Specialists not conducting follow up when signs of abuse, neglect and exploitation are identified, the Specialist will immediately follow up with the consumer as required per the Adult Protective Services Policy. Immediate action is taken to protect the health and welfare of the consumer. If it is determined a provider or Specialist was aware of an incident of abuse, neglect and exploitation but did not appropriately report the incident, corrective action will be taken. This may include training, probation, or termination depending on the severity of the situation.

When it is identified that a complaint regarding a provider was not addressed within required timeframes, it is remediated by addressing the complaint about the provider immediately. If the complaint has already been partially addressed, but not resolved, the Specialist will contact the consumer to follow-up on their needs and determine if additional action is warranted. If the complaint has been resolved, but was not addressed per timeframes in policy, the Specialist will be retrained on the importance of follow up on complaints according to timeframes in policy.

When it is identified that there was a critical incident and appropriate follow up was not completed as per policy, the remediation is accomplished by first addressing the critical incident immediately using the appropriate follow-up procedure. If the critical incident has been addressed, but was not addressed using appropriate follow-up, the Specialist and the LTSS Regional Supervisor review the process and determine what prevented the incident from being addressed appropriately and remediate as necessary, including appropriate follow up.

Individual problems identified in which consumers are being restrained or secluded while receiving waiver services will be addressed through provider education and/or by opening an Adult Protective Service (APS) case to investigate as appropriate. In addition, consideration to terminate a waiver provider will be pursued if warranted. Overall trends identified through responses from the Quality of Life Survey, and critical incident reports regarding restraints and seclusion will be targeted for improvement in the continuous quality improvement process.

When a quarterly Care Plan Review identifies that a consumer has not received information regarding preventative health care, the Specialist remediates the problem by immediately providing the educational materials on preventative health care to the consumer.

When it is determined that a consumer is not receiving preventative health care, the Specialist will discuss with the consumer, the importance of preventative health care, the preventative health care that is available and if he/she chooses, include a preventative health care goal on the consumer's Care Plan. If trends are identified that consumers not receiving appropriate preventative health care, options to increase the performance of this measure may include: educational activities, hosting preventative health care events and enlisting assistance from providers to offer information and education on preventative health care.

When individual problems are identified through the Critical Incident Review Team (CIRT) process, the identified issues are forwarded to LTSS Regional Supervisors who then work with Specialists to assure resolution of the identified issues. When trends are identified recommendations for improvements are made by the Critical Incident Review Team and/or the Waiver Review Committee.

If, over time, a trend is identified that an individual Specialist is not following procedures, the LTSS Regional Supervisor will determine the appropriate corrective action that may be required including training, probation, or termination depending on the severity of the situation.

Data aggregation and analysis for the Health and Welfare assurances will be conducted quarterly by the Home and Community-Based Services (HCBS) Program Manager. Trends are identified by looking at completed statewide reviews over a series of review periods. Data analysis and trends are presented to the Waiver Review Committee on a quarterly basis. The Waiver Review Committee will determine how statewide trends can be remediated and how additional staff training or changes to the waiver design could result in quality improvements.

Guidance and training is developed and implemented as necessary through revisions to policy and procedure and is communicated in person, through online webinars or in email correspondence to LTSS staff.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS

that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 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.

All data aggregation and analysis is completed by the Home and Community-Based Services (HCBS) Program Manager. The HCBS Program Manager begins the process of trend identification as aggregation and analysis is being conducted. Data and trends are then presented to the Waiver Review Committee. The Waiver Review Committee is led by the HCBS Program Manager and includes the following additional members: Division of Long Term Services and Supports HCBS Program Manager, Director, Deputy Division Director, Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, Training Coordinator, Regional Managers,Regional Supervisors, and two Specialists. The Waiver Review Committee meets quarterly to discuss consumer and provider issues and to set priorities for system-wide quality improvement. As a result of an analysis of the discovery and remediation information presented to the Waiver Review Committee, system improvements are identified and design changes are made.

Effective compilation and communication of quality management information requires an appropriate infrastructure that is designed for that purpose. The backbone of support for continuous quality improvement consists of internal Medicaid Management Information System (MMIS), SAMS and Ombudsmanager databases and their associated subsystems, and effective, objective reviews completed by the Regional Supervisors.

Comparative data gleaned from MMIS, SAMS, Ombudsmanager and record reviews is evaluated by the Waiver Review Committee to determine if system changes are warranted. Review of these reports may also lead to initiation of new improvement projects to benefit waiver consumers.

The following general processes and criteria guide the setting of priorities in implementing system improvements:

Prioritization:

The Waiver Review Committee prioritizes quality improvement activities and projects from those opportunities that provide the most benefit to the consumer, the community, providers, organization, and funding entities, while at the same time maximizing use of quality improvement resources. Consideration is given to the issues based on the following criteria:

1) Regulatory Requirements - required by law or funding sources;
2) High Risk - likelihood of adverse events or outcomes;
3) High Volume - affects many individuals;
4) High Cost - causes financial drain on system;
5) High Impact - potential to make significant change;
6) High Likelihood of Success - easy to implement and provides successful outcome;
7) Problem Prone - causes major problems if it occurs;
8) Feasibility of Time and Resources - cost/staff commitment required;
9) Measurability - data and resources can capture necessary information; and
10) Readiness to Address Issue - the time, situation, and climate are right.

After the Waiver Review Committee has identified a need for system improvement and decided action is needed, the design and development of the processes for implementing the system improvement is accomplished by the Waiver Review Committee, in coordination with other entities impacted, primarily service providers, where warranted.

Implementation of the systems improvement activities will be managed by the HCBS Program Manager and will involve Specialists, Regional Supervisors, Regional Managers, and State Office Program staff as needed. Guidance and training will be provided following each quarterly Waiver Review Committee meeting to the Division of Long Term Services and Supports staff through online webinars. Additional guidance and training will be developed and implemented as necessary through revisions to policy and procedure and may be communicated in person, through online webinars or in email correspondence to LTSS staff.

If, over time, a trend is identified where an individual or a group of Specialists are not following the waiver or policies or processes as specified, the Waiver Review Committee will design and implement staff development activities to remediate identified issues.

Progress on system improvement projects is reported at quarterly Waiver Review Committee meetings and is shared with Specialists, Regional Supervisors, Regional Managers, providers and other stakeholders with primary interest in the area targeted for improvement efforts.

The Internal Waiver Review Committee (IWRC) also serves as a resource for system improvements. The IWRC is comprised of the HCBS Waiver Program Managers of each of the four HCBS waivers in South Dakota, a representative from the Division of Medical Services (the Medicaid Agency) and other representatives from the Department of Social Services and the Department of Human Services. At quarterly IWRC meetings, HCBS Waiver Program Managers present information about trends in data, renewal application or amendment progress, and areas of concern. The IWRC quarterly 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.

The responsibility for monitoring the effectiveness of the waiver quality improvement strategies is continuous and ongoing. The quality assurance review process is the initial line of monitoring and analyzing the effectiveness of system design changes that evolved through the evaluation of performance measures. Issues of non-compliance are documented by the reviewers, aggregated and analyzed by the HCBS Program Manager and brought forward for analysis by the Waiver Review Committee. A necessity for changes in the quality system is indicated when repeated issues and problems are identified and/or compliance is below 86%. Recommendations for system changes will be made by the Waiver Review Committee including timeframes for expected improvement, and will be implemented by the HCBS Program Manager and State Office Program staff.

The effectiveness of System Design changes is reviewed on a quarterly basis during the Waiver Review Committee Meetings. The success of the changes is measured according to a negative or positive change in the overall discovery data. If there is not a positive change in the overall discovery data, the Waiver Review Committee determines if more time may be needed to determine success or whether additional system changes are necessary. When additional changes are necessary, new recommendations are made and the monitoring and analyzing process restarts.

Information on systems improvements is presented to internal stakeholders and the Internal Waiver Review Committee on a quarterly basis and to providers and other stakeholders with primary interest in the area targeted for improvement efforts.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Waiver Review Committee meets quarterly to review and analyze information from the previous quarters and to review progress of system improvement projects. Quality measure trends and issues are presented, discussed, and evaluated to inform decisions on additional actions to improve quality. The Waiver Review Committee periodically reviews and evaluates the quality improvement strategy, performance measures, sampling strategies, and processes for remediation and improvement. The evaluation compares performance to anticipated benchmark performance, analyzes trends in performance improvement/decrement, and analyzes remediation reports to identify systemic failures and reviews reports and descriptions of best-practice quality improvement approaches from other states for applicable practice to addressing performance issues. Based upon evaluation, the Waiver Review Committee may identify areas in need of improvement and decide upon modification to existing strategies or development and implementation of additional improvement strategies. The Waiver Review Committee evaluates the Quality Management Strategy at least annually and revises it as necessary.

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).*

Providers enrolled to provide waiver services are required to submit an A-133 independent audit annually if they meet the criteria for that level of audit. Many providers voluntarily have audits conducted even if they are not required to submit an A-133. The South Dakota Department of Legislative Audit conducts an annual independent audit of the Department of Social Services Medicaid program, including the waiver program.

Waiver claims are subject to a number of post payment reviews by our Surveillance and Utilization Review System (SURS) unit as well as the Payment Error Rate Measurement (PERM) review process. Both the independent audit and post payment reviews include statistically valid sampling methodologies.

Under 42 C.F.R. part 456, South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under § 42 CFR 456.23. Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

The SURS unit completes several off site audits throughout the year.
1.Annually, an internal post payment review for waiver providers take place. Claims data is pulled for each service code and the five providers with the highest reimbursement for each service are reviewed. Additionally, providers with significantly increased reimbursement for the service code from the last year are also reviewed. The five providers with the highest reimbursements for each service are re-reviewed after six months.
2.Annually, an internal post payment review for all providers (including waiver providers) based on spike reports, which identify providers with reimbursement more than 125% over the previous year.
3.Ongoing, an internal post payment review of billing issues specific to procedure codes and/or providers.
4.Ongoing, an internal post payment review of claims submitted by providers suspected of fraud.

The Department of Social Services participates in the Payment Error Rate Measurement (PERM) review process which begins a new cycle every three years. The PERM review employs federally contracted agencies to conduct a series of reviews. These reviews include an eligibility review, a review of data processing and claims paid, and a medical review. The review is coordinated by the Division of Medical Services. The PERM review takes approximately 2 years to complete as the various review components are conducted one after the other.

When any level of the PERM review creates questions, the Provider is contacted to provide additional documentation as necessary.

In the case of waiver services, case coordination is handled by the Division of Long Term Services and Supports. Follow-up on eligibility and/or medical questions generated by the PERM review are routed to the HCBS waiver program to provide necessary documentation.

Providers must sign a standard Provider Agreement upon enrollment as a Medicaid provider. The Provider Agreement contains the following financial integrity components:

(1) Provider agrees to keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services rendered and billings made under the medical assistance program, and agrees to furnish Medical Services and/or Medicaid Fraud Control Unit (MFCU) and/or Department of Health & Human Services (HHS), upon request, such information regarding any payments claimed for providing these services. Provider agrees to obtain a written waiver of the physician-patient privilege and release of medical records from each patient for the purposes of allowing access to the pertinent patient records and facilities by Medical Services, MFCU and/or HHS. Access includes, but is not limited to, the examination, inspection, photocopying and/or auditing of any requested records. Provider understands that failure to submit or failure to retain adequate documentation for all services billed to the medical assistance program may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of Provider from participation in the medical assistance program, and may result in civil or criminal liability.

(2) Provider acknowledges that by submitting a claim to the medical assistance program, Provider certifies that the services were medically necessary, were rendered prior to the submission of the claim to the medical assistance program and that the services were rendered by Provider or incident to Provider's professional service by an employee, and in the case of an individual practitioner, under Provider's immediate personal supervision as permitted by the medical assistance program.

(3) Provider agrees to submit claims in accordance with billing instructions and as required under any and all state

regulations.

(4) Provider agrees to submit claims that are true, accurate, and complete. Provider acknowledges by Provider's signature on this agreement that Provider understands that payment and satisfaction of each claim will be from Federal and State funds and that any false claims, statements or documents, or concealment of material fact, may be prosecuted under applicable Federal and State law.

(5) Provider agrees to be individually responsible and accountable for the completion, accuracy, and validity of all claims submitted, including claims submitted for Provider by other parties. Provider further agrees to not make or cause to be made a claim, knowing the claim to be false, in whole or in part, by commission or omission or in any other respect contrary to the provisions of South Dakota Codified Law (SDCL) Chapter 22-45.

(6) Provider agrees that claims for services and supplies rendered to medical assistance recipients shall not exceed the usual and customary charges by Provider to the general public for the same services and supplies. Provider further agrees to provide Medical Services and/or MFCU and/or HHS access to Provider's usual and customary billing practices.

(7) Provider agrees to accept as payment in full the amounts paid in accordance with the reimbursement rates established by Medical Services, including any authorized cost sharing as allowed by Medical Services.

(8) Provider acknowledges that Medical Services is the payer of last resort (subject to certain exceptions) and acknowledges its obligation to pursue payment from all other liable parties. Provider further agrees that in the event Provider receives payment from the medical assistance program in error or in excess of the amount properly due under the applicable rules and procedures, Provider will promptly notify Medical Services and arrange for the return of any excess money so received.

(9) Provider agrees that failure to comply with any portion of this Provider Agreement will be good cause for termination of this agreement.

(10) Provider agrees that any improper submission of claims, or actions deemed an abuse of the medical assistance program or actions involving medical assistance program abuse which result in administrative, civil or criminal liability, will be good cause for termination of this agreement.

(11) This agreement will be automatically terminated if Provider is convicted (including any form of suspended sentence) of any crime determined to be detrimental to the best interests of the Medical Assistance Program, if Provider has been suspended or terminated from participation in Medicare, or if Provider's license is surrendered, lapsed, suspended, or revoked.

(12) Provider agrees to accept payment from the medical assistance program via electric funds transfer.

Additional claims review at the State level to ensure the integrity of provider billings for Medicaid payment of waiver services includes the generation of a quarterly report of waiver expenditures from the Medicaid Management Information System (MMIS). As noted in the Performance Measures for the Financial Accountability assurance, these reviews are done using a representative sample with a confidence interval = 95%, +/-5%. The universe is all waiver claims for the quarter. RAO Soft is utilized to establish how many claims must be reviewed and an excel random sample function is utilized to create a random sample.

Finally, when the Home and Community-Based Services Program Manager, or Regional Office Supervisors conduct onsite reviews once every three years for providers of homemaker, personal care, and nursing services, the reviewer ensures the provider has required billing procedures in place. In addition, the reviewer evaluates a sample of recipients to ensure providers are billing as authorized and there is documentation to support Waiver claims. Individual problems identified are brought to the attention of the Waiver provider and are remediated.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of waiver service claims that were submitted for approved services.
Numerator = Waiver service claims that were submitted for approved services
Denominator = Waiver service 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%, +/-5%*
☐ ***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 service claims that were submitted for consumers that were enrolled in the waiver on the date the service was delivered. Numerator = Number of claims submitted for consumers with current enrollment 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%, +/-5%*
☐ ***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 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.

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%, +/-5%*
☐ ***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 in home service claims paid according to the reimbursement methodology for an approved service for eligible waiver participants. Numerator = The number of sampled claims that are paid according to the reimbursement methodology. Denominator = The total number of sampled claims.

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% +/- 9%*
☐ ***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:
Percent of rates established utilizing cost reports that are consistent with the rate methodology in the approved waiver. Numerator = Number of Rates established utilizing cost reports that are consistent with rate methodology in the approved waiver. Denominator = Number of Rates

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
budget and finance records, State Plan fee schedule, and usual customary charges fee schedule,

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 or rates

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 +/- 9%*
☐ ***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.*

Data to ensure that waiver service claims are submitted for approved waiver services and for consumes enrolled in the waiver is obtained through quarterly reports of all waiver claims generate from the Medicaid Management Information System (MMIS). The universe is all claims paid with waiver funds. The number of waiver claims for the quarter is entered in to the Raosoft sample size calculator to determine the sample size. The data is tracked in Excel spreadsheets.
In order to ensure billed services have been rendered, waiver consumers will be asked during the six month survey to confirm that the services authorized were received in the month prior to the survey. The universe is the total number of waiver survey respondents for the quarter. The number of survey respondents for the quarter is entered into the Raosoft sample calculator to determine the sample size. Any survey respondents in the random sample that indicate that all authorized services were not rendered will be reviewed to ensure the services were not billed in excess of what was provided. The data is tracked in Excel spreadsheets.

Data to ensure that in home services claims are paid accurately for an approved service for eligible waiver participants is obtained from MMIS, provider documentation, and LTSS authorizations for services. A representative random sample of in home service claims (homemaker, personal care, nursing, adult companion, respite care, chore services) will be reviewed. LTSS staff review all documentation to ensure payment was correct according to processing and payment methodologies and to ensure the claim was billed and paid according to the services authorized by the program rules. The total number of in home services claims for the previous year will be entered into the Raosoft calculator to determine the sample size. The margin of error of the representative sample for this measure will be +/- 9%. We have increased the margin of error on this sample due to time required to request and obtain data from providers and review documentation for claims, which often cover 30 days of services.

For rates set utilizing cost reports, the HCBS Manager will ensure that the established rate was consistent with the rate methodology in the approved waiver, by comparing the established rate for the fiscal year for these services to Budget and Finance records. Information will be reviewed to ensure the rate for these services is within 90% of the reported average cost of providing the service. The data is tracked in Excel spreadsheets.

For rates that are paid according to the State Plan fee schedule and/or the provider's usual and customary charge, the fee schedule will be reviewed and/or information will be requested from providers to ensure that claims have not been paid in excess of the State Plan fee schedule and/or the provider's usual and customary charge. Data is obtained through quarterly reports of waiver claims generated from MMIS. The universe is all waiver claims in which the rates are set utilized the State Plan fee schedule and/or usual and customary charges. The number of applicable waiver claims for the quarter is entered in to the Raosoft sample size calculator to determine the sample size. The margin of error of the representative sample for this measure will be +/- 9%. We have increased the margin of error on this sample due to time required to request and obtain data from providers. The data is tracked in Excel spreadsheets.

b. Methods for Remediation/Fixing Individual Problems

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

When individual problems are identified, remediation occurs by recalling the payment made with Medicaid money and paying for the services with alternative funding.

If it is determined that an LTSS Specialist incorrectly authorized services, Specialist is directed to correct the authorization for services and additional training on waiver processes and procedures is provided. When trends are identified, personnel action or termination may occur.

If it is determined a provider is submitting incorrect claims corrective action will be taken. First, the Authorization for Services will be reviewed to make sure the services authorized were correct. If there is a mistake on the Authorization, the mistake will be rectified immediately. In this case, monies paid for the incorrect services may be recalled and those services will be paid for with alternate funding. If the Authorization is accurate and the provider is simply billing incorrectly, remediation may include training on billing processes and freezing payments to the provider until the monies paid for the incorrect services is returned and the provider has revised its billing processes.

If it is determined that services that have been paid have not been rendered, funds will be recalled and follow up with the provider will take place. Remediation may include training on billing processes and freezing payments to the provider until the monies paid for services that are not rendered is returned and the provider has revised its billing processes. Corrective action with the provider will take place as necessary.

If a comparison of the rates and the cost report data indicates that the rates are not within 90% of the reported cost of providing the service, the Division of Long Term Services and Supports will refer the information to the Provider Rate Workgroup ,established in 2017, for review.

If it is determined that waiver claims are not paid at or below the rate as specified in the fee schedule or exceed the provider's usual and customary charges, the monies paid for the services will be recalled and reimbursed at the rate according to the fee schedule. Corrections to the MMIS system will be made if needed and provider and staff training will be completed as necessary.

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 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).*

Rates for homemaker, personal care, respite, adult companion, chore, nursing, adult day, meals, & Assisted Living (AL) are prospective rates modeled using historical costs as the basis. Cost report information is submitted annually to assess the adequacy of payment models implemented. DHS utilizes stakeholder workgroups to develop rate-setting methodologies. The workgroups, both informal & formal, include representation from providers & agencies fiscal, program & service delivery staff. The workgroup process supports a comprehensive & transparent approach to rate setting. In addition to annual reviews of cost report data, rates are adjusted annually based on the Governor's recommended budget & final legislative appropriation. DHS requires a standardized cost report submitted by providers after the close of their fiscal year. The cost reports summarize expenses associated with provision of waiver services & corresponding revenue. Aggregation & analysis of data submitted in cost reports by providers from across the state, allows DHS to ensure rates are reflective of the actual cost of service provision. Provider reimbursement rates are available to the public online at http://dhs.sd.gov/LTSS. Meal rates vary therefore those rates are not included on the fee schedule. Meal rates are based on cost report data specific to individual providers. The fee schedule will be updated with rates for services upon approval of this amendment. The information below includes specific information regarding each service, the rate methodology, entities responsible for rate setting, frequency of rate updates and opportunities for public comment.

1)Homemaker, Personal Care, In-Home Nursing, Respite, Adult Companion, Chore Services, Adult Day
a)Methods employed to establish provider payment rates: Utilizing stakeholder input, the rate methodology establishes a prospective rate based on historical cost. The rate model utilizes cost components including: salary, benefits, & operating costs. Cost reports are submitted by providers on an annual basis so the cost of providing the service can be analyzed & compared to modeled rate. If the rate is sufficient according to the cost reports, the proposed rate for the upcoming fiscal year is increases based on appropriated inflation. If cost reports show that the cost of providing the service exceeds the modeled rate, the information is used to develop the rate for the following fiscal year.

2)Meals
a)Methods that are employed to establish provider payment rates: Cost reports are submitted by providers on an annual basis. This information is utilized to determine if rate adjustments are necessary.

3)Assisted Living
a)Methods that are employed to establish provider payment rates: Cost reports are submitted by providers on an annual basis so the cost of providing the service can be analyzed. If the rate is sufficient according to cost reports, the proposed rate for the upcoming fiscal year is increased based on appropriated inflation. If cost reports show that the cost of providing the service exceeds the current rate, the information is used to develop the rate for the following fiscal year Aggregation and analysis of data submitted in cost reports by providers from across the state allows South Dakota to establish rates reflective of actual costs.
Senate Bill 147, passed in FY17, requires a reevaluation of rate methodologies at least once every 5 years. The AL rate methodology review workgroup was convened in 2018 to evaluate the existing rate methodology and proposed to continue utilization of cost reports, in addition to implementation of a tiered rate of reimbursement. In order to establish rate tiers, the State collaborated with workgroup members to identify AL consumer needs that typically require additional staff time and resources. The State worked with an outside entity with expertise in the Community Health Assessment (CHA) and algorithms to assist in identifying three tiers based on Activities of Daily Living (ADL)score and RUG categories that correspond to consumer needs requiring additional time and resources identified by the AL rate methodology review workgroup.
The Department used the 2018 Provider cost reports to determine the median cost per day for Assisted Living services. The Department added inflation based on the CPI. The steps for calculating the base rate were as follows: 1. Determined total days as reported on costs reports; 2. Determined total expenditures as reported on cost reports; 3. Calculated cost per day as reported on cost reports; 4. Determined the standard deviations of 1 as reported on cost reports; 5. Removed facilities over or under the standard deviation of cost per day; 6. Averaged the total cost per day by facility minus outliers; 7. Subtracted the room and board per day amount from amount calculated in step 6 to get Tier base rate. The increase in tiers is based on the percentage increase in care from the base rate needed to serve individuals in each tier. Tier 1 anticipates a .5 hour per day of additional staff time (18% increase) in care needs over the base rate; tier 2 anticipates a one hour per day of additional staff time (37% increase) in care needs over individuals in the base rate.

Opportunities for public comment for the above services include the following:
Rates are developed in collaboration with providers and associations with representation from provider groups including the AL Association of SD, the SD Assoc of Healthcare Organizations, & the SD Health Care Assoc; During SD's annual legislative session, public hearing for budget allocations, including rate adjustments are open to the public. Interested

parties including providers and provider representatives regularly attend & testify in support of or opposition of the proposed budget changes each year. Any proposed changes to the Administrative Rules of SD are approved by the legislative hearing process and subject to public input and testimony.

4)Medical Equipment and Medical Supplies
a)Methods that are employed to establish provider payment rates: When the State Plan has been exhausted, the rate of payment for LTSS Medical Equipment is limited to the lesser of the provider's usual & customary fee or the fee contained on the department's website located at http://dss.sd.gov/medicaid/providers/feeschedules/dhs/.
Fee schedule rates are developed using Medicare & other State Medicaid rates.
b)Entities responsible for rate determination: DHS, LTSS and Medical Services

5)ERS
a)Methods that are employed to establish provider payment rates: Provider bills usual & customary charge.
b)Entities responsible for rate determination: DHS, LTSS and Medical Services
c)Frequency of rate updates: Evaluated annually. Last rate update in 2015. Evaluated as needed based on providers usual & customary provider rate increases.
6)Nutritional Supplements, Environmental Accessibility Adaptations/Community Transition Supports,
a)Methods that are employed to establish provider payment rates: Provider bills usual & customary charge.
b)Entities responsible for rate determination: DHS, LTSS and Medical Services
c)Frequency of rate updates: Evaluated annually based on provider feedback and providers usual & customary provider rate increases. Last rate update in 2017.

7) Community Living Home (CLH)/Structured Family Caregiving(SFC)
a.)Methods that are employed to establish provider payment rates: DHS Budget and Finance utilized the May 2016 Bureau of Labor Statistics National Industry Employment and Wage Estimates, Personal Care Services (median and daily wages for occupation codes 39-1000 and 39-9021) to calculate a daily rate. The base rate was increased by 45.20 % to accommodate for benefits and taxes (18.8%); paid time off and training (6.4%); Administration overhead (20%). Data source for accommodations was in home services providers cost reports for SFY 2016. The State surveyed all in-home service providers that submitted a 2016 cost report (45 of 51 in home service providers). Since CLH and SFC services providers are not currently enrolled, the in home services cost reports were utilized as a stand in for these services. In home services include homemaker and personal care and are similar in nature to services that will provided in these residential settings. Next, the calculated rate was adjusted for staffing ratios of 1:2 for a 24 hour caregiver. A Consumer Price Index-Urban increase of 1.86% was added to bring the wages to current year data. Services are reimbursed in three tiers. In order to establish tiers, the State worked with an outside entity with expertise in the Community Health Assessment (CHA) and algorithms to assist in identifying three tiers based on ADL score and RUG categories. The increase in tiers is based on the percentage increase in care from the base tier needed to serve individuals in each tier. Tier 2 anticipates a 25% increase in care needs over tier 1; tier 3 anticipates a 40% increase in care needs over individuals in tier 1. The base wage is higher than the final wage due to a 1:2 staffing ratio for all services. The cost factors were totaled and divided by two in order to arrive at the final rate for each tier. 2016 in home provider cost reports were used for calculation of the Employee Benefits & Taxes and Administrative Overhead. Salaries for in in-home services closely mirrored the salaries for a 24-hour caregiver on the Dept of Labor Bureau and Statistics database.
c.) Frequency of rate updates: Evaluated annually

Public comment The rate methodology for CL and SFC were developed in collaboration with the an LTSS stakeholder workgroup with representation from provider groups including the AL Association of SD, the SD Association of Healthcare Organizations, the SD Health Care Association, AARP, and a cross section of current providers of existing waiver services.

8) Community Transition Coordination
a)Methods that are employed to establish provider payment rates: The rate for community transition coordination was established utilizing an existing rate for a similar service within DHS Division of Developmental Disabilities. Since community transition coordination closely resembles conflict-free case management (CFCM) within the CHOICES waiver, LTSS utilized the same rate used for CHOICES waiver. Per the CHOICES waiver, The CFCM rate was derived in Oct 2015 from the Community Support Provider cost report data from salaries, benefits, taxes, and overhead for existing case managers. A cost report is submitted by all providers annually. SD Dept of Labor wage statistics for similar professions is compared to the cost report data to ensure the rate is adequate. This comparison is completed at a

minimum of every 5 yrs during the rebase. Cost report information is utilized to determine if rate adjustments are necessary. Rate adjustments will be calculated using the inflationary rate approved for qualified providers by the SD State Legislature. The state will rebase the case management rate on a 5 yr cycle.

For all services, there are opportunities for public comment on rate methodologies during Waiver public comment periods including meetings of the Tribal Consultation, Medicaid Advisory Committee, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the waiver amendment.

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:

Business rules defining the processes for adjudicating claims are built into the payment system. The system looks at individual eligibility for the year and compares it to the date of service. If the individual's eligibility matches the date of service, the claim is paid. If the individual's eligibility does not match the date of service, the claim is assigned to pending or denied status. Pending claims are individually reviewed and approved or denied based on additional information. All paid claims are subject to Payment Error Rate Measurement (PERM) review.

Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted.

Under 42 CFR. part 456, South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under § 42 CFR 456.23. Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

Additional claims review at the State level to ensure the integrity of provider billings for Medicaid payment of waiver services includes the generation of a quarterly report of waiver expenditures from MMIS. From the report, a random selection of claims are compared to consumer data to ensure the claims were for current consumers and authorized services. As noted in the Performance Measures for the Financial Accountability assurance, these reviews are done using a representative sample with a confidence interval = 95%, +/-5%.

Also, when Long Term Services and Supports Regional Managers conduct their quarterly review, they access claims paid and compare them to the consumer's Care Plan to ensure the services paid for were in the consumer's Care Plan and the services in the Care Plan were provided.

When claims are identified as having been paid in error, the funds will be recovered. If the error was caused by the State, the monies owed to the provider would be paid with non-Medicaid dollars. If the error was caused by the provider and it is determined the provider did not provide the service, or provided the service without authorization, the provider would be required to reimburse Medicaid for those services.

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 §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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:*

- [x] ***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 methodology used by Department of Human Services Budget and Finance to set reimbursement rates for residential services clearly establishes the delineation between services reimbursed by the waiver and room and board expenses paid for by the consumer. The standardized cost report outlined in Section 1-2 require providers to separately report waiver services and room and board services so that the rate methodology for services does not include these costs.

When a consumer is determined eligible by the DSS Division of Economic Assistance for the HOPE Waiver, the consumer maintains a standard needs allowance as described in Appendix B-5. The needs allowance is to be used by the consumer to cover the cost of room and board in the residential setting.

The Department of Social Services issues an annual letter to qualified providers of Assisted Living and Community Living Home services on behalf of each waiver participant. The letter clearly separates the services that will be reimbursed through the Waiver and the amount of money the Assisted Living or Community Living Home may collect directly from the consumer for room and board.

For structured family caregiving providers, the room and board is excluded from the Medicaid payment. The room and board amount to be paid by a consumer living in the principal caregiver's home is an amount agreed upon by the consumer and the principal caregiver, consistent with state requirements and reflected in a residential agreement.

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	9313.53	6518.00	15831.53	29485.00	12273.00	41758.00	25926.47
2	10080.33	7146.00	17226.33	30085.00	13896.00	43981.00	26754.67
3	7979.67	7740.00	15719.67	31643.00	15575.00	47218.00	31498.33
4	9189.12	8397.90	17587.02	32718.86	18985.93	51704.79	34117.77
5	10469.01	9111.72	19580.73	33831.30	23143.84	56975.14	37394.41

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	1827		1827
Year 2	2065		2065
Year 3	2295		2295
Year 4	2527		2527
Year 5	2782		2782

Appendix J: Cost Neutrality Demonstration

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

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

The FY11, FY12, FY13, and FY14 372 lag reports were utilized to identify the average length of stay. The historical change in the length of stay was applied to determine average length of stay for this waiver renewal.

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:*

372 Lag reports for FY18 and F19 were utilized to update Years 2, and 3 to reflect actual service expenditures. For Year 4 and Year 5 projections, 372 lag reports for FY18 and FY19 were utilized to determine average participant growth per service. The average increase was applied to each service. The initial projections were compared to currently budgeted expenditures and adjusted as necessary.
The Average cost was adjusted for anticipated inflationary increase for services with set rates. Year 3 (FY19) claims data was utilized to project average costs for services with usual and customary charges and services with varying rates for Years 4 and 5.
Year 3 (FY19) claims data was utilized to determine average units for Years 4 and 5.

Formula = (Users)(average units per user)(cost per unit) =total cost for service

Users: For years 2 and 3, actual users for each services were utilized. Calculated % increase in waiver users for Waiver years 4-5 (based on 372 lag reports). Applied average increase for each service and made adjustments as necessary to accommodate for outliers.
Average units per user: for years 2 and 3 utilized 372 lag reported to determine. Utilized year 3 data (from 372 lag report) to determine average units per user per service. Applied year 3 average units per user per service to years 4 and 5.

Cost/unit: for years 2 and 3 utilized 372 lag reported to determine. For year from 4&5 utilized year 3 claims data and anticipated rate changes to determine average cost per unit per service.

Adjustments were made to users, average units per user, and cost/unit based on anticipated and/or historical trend changes within each service.

Community Transition Supports
Formula = (Participants) (1 transition) (cost per transition)

Participants: The number of participants for community transition supports was estimated based on 2016 MFP data; lower needs Nursing Facility residents and HOPE recipients indicating they want to live elsewhere. It is anticipated that upon implementation there will be an influx of participants and that new participants will begin to taper once low needs consumers are transitioned into a less restrictive setting.
Average units per user: Each transition is 1 unit.

Cost per unit: The cost per unit was projected utilizing historical data (FY15, FY16, and FY17) for South Dakota's Money follows the Person program for consumers that transitioned to the HOPE waiver.

Formula = Total MFP expenditures/Total MFP participants

Community Transition Coordination

Participants: The number of participants for community transition supports was estimated based on 2016 MFP data; lower needs Nursing Facility residents and HOPE recipients indicating they want to live elsewhere. It is anticipated that upon implementation there will be an influx of participants and that new participants will begin to taper once low needs consumers are transitioned into a less restrictive setting.
Average units per user: The average number of units per user was based on an estimate of average time needed for a successful transition and analyzed against other states that have transition services in their waivers.
Cost per unit: The cost per unit was based on the current rate for conflict free case management in the CHOICES waiver.

Assisted Living:
For year 5 of this waiver, utilized anticipated participants based on growth a indicated above. Projections for number of participants in each tier were based on assessment data of current Assisted Living participants.

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:*

372 Lag reports for FY18 and F19 were utilized to update Years 2, and 3 to reflect actual expenditures.
372 lag reports for FY17, FY18, and FY19 were used to identify historical expenditures. The average increase (8.5 %) was applied to Years 4 and 5 of the waiver.

Step 1. Entered actual acute services for waivers year 1-3.
Step 1. Calculated actual increase/decrease in acute care services for Waiver years 1-3 (based on 372 lag reports)
Step 2. Applied average (8.5%) to project years 4 and 5.

As more individuals move to home and community-based services, the percent of people with higher acute medical needs remain in a nursing facility, contributing to the difference in growth between Factor D' and Factor G'.

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:*

372 Lag reports for FY18 and F19 were utilized to update Years 2, and 3 to reflect actual expenditures
372 lag reports for FY17, FY18, and FY19 were used to identify historical expenditures. The average increase (3.4%) was applied to Years 4 and 5 of the waiver.
South Dakota used historical claims data; therefore, costs for prescription drugs were not included in the projections for D'.

Step 1. Entered actual LTC services for waivers year 1-3.
Step 1. Calculated actual increase in long term care services for Waiver years 1-3 (based on 372 lag reports)
Step 2. Applied average (3.4%) to project years 4 and 5.

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:*

372 Lag reports for FY18 and F19 were utilized to update Years 2, and 3 to reflect actual expenditures
372 lag reports for FY17, FY18, and FY19 were used to identify historical expenditures. The average increase (21%) was applied to Years 4 and 5 of the waiver. South Dakota used historical claims data; therefore, costs for prescription drugs were not included in the projections for D'.

Step 1. Entered actual LTC acute care services for waivers year 1-3.
Step 1. Calculated actual increase in LTC acute care services for Waiver years 1-3 (based on 372 lag reports)
Step 2. Applied average (21.9%) to project years 4 and 5.

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	
Respite Care	
Homemaker	
In-Home Nursing Services	
Personal Care	
Specialized Medical Equipment	
Specialized Medical Supplies	
Adult Companion Services	
Assisted Living	

Waiver Services	
Chore Services	
Community Living Home	
Community Transition Coordination	
Community Transition Supports	
Emergency Response System (ERS)	
Environmental Accessibility Adaptations	
Meals	
Nutritional Supplements	
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:						37879.06
Adult Day Services	1 hour	13	524.06	5.56	37879.06	
Respite Care Total:						831110.28
Respite Care	1 hour	77	429.00	25.16	831110.28	
Homemaker Total:						1037548.08
Homemaker	1 hour	522	79.00	25.16	1037548.08	
In-Home Nursing Services Total:						666624.00
In-Home Nursing Services	1 hour	420	32.00	49.60	666624.00	
Personal Care Total:						603236.16
Personal Care	1 hour	444	54.00	25.16	603236.16	
Specialized Medical Equipment Total:						256206.48
Specialized Medical Equipment	each	237	8.00	135.13	256206.48	
Specialized Medical Supplies Total:						689661.00

GRAND TOTAL:	17015819.58
Total Estimated Unduplicated Participants:	1827
Factor D (Divide total by number of participants):	9313.53
Average Length of Stay on the Waiver:	267

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Supplies	1 month	801	12.00	71.75	689661.00	
Adult Companion Services Total:						121900.20
Adult Companion Services	1 hour	51	95.00	25.16	121900.20	
Assisted Living Total:						12383806.50
Base	day	1118	273.50	40.50	12383806.50	
Tier 1	day	0	0.00	40.50	0.00	
Tier 2	day	0	0.00	40.50	0.00	
Chore Services Total:						77291.52
Chore Services	1 hour	64	48.00	25.16	77291.52	
Community Living Home Total:						0.00
Community Living Home	day	0	0.00	42.37	0.00	
Community Transition Coordination Total:						0.00
Community Transition Coordination	1 hour	0	0.00	50.12	0.00	
Community Transition Supports Total:						0.00
Community Transition Supports	each	0	0.00	3138.47	0.00	
Emergency Response System (ERS) Total:						68256.00
Emergency Response System (ERS)	1 month	237	9.00	32.00	68256.00	
Environmental Accessibility Adaptations Total:						60000.00
Environmental Accessibility Adaptations	each	15	1.00	4000.00	60000.00	
Meals Total:						105255.50
Meals	each	119	145.00	6.10	105255.50	
Nutritional Supplements Total:						77044.80
Nutritional Supplements	each	96	114.65	7.00	77044.80	
Structured Family Caregiving Total:						0.00

GRAND TOTAL:	17015819.58
Total Estimated Unduplicated Participants:	1827
Factor D (Divide total by number of participants):	9313.53
Average Length of Stay on the Waiver:	267

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Structured Family Caregiving	1 day	0	0.00	42.37	0.00	
			GRAND TOTAL:			17015819.58
			Total Estimated Unduplicated Participants:			1827
			Factor D (Divide total by number of participants):			9313.53
			Average Length of Stay on the Waiver:			267

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:						30679.83
Adult Day Services	1 hour	13	409.72	5.76	30679.83	
Respite Care Total:						98884.01
Respite Care	1 hour	25	156.71	25.24	98884.01	
Homemaker Total:						2375349.02
Homemaker	1 hour	781	120.50	25.24	2375349.02	
In-Home Nursing Services Total:						1997576.39
In-Home Nursing Services	1 hour	631	63.62	49.76	1997576.39	
Personal Care Total:						3444290.78
Personal Care	1 hour	720	189.53	25.24	3444290.78	
Specialized Medical Equipment Total:						58354.00
Specialized Medical Equipment	each	179	1.00	326.00	58354.00	
Specialized Medical Supplies Total:						546641.52
Specialized Medical Supplies	1 month	761	12.00	59.86	546641.52	
Adult Companion						1715512.32
			GRAND TOTAL:			20815883.11
			Total Estimated Unduplicated Participants:			2065
			Factor D (Divide total by number of participants):			10080.33
			Average Length of Stay on the Waiver:			267

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:						
Adult Companion Services	1 hour	240	283.20	25.24	1715512.32	
Assisted Living Total:						10097200.99
Base	1 day	1052	236.29	40.62	10097200.99	
Tier 1	day	0	0.00	40.62	0.00	
Tier 2	day	0	0.00	40.62	0.00	
Chore Services Total:						15768.69
Chore Services	1 hour	17	36.75	25.24	15768.69	
Community Living Home Total:						0.00
Community Living Home	1 day	0	60.00	42.37	0.00	
Community Transition Coordination Total:						0.00
Community Transition Coordination	1 hour	0	120.00	50.12	0.00	
Community Transition Supports Total:						0.00
Community Transition Supports	each	0	1.00	3138.47	0.00	
Emergency Response System (ERS) Total:						112094.40
Emergency Response System (ERS)	1 month	386	12.00	24.20	112094.40	
Environmental Accessibility Adaptations Total:						135.00
Environmental Accessibility Adaptations	each	1	1.00	135.00	135.00	
Meals Total:						220188.71
Meals	each	212	164.60	6.31	220188.71	
Nutritional Supplements Total:						103207.44
Nutritional Supplements	each	184	80.13	7.00	103207.44	
Structured Family Caregiving Total:						0.00
Structured Family Caregiving	1 day	0	60.00	42.37	0.00	

GRAND TOTAL:	20815883.11
Total Estimated Unduplicated Participants:	2065
Factor D (Divide total by number of participants):	10080.33
Average Length of Stay on the Waiver:	267

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						63712.60
Adult Day Services	1 hour	22	513.48	5.64	63712.60	
Respite Care Total:						116897.40
Respite Care	1 hour	36	126.25	25.72	116897.40	
Homemaker Total:						721198.69
Homemaker	1 hour	112	235.01	27.40	721198.69	
In-Home Nursing Services Total:						946608.68
In-Home Nursing Services	1 hour	77	209.36	58.72	946608.68	
Personal Care Total:						1978037.51
Personal Care	1 hour	145	497.87	27.40	1978037.51	
Specialized Medical Equipment Total:						48038.40
Specialized Medical Equipment	each	192	1.00	250.20	48038.40	
Specialized Medical Supplies Total:						474696.00
Specialized Medical Supplies	1 month	760	12.00	52.05	474696.00	
Adult Companion Services Total:						1534156.85
Adult Companion Services	1 hour	252	236.70	25.72	1534156.85	
Assisted Living Total:						11629039.10
Base	1 day	1080	222.84	48.32	11629039.10	
Tier 1	day	0	0.00	48.32	0.00	
				GRAND TOTAL:		18313349.34
				Total Estimated Unduplicated Participants:		2295
				Factor D (Divide total by number of participants):		7979.67
				Average Length of Stay on the Waiver:		267

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier 2	day	0	0.00	48.32	0.00	
Chore Services Total:						26419.07
Chore Services	1 day	23	44.66	25.72	26419.07	
Community Living Home Total:						0.00
Community Living Home	1 hour	0	267.00	42.37	0.00	
Community Transition Coordination Total:						12028.80
Community Transition Coordination	each	2	120.00	50.12	12028.80	
Community Transition Supports Total:						6276.94
Community Transition Supports	month	2	1.00	3138.47	6276.94	
Emergency Response System (ERS) Total:						151891.20
Emergency Response System (ERS)	month	480	12.00	26.37	151891.20	
Environmental Accessibility Adaptations Total:						41907.96
Environmental Accessibility Adaptations	each	12	1.00	3492.33	41907.96	
Meals Total:						278685.45
Meals	each	250	168.39	6.62	278685.45	
Nutritional Supplements Total:						153058.50
Nutritional Supplements	1 day	225	97.18	7.00	153058.50	
Structured Family Caregiving Total:						130696.20
Structured Family Caregiving	1 day	26	118.64	42.37	130696.20	
				GRAND TOTAL:		18313349.34
				Total Estimated Unduplicated Participants:		2295
				Factor D (Divide total by number of participants):		7979.67
				Average Length of Stay on the Waiver:		267

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:						68401.37
Adult Day Services	1 hour	26	453.59	5.80	68401.37	
Respite Care Total:						117797.87
Respite Care	1 hour	34	130.84	26.48	117797.87	
Homemaker Total:						765621.00
Homemaker	1 hour	118	227.82	28.48	765621.00	
In-Home Nursing Services Total:						942320.87
In-Home Nursing Services	1 hour	78	197.92	61.04	942320.87	
Personal Care Total:						2037592.49
Personal Care	hour	148	483.41	28.48	2037592.49	
Specialized Medical Equipment Total:						50875.82
Specialized Medical Equipment	each	206	1.00	246.97	50875.82	
Specialized Medical Supplies Total:						41504.00
Specialized Medical Supplies	each	100	1.00	415.04	41504.00	
Adult Companion Services Total:						2097597.84
Adult Companion Services	1 hour	325	231.83	27.84	2097597.84	
Assisted Living Total:						14946259.50
Base	1 day	1114	267.00	50.25	14946259.50	
Tier 1	day	0	0.00	50.25	0.00	
Tier 2	day	0	0.00	50.25	0.00	
Chore Services Total:						33949.74
Chore Services	1 hour	29	44.21	26.48	33949.74	
Community Living Home Total:						0.00
Community Living Home	1 day	0	267.00	42.37	0.00	

GRAND TOTAL:	23220899.30
Total Estimated Unduplicated Participants:	2527
Factor D (Divide total by number of participants):	9189.12
Average Length of Stay on the Waiver:	267

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Coordination Total:						30072.00
Community Transition Coordination	hour	5	120.00	50.12	30072.00	
Community Transition Supports Total:						15692.35
Community Transition Supports	each	5	1.00	3138.47	15692.35	
Emergency Response System (ERS) Total:						234942.24
Emergency Response System (ERS)	1 month	598	12.00	32.74	234942.24	
Environmental Accessibility Adaptations Total:						88666.48
Environmental Accessibility Adaptations	each	28	1.00	3166.66	88666.48	
Meals Total:						370453.92
Meals	each	297	172.52	7.23	370453.92	
Nutritional Supplements Total:						195273.80
Nutritional Supplements	each	291	332.20	2.02	195273.80	
Structured Family Caregiving Total:						1183878.00
Structured Family Caregiving	1 day	100	267.00	44.34	1183878.00	
				GRAND TOTAL:		23220899.30
				Total Estimated Unduplicated Participants:		2527
				Factor D (Divide total by number of participants):		9189.12
				Average Length of Stay on the Waiver:		267

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						78924.66
				GRAND TOTAL:		29124798.41
				Total Estimated Unduplicated Participants:		2782
				Factor D (Divide total by number of participants):		10469.01
				Average Length of Stay on the Waiver:		267

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Adult Day Services	1 hour	30	453.59	5.80	78924.66	
Respite Care Total:						110868.58
Respite Care	1 hour	32	130.84	26.48	110868.58	
Homemaker Total:						798062.57
Homemaker	1 hour	123	227.82	28.48	798062.57	
In-Home Nursing Services Total:						990645.02
In-Home Nursing Services	1 hour	82	197.92	61.04	990645.02	
Personal Care Total:						2133965.10
Personal Care	1 hour	155	483.41	28.48	2133965.10	
Specialized Medical Equipment Total:						54580.37
Specialized Medical Equipment	each	221	1.00	246.97	54580.37	
Specialized Medical Supplies Total:						34448.32
Specialized Medical Supplies	month	83	1.00	415.04	34448.32	
Adult Companion Services Total:						2572181.67
Adult Companion Services	hour	419	231.83	26.48	2572181.67	
Assisted Living Total:						19167070.26
Base	1 day	463	267.00	53.75	6644628.75	
Tier 1	1 day	347	267.00	63.43	5876726.07	
Tier 2	1 day	338	267.00	73.64	6645715.44	
Chore Services Total:						42144.51
Chore Services	1 hour	36	44.21	26.48	42144.51	
Community Living Home Total:						56563.95
Community Living Home	1 day	5	267.00	42.37	56563.95	
Community Transition Coordination Total:						150360.00
Community					150360.00	

GRAND TOTAL:	29124798.41
Total Estimated Unduplicated Participants:	2782
Factor D (Divide total by number of participants):	10469.01
Average Length of Stay on the Waiver:	267

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Coordination	1 hour	25	120.00	50.12		
Community Transition Supports Total:						78461.75
Community Transition Supports	each	25	1.00	3138.47	78461.75	
Emergency Response System (ERS) Total:						293088.48
Emergency Response System (ERS)	1 month	746	12.00	32.74	293088.48	
Environmental Accessibility Adaptations Total:						94999.80
Environmental Accessibility Adaptations	each	30	1.00	3166.66	94999.80	
Meals Total:						440303.82
Meals	each	353	172.52	7.23	440303.82	
Nutritional Supplements Total:						252312.54
Nutritional Supplements	each	376	332.20	2.02	252312.54	
Structured Family Caregiving Total:						1775817.00
Structured Family Caregiving	1 day	150	267.00	44.34	1775817.00	

GRAND TOTAL:	29124798.41
Total Estimated Unduplicated Participants:	2782
Factor D (Divide total by number of participants):	10469.01
Average Length of Stay on the Waiver:	267