

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

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

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

1. Major Changes

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

The Division of Adult Services and Aging Home and Community-Based Services Waiver is due for renewal on July 1, 2016 with an anticipated effective date of October 1, 2016 through September 30, 2021. The changes that have been included in the waiver renewal application are described below.

First, there have been changes to the services. Chore services will be added as an available service for waiver consumers. Additionally, the medical equipment definition will be expanded. The new definition will allow Adult Services and Aging to provide a wider range of medical equipment, including assistive technology, which is anticipated to enable consumers to remain living in their homes and communities. In the current waiver, meals and nutritional supplements are defined as the same service. In the renewal application meals and nutritional supplements will be defined as two separate services. The meals and nutritional supplements service definitions remain unchanged, but separating the services will streamline the reporting on expenditures for these services.

Second, the maintenance needs allowance for an in-home consumer will increase from SSI plus \$300, to 300% of SSI. This is in response to increasing cost of living expenses and the difficulty in-home consumers have in meeting their financial obligations. The increased needs allowance will reduce the consumer's responsibility to share in the cost of his/her services, making the waiver a more viable option for consumers.

Third, the earned income allowance for a consumer residing in an Assisted Living will be \$75. This will benefit consumers residing in Assisted Livings as they will be able to keep up to \$75 in earned income in addition to a \$60 maintenance needs allowance.

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 Services (ASA) Waiver for South Dakotans
- C. **Type of Request: renewal**

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

3 years 5 years

Original Base Waiver Number: SD.0189

Draft ID: SD.010.06.00

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

Regular Waiver 

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

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 in 42 CFR §440.160

Nursing Facility

Select applicable level of care

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

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



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

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

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



1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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



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

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.**

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

- A program authorized under §1915(i) of the Act.**
- A program authorized under §1915(j) of the Act.**
- A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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 South Dakota Department of Social Services is an umbrella state agency for nine Divisions including the Division of Economic Assistance (determines financial eligibility), Division of Medical Services (State Medicaid Agency) and the Division of Adult Services and Aging (Single State Unit on Aging). As the State Unit on Aging, the Division of Adult Services and Aging is the managing agency for the Home and Community-Based Services (HCBS) Waiver for South Dakotans. The purpose of the HCBS waiver is to provide services to elderly South Dakotans age 65 and older as well as individuals over the age of 18 who have a qualifying disability in the least restrictive community environment available. The goal of the HCBS Waiver is to reduce unnecessary nursing facility care by providing individuals with community-based services to remain at home or in their communities as long as they remain safe and/or choose to live there. The Division of Adult Services and Aging 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 HCBS waiver services by contacting the Division of Adult Services and Aging who employs Adult Services and Aging Specialists (63 FTE), in 24 ASA 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 ASA 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 ASA offices also function as a ‘No Wrong Door’ connecting individuals to Home and Community-Based Services.

The Adult Services and Aging Specialists perform intake and referral, options planning, assessment, and person centered care planning in addition to case management and follow-up. ASA 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 ASA Specialist after exploring all available resources, including natural supports, assists the individual to access waiver services through a person centered planning process.

The HCBS 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. Services available through the HCBS Waiver include: assistive devices, nutritional supplements, meals, homemaker services, personal care services, nursing services, adult companion services, respite care, adult day services, specialized medical supplies, specialized medical equipment, emergency response systems, environmental accessibility adaptations and telehealth. Waiver services are provided by community-based agencies and facilities that have successfully enrolled as Medicaid providers and met all qualification requirements. Adult Services and Aging ensures the providers authorized to provide services are qualified and that financial integrity is maintained. Additionally, the Division of Adult Services and Aging 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: Stakeholder engagement is an integral component of Adult Services and Aging's (ASA) HCBS Services waiver. During the five year waiver, the State secures stakeholder and public input through a variety of methods. Regular community outreach allows the public and stakeholders to provide feedback on service delivery and quality improvement. Adult Services and Aging (ASA) Specialists, Regional Supervisors, Regional Managers and State program office 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 to the ASA Specialist who provides their case management. Providers have continuous opportunities during provision of waiver services to consumers to express concerns or satisfaction with waiver processes. Waiver service providers directly communicate with ASA staff and the HCBS Program Manager and State program staff present changes and program information to various provider association meetings and conferences.

In preparation for this waiver renewal the ASA gave providers, consumers, and other stakeholders several opportunities to offer feedback on potential updates to the waiver. In response to recommendations from South Dakota's 2015 Long Term Care Study Update completed by Abt Associates, ASA formed a HCBS Workgroup which met three times from May to August 2015 to explore options to increase availability of community-based services. Workgroup members included: consumers, caregivers, in-home service providers, home health agencies, assisted livings, nursing facilities, SD Departments of Health, Social Services, and Human Services, the SD Association of Health Care Organizations, the SD Health Care Association, SD Advisory Council on Aging, the Alzheimer's Association, AARP, and representatives from the SD legislature. Recommendations from the HCBS Workgroup were finalized in November 2015. In preparation for the first HCBS Workgroup meeting a survey was mailed to ASA consumers to gather information on current and future home and community-based service needs. ASA Specialists were surveyed for their input regarding the provision of additional waiver services. Workgroup members reviewed the survey results in addition to information from the 2015 South Dakota's Long Term Care Study Update completed by Abt and information on surrounding states HCBS waivers. In follow-up to the HCBS Workgroup's final recommendations, a survey was sent to in-home providers to ascertain interest and feasibility to provide additional waiver services. The public and stakeholder input secured through the HCBS Workgroup and follow up surveys was the basis for many of the changes the HCBS waiver renewal application.

Revisions to the HCBS waiver were presented, with the opportunity for stakeholders to ask questions and offer feedback, at meetings of Tribal Consultation on 04/14/16, the SD Advisory Council on Aging on 04/08/16, and the State Medicaid Advisory Board on 04/28/16. On 05/04/16 through an online webinar ASA Specialists, Regional Supervisors and Regional Managers were also provided with information on the HCBS waiver renewal and given the opportunity to ask questions and provide feedback.

As required by CMS, the thirty day formal public comment period was held from 05/25/16 to 06/24/16. The HCBS waiver renewal application with a summary of changes as well as a pre-recorded online webinar was made available to the public, consumers, providers, stakeholders, and Division of Adult Services and Aging staff through the Department of Social Services website. Hard copies of the Waiver Renewal Application and corresponding PowerPoint presentation were also made available upon request through email, mail or phone. Two town hall call-in conference calls were held on 06/08/16 and 06/14/16 providing consumers, in-home providers and other stakeholders opportunities to provide input on the HCBS waiver renewal changes and to ask questions.

Letters were mailed to all consumers receiving HCBS Waiver services, in-home providers and Assisted Living providers with a summary of changes and instructions on how to comment through email, mail, phone or town hall conference call. Public Comment posters were distributed to 63 Department of Social Services offices across the state as well as to in-home providers, Assisted Living providers and provider associations. Providers were asked to post the poster in areas visible to the public. The SD Legislative Research Council was sent a public notice announcement for the HCBS Waiver Application to provide notification of the public notice period. Notification of the public comment period was sent to the Tribal leaders of the nine Tribes in SD. Public comment was also secured for the Statewide Transition Plan which is incorporated into this waiver renewal application.

There is a formal process for updating changing requirements associated with the HCBS 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. Revised rules will be presented to the SD Legislative Interim Rules Committee for hearing following approval of the HCBS waiver renewal application by CMS. ASA policies are revised when updates to the waiver are made. HCBS waiver related policy updates are reviewed with the Waiver Review Committee as well as an internal ASA Policy Workgroup regarding revisions to policy and procedure.

- 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:

Aker

First Name:

Sara

Title:

Deputy Director

Agency:

Department of Social Services, Division of Medical Services

Address:

Address 2:

City:

State: **South Dakota**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **South Dakota**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **South Dakota**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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.

STATEMENT OF PURPOSE

The Centers for Medicare and Medicaid Services (CMS) issued a final rule effective on March 17, 2014 requiring all states to review and evaluate Home and Community-Based Services (HCBS) settings, including residential and non-residential settings that are funded through South Dakota's four Medicaid 1915(c) waivers. States are required to ensure all HCBS settings comply with the new federal regulations that all individuals receiving HCBS are integrated in and have full access to their communities, including opportunities to engage in community life, work in integrated environments, and control their own personal resources. The federal citation for the new rule is 42 CFR 441.301(c) (4)-(5). More information on the final rule can be found on the CMS website at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html> The Transition Plan allows states to take incremental steps towards full compliance with the federal regulation; full compliance must be achieved by 2019. New providers must demonstrate compliance upon Medicaid enrollment.

Operation of Home and Community Based Services (HCBS) in South Dakota is shared between the Department of Social Services (DSS) and the Department of Human Services (DHS). To ensure the transition plan accurately reflected all HCBS settings in South Dakota, DSS and DHS formed a collaborative workgroup representing each of the four Medicaid waivers and the state Medicaid agency. The workgroup assessed compliance with the HCBS Settings federal regulations and drafted this transition plan to identify action steps and timelines for South Dakota's compliance with the new federal regulations.

A draft Statewide Transition Plan that applies to all of South Dakota's 1915(c) waivers was open for public comment for 30 days from February 2, 2015 through March 4, 2015 to allow all individuals, providers and stakeholders an opportunity to provide input to the plan. South Dakota's Statewide Transition Plan was initially submitted to CMS on March 12, 2015.

South Dakota received comments from CMS regarding the initial submission of this plan on October 15, 2015. This plan has been revised to reflect the clarification and comments from CMS. CMS's Clarification and/or Modifications required for Initial Approval Letter may be viewed online. This plan was available for public comment from February 29, 2016 to March 30, 2016. South Dakota submitted this plan to CMS on April 6, 2016.

This plan will be open for further comment as other changes and updates are made to the Transition Plan over the course of the Transition Plan period. Upon conclusion of the transition plan period in 2019, the elements of this plan will be requirements of each HCBS waiver; providers will be required to be fully compliant with all elements of the federal regulation by the end of the transition plan period. South Dakota will incorporate the federal regulations into regular reviews of providers.

South Dakota anticipates the plan will be open for comment in the near future for the following:

1. Heightened Scrutiny Waiver Request: Anticipated Fall 2016

Additionally, each waiver renewal or amendment requires South Dakota to perform public comment and submit a waiver specific transition plan to CMS. South Dakota's HCBS (ASA) Waiver will be renewed on the following dates:

Waiver Renewal Date: October 1, 2016

Renewal Submission Date: July 1, 2016

MEDICAID WAIVERS IN SOUTH DAKOTA

South Dakota is designated as a frontier state by the Affordable Care Act. A frontier state is a state in which at least 50 percent of the counties are frontier counties; a frontier county is a county where the population per square mile is less than 6. Frontier counties are best described as sparsely populated rural areas that are geographically isolated from population centers and services. Over half of South Dakotans live in a county that has been classified as a rural non-metro county by the Office of Management and Budget. Of the 311 incorporated towns and cities in South Dakota, only 27 have populations greater than 2,500 people.

South Dakota has nine federally recognized tribes within its boundaries, which have independent, sovereign relationships with the federal government. The majority of South Dakota's reservations are geographically isolated in frontier locations.

South Dakota's frontier landscape presents unique challenges for service delivery. Rural and frontier communities face difficulties maintaining a healthcare workforce. Rural regions cannot easily compete with wages and amenities available to physicians and other professionals in more urban areas. As of July 2014, 48 of South Dakota's 66 counties were classified as a medically underserved area or population by the South Dakota Department of Health. As a result, healthcare services are often clustered within one community in a region, which can result in long trips for individuals who need to receive services. Public transportation is usually limited or unavailable in rural and frontier areas, making access to healthcare providers even more difficult for populations served by Medicaid in those areas.

South Dakota strives to ensure that individuals can receive services at their closest source of care. This is particularly true of South Dakota's 1915(c) waivers. Home and community based services (HCBS) in South Dakota have been historically provided through four 1915(c) HCBS Waivers. Each waiver targets a specific population and provides a menu of services to meet the needs of the target population. South Dakota has structured its waivers to meet the needs of individuals who live in rural and frontier areas. As the state Medicaid agency, the Department of Social Services provides oversight to all of South Dakota's Medicaid waivers.

HOME AND COMMUNITY-BASED SERVICES (ASA) WAIVER

The Home and Community-Based Services (HCBS) Waiver for South Dakotans is administered by the South Dakota Department of Social Services' Division of Adult Services and Aging (ASA), and is commonly referred to as the ASA waiver in South Dakota. ASA is responsible for assessing individuals, developing care plans, authorizing waiver services, and monitoring service delivery. ASA also conducts all continuous quality improvement (CQI) activities, including data collection, aggregation, analysis, trend identification, and design changes and implementation. The ASA waiver was renewed by CMS on October 1, 2011 and, at that time, was expanded to include two new services – Adult Companion Services and Environmental Accessibility Adaptations.

The primary goal of the HCBS (ASA) Waiver is to provide services to the elderly and consumers with a qualifying disability over the age of 18 in their homes or the least restrictive community environment available to them. The waiver provides a wide range of services with the goal of meeting the individual needs of each waiver consumer. Individuals qualifying for the HCBS (ASA) Waiver must meet nursing facility level of care.

HCBS (ASA) 1915(c) WAIVER SERVICES

- Adult Day Services
- Homemaker
- Personal Care
- Respite Care
- Specialized Medical Equipment
- Specialized Medical Supplies
- Adult Companion Services
- Assisted Living
- Environmental Accessibility Adaptations
- In-Home Nursing Services
- Meals and Nutritional Supplements
- Personal Emergency Response Systems (PERS)

Adult Day Services are provided in adult day settings; South Dakota currently has 2 enrolled providers located at four adult day settings that provide services. South Dakota's Adult Day settings are described in detail in the Non-Residential Settings Assessment Section. A list of Adult Day Settings in South Dakota may be obtained on the Aging and Disability Resource Center's website. Not all settings offering Adult Day services are enrolled in Medicaid to provide Adult Day services.

Assisted Living services are provided in assisted livings. South Dakota evaluated assisted living settings in this transition plan. See the HCBS (ASA) Waiver Assessment Results and Action Items section for results specific to Assisted Livings. A list of South Dakota's Assisted Livings may be obtained on the Aging and Disability Resource Center's website or on the Department of Health's website. Not all Assisted Livings in South Dakota are enrolled in Medicaid.

SETTINGS ANALYSIS

South Dakota studied the federal regulation and guidance published by the Centers for Medicare and Medicaid Services and determined that the statewide transition plan should reflect both an assessment of state policy and current policies and practice in settings. South Dakota's analysis of the federal regulation was implemented in two ways: through a review of State Policies, including each Medicaid 1915(c) Waiver and Administrative Rule of South Dakota and an assessment of residential and non-residential HCBS settings in South Dakota by providers, state staff, and individuals.

STATE POLICY ANALYSIS

South Dakota's systemic assessment analyzed all applicable Administrative Rules, Codified Laws, and Waivers related to the provision of Home and Community Based Services in South Dakota. State staff from the Department of Social Services and Department of Human Services reviewed the provisions of the federal regulation and compared those requirements to South Dakota's 1915(c) waivers, South Dakota Codified Law (SDCL), and the Administrative Rules of South Dakota (ARSD) that govern licensure and Medicaid participation. The applicable articles for licensure and Medicaid participation are listed in the following sections. Articles are organized into chapters, and chapters are further made up of individual rules. State staff conferred with the South Dakota Department of Health on applicable ARSD related to DOH licensure and renewal. South Dakota found no conflicts between the federal regulation and State policies. However, South Dakota identified a conflict between the HCB Settings Rule and the emphasis on continuum of care models from the Administration for Community living (ACL) and other federal entities. Despite this conflict, South Dakota understands per CMS direction on this issue that all settings must meet all requirements of the federal regulations, including heightened scrutiny review.

A crosswalk of federal regulations to the applicable state standards for the HCBS (ASA) Waiver and the CHOICES waiver are provided in the following pages. The tables contain citation and hyperlink to applicable state standards and South Dakota's interpretation of the intent of the state standard. South Dakota categorized each of the state standards as one of the following:

- 1) Reinforce: The state standard supports the federal regulation.
- 2) Silent On: State standards are not related to the federal regulation.
- 3) Conflict: State standards disagree with the federal regulation.

Complete text of South Dakota's approved Medicaid Waivers is available online. Administrative Rule of South Dakota and South Dakota Codified Law is maintained by the South Dakota Legislative Research Council and is available online.

Assisted Living Centers must be licensed by the South Dakota Department of Health to enroll. Assisted Livings must meet the standards found in Administrative Rule of South Dakota Article 44:70 to be licensed. Adult Day Settings are not licensed by the state of South Dakota. Division of Adult Service and Aging staff perform annual assessments of standalone adult day settings. All Medicaid providers must follow the applicable rules in Article 67:16. The HCBS (ASA) Waiver is

further governed by Article 67:44.

The following review applies to Assisted Living Settings in South Dakota.

**See transition plan for graphic.

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(i) Setting is integrated in and supports full access to the greater community.

APPLICABLE STATE STANDARD:

- DOH Licensure ARSD §44:70:02:20; HCBS (ASA) Rules ARSD §67:44:03:01

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(ii) Setting selected by the individual from setting options.

APPLICABLE STATE STANDARD:

- HCBS Waiver Appendix B, B-7: Freedom of Choice; SD Medicaid Rules ARSD §67:16:01:04; HCBS (ASA) Rules ARSD §67:44:03:04

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(iii) Ensures individuals rights of privacy, dignity and respect, and freedom from coercion and restraint.

APPLICABLE STATE STANDARD:

- DOH Licensure ARSD Chapter 44:70:09

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(iv) Optimizes autonomy and independence in making life choices.

APPLICABLE STATE STANDARD:

- HCBS Waiver Appendix B, B-7: Freedom of Choice; SD Medicaid Rules ARSD §67:16:01:04; HCBS (ASA) Rules ARSD §67:44:03:04; DOH Licensure ARSD Chapter 44:70:09

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(v) Facilitates choice regarding services and who provides them.

APPLICABLE STATE STANDARD:

- South Dakota Codified Law SDCL 34-1-20; HCBS Waiver Appendix B, B-7: Freedom of Choice; SD Medicaid Rules ARSD §67:16:01:04; HCBS (ASA) Rules ARSD §67:44:03:04; DOH Licensure ARSD §44:70:09:07

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(vi)(A) Individual has a lease or other legally enforceable agreement.

APPLICABLE STATE STANDARD:

- DOH Licensure ARSD §44:70:09:02 and ARSD §44:70:09:14

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(vi)(B) Individual has privacy in his/her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit.

APPLICABLE STATE STANDARD:

- DOH Licensure ARSD Chapter 44:70:09

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(vi)(C) Individual controls his/her own schedule including access to food at any time.

APPLICABLE STATE STANDARD:

- DOH Licensure ARSD §44:70:09:09 and ARSD Chapter 44:70:06

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(vi)(D) Individual may have visitors at any time.

APPLICABLE STATE STANDARD:

- DOH Licensure ARSD Chapter 44:70:09

INTENT OF STATE STANDARD:

- Reinforce

FEDERAL REGULATION:

- 42 CFR 440(c)(4)(vi)(E) Setting is physically accessible.

APPLICABLE STATE STANDARD:

- DOH Licensure ARSD Chapter 44:70:02 and ARSD Chapter 44:70:10

INTENT OF STATE STANDARD:

- Reinforce

RESIDENTIAL SETTINGS ASSESSMENT METHODOLOGY

South Dakota measured settings against all regulatory requirements for home and community based settings defined in the federal regulation. South Dakota identified seven key concept areas for assessment: Location, Living Arrangements, Privacy, Dignity and Respect, Physical Accessibility, Autonomy, and Community Integration. South Dakota used these concept areas to group similar questions together. Assessment questions were developed using guidance from CMS' HCBS Tool Kit and South Dakota's analysis of the federal regulation.

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

Home and Community Based Services

South Dakota Residential Settings Assessment Plan

**See transition plan for graphic.

PROVIDER SELF-ASSESSMENT

Providers were required to complete a self-assessment of their setting. The self-assessment contained 57 questions spread between the seven concept areas. The assessment was prepared collaboratively by the Department of Social Services and the Department of Human Services. A pilot group consisting of three Community Support Providers and three Assisted Living providers was engaged to preliminarily complete a draft assessment and provide feedback. Based on feedback from the pilot group, South Dakota modified the self-assessment to allow providers to include narrative about restrictions and limits specific to their setting.

South Dakota incorporated a provider education period into the assessment process. South Dakota held a series of webinars and distributed an informational letter to HCBS residential setting providers in August 2014. South Dakota Medicaid also developed a website containing informational materials, links to CMS guidance, slides and recordings from webinars, and provider communication. The website is accessible at: <http://dss.sd.gov/medicaid/hcbs.aspx>

Before releasing the self-assessment, South Dakota Medicaid held a series of webinars detailing the self-assessment and explaining how data gathered in the self-assessment would be used by South Dakota Medicaid. The webinar showed providers how to utilize the online self-assessment tool in Survey Monkey and explained terms used in the self-assessment. Following the self-assessment webinars, the self-assessment was distributed to providers via email. All providers were required to complete the self-assessment for each Assisted Living, Group Home, and Supervised Apartment setting. The self-assessment was available for completion from September 24, 2014 through October 25, 2014. South Dakota received a response from all enrolled providers.

Setting Type: Assisted Living

Number of Settings: 132

Number of Provider Self-Assessments: 132
% of Self-Assessments Received: 100%

STATE STAFF ON-SITE VALIDATION ASSESSMENT

South Dakota used state staff to complete an on-site review of residential settings to verify the results of the provider self-assessment. The staff assessment was a subset of questions from the Provider Self-Assessment. Information identifying the setting such as address or NPI was captured on both the state staff assessment and provider self-assessment to check the validity of provider responses. The state staff assessment represents all assisted living and community support providers. All assisted living settings were assessed by state staff and a random proportionate sample of group homes and supervised apartment settings across South Dakota's 9 Community Support Providers (CSPs).

Setting Type: Assisted Living
Number of Settings: 132
Number of State Staff Assessments: 132
% of State Staff Assessments Received: 100%

The state staff assessment contained 18 questions from the provider self-assessment that staff observed through a site visit to the setting.

Prior to performing assessments state staff were trained on the federal regulation and instructed about what to look for during the site visit to the setting. South Dakota assigned staff familiar with the setting to complete the staff assessment. Assessment of assisted living settings was completed by the Adult Services and Aging staff assigned to the setting. Assessment of CSPs was completed by Division of Developmental Disabilities Program Specialists. The state staff assessment was completed from October 25, 2014 through November 30, 2014.

HCBS INDIVIDUAL INTERVIEW

South Dakota facilitated an interview of individuals receiving HCBS supports in a residential setting to validate the results of the provider self-assessment. State staff facilitated the interviews during their on-site review of residential settings. A sample of recipients from both the CHOICES and ASA waiver were interviewed. Individual interviews focused on the individual's perception of the setting, including the individual's choice of living arrangements, treatment from provider staff, privacy in the setting, ability to choose an individual schedule, choose when, where and what to eat, and the ability to come and go at any time. Individuals were also asked an open ended question about the individual's thoughts about where they live.

The HCBS individual interview contained 13 questions from the provider self-assessment that are specific to individual's experiences in the setting. Information identifying the setting such as address or NPI was captured on both the HCBS individual interview and provider self-assessment to check the validity of provider responses.

State staff facilitated the individual interview and entered the interview results online. Interviews were completed by guardians when an individual had a designated legal guardian. The individual interviews were completed from October 25, 2014 through November 30, 2014.

ASSESSMENT DATA ANALYSIS

South Dakota Medicaid performed an analysis of the interrelationship of the data gathered from provider self-assessments, state staff on-site validation assessments and HCBS individual interviews to determine areas already in compliance and areas in need of improvement. A summary of the data analysis process is described in the flow chart and sections below. The assessment results are posted in graphs under each key concept area specific to each waiver.

Home and Community Based Services Final Rule
South Dakota Residential Settings Assessment Data Analysis
**See transition plan for graphic.

LIMITS EVALUATION

Provider responses and clarifying comments made in the assessment were carefully analyzed by South Dakota Medicaid for optimal and non-optimal responses. Optimal responses indicated compliance with the HCBS federal regulation. Non-optimal responses indicated that additional actions were necessary for compliance with the federal regulation. In the assessment, providers had the option to indicate compliance in one of three ways: 1. Yes, there are no restrictions; 2. Yes, with limits; 3. No

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

SETTINGS SUBJECT TO HEIGHTENED SCRUTINY REVIEW

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

- Is the setting also a Nursing Facility?
- Is the setting on the grounds of, or adjacent to an institution?
- Is there another group home, supervised apartment, or assisted living on the same block?
- Does the setting isolate individuals from the broader community?

South Dakota performed site specific follow-up at each setting where a non-optimal response to one of the four questions was indicated by a provider in the provider self-assessment. South Dakota determined that no Community Support Provider settings required heightened scrutiny review.

Follow-up assessments were performed on-site by Adult Services and Aging Regional Managers. The follow-up assessment assessed the nature of the setting and the community integration options available to individuals living in the setting. The follow-up assessment also assessed the availability of other home and community based services and settings in the community. Finally, the follow-up assessment documented the location of the setting in the community. Specifically, when a setting was adjacent to, or on the grounds of an institution, the follow-up assessment analyzed the other buildings surrounding the setting such as schools, private residences, retail businesses, churches, etc.

86% HCBS QUALITY ASSURANCE THRESHOLD

CMS’s current quality assurance system requires that states submit an evidentiary report on all performance measures including the remediation taken for each systemic and individual instance when a performance measure has less than 100% compliance. States are required to implement statewide quality improvement projects/remediation when the threshold of compliance with a measure is at or below 85%.

South Dakota Medicaid applied this compliance threshold to the assessment results. Assessment items at or below 85% in either the provider self-assessment or the aggregated quality assurance results were determined to be systematic in nature and statewide action steps to address remediation were developed and are included in this transition plan. When an assessment item indicated compliance at or above 86%, statewide action steps were not developed; remediation will be pursued on an individual basis. Individual remediation is described in the next section. All providers will be required to reach 100% compliance with all federal requirements by the end of the transition plan period.

INDIVIDUAL REMEDIATION

South Dakota will require all providers to perform individual remediation to ensure 100% compliance with federal requirements by the end of the transition plan period. South Dakota’s individual remediation process is described in the flow chart below:

Home and Community Based Services Final Rule

Remediation Process Flow Chart

**See transition plan for graphic.

1. Education about State and Federal Expectations
2. Provider Re-Assess Compliance
3. Provider Implementation
4. State Evaluation
5. Recommendations for Compliance
6. Attest to Compliance in Supplemental Agreement

South Dakota will release information to providers beginning in 2016. South Dakota will incorporate assessment of state and federal expectations into annual on-site reviews beginning in 2017. Providers who do not meet expectations will receive a notification of non-compliance and will be asked to submit a corrective action plan to the Department. South Dakota will add language to supplemental provider agreements for providers to attest to compliance with the provisions of the federal regulation.

DIFFERENCE BETWEEN STATEWIDE AND INDIVIDUAL REMEDIATION PLANS

When South Dakota determines that an action requires statewide remediation, all providers will receive direct and specific education about the action item. All providers will be required to submit evidence of compliance by the target completion date identified in this Statewide Transition Plan, even if they were initially assessed as compliant.

When a concept area or item is subject to individual remediation, South Dakota will inform providers of state expectations. Non-compliant providers will be given an opportunity to become compliant prior to the planned state evaluation. If a provider is found to still be non-compliant during the state evaluation, they will be required to complete a corrective action plan with timeframes demonstrating a plan for compliance. If a provider fails to successfully implement a corrective action plan to correct an area of non-compliance the setting will be unenrolled as a HCBS provider. State evaluations will be implemented as an on-going process.

RELOCATION OF BENEFICIARIES

South Dakota anticipates that all enrolled settings will be able to comply with the federal regulation. However, in the rare likelihood that a provider closes or it is determined that a setting will not be able to meet the new federal requirements, South Dakota's Adult Services and Aging (ASA) Specialists and DHS Resource Coordinators will provide support to any recipients who must relocate. Individuals will receive detailed information about the options available in their community and the state. Options for individuals will prioritize other HCB services available in the community. If no options are available in the community, options for HCB services in other communities will be discussed with the individual. In cases where other HCB options are not available, relocation may also include intermediate care facilities or skilled nursing facilities when an individual meets the level of care requirements.

South Dakota already has processes in place in the event of closure of a facility or setting. Notification requirements for the closure of a facility are located in South Dakota's Administrative Rule in ARSD §44:70:09:14 and ARSD 46:11:08:05. South Dakota will follow a similar process for relocation, including notification and meetings with the individual, notification to family members, an assessment of options available to the individual, and a plan for relocation from the setting.

When it is determined that a setting will not be able to be compliant with the final rule, South Dakota's ASA Specialists and DHS Resource Coordinators will meet with the recipient within 30 days of the determination to discuss placement options with the individual and develop a plan for relocation of the individual. South Dakota's ASA Specialists and DHS Resource Coordinators will additionally inform the family of the individual of the relocation. Individuals and family members will be given at least 30 days to evaluate options for relocation. Relocation will take place in a timely manner; however, relocation may vary in length due to the rural nature of the state and limited provider options. Each relocation will be unique to the individual, the options available to the individual, and the choice of the individual. All individuals will be relocated by the end of the transition plan period.

NON-RESIDENTIAL SETTINGS ASSESSMENT METHODOLOGY

South Dakota currently has 2 enrolled providers of Adult Day services under the HCBS (ASA) waiver that are located at 4 settings.

The Department of Social Services performs annual site assessments at the two active providers. Settings are co-located with other services for adults; including a nutrition site, a senior activity center, and day resources for veterans. The other setting is a stand-alone day center that also includes day resources for veterans. Individuals who receive services at these settings live in their homes and are integrated into the community.

South Dakota 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. South Dakota determined these settings meet the intent of the federal regulations and do not require further action to be compliant. South Dakota will require each enrolled setting to sign a supplemental agreement attesting to compliance with the requirements of the federal regulations.

Setting Type: Adult Day

Number of Settings: 4

Number of State Staff Assessments: 4

% of State Staff Assessments Received: 100%

South Dakota determined that all adult day settings are fully compliant based on the state staff assessment.

SETTINGS SUBJECT TO HEIGHTENED SCRUTINY REVIEW

In the federal regulations, CMS identified types of settings that are subject to heightened scrutiny review. These settings are

presumed to have the effect of isolating individuals from the broader community or have the qualities of an institution. Of the 132 enrolled assisted living settings, South Dakota's initial assessment suggests that 59 assisted living settings may require additional analysis per CMS's available guidance on settings subject to heightened scrutiny review. Six of the 59 settings have unenrolled since 3/12/2015. Upon settings clarification from CMS that settings on the grounds of or adjacent to privately-owned institutions are not subject to heightened scrutiny, South Dakota was able to reduce the number of settings subject to heightened scrutiny to 43 total. South Dakota performed an on-site review of each of the settings. From initial on-site analysis, South Dakota anticipates that further evaluation will demonstrate all settings meet the home and community based requirements or that some settings may not require heightened scrutiny review.

Initial analysis of these settings revealed that all settings that may be subject to heightened scrutiny review are located in small rural communities in South Dakota. In small and rural communities, many settings serve dual roles as both a long-term care facility and an assisted living. Dual long-term care facility and assisted living settings are often the only HCB option available for consumers who want to remain in their community but are no longer willing or able to maintain their own home.

Home and Community Based Services Final Rule SETTINGS SUBJECT TO HEIGHTENED SCRUTINY REVIEW

**See transition plan for graphic.

In some areas of South Dakota, the population simply cannot support separate Assisted Living and long-term care facilities. Instead, a wing or a percentage of the beds in the long-term care facility are designated as assisted living beds. Situations where individual rooms or suites within the long-term care facility have been designated as assisted living have historically been in response to a need in the community.

Removing the choice of an assisted living room in a long-term care facility in rural and frontier areas has the predominant effect of limiting choice for individuals to remain in their community. In some cases dual long-term care facilities and assisted livings are the only assisted living option in their community. Without these settings, individuals would be forced to leave their community to continue to receive home and community based services. South Dakota believes individuals served in small towns and rural communities deserve the choice to reside in their community when receiving services from the HCBS (ASA) waiver.

Additionally, South Dakota disagrees with the premise that settings physically sharing a wall with another institution, such as a hospital or nursing home, are presumed not to meet the requirements of an HCB setting. These settings operate separately and distinct from a hospital or nursing home and the physical co-location near other healthcare providers not only supports access to healthcare, but is considered an advantage for individuals who are allowed to age in place or remain with a spouse requiring a higher level of care in a long-term care facility. South Dakota believes the person-centered planning model supports offering a choice for individuals to remain in their communities and receive HCB services.

LIST OF SETTINGS SUBJECT TO HEIGHTENED SCRUTINY REVIEW

The Centers for Medicare and Medicaid Services (CMS) requires states to include a list of settings names and addresses of settings that are subject to heightened scrutiny review. South Dakota's initial assessment of these settings was limited in scope; however, it was identified that several of the settings subject to heightened scrutiny are part of a continuum of care model. South Dakota included continuum of care settings with other settings identified for heightened scrutiny review. Facilities in South Dakota have adopted this model and the number of continuum of care campuses will likely increase as the Administration for Community Living (ACL) and other Federal agencies have historically advocated for individuals to age in place in a continuum of care model. South Dakota received guidance from CMS that all settings must meet the federal requirements, including applicable heightened scrutiny review.

Further feedback from community members, providers, and individuals residing in heightened scrutiny settings is necessary to further refine South Dakota's analysis of these settings. South Dakota will further scrutinize these settings and gather more information from providers, stakeholders, community members, and residents. South Dakota anticipates the additional analysis will support our preliminary findings and demonstrate the HCB nature of these settings. South Dakota plans to complete the additional analysis by August 31, 2016 utilizing an external vendor. South Dakota will publish a list of settings for public notice as required by CMS upon completion of the analysis.

HCBS (ASA) WAIVER ASSESSMENT RESULTS AND ACTION ITEMS

OVERVIEW

The provider self-assessment was completed by 132 HCBS Assisted Living providers. Results are shown below for the

provider self-assessment, staff assessment, and the HCBS individual interviews. The data indicates that on a statewide level, Assisted Living providers meet the intent of the federal regulations. Data gathered from providers is supported by similar results in the staff assessment and individual interviews.

ASSESSMENT RESULTS

**See transition plan for graphic.

Provider Self-Assessment:

- Optimal: 90%
- Non-Optimal: 10%

State Staff Assessment:

- Optimal: 91%
- Non-Optimal: 9%

Individual/Guardian Interviews:

- Optimal: 86%
- Non-Optimal: 14%

The following tables further delineate the pie graph information, showing discrepancies between the provider responses and the quality assurance results. South Dakota heavily weighed the quality assurance results as a check on self-reported data from providers. Using CMS's 86% quality assurance threshold, South Dakota identified strengths and areas for improvement by each concept area.

STRENGTHS

As shown in the table below, the Dignity and Respect, Autonomy, Physical Accessibility, and Location concept areas were at or above the 86% compliance threshold. South Dakota will use individual remediation to address issues in these concept areas. Individual remediation will be addressed by concept area. DSS will provide additional education about state and federal expectations in the concept area. Following education, providers will re-assess their policies and practices and address any issues in the concept area. DSS will review the concept area during an on-site visit to the setting. If any remaining issues are found to be non-compliant with the federal regulations, DSS will work individually with the provider to determine specific remediation steps. Individual remediation will take place over the course of the transition plan to ensure 100% compliance in each concept area.

ASSESSMENT RESULTS

**See transition plan for graphic.

Dignity and Respect

- Provider Assessment Results: 99%
- Quality Assurance Results: 97%
- Difference: -2%

Autonomy

- Provider Assessment Results: 97%
- Quality Assurance Results: 97%
- Difference: 0%

Physical Accessibility

- Provider Assessment Results: 88%
- Quality Assurance Results: 95%
- Difference: +7%

Location

- Provider Assessment Results: 86%
- Quality Assurance Results: 95%
- Difference: +9%

AREAS FOR IMPROVEMENT

As shown in the table below, either the Provider Assessment results or the Quality Assurance Results were below 86% in

the Privacy, Community Integration and Living Arrangements concept areas. South Dakota will address these concept areas from a systemic perspective. South Dakota will use statewide action steps to address issues in the concept areas listed below. Actions steps are described by concept area in the following pages.

ASSESSMENT RESULTS

**See transition plan for graphic.

Privacy

- Provider Assessment Results: 87%
- Quality Assurance Results: 71%
- Difference: -16%

Community Integration

- Provider Assessment Results: 85%
- Quality Assurance Results: 95%
- Difference: +10%

Living Arrangements

- Provider Assessment Results: 79%
- Quality Assurance Results: 79%
- Difference: 0%

From the assessment results, South Dakota determined that many South Dakota Assisted Living settings already substantially meet the intent of the federal regulation with minor items to remediate over the course of the transition period. Other Assisted Living settings in South Dakota will require modifications or heightened scrutiny review in accordance with the federal regulation. South Dakota has grouped settings by this methodology in the following chart. The following categories align with South Dakota's original assessment performed in fall 2014.

For the purposes of communicating and reporting completion of action steps and milestones to CMS and future assessment results, South Dakota will categorize these settings using CMS suggested language as those settings presumed to have the qualities of an institution, those that fully comply, and those that do not comply but could with modifications.

Assisted Livings

- Required Heightened Scrutiny Review: 53
- Substantially Meet Federal Requirements: 47
- Will Require Modifications: 23
- Unenrolled since 3/12/2015: 9

**See transition plan for graphic.

DIGNITY/RESPECT

Analysis of the assessment results revealed the dignity and respect concept area to be above the 86% threshold. South Dakota will work with Assisted Living providers on an individual basis to remediate any non-optimal findings through trainings, education about state and federal expectations, and technical assistance. South Dakota closely monitors dignity and respect through the ASA Quality of Life Assessment and through quarterly local visits.

ASSESSMENT RESULTS

**See transition plan for graphics.

Provider Self-Assessment:

- Optimal: 99%
- Non-Optimal: 1%

State Staff Assessment:

- Optimal: 100%
- Non-Optimal: 0%

Individual/Guardian Interviews:

- Optimal: 94%
- Non-Optimal: 6%

ACTION STEPS

Expectation: Providers perform Individual Remediation

Compliance Action Step:

- 1.1 Educate providers of state and federal expectations.
- 1.2 Providers Re-Assess Compliance.
- 1.3 State Assessment of Expectations

Measurable Outcomes:

- 1.1 State Expectations Guide
- 1.2 Provider Practice or Policy Change
- 1.3 On-Site Review

Responsible Agency:

- 1.1 DSS
- 1.2 Assisted Living Providers
- 1.3 DSS

Target Completion:

- 1.1 May 31, 2016
- 1.2 December 31, 2016
- 1.3 January 1, 2017 & On-Going

AUTONOMY

Analysis of the assessment results revealed the autonomy concept area to be above the 86% threshold. South Dakota will work with Assisted Living providers on an individual basis to remediate any non-optimal findings through trainings, education about state and federal expectations, and technical assistance to ensure individuals have flexibility in planning their activities of daily living and that schedules correspond to individual needs and preferences. South Dakota closely monitors autonomy through the ASA Quality of Life Assessment and through quarterly visits.

ASSESSMENT RESULTS

**See transition plan for graphics.

Provider Self-Assessment:

- Optimal: 97%
- Non-Optimal: 3%

State Staff Assessment:

- Optimal: 95%
- Non-Optimal: 5%

Individual/Guardian Interviews:

- Optimal: 99%
- Non-Optimal: 1%

ACTION STEPS

Expectation: Providers perform Individual Remediation

Compliance Action Step:

- 1.1 Educate providers of state and federal expectations.
- 1.2 Providers Re-Assess Compliance.
- 1.3 State Assessment of Expectations

Measurable Outcomes:

- 1.1 State Expectations Guide
- 1.2 Provider Practice or Policy Change
- 1.3 On-Site Review

Responsible Agency:

- 1.1 DSS
- 1.2 Assisted Living Providers
- 1.3 DSS

Target Completion:

- 1.1 May 31, 2016
- 1.2 December 31, 2016
- 1.3 January 1, 2017 & On-Going

PHYSICAL ACCESSIBILITY

Analysis of the assessment results revealed the physical accessibility concept area to be above the 86% threshold. The Division of Adult Services and Aging will work with the South Dakota Department of Health (DOH) and providers on an individual basis to remediate any non-optimal findings over the course of the transition plan. For example, South Dakota anticipates individual remediation will include ensuring appliances are accessible to individuals. South Dakota closely monitors health, safety, and sanitation through quality assurance review in cooperation with DOH. South Dakota also assesses compliance through the ASA Quality of Life Assessment, quarterly visits, and DOH site reviews.

ASSESSMENT RESULTS

**See transition plan for graphics.

Provider Self-Assessment:

- Optimal: 88%
- Non-Optimal: 12%

State Staff Assessment:

- Optimal: 95%
- Non-Optimal: 5%

ACTION STEPS

Expectation: Providers perform Individual Remediation

Compliance Action Step:

- 1.1 Educate providers of state and federal expectations.
- 1.2 Providers Re-Assess Compliance.
- 1.3 State Assessment of Expectations

Measurable Outcomes:

- 1.1 State Expectations Guide
- 1.2 Provider Practice or Policy Change
- 1.3 On-Site Review

Responsible Agency:

- 1.1 DSS
- 1.2 Assisted Living Providers
- 1.3 DSS

Target Completion:

- 1.1 May 31, 2016
- 1.2 December 31, 2016
- 1.3 January 1, 2017 & On-Going

LOCATION

ASSESSMENT RESULTS

**See transition plan for graphic.

Analysis of the assessment results revealed the location concept area to meet the 86% threshold. This concept area contained questions used to identify settings that are subject to heightened scrutiny review. Further details about settings that are subject to heightened scrutiny review by federal regulation are located in the section titled SETTINGS SUBJECT

TO HEIGHTENED SCRUTINY REVIEW.

Provider Self-Assessment:

- Optimal: 86%
- Non-Optimal: 14%

State Staff Assessment:

- Optimal: 91%
- Non-Optimal: 9%

Individual/Guardian Interviews:

- Optimal: 97%
- Non-Optimal: 3%

ACTION STEPS

Expectation: Providers perform Individual Remediation

Compliance Action Step:

- 1.1 Educate providers of state and federal expectations.
- 1.2 Providers Re-Assess Compliance.
- 1.3 State Assessment of Expectations

Measurable Outcomes:

- 1.1 State Expectations Guide
- 1.2 Provider Practice or Policy Change
- 1.3 On-Site Review

Responsible Agency:

- 1.1 DSS
- 1.2 Assisted Living Providers
- 1.3 DSS

Target Completion:

- 1.1 May 31, 2016
- 1.2 December 31, 2016
- 1.3 January 1, 2017 & On-Going

PRIVACY

Analysis of the provider self-assessment results revealed the privacy concept area to be above the 86% threshold. However, quality assurance results indicated a need for statewide remediation in this area.

ASSESSMENT RESULTS

**See transition plan for graphic.

Provider Self-Assessment:

- Optimal: 87%
- Non-Optimal: 13%

State Staff Assessment:

- Optimal: 71%
- Non-Optimal: 29%

Individual/Guardian Interviews:

- Optimal: 72%
- Non-Optimal: 28%

ACTION STEPS

South Dakota identified bedroom door locks and shared bedrooms as areas for improvement in this concept area. The quality assurance results indicated that many individuals are unable to lock their bedroom doors in their setting. Providers also indicated that many individuals are unable to lock their bedroom doors, but health and safety risks exist or individuals

have never expressed interest in locking their bedroom door. South Dakota will require all individuals to be able to lock their door or have any limits or restrictions justified and documented in the person-centered care plan. South Dakota will expect providers to begin implementing locks on or before July 1, 2016. Lock installation may be staggered, but must be completed by March 2018.

South Dakota currently offers all individuals a choice of Assisted Living providers with private and shared bedrooms. Although private bedrooms are not available in every setting or town in South Dakota, individuals are able to exercise choice in the person-centered planning process when they are determined eligible for an HCBS waiver. South Dakota will document this choice in the person-centered plan and will additionally educate providers about roommate selection. South Dakota will require all providers to have a roommate choice policy in place on or before December 31, 2015.

Expectation #1: In provider owned or leased properties, individuals should be able to lock the door to their bedroom from non-staff if capable.

Compliance Action Step:

- 1.1 Educate providers of state and federal expectations.
- 1.2 Document health and welfare concerns in person-centered care plan.
- 1.3 All provider-owned or leased settings implement locks for capable individuals.

Measurable Outcomes:

- 1.1 Educational Webinar, Informational Bulletin
- 1.2 100% compliance in quarterly plan reviews
- 1.3 100% compliance in annual site reviews

Responsible Agency:

- 1.1 DSS
- 1.2 DSS and Assisted Living Providers
- 1.3 DSS and Assisted Living Providers

Target Completion:

- 1.1 May 31, 2016
- 1.2 July 1, 2016
- 1.3 March 17, 2018

Expectation #2: Individuals will be offered a choice between setting options with private and shared bedrooms.

Compliance Action Step:

- 2.1 Document setting choice between private and shared bedrooms in person-centered care plan.

Measurable Outcomes:

- 2.1 100% compliance in quarterly plan reviews

Responsible Agency:

- 2.1 DSS

Target Completion:

- 2.1 July 1, 2015 Complete & On-Going

Expectation #3: When an individual shares a bedroom, they will be able to choose their roommate.

Compliance Action Step:

- 3.1 Educate providers of state and federal expectations.
- 3.2 Providers implement a policy that allows individuals choice of roommates as available

Measurable Outcomes:

- 3.1 Educational Webinar, Informational Bulletin
- 3.2 100% compliance in annual site reviews

Responsible Agency:

- 3.1 DSS
- 3.2 DSS and Assisted Living Providers

Target Completion:

- 3.1 June 30, 2015 Complete
- 3.2 December 31, 2015 In-Progress

Expectation #4: Providers perform Individual Remediation

Compliance Action Step:

- 4.1 Educate providers of state and federal expectations.
- 4.2 Providers Re-Assess Compliance.
- 4.3 State Assessment of Expectations

Measurable Outcomes:

- 4.1 State Expectations Guide
- 4.2 Provider Practice or Policy Change
- 4.3 On-Site Review

Responsible Agency:

- 4.1 DSS
- 4.2 Assisted Living Providers
- 4.3 DSS

Target Completion:

- 4.1 May 31, 2016
- 4.2 March 31, 2017
- 4.3 April 1, 2018 & On-Going

LIVING ARRANGEMENTS

Analysis of the provider self-assessment results revealed the living arrangement concept area to be below the 86% threshold. Quality assurance results also indicated a need for statewide remediation in this area.

ASSESSMENT RESULTS

**See transition plan for graphic.

Provider Self-Assessment:

- Optimal: 79%
- Non-Optimal: 21%

State Staff Assessment:

- Optimal: 77%
- Non-Optimal: 23%

Individual/Guardian Interviews:

- Optimal: 80%
- Non-Optimal: 20%

ACTION STEPS

South Dakota identified access to food and immediate access to the setting as areas for improvement in this concept area. Providers indicated that access to food often had limits related to meal times, set menus, and specified locations in the Assisted Living. South Dakota will work to optimize individual choice and access to food by educating providers regarding state and federal expectations. Settings must begin implementing supports on or before July 1, 2016. Implementation of supports may be staggered but all supports in this area must be implemented by March 2019.

In the provider self-assessment, South Dakota asked providers if individuals were given keys to the setting. Providers indicated that individuals may have other means of accessing the setting apart from keys, such as setting staff, a key pad, or key fob. South Dakota will require each individual to have immediate access to the setting by a key or other means by March 2018.

**See transition plan for graphic.

Expectation #1: Individuals are able to choose what time and where to eat. Individuals are able to make or request an alternative to any planned meals within their resources.

Compliance Action Step:

- 1.1 Educate providers of state and federal expectations.
- 1.2 The setting offers reasonable alternative to planned meals.
- 1.3 Individuals are able to make an alternative meal within their resources.
- 1.4 All individuals can elect to eat at an alternative time.
- 1.5 All individuals can elect to eat in their room.

Measurable Outcomes:

- 1.1 Educational Webinar, Informational Bulletin
- 1.2 100% compliance in annual site reviews
- 1.3 100% compliance in annual site reviews
- 1.4 100% compliance in annual site reviews
- 1.5 100% compliance in annual site reviews

Responsible Agency:

- 1.1 DSS
- 1.2 Assisted Living Providers
- 1.3 Assisted Living Providers
- 1.4 Assisted Living Providers
- 1.5 Assisted Living Providers

Target Completion:

- 1.1 April 31, 2016
- 1.2 March 17, 2019
- 1.3 March 17, 2019
- 1.4 March 17, 2019
- 1.5 March 17, 2019

Expectation #2: Individuals have immediate access to the setting 24/7.

Compliance Action Step:

- 2.1 Educate providers about state and federal expectations.
- 2.2 All settings are immediately accessible to individuals 24/7 by key or other means such as setting staff, key pad/fob, etc.

Measurable Outcomes:

- 2.1 Educational Webinar, Informational Bulletin
- 2.2 100% compliance in annual site reviews

Responsible Agency:

- 2.1 DSS
- 2.2 Assisted Living Providers

Target Completion:

- 2.1 July 31, 2016
- 2.2 March 17, 2018

Expectation #3: Providers perform Individual Remediation

Compliance Action Step:

- 3.1 Educate providers of state and federal expectations.
- 3.2 Providers Re-Assess Compliance.
- 3.3 State Assessment of Expectations

Measurable Outcomes:

- 3.1 State Expectations Guide

3.2 Provider Practice or Policy Change

3.3 On-Site Review

Responsible Agency:

3.1 DSS

3.2 Assisted Living Providers

3.3 DSS

Target Completion:

3.1 May 31, 2016

3.2 June 30, 2017

3.3 July 1, 2018 & On-Going

COMMUNITY INTEGRATION

Analysis of the provider self-assessment results revealed the living arrangement concept area to be below the 86% threshold. Quality assurance results indicated that South Dakota providers are already successful in this area.

ASSESSMENT RESULTS

**See transition plan for graphic.

Provider Self-Assessment:

- Optimal: 85%
- Non-Optimal: 15%

State Staff Assessment:

- Optimal: 95%
- Non-Optimal: 5%

Individual/Guardian Interviews:

- Optimal: 95%
- Non-Optimal: 5%

ACTION STEPS

South Dakota identified access to community activities and events from the setting at any time and employment in an integrated setting as areas for improvement in this concept area. Access to transportation and need for supervision emerged as common barriers to individual's community access. Although providers indicated these barriers in the provider self-assessment, individual interviews showed that individuals do not experience barriers to accessing community activities and events. Further communication with providers revealed that some providers indicated limits existed any time that they were not able to be the sole source of transportation and supervision in the community, even though policy would allow recipients to leave on their own as they are able or with family or friends. South Dakota believes it would be unnecessarily burdensome to require providers to be the sole source of transportation and supervision in the community. South Dakota will work with providers to emphasize natural supports in the community. Additionally, South Dakota plans to collaborate with stakeholders, providers, and individuals to perform further analysis of community access. South Dakota plans to complete the analysis by June 30, 2017. We expect findings to drive additional action in this area, either through individual remediation or statewide action steps.

Assisted Living providers commonly indicated that individuals living in their setting do not often desire to work or volunteer because they are retired, which South Dakota anticipated due to the age of most assisted living residents. South Dakota's analysis of the HCBS (ASA) waiver indicated that eligibility requirements for earned income may act as a disincentive for employment. South Dakota plans to remove this disincentive in the October 2016 waiver renewal. South Dakota will educate providers regarding state and federal expectations for supports for individuals who desire to work or volunteer by March 2016. Settings must provide supports in this area on or before October 1, 2016.

**See transition plan for graphic.

Expectation #1: Providers facilitate access to community activities and events.

Compliance Action Step:

- 1.1 Educate providers of state and federal expectations.
- 1.2 Collaborate with stakeholders and providers to perform further analysis.

1.3 Increase provider knowledge of use of natural supports.

Measurable Outcomes:

- 1.1 Statewide education; Webinars, FAQ, Annual Newsletter
- 1.2 Additional Actions, as needed
- 1.3 Statewide education; Webinars, FAQ, Annual Newsletter

Responsible Agency:

- 1.1 DSS
- 1.2 DSS, Assisted Living Providers, Stakeholders
- 1.3 DSS

Target Completion:

- 1.1 July 31, 2016
- 1.2 June 30, 2017
- 1.3 July 31, 2016

Expectation #2: Providers arrange supports for an individual to work or volunteer in an integrated setting when an individual is interested in working or volunteering.

Compliance Action Step:

- 2.1 Educate providers about state and federal expectations.
- 2.2 Change HCBS (ASA) waiver eligibility requirements for earned income.

Measurable Outcomes:

- 2.1 Statewide education; Webinars, FAQ, Annual Newsletter
- 2.2 2016 Waiver Renewal

Responsible Agency:

- 2.1 DSS
- 2.2 DSS

Target Completion:

- 2.1 May 31, 2016
- 2.2 October 1, 2016

Expectation #3: Providers perform Individual Remediation

Compliance Action Step:

- 3.1 Educate providers of state and federal expectations.
- 3.2 Providers Re-Assess Compliance.
- 3.3 State Assessment of Expectations

Measurable Outcomes:

- 3.1 State Expectations Guide
- 3.2 Provider Practice or Policy Change
- 3.3 On-Site Review

Responsible Agency:

- 3.1 DSS
- 3.2 Assisted Living Providers
- 3.3 DSS

Target Completion:

- 3.1 May 31, 2016
- 3.2 December 31, 2017
- 3.3 January 1, 2018 & On-Going

PLAN FOR CONTINUOUS COMPLIANCE AFTER TRANSITION PLAN

South Dakota will ensure providers maintain compliance with the federal regulations for each 1915(c) waiver following the end of the transition plan. South Dakota will ensure compliance through a variety of mechanisms including ombudsman visits, on-site provider reviews and care planning activities. South Dakota will incorporate the federal regulations into existing review mechanisms, grievance procedures, and annual education during care planning meetings. In addition to these activities, each waiver identified specific activities to ensure on-going compliance.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

IMPLEMENTATION MILESTONES

Year 1: March 2014 – March 2015

Year 2: March 2015 – March 2016

Graphic here, please see _____.

- June 30, 2015: Privacy - 3.1 Educate providers of state and federal expectations. COMPLETE
- July 1, 2015: Privacy - 2.1 Document setting choice between private and shared bedrooms in person-centered care plan. COMPLETE
- December 31, 2015: Privacy - 3.2 Providers implement a policy that allows individuals choice of roommates as available IN

PROGRESS

Year 3: March 2016 – March 2017

Graphic here, please see _____.

- April 31, 2016: Living Arrangements - 1.1 Educate providers of state and federal expectations.
- May 31, 2016: All Concept Areas - Educate providers of state and federal expectations for Individual Remediation.
- May 31, 2016: Privacy - 1.1 Educate providers of state and federal expectations for Individual Remediation.
- May 31, 2016: Community Integration - 2.1 Educate providers of state and federal expectations.
- July 1, 2016: Privacy – 1.2 Document health and welfare concerns in person-centered care plan.
- July 31, 2016: Living Arrangements - 2.1 Educate providers of state and federal expectations.
- July 31, 2016: Community Integration – 1.1 Educate providers of state and federal expectations.
- July 31, 2016: Community Integration – 1.3 Increase provider knowledge of natural supports.
- October 1, 2016: Community Integration - 2.2 Change HCBS (ASA) waiver eligibility requirements for earned income.
- December 31, 2016: Dignity & Respect - 1.2 Provider Re-Assess Compliance
- January 1, 2017 & On-Going: Dignity & Respect - 1.3 State Assessment of Expectation

Year 4: March 2017 – March 2018

Graphic here, please see _____.

- March 30, 2017: Location - 1.2 Provider Re-Assess Compliance
- April 1, 2017 & On-Going: Location - 1.3 State Assessment of Expectation
- June 30, 2017: Community Integration - 1.2 Collaborate with stakeholders and providers to perform further analysis.
- June 30, 2017: Physical Accessibility - 1.2 Provider Re-Assess Compliance
- July 1, 2017 & On-Going: Physical Accessibility - 1.3 State Assessment of Expectation
- September 30, 2017: Autonomy - 1.2 Provider Re-Assess Compliance
- October 1, 2017 & On-Going: Autonomy - 1.3 State Assessment of Expectation
- December 31, 2017: Community Integration - 3.2 Provider Re-Assess Compliance
- January 1, 2018 & On-Going: Community Integration - 3.3 State Assessment of Expectation

Year 5: March 2018 – March 2019

Graphic here, please see _____.

- March 17, 2018: Privacy - 1.3 All provider-owned or leased settings implement locks for capable individuals.
- March 17, 2018: Living Arrangements - 2.2 All settings are immediately accessible to individuals 24/7 by key or other means such as setting staff, key pad/fob, etc.
- March 31, 2018: Privacy - 4.2 Provider Re-Assess Compliance

- April 1, 2018 & On-Going: Privacy - 4.3 State Assessment of Expectation
- June 30, 2018: Living Arrangements - 3.2 Provider Re-Assess Compliance
- July 1, 2018 & On-Going: 3.3 State Assessment of Expectation
- March 17, 2016: 1.2 The setting offers reasonable alternative to planned meals.
- March 17, 2016: 1.3 Individuals are able to make an alternative meal within their resources.
- March 17, 2016: 1.4 All individuals can elect to eat at an alternative time.
- March 17, 2016: 1.5 All individuals can elect to eat in their room.

FEBRUARY 2015 PUBLIC INPUT AND PUBLIC NOTICE PUBLIC INPUT OPPORTUNITIES FOR PLAN SUBMITTED 3/12/2015

In addition to the formal public notice period required by CFR, South Dakota engaged providers, individuals, and stakeholders throughout the transition plan assessment and preparation process. All mailings and slides and recordings of webinars are available online at: <http://dss.sd.gov/medicaid/hcbs.aspx>

FINAL RULE EDUCATION ACTIVITIES

- Provider Final Rule Educational Mailing: August 25, 2014
- Provider Final Rule Overview Webinar: August 29, 2014 and September 2, 2014
- Tribal Consultation Final Rule Overview Presentation: October 9, 2014
- Stakeholder Educational Mailing: November 14, 2014

ASSESSMENT PUBLIC INPUT ACTIVITIES

- Assessment Provider Pilot Group: August 29, 2014 to September 11, 2014
- Provider Assessment Education Mailing: September 12, 2014
- Provider Assessment Education Webinar: September 23, 2014 and September 24, 2014

ASSESSMENT RESULTS AND DRAFT TRANSITION PLAN PUBLIC INPUT ACTIVITIES

HCBS (ASA) Waiver Provider & Stakeholder Webinars:

- o January 4, 2015
- o January 5, 2015
- o January 12, 2015
- Tribal Consultation Presentation: January 8, 2015
- CHOICES Core Stakeholder Presentation: January 5, 2015
- DHS Community Support Providers Presentation: January 14, 2015

FORMAL PUBLIC NOTICE PERIOD

South Dakota's Formal Public Notice Period began on February 2, 2015 and ended on March 4, 2015. South Dakota engaged providers, individuals, and stakeholders during the Public Notice Process. All mailings and notification materials are available online at: <http://dss.sd.gov/medicaid/hcbs.aspx>.

South Dakota offered four ways to make a comment on the transition plan:

1)E-Mail:

South Dakota created an e-mail address specifically for comments and questions regarding the transition plan. The e-mail address is hcbs@state.sd.us.

2)Mail:

South Dakota accepted written comments via mail to South Dakota Medicaid.

3)Phone:

South Dakota accepted comments and questions made by phone. Contact information was listed for the HCBS (ASA) Waiver, CHOICES Waiver, ADLS Waiver, Family Support 360 Waiver and South Dakota Medicaid.

4)Public Forums and Town Hall Conference Calls:

The Department of Human Services offered three in-person meetings and one town hall conference call to accept public comments and questions. The Department of Social Services offered two Town Hall conference calls to accept public comments and questions.

Public Forums:

- o February 9, 2015: Watertown, SD 9:00 am – 10:30 am CST
- o February 9, 2015: Sioux Falls, SD 1:00 pm – 2:30 pm CST
- o February 10, 2015: Rapid City, SD 9:00 am – 10:30 am MST

Town Hall Conference Calls:

- o February 12, 2015: Webinar 9:00 am – 10:30 am CST
- o February 18, 2015: Conference Call 9:00 am – 10:00 am CST

o February 19, 2015: Conference Call 4:00 pm – 5:00 pm CST
South Dakota performed the following activities related to public notice:

TRIBAL CONSULTATION

South Dakota distributed the draft transition plan to all of South Dakota's nine tribes via e-mail on February 2, 2015. The e-mail contained a letter describing the transition plan, how the plan affects Native Americans in South Dakota, and how to make a comment on the plan. The e-mail also contained a direct link to where the transition plan could be viewed online and PDF of the transition plan.

South Dakota provided an in-depth presentation of the draft transition plan in advance of the Public Notice period at the January 8, 2015 Medicaid Tribal Consultation Meeting. South Dakota Medicaid meets with members of South Dakota's nine tribes each quarter.

PROVIDER, STAKEHOLDER, AND PUBLIC NOTIFICATION

South Dakota made the draft transition plan available on the Department of Social Services' website on February 2, 2015. The draft transition plan may be viewed online: <http://dss.sd.gov/medicaid/hcbs.aspx>. South Dakota made written copies of the transition plan available to individuals who contacted South Dakota Medicaid for assistance. Notice of the transition plan was also given on the Department of Human Service's website.

South Dakota engaged providers, stakeholders, individuals, and the public during the Public Notice Period. South Dakota distributed the transition plan via e-mail to providers, stakeholders, and others via e-mail on February 2, 2015. A copy of the letter sent to providers is available online: <http://dss.sd.gov/medicaid/hcbs.aspx>. Additional notice of the transition plan and how to make a comment was sent to stakeholders by the waiver managers of each of South Dakota's four Medicaid waivers.

South Dakota published notice of the transition plan and comment period in the South Dakota Legislative Research Council Register. Notice was provided every week during the public notice period:

February 2, 2015: <http://legis.sd.gov/docs/rules/Register/02022015.pdf>

February 9, 2015: <http://legis.sd.gov/docs/rules/Register/02092015.pdf>

February 17, 2015: <http://legis.sd.gov/docs/rules/Register/02172015.pdf>

February 23, 2015: <http://legis.sd.gov/docs/rules/Register/02232015.pdf>

March 2, 2015: <http://legis.sd.gov/docs/rules/Register/03022015.pdf>

Notice of the transition plan was also published in three newspapers around the state. On February 4, 2015, notice was published in the Watertown Public Opinion and the Rapid City Journal. On February 5, 2015, notice was published in the Sioux Falls Argus Leader.

The Department of Social Services and the Department of Human Services created posters advertising the transition plan and providing information on how to make a comment. The posters were hung in all 63 DSS local offices. DSS and DHS additionally requested providers hang the posters in a public place in their setting.

Notice of the transition plan was also distributed in stakeholder newsletters such as the South Dakota Association of Healthcare Organizations Unified Voice.

PUBLIC COMMENTS FOR PLAN SUBMITTED 3/12/2015

South Dakota responded to all comments received during the formal public notice period. As a result of comments received, South Dakota added additional narration to the CHOICES section of the transition plan. No other changes were made to the transition plan. South Dakota received favorable feedback from Tribal Consultation and letters of support from multiple provider and stakeholder groups. Comments are summarized by subject area; similar comments are summarized together.

SETTINGS SUBJECT TO HEIGHTENED SCRUTINY

Several stakeholders commented on the necessity of settings that are also long term care facilities located in rural locations or towns. Commenters offered anecdotal evidence of the need in their communities and questioned how they can relay the information to the State and CMS during the heightened scrutiny review process. A few stakeholders commented that more flexibility regarding the classification of beds is needed for settings in remote areas where skilled nursing facilities are located but no assisted living options exist.

South Dakota agrees that these facilities are necessary and exist to fill a need in rural and remote communities. South Dakota will work closely with providers prior to the 2016 HCBS (ASA) Waiver renewal to document justification of these settings.

PRIVACY

Several stakeholders commented on the requirement for facilities to provide locking doors. Commenters questioned how they should implement this requirement for individuals who may not be capable of locking a door. Commenters questioned what documentation would be required in a care plan when an individual was not capable of locking a door.

South Dakota responded that all individuals should be able to lock their door. South Dakota explained that modifications to this requirement will be allowed when there is a specific and assessed need. The Department of Social Services will provide more detailed information about state expectations for care plan documentation through education outlined in the action steps in the transition plan.

Several stakeholders commented that they do not offer private rooms in their facility and were concerned they would be required to offer private rooms.

The federal rules require an individual to have a choice among setting options with private and shared bedrooms. South Dakota will ensure this requirement is met from a state perspective as stated in the transition plan.

PHYSICAL ACCESSIBILITY

One stakeholder commented that physical accessibility in homes in the community can be an issue in the CHOICES waiver; more individuals could move from larger settings if more homes were accessible.

South Dakota agrees and supports opportunities for smaller home sizes through the activities of the DHS Financial Workgroup as well as DHS's continuous quality improvement strategies.

One stakeholder commented that there should be regular maintenance and upgrades made to CSP facilities. South Dakota agrees; the Department of Human Services will continue to partner with the South Dakota Department of Health and providers to review facilities.

LIVING ARRANGEMENTS

Several stakeholders commented on the requirements related to access to food. Commenters were concerned that some individuals may choose to eat exclusively in their rooms and will miss out on benefits from movement and social interaction in the shared dining experience. Other stakeholders expressed concern about the new requirements and individuals who may have dietary restrictions.

South Dakota agrees that meal times are a valuable opportunity for social interaction and mobility, especially for individuals living in Assisted Livings; however, residential settings should reflect a home-like atmosphere which includes the opportunity to eat alone if the individual chooses. South Dakota will expect dietary restrictions to appear in a care plan as a modification. South Dakota will provide more detailed guidance to providers about state and federal expectations when this action step is implemented.

Several stakeholders commented that requiring a posted grievance policy is not conducive to a home-like environment. One commenter suggested that individuals should be educated regarding grievance procedures and their right to have an advocate file a grievance on their behalf.

South Dakota agrees that posted grievance policies do not reflect a typical home environment. The Department of Human Services currently requires all individuals to receive notification about how to make a complaint during the annual care plan meeting with the individual. South Dakota will continue to seek guidance from CMS about how to meet this requirement and maintain a home-like environment.

Several stakeholders commented that HUD signs are required to be posted in front of homes and are identifiable as homes for individuals with disabilities.

South Dakota agrees. South Dakota will continue to seek guidance from CMS about how to meet this requirement and maintain a home-like environment.

Several stakeholders commented that they would like to see more options for integrated living opportunities in the CHOICES waiver, including individuals living with more typical peers.

South Dakota asked for clarification in regards to what was meant by "typical peers." Stakeholders responded that they meant individuals with similar disabilities living together. The Department of Human Services supports integrated living

environments that are determined through informed choice and person-centered planning.

One stakeholder would like to see more technology utilized in homes.

South Dakota agrees that technology promotes integrated living opportunities. DHS explained to stakeholders the implementation of a technology pilot that is currently in the planning phase.

One stakeholder requested language in a lease contain simple and understandable terms for guardians and self-advocates. The commenter also suggested CSP facilitated education regarding South Dakota tenant/landlord laws for individuals.

South Dakota agrees that individuals should have access to lease requirements in terms that are simple and understandable. South Dakota supports education for individuals regarding their rights. These concerns will be addressed through action steps identified in the transition plan.

One stakeholder questioned if a formal lease was necessary.

South Dakota believes that individuals served by an HCBS waiver must have the same protections afforded to individuals under South Dakota's tenant/landlord laws.

One stakeholder commented that individuals' lives could be improved if individuals were aware of their ability to request rights restrictions be lifted and were provided supports to challenge rights restrictions decisions.

South Dakota agrees that individuals benefit from living in the least restrictive environment. During the annual care planning process, self-advocates and their families are educated about how to submit a grievance to the provider or the Division of Developmental Disabilities.

COMMUNITY INTEGRATION

Several stakeholders commented on the challenges associated with transportation, especially in rural areas. Stakeholders noted that public transit is not always immediately available. Stakeholders noted transportation needs limit community involvement.

South Dakota agrees that finding transportation to meet individuals' immediate needs can be challenging. South Dakota encourages providers to connect individuals with community organizations and emphasize natural supports to meet transportation needs. The Department of Social Services plans to perform further analysis in this area as stated in the transition plan.

Several stakeholders commented on increasing the use of natural supports to engage individuals in the community. Commenters suggested using more community resources and volunteer opportunities to increase community involvement.

South Dakota agrees and encourages providers to find ways to utilize natural supports to support community integration and involvement. South Dakota will provide education to Assisted Living and Community Support Providers on best practices and strategies for increasing the use of natural supports as stated in the transition plan. South Dakota also supports the use of existing community resources to support community integration.

Several stakeholders commented about the need to engage individuals and families early about opportunities for employment and connection to other community resources.

South Dakota agrees that families benefit from early engagement regarding opportunities for employment and connection to other resources in the community.

One stakeholder commented that self-care is important and that providers should help individuals be clean and find appropriate clothing to wear in the community.

South Dakota agrees that education and supports related to self-care is important, but also emphasizes individual choice in apparel and appearance.

Several commenters expressed the need to work with more employers and job coaches to find more opportunities to employ individuals with disabilities. Commenters expressed the need for more creative thinking.

South Dakota is already pursuing action in this area through the Employment Works Initiative. South Dakota will continue

to work on this area throughout the transition plan period.

One commenter expressed concern that individuals with disabilities will lose opportunities for employment if a sub-minimum wage is revoked.

South Dakota responded that that conversation is happening at the federal level and is outside the scope of the transition plan.

One stakeholder commented that requirements to pursue employment before day programs may be too much and that some individuals may not be employable.

South Dakota responded that federal regulation requires states to pursue vocational rehab prior to accessing supports within a segregated workshop.

STAFFING AND FUNDING CONSIDERATIONS

Several stakeholders commented that the new requirements may make it more time intensive for staff to care for individuals. Commenters expressed the need for more staff and that there are challenges associated with funding limitations. Several commenters expressed the need for the state and federal government to make more funding available for staffing.

South Dakota discussed opportunities for utilizing natural supports and shared living to address individuals' needs in the community and reduce reliance on paid staff. South Dakota will address natural supports through action steps in the transition plan.

One stakeholder commented that Community Support Providers need oversight to ensure proper training is being provided to all workers who support individuals with disabilities.

South Dakota provides oversight of CSPs to ensure that pre-service, in-service, and continuing education requirements are met.

Several stakeholders commented about high staff turnover in Community Support Providers.

South Dakota discussed opportunities for utilizing natural supports, shared living, and technology as ways to reduce reliance on paid staff.

MISCELLANEOUS COMMENTS

Several stakeholders commented that they would like to see increased communication between providers across the state to share best practices, connections, and to promote more consistency between providers serving the CHOICES waiver.

The Department of Human Services is developing a secure platform within the DHS website for providers to exchange best practices, communication, and connections. DHS invited providers to raise best practices on the monthly webinar series.

One stakeholder commented that although individuals seem satisfied with current services, individuals may benefit from increased exposure to new experiences.

South Dakota agrees and will implement this through action steps in the transition plan.

Several stakeholders requested additional clarification in the CHOICES waiver section regarding assessment results.

South Dakota added additional narrative in the CHOICES waiver section in response to questions about assessment results.

One commenter requested that results include a comparison of community support provider agencies.

South Dakota is not releasing individual provider information at this time.

One stakeholder questioned if assessments were applicable to real living environments.

South Dakota developed the assessments based on guidance from the CMS Toolkit prepared for the federal regulations.

Several stakeholders questioned where conflict-free case management fits into the transition plan.

South Dakota responded that although conflict-free case management is a requirement of the federal regulation it is not a requirement of the transition plan.

STATEMENTS OF SUPPORT

Stakeholders and individuals expressed satisfaction with the assessment and the transition plan process. Individuals

expressed satisfaction with the work of the state and providers; commenters said that results appear to be an accurate reflection of services.

South Dakota appreciates the statements of support.

Community Support Providers of South Dakota, South Dakota Association of Healthcare Organizations, South Dakota Advocacy Services, South Dakota Health Care Association, and South Dakota Coalition of Citizens with Disabilities submitted statements of support for South Dakota's Statewide HCBS Transition Plan. Associations indicated that they were pleased with actions by the Department of Social Services and Department of Human Services that engaged providers, stakeholders, and individuals throughout the transition plan process.

South Dakota appreciates the statements of support.

MARCH 2016 PUBLIC INPUT AND PUBLIC NOTICE

South Dakota's Formal Public Notice Period began on February 29, 2016 and ended on March 30, 2016. South Dakota engaged providers, individuals, and stakeholders during the Public Notice Process. All mailings and notification materials are available online at: <http://dss.sd.gov/medicaid/hcbs.aspx>.

South Dakota offered four ways to make a comment on the transition plan:

5)E-Mail:

South Dakota used the e-mail address created specifically for comments and questions regarding the transition plan. The e-mail address is hcbs@state.sd.us.

6)Mail:

South Dakota accepted written comments via mail to South Dakota Medicaid.

7)Phone:

South Dakota accepted comments and questions made by phone. Contact information was listed for the HCBS (ASA) Waiver, CHOICES Waiver, ADLS Waiver, Family Support 360 Waiver and South Dakota Medicaid.

8)Public Forums and Town Hall Conference Calls:

The Department of Social Services offered two Town Hall conference calls to accept public comments and questions.

Town Hall Conference Calls:

o March 9, 2016: 9:00 – 10:00 am CST

o March 10, 2016: 4:00 – 5:00 pm CST

South Dakota performed the following activities related to public notice:

TRIBAL CONSULTATION

South Dakota distributed the draft transition plan to all of South Dakota's nine tribes via e-mail on February 29, 2016. The e-mail contained a letter describing the transition plan, how the plan affects Native Americans in South Dakota, an overview of the changes to the transition plan and how to make a comment on the plan. The e-mail also contained a direct link to where the transition plan could be viewed online and a PDF of the transition plan.

South Dakota provided a presentation on the changes to the transition plan in advance of the Public Notice period at the January 12, 2016 Medicaid Tribal Consultation Meeting. South Dakota Medicaid meets with members of South Dakota's nine tribes each quarter.

PROVIDER, STAKEHOLDER, AND PUBLIC NOTIFICATION

South Dakota made the draft transition plan and a document describing the changes to the transition plan available on the Department of Social Services' website on February 29, 2016. The draft transition plan may be viewed online: <http://dss.sd.gov/medicaid/hcbs.aspx>. South Dakota made written copies of the transition plan available to individuals who contacted South Dakota Medicaid for assistance. Notice of the transition plan was also given on the Department of Human Service's website.

South Dakota engaged providers, stakeholders, individuals, and the public during the Public Notice Period. South Dakota distributed the transition plan and an overview of the changes to the plan via e-mail to providers, stakeholders, and others on February 29, 2016. A copy of the letter sent to providers is available online: <http://dss.sd.gov/medicaid/hcbs.aspx>. Additional notice of the transition plan and how to make a comment was sent to stakeholders by the waiver managers of South Dakota's four Medicaid waivers.

South Dakota published notice of the transition plan and comment period in the South Dakota Legislative Research Council Register on February 29, 2016: <http://legis.sd.gov/docs/rules/Register/02292016.pdf>

The Department of Social Services created posters advertising the transition plan and providing information on how to make a comment. The posters were hung in all 63 DSS local offices. DSS and DHS additionally requested providers hang the posters in a public place in provider owned and operated settings. An example of the poster is shown below. The Department of Human Services also provided information about the plan and opportunities to make a comment via social

media. Information about opportunities to make a comment and how to view the plan were distributed on the Department's Facebook page.

Graphic here, please see _____.

PUBLIC COMMENTS FOR PLAN SUBMITTED 4/6/2016

South Dakota responded to all comments received during the formal public notice period. As a result of additional clarifying information from CMS during the Public Notice Period, South Dakota revised the number of settings subject to heightened scrutiny review to not include settings adjacent to private institutions. Based on comments received, DSS and DHS added information about future opportunities for comment, direct links to lists of providers; and additional information about the individual interviews performed by DSS and DHS during the validation process. No other changes were made to the transition plan. South Dakota received favorable feedback from Tribal Consultation and providers. Comments are summarized by subject area; similar comments are summarized together.

Conflict Free Case Management

Several stakeholders asked if the Transition Plan was related to Conflict Free Case Management.

South Dakota explained that Conflict Free Case Management is a component of the Final Rule, but is separate from the HCBS Transition Plan. South Dakota directed stakeholders to Conflict Free Case Management information for the CHOICES and ADLS waivers.

Next Steps

Several stakeholders requested information on next steps for the action steps in the transition plan and heightened scrutiny. South Dakota explained that the revised transition plan will be submitted to CMS and South Dakota will continue to work on the action items in the timeframes specified in the transition plan. DSS will work to gather additional information relative to heightened scrutiny over the next several months. Once the state has completed analysis of those settings, the state will hold a public comment period on the settings before submission of the heightened scrutiny settings to CMS.

Statewide Transition Plan and Waiver Programs in South Dakota

Several commenters asked how the transition plan would change waiver programs in South Dakota and how the transition plan affected each waiver.

South Dakota gave an overview of the final rule and the intent to ensure individuals receiving HCBS have full access to the benefits of living in the community. South Dakota explained that the transition plan applies to all four HCBS waivers, but many of the provisions are specific to provider owned and operated settings, so many of the actions steps are focused on settings in the CHOICES and HCBS(ASA) waivers.

Several stakeholders expressed concern that the HCBS regulations would negatively affect the care of waiver recipients currently receive. One commenter expressed concern that the regulations were made by individuals far removed from the hands-on work of providing care and that providers and provider staff are already doing the best they can for individuals with disabilities.

South Dakota understands the concerns raised by the stakeholders. DSS and DHS are working with providers to continue to provide quality services for individuals while ensuring compliance with the final rule.

Several commenters requested additional information about the differences between South Dakota's four Home and Community Based Services Waivers.

South Dakota gave a brief explanation of the differences and connected the commenters with the waiver managers for additional information and clarifying questions.

Settings in South Dakota

One commenter requested that DSS/DHS provide information about which settings will be assessed under the review process.

South Dakota updated the transition plan with hyperlinks to websites where individuals and stakeholders may obtain a list of Assisted Livings Providers, Adult Day Providers and Community Support Providers.

Setting Classification and Provider

One commenter suggested that the process and associated public comment periods be more clearly explained in an effort to facilitate better understanding about timelines and the comment process associated with steps in the transition process.

South Dakota added additional information regarding future opportunities for comment and information about waiver specific transition plans and the opportunity for individuals to comment on a waiver specific transition plan. South Dakota also added information about how the federal regulations are a requirement for any new provider and that all providers will be expected to be fully compliant with the federal regulations at the end of the transition plan period in March 2019.

Provider Compliance

One commenter suggested that the state provide additional information about the timeline for providers to come into compliance with the federal regulations.

South Dakota will follow the timelines outlined in the Implementation Milestones section of this Transition Plan. All providers will be expected to be 100% compliant by the end of the transition plan period in March 2019.

Provider Self-Assessments & State Staff Assessments

One commenter requested information about additional assessment steps after the initial provider self-assessment and staff assessment.

South Dakota will assess provider compliance with the action steps outlined in this transition plan. Additionally, South Dakota will incorporate the federal requirements into on-going reviews of settings, including but not limited to ombudsman visits, on-site reviews, and annual care plan meetings with individuals. All providers must be fully compliant at the end of the transition plan period in March 2019.

Transportation

One commenter noted that transportation can often be a barrier to accessing the community and requested that the state work to ensure providers are planning and promoting community integration by providing, planning, or facilitating transportation opportunities.

South Dakota will address transportation through action steps outlined in this plan.

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.

Division of Adult Services and Aging

(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:

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:

The Division of Adult Services and Aging is a Division within the South Dakota Department of Social Services, the single State Medicaid Agency for the State of South Dakota. The Division of Adult Services and Aging is responsible for the overall operation and management including reporting of the Home and Community-Based Services (HCBS) Waiver. 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 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.

The designated State Medicaid Director provides oversight and guidance by meeting with the Division of Adult Services and Aging HCBS Program Manager as warranted to ensure compliance with Federal Regulations and Requirements, i.e., review of 372 Evidence Report, HCBS Waiver application, Home and Community-Based Services Waiver Policy, HCB Settings Requirements and HCB Settings Transition Plan.

- 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:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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:

^
v

- 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:

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v

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:

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v

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:

^
v

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
Participant waiver enrollment	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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 Home and Community-Based Services (HCBS) Waiver program. If individual problems are identified in the administration of the HCBS waiver or in the Division of Adult Services and Aging’s performance of specific delegated waiver functions, identified problems will be remediated between the State Medicaid Agency and the Division of Adult Services and Aging. 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 DSS 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age		Maximum Age	
					Maximum Age Limit	No Maximum Age Limit
	<input checked="" type="checkbox"/>	Disabled (Physical)	18		64	
	<input checked="" type="checkbox"/>	Disabled (Other)	18		64	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups						
	<input type="checkbox"/>	Brain Injury				<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS				<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile				<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent				<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both						
	<input type="checkbox"/>	Autism				<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability				<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability				<input type="checkbox"/>
<input type="checkbox"/> Mental Illness						
	<input type="checkbox"/>	Mental Illness				
	<input type="checkbox"/>	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 ASA 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	1776
Year 2	1834
Year 3	1895
Year 4	1957
Year 5	2022

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

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

- The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Waiver applications are 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 an assisted living facility 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 and the Physician's Order.

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 Adult Services and Aging Nurse Consultant, a Registered Nurse licensed to practice in the State of South Dakota, and a Division of Adult Services and Aging Specialist. When the Adult Services and Aging (ASA) Specialist who sits on the Medical Review Team is the one who completes the Community Health Assessment in the case under review, an alternate ASA Specialist is assigned to assure the Level of Care determination does not include the ASA 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
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

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

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA 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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL**
- % of FPL, which is lower than 100%.**
- Specify percentage amount:
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**

(Complete Item B-5-b (SSI State) and Item B-5-d)

- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State) (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan

Select one:

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

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

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.

- 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:

South Dakota uses the current definition of a community spouse in 1924 of the Act.

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:

Deduction for maintenance of community spouse. The spouse is allowed a deduction from the institutionalized spouse's income for the maintenance needs of the community spouse. The deduction is that amount remaining after subtracting the community spouse's monthly income from the maintenance allowance and any excess shelter allowance.

Computation of community spouse's maintenance allowance and excess shelter allowance. The community spouse's monthly minimum maintenance allowance is 150 percent of the federal poverty income level established in § 67:11:01:03 for two persons divided by 12. The excess shelter allowance is determined by subtracting 30 percent of the minimum maintenance allowance from the community spouse's shelter costs. Shelter costs include rent or mortgage costs, trailer parking space fees, taxes and insurance on the premises, and condominium or cooperative maintenance charges for the couple's principal residence. Shelter costs also include the applicable supplemental nutrition assistance program utility allowance. Rent, mortgage, taxes, insurance, and condominium and cooperative maintenance charges paid less frequently than monthly are prorated for the period of intent. The combined spousal allowances may not exceed \$2,981 unless a greater allowance is provided for under a court order of support or if through the fair hearing process it is determined that a greater amount of need exists because of circumstances resulting in financial duress. These deductions are not permissible if the institutionalized spouse does not make the income available to the community spouse.

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:

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

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

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

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

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

Specify the entity:

- Other**
Specify:

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

Per Administrative Rules of South Dakota (ARSD) 67:45:01 all initial evaluations of Level of Care for waiver applicants are conducted by a 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 Adult Services and Aging Nurse Consultant, a Registered Nurse licensed to practice in the State of South Dakota, and a Division of Adult Services and Aging Specialist. When the Adult Services and Aging (ASA) Specialist who sits on the Medical Review Team is the one who completes the Community Health Assessment in the case under review, an alternate ASA Specialist is assigned to assure the Level of Care determination does not include the ASA 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) and Physician's Order. Medical Review Team members receive training from the Home and Community-Based Services (HCBS) Program Manager and the ASA 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 ASA Specialists receive twelve hours of 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 ASA 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 Adult Services and Aging hires individuals for the position of Adult Services and Aging 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 and the Physician's Order.

- 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 Home and Community-Based Services (HCBS) 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, an Adult Services and Aging (ASA) Specialist assigned to the consumer's case completes the Community Health Assessment (CHA), requests a completed Physician's Order, and submits all documentation needed to determine Level of Care to 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 ASA Specialist's role on the Medical Review Team is to review the consumer's psychosocial functioning and service needs. Based on this information the ASA Specialist makes a recommendation to an ASA Nurse Consultant, a Registered Nurse, as to how the individual's overall service needs may best be met. The ASA Nurse Consultant's role on the Medical Review Team is to review the consumer's medical needs and report to the ASA Nurse Consultant Program Manager, a Registered Nurse. The ASA Specialist on the Medical Review Team reports to the Division of Adult Services and Aging Regional Supervisor. This process thereby includes two opportunities for checks and balances on the Level of Care determination.

The Medical Review Team then provides the Division of Adult Services and Aging and the Division of Economic Assistance with a Level of Care Determination. To assist in maintaining a seamless eligibility review a Long-Term Care Benefit Specialist with the Division of Economic Assistance confirms information from the consumer's long term care application on financial and other non-financial eligibility components. The Home and Community-Based Services "HCBS Waiver Communication Template" is utilized to confirm the consumer's eligibility status. The ASA Specialist may authorize services on or after the date for which the following criteria are met: Financial eligibility determination, Level of Care determination, completed and signed Care Plan and receipt of the "HCBS Waiver Communication Template" from the Long-Term Care Benefit Specialist.

The same process is utilized for both the initial Level of Care evaluation and re-evaluation. The ASA 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 ASA 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 ASA 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 ASA Specialist offers the consumer Options Planning and assists the consumer to transition to other available services and supports provided through the Division of Adult Services and Aging, 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*):

The Division of Adult Services and Aging Specialist provides case management to all waiver consumers. As such, an Adult Services and Aging (ASA) Specialist is responsible for the timely Level of Care re-evaluations of their assigned consumers. To assist the ASA 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 ASA Specialist when the consumer requires a reassessment and Level of Care re-evaluation. The ASA 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 an ASA Specialist who completes the reassessment also serves on the Medical Review Team, an alternate ASA 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 ASA Regional Manager 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 Adult Services and Aging Nurse Consultant Program Manager.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

FileDirector, a document reviewing system and SAMS database

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

Data Aggregation and Analysis:

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

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

Data Aggregation and Analysis:

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

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 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%, +/-9%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

- 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 Adult Services and Aging has ten Adult Services and Aging (ASA) Regional Supervisors who supervise ASA Specialists located in 24 offices around the state. Each month, the Home and Community-Based Services Program Manager obtains a report of all Level of Care determinations made the previous month and randomly assigns them to the ASA Regional Supervisors for review. The ASA 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.

Quarterly the HCBS Program Manager provides the ASA Nurse Consultant Program Manager with a random sample of the Level of Care determinations to review to ensure the Level of Care criteria was accurately applied. 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 universe for the random sample is all Level of Care determinations made during the previous quarter. The Raosoft sample size calculator is utilized to identify the number of Level of Care determinations that will need to be reviewed.

The results of the Level of Care reviews are aggregated on a quarterly basis. The results of the reviews are presented at quarterly Waiver Review Committee meetings and recommendations for improvement are made when trends are identified. The Waiver Review Committee is led by the HCBS Program Manager and includes the following additional members: Division of Adult Services and Aging Director and Deputy Division Director, ASA Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, ASA Training Coordinator, ASA Regional Managers, two ASA Regional Supervisors, and two ASA Specialists.

b. Methods for Remediation/Fixing Individual Problems

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

100% of the Level of Care determinations are reviewed by the Adult Services and Aging 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 Adult Services and Aging (ASA) 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 Home and Community-Based Services (HCBS) Program Manager assigns a random sample of Level of Care determinations to the Nurse Consultant Program Manager. The Nurse Consultant Program Manager reviews a random sample of the Level of Care determinations to ensure that the Level of Care criteria was 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 ASA Specialist is not correctly applying the Level of Care criteria, or if the problems are not individual specific. 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 will examine 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 of Adult Services and Aging Director and Deputy Division Director, ASA Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, ASA Training Coordinator, ASA Regional Managers, two ASA Regional Supervisors, and two ASA Specialists.

ii. Remediation Data Aggregation

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

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

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 Adult Services and Aging (ASA) Specialist through the assessment and person centered care planning process discusses the Home and Community-Based Waiver Services that are available to meet the consumer's needs at home or in an assisted living. The ASA 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 Home and Community-Based Waiver Services and Assisted Living services 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 Home and Community-Based Services Waiver Policy instructs the ASA 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, document that the consumer or authorized representative was informed of a choice in the provision of care available in a nursing facility or through the Home and Community-Based Services 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 Social Services (DSS) 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 DSS staff are utilized to arrange for Interpreters to accompany the Adult Services and Aging 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 community, i.e., Lakota and are utilized in addition to family members or other natural supports who serve as the consumer’s interpreter. Department of Social 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 DSS staff that provide interpreter services to the Department of Social 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 Adult Services and Aging Programs are available in Spanish and can be accessed by individuals who are Limited English Proficient at Department of Social 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	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Respite 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	Emergency Response System (ERS)		
Other Service	Environmental Accessibility Adaptations		
Other Service	In-Home Nursing Services		
Other Service	Meals		
Other Service	Nutritional Supplements		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service:

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:**

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

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

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

Service Definition (Scope):

Adult Day Services provide regular care, supervision and structured activities in a non-institutional community-based setting to a consumer residing in his or her own home for part of the day. Adult Day Services may provide limited nursing services such as health screening, blood pressure checks, medication management, and a general assessment of the consumer's condition. Nutritious meals/snacks are available but are billed as a separate service.

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:**

Provider Type:

Senior Center

Provider Qualifications**License (specify):**

Not Applicable

Certificate (specify):

Not Applicable

Other Standard (specify):

Providers must enroll to become a Medicaid provider. Enrollment includes submitting a signed Provider Agreement.

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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):

Providers must enroll to become a Medicaid provider. Enrollment includes submitting a signed Provider Agreement.

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

State Medicaid Agency - specifically the Division of Adult Services and Aging

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:

Homemaker ▾

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

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

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

Service Definition (Scope):

In-home services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) 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 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.

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: Statutory 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 in-home providers of homemaker services must enroll as 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, specifically the Division of Adult Services and Aging.

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:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

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

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

Service Definition (Scope):

In-home Personal Care services are those services that are provided when personal care furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State Plan. The provider qualifications specified in the State Plan apply. Personal Care tasks include the assistance provided to a consumer living at home to perform his or her activities of daily living. 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.

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

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

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

Service Type: Statutory 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 in-home providers of personal care services must enroll as 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, specifically the Division of Adult Services and Aging.

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:

Category 4:

▼

Sub-Category 4:

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

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

Service Definition (Scope):

Respite Care is the temporary substitute supports or living arrangements for care receivers in order to provide a period of relief or rest to the primary caregiver on an intermittent, occasional or emergency basis. Respite Care is available to eligible individuals who reside with unpaid caregivers.

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	Long-term care facility
Agency	Private and hospital-based in-home service providers
Agency	Assisted Living facilities

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 to become Medicaid providers. Enrollment includes providing verification of current, valid licensure and signing a Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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):

Providers must enroll to become Medicaid providers. Enrollment includes signing a Provider Agreement. Providers must also sign a Supplemental Provider Agreement and sign and complete a Provider Quality Management Self-Assessment.

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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 facilities

Provider Qualifications**License (specify):**

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

Certificate (specify):

Not Applicable

Other Standard (specify):

Assisted Living facilities must enroll to become Medicaid providers. Enrollment includes providing verification of current, valid licensure and signing a Provider Agreement.

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Specialized medical equipment enables a consumer to increase his or her ability to perform activities of daily living and assists a consumer to remain living safely at home. This includes, but is not limited to, the rental, purchase, and/or installation of devices, controls, sensors, or appliances such as devices programmed to automatically dispense medications, equipment that monitors health status (e.g., telehealth), wheelchairs, walkers, hospital beds, and assistive devices. Medical equipment reimbursed with waiver funds are in addition to any medical equipment furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the consumer.

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	Durable Medical Equipment supplier
Agency	Private and hospital-based in-home service providers
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:**

Durable Medical Equipment supplier

Provider Qualifications**License (specify):**

Not Applicable

Certificate (specify):

Not Applicable

Other Standard (specify):

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

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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 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, specifically the Division of Adult Services and Aging.

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:**

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 to become Medicaid providers. Enrollment includes providing verification of current, valid licensure and signing a Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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 Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:



Category 2:

Sub-Category 2:



Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



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

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

Service Definition (*Scope*):

Specialized medical supplies are disposable supplies which are necessary to maintain a consumer's health, manage a medical or physical condition, improve functioning, or enhance independence. Supplies provided must be of direct medical or remedial benefit to the consumer and may include: incontinence supplies, diabetic supplies, wound care supplies, and other supplies not covered under the Medicaid State 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.

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 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, specifically the Division of Adult Services and Aging.

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 to become Medicaid providers. Enrollment includes providing verification of current, valid licensure and signing a Provider Agreement.

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:

Durable Medical Equipment suppliers

Provider Qualifications**License (specify):**

Not Applicable

Certificate (specify):

Not Applicable

Other Standard (specify):

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

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:
Adult Companion Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Non-medical care, assistance, and socialization provided to a consumer living at home. Companions may assist the consumer with transportation and support in shopping, pharmacy pick-ups, non-medical appointments, and activities that support a consumer to participate in the community. Companions may also transport and accompany the consumer to events or socialization activities that meet his or her personal goal as identified 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 in-home providers of companion services must enroll as waiver providers. The enrollment process includes completing an enrollment application, signing a 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 will be responsible for maintaining and submitting proof of insurance and are responsible for liability.

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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

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

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

Service Definition (Scope):

Personal care and supportive services such as homemaker, chore, and meal preparation that are furnished to a consumer who resides 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. 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.

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 Facilities

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 Facilities

Provider Qualifications

License (specify):

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

Certificate (specify):

Not Applicable

Other Standard (specify):

Assisted Living facilities must enroll to become Medicaid providers. Enrollment includes providing verification of current, valid licensure and signing a Provider Agreement.

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:

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:**Category 4:**

Sub-Category 4:

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

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

Service Definition (Scope):

Chore services needed to maintain the consumer's home in a healthy and safe environment. Chore services may include, but are not limited to, the following tasks: 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.

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 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: Chore Services

Provider Category:

Agency

Provider Type:

Community-based organizations

Provider Qualifications

License (specify):

Not Applicable

Certificate (specify):

Not Applicable

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:

Private and hospital-based in-home service providers

Provider Qualifications

License (specify):

Not Applicable

Certificate (specify):

Not Applicable

Other Standard (specify):

Providers must enroll to become Medicaid providers. Enrollment includes signing a Provider Agreement. Providers must also sign a Supplemental Provider Agreement and sign a Provider Quality Management Self-Assessment.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:

Emergency Response System (ERS)

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

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

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

Service Definition (Scope):

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.

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	Utility companies
Agency	Telephone cooperatives
Agency	Private and hospital-based in-home service providers
Agency	Durable Medical Equipment supplier

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*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

Frequency of Verification:

Annual

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):

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

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

Frequency of Verification:

Annual

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):

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

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

Frequency of Verification:

Annual

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, 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, specifically the Division of Adult Services and Aging.

Frequency of Verification:

Annual

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):

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

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

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:**

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

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

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

Service Definition (Scope):

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.

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

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):

Providers must enroll to become a Medicaid provider. Enrollment includes submitting a signed Provider Agreement.

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

The qualified provider agencies will work with the Division of Adult Services and Aging to reimburse the vendors/contractors/suppliers hired to complete the environmental accessibility adaptations. ASA Specialists will provide oversight and monitoring of environmental adaptations.

Frequency of Verification:

The community organization will be monitored annually.

The vendors/contractors/suppliers will be monitored throughout the installation of the authorized environmental adaptations.

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:

In-Home Nursing Services

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Individual and continuous nursing care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State of South Dakota Codified Law. Services are provided to consumer's who live at home. Services that are provided when personal care 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. The additional amount of services that may be provided through the waiver is the provision of additional nursing services over and above the amount allowed in the State 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: 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):

In-Home Nursing service providers must enroll as 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, specifically the Division of Adult Services and Aging.

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:

▼

Category 4:

Sub-Category 4:

▼

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

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

Service Definition (Scope):

Nutritious meals, provided to a consumer who lives at home, which follow federal dietary guidelines and are provided for lunch or 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.

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):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

Frequency of Verification:

Annual

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):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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:

▼

Category 4:

Sub-Category 4:

▼

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

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

Service Definition (Scope):

Nutritional supplements provided to a consumer who lives at home and is below his or her medically recommended body weight; nutritionally deficient or malnourished; or to manage a skin condition or promote wound healing.

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 Meals providers
Agency	Community-based organizations
Agency	Pharmacy

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:

Senior Meals providers

Provider Qualifications

License (specify):

Not Applicable

Certificate (specify):

Not Applicable

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging

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:

Community-based organizations

Provider Qualifications

License (specify):

Not Applicable

Certificate (specify):

Not Applicable

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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 to become Medicaid providers. Enrollment includes providing verification of current, valid licensure and signing a Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, specifically the Division of Adult Services and Aging.

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.

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

The Division of Adult Services and Aging 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. Adult Services and Aging Specialists function as case managers for a caseload of waiver and non-waiver consumers.

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):

Effective June 1, 2015 the Supplemental Provider Agreement requires in-home providers of homemaker, personal care, nursing and adult companion services to conduct State/FBI background checks to screen for abuse, neglect and exploitation on all employees hired to work in the homes of consumers. During annual on-site reviews the Division of Adult Services and Aging 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).

Effective June 1, 2016 the Supplemental Assisted Living Provider Agreement will require all employees of assisted living centers to conduct State/FBI background checks.

The Department of Social Services conducts State/FBI background checks on each person hired in the following employment positions with the Division of Adult Services and Aging: Home Health Aide, ASA Specialists, ASA Supervisors and ASA 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).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Long-Term Care Facilities	
Assisted Living Facilities	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Long-Term Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Meals	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Chore Services	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>
Adult Companion Services	<input type="checkbox"/>
Respite Care	<input checked="" type="checkbox"/>
Adult Day Services	<input type="checkbox"/>
Emergency Response System (ERS)	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Assisted Living	<input checked="" type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
In-Home Nursing Services	<input type="checkbox"/>
Specialized Medical Supplies	<input type="checkbox"/>

Facility Capacity Limit:

Per license of facility

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Meals	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Chore Services	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>
Adult Companion Services	<input type="checkbox"/>
Respite Care	<input checked="" type="checkbox"/>
Adult Day Services	<input type="checkbox"/>
Emergency Response System (ERS)	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Assisted Living	<input checked="" type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
In-Home Nursing Services	<input type="checkbox"/>
Specialized Medical Supplies	<input type="checkbox"/>

Facility Capacity Limit:

Per license of facility

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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.*

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.

An in-home provider may hire relatives/legal guardians of consumers to provide homemaker, personal care, nursing, chore, adult companion, and respite care. The relative/guardian must meet all of the qualifications and training requirements for employees of the in-home provider. The in-home provider makes the decision to hire or not hire employees and is responsible for the oversight of its employees, including relatives/legal guardians. Relatives/legal guardians must adhere to the consumer's approved Care Plan.

- 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 Adult Services and Aging Regional Offices or the Home and Community-Based Services (HCBS) Program Manager at the Department of Social Services' State Office. The Division of Adult Services and Aging Specialists direct potential providers wanting 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. Adult Services and Aging (ASA) 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, ASA Regional Supervisors complete a Home and Community-Based (HCB) Settings ASA 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 Adult Services and Aging Regional Office that the provider is an enrolled waiver provider. The Division of Adult Services and Aging Regional 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 State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

Performance Measures

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

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

Performance Measure:

Number and 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:

Provider enrollment form, including copy of current licensure.

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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:

List of licensed providers supplied by the Department of Health and list of enrolled providers supplied by Provider Enrollment team.

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

Data Aggregation and Analysis:

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

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

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
--	--	--

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of non-licensed/non-certified provider applicants by provider type who met initial waiver provider qualifications. Numerator = number of non-licensed/non-certified provider applicants of homemaker, personal care, nursing, and companion care, who met initial waiver provider qualifications. Denominator = number of non-licensed/non-certified provider applicants by provider type.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

For non-licensed providers of all types, approved provider enrollment verification or confirmation.

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

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

Data Aggregation and Analysis:

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

- 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):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

This data source applies to in-home providers of homemaker, personal care, and nursing services,

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

Data Aggregation and Analysis:

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

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

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

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 and annually thereafter. On-site reviews are performed by ASA 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 during the on-site 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 of Adult Services and Aging Waiver Review Committee. The Waiver Review Committee is led by the HCBS Program Manager and includes Division of Adult Services and Aging staff: Director and Deputy Division Director, Nurse Consultant Program Manager, SAMS Program Manager, Training Coordinator, Regional Managers, Regional Supervisors, and ASA 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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

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. ASA Regional Supervisors do 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 ASA 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 each year and an onsite review is completed 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 be terminated as a waiver provider. If it is determined during the onsite 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 ASA 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 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

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.

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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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Assisted Living and Adult Day settings were reviewed for compliance with the HCB Settings Requirements. All Adult Day settings were determined compliant and will be assessed on an annual basis to ensure continued compliance.

Assisted Living settings were assessed and are working towards compliance. South Dakota is further assessing settings that were initially identified as potential Heightened Scrutiny Settings. The HCB Settings Requirements will be incorporated into the Adult Services and Aging Specialists quarterly visits to Assisted Livings to ensure that settings will be compliant by the end of the transition plan period and to ensure ongoing compliance with HCB Settings requirements. The Quality of Life Survey, which is completed with waiver consumers at the six month review, will be utilized to assess the consumer's satisfaction and overall experience in the setting.

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:

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v

- Social Worker**

Specify qualifications:

^
v

- Other**

Specify the individuals and their qualifications:

The Division of Adult Services and Aging employs Adult Services and Aging (ASA) 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 Adult Services and Aging 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 Adult Services and Aging 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.

Adult Services and Aging 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 Adult Services and Aging 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 assisted living services.
- c. Obtains physician's orders for authorization of in-home services.
- 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 Adult Services and Aging 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 Adult Services and Aging (ASA) Specialist provides information about the Home and

Community-Based Services Waiver, service options, and service provider options that are available 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 available 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 ASA 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 ASA 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 Adult Services and Aging 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 Adult Services and Aging (ASA) 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 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 a consumer's individual responses, if the ASA Specialist believes the consumer under-estimated (or over-estimated) his/her needs, the ASA Specialist will offer an in-home visit to the consumer to further assess and ascertain his/her need for community-based services and supports. The SD Choices intake screen includes items which are completed by the ASA 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 ASA 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 which are completed by the ASA 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, Dehydration, Feeding Tube, Prevention, Appropriate Mediations, 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 ASA Specialist shares with the consumer the type of services he/she may be eligible for through the Division of Adult Services and Aging. When waiver services may be able to meet the needs of the consumer, information on the Home and Community-Based Services Waiver and assistance on applying for financial eligibility are provided to the consumer. The ASA Specialist gathers and reviews all relevant documentation (i.e., completed SD Choices and Community Health Assessment) and information obtained during intake. The ASA Specialist schedules a meeting with the consumer in his/her home to develop the Care Plan within thirty days of the intake. The ASA 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 ASA 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 ASA Specialist discusses available options with the consumer and his/her representative for addressing unmet needs. The ASA 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 ASA 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 Adult Services and Aging, 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 ASA 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 ASA 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 ASA 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 Adult Services and Aging 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 Adult Services and Aging (ASA) 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 ASA 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 ASA 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 ASA Specialist to the consumer on evacuation plans for fire (i.e., smoke detector, fire extinguisher), emergency shelter plan for tornado (i.e., weather alert, interior room plan) and a plan for blizzard/power outage (i.e., food and water supply, power/heat alternative source). The ASA 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 ASA 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 ASA 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 (i.e., 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 ASA 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 ASA Specialist reminds consumers with identified critical service needs that during inclement weather providers may not be able to deliver scheduled services. The ASA 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, i.e., 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, but the Adult Services and Aging (ASA) Specialist can help the consumer obtain information about the qualified providers of the waiver services in the Care Plan. The ASA 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 ASA 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 ASA 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 ASA 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 ASA 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):

Care Plans are developed by the Division of Adult Services and Aging, a Division of the Department of Social Services, the State of South Dakota's Single Medicaid Agency. As such, consumer Care Plans approved by Adult Services and Aging Specialists and Regional Supervisors are, in effect, approved by the Medicaid Agency.

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 Adult Services and Aging employs Adult Services and Aging (ASA) 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 ASA 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 ASA 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 ASA 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 Adult Services and Aging 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 Adult Services and Aging 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 ASA 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 ASA Specialist as a mandatory reporter per South Dakota Codified Law 22-46 follows the Adult Protective Services Policy. Additionally, the ASA 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 ASA Specialist may contact law enforcement to perform a "welfare check" or to accompany the ASA Specialist on a "welfare check".

In accordance with South Dakota Codified Law (SDCL) 22-46 providers are mandated to immediately 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 immediately notify the Division of Adult Services and Aging 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 ASA Specialist documenting the circumstances of any incident that involves serious injury, missing person, or death. Providers are directed to alert ASA 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 ASA 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 ASA 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 ASA 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 ASA 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 ASA 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 ASA 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 ASA Specialist in regular communication, i.e., quarterly contacts, six month review, annual review, and communication with the ASA Specialist by the consumer, his/her family or authorized representative, or service provider. Through these opportunities the ASA Specialists seeks to assure the consumer's needs continue to be met through the provision of waiver and/or non-waiver services. The ASA Specialist meets with the consumer in his/her home twice per year, at the six month review and again at the annual review. The ASA Specialist communicates, i.e., quarterly contacts with the consumer 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 ASA Specialist will schedule a home visit to ascertain whether a reassessment needs to be completed and/or changes to the Care Plan are warranted resulting in the Care Plan being 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 ASA 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 ASA 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 ASA 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 ASA 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 ASA 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 ASA 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. Critical Incident spreadsheets are submitted to the Home and Community-Based Services (HCBS) Program Manager following quarterly reviews conducted by the ASA Regional Supervisors. 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 ASA Regional Supervisor who works with the specific ASA 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Data Aggregation and Analysis:

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

Performance Measure:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%, +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

Data Aggregation and Analysis:

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

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

- 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 participant’s needs.*

Performance Measures

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

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

Performance Measure:

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:

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Aggregation and Analysis:

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

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

d. **Sub-assurance:** *Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

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

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

Performance Measure:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

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

Data Aggregation and Analysis:

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

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

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

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

Performance Measure:

Number and percent of consumers who are offered choice between waiver services and institutional care, choice of waiver services, and choice of providers.

Numerator = Number of consumers offered choice. Denominator = Number of consumers reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

The continuous quality improvement activities for the Care Plan sub-assurances are conducted primarily by the Division of Adult Services and Aging Regional Supervisors, Regional Managers and the Home and Community-Based Services (HCBS) Program Manager. The ASA 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 ASA 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 ASA 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 ASA Regional Supervisors to review consumer Care Plans remotely on their office computers. To ensure Performance Measures are being met, the ASA 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 ASA Regional Managers.

The HCBS Program Manager maintains and provides Excel Spreadsheets to the ASA Regional Supervisors and ASA 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 Work Group quarterly. The Waiver Work Group 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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Division of Adult Services and Aging 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 ASA 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 waiver services and/or providers, the ASA Specialist contacts the consumer by telephone or when warranted arranges a home visit to provide the consumer with a choice in waiver services and/or providers. 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 ASA 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 ASA 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 ASA 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 ASA 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 ASA 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 ASA Specialist is retrained on the Division of Adult Services and Aging policies and procedures including waiver processes and Care Plan development. Trends are identified to determine if individual ASA Specialists are consistently not following the Division's policies and procedures in the development of Care Plans, or if the problems are not ASA 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: ASA Director and Deputy Division Director, Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, Training Coordinator, Regional Managers, Regional Supervisors, and ASA 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.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
- Yes

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

Appendix E: Participant Direction of Services

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 individuals 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 Adult Services and Aging 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).

Types of critical events or incidents that the State requires to be reported for review and follow-up action by an appropriate authority:

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”.

Reporting of exploitation is not mandatory per South Dakota law; however, it 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, Adult Services and Aging (ASA) requires In Home waiver and Assisted Living providers to report all incidents involving serious injury, missing person, or death of waiver consumers to ASA.

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 ASA 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 ASA, specifically ASA Specialists, Supervisors are included in this group. These individuals must make an oral or written report within 24 hours to the Department of Social 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 all HCBS 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 Social 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 waiver providers are mandated to report any suspected abuse or neglect of a consumer. In home waiver providers are reminded of this requirement in the Supplemental Agreement which is signed by all in home providers each year. The Provider must immediately following receipt of information notify ASA of any consumer-related concerns, incidents and occurrences, including possible exploitation, that are not consistent with routine care. In addition, in home waiver providers must submit an incident report to the ASA Specialist documenting the circumstances of any incident that involves serious injury, missing person, or death.

The Department of Health provides reporting instructions to providers, including Assisted Living 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 Hour

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. From 483.13 (b)(c)

Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. From 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. From Administrative Rules of South Dakota (ARSD).

All Others per ARSD: 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.

When a Specialist receives a report of missing person, serious injury or death in an Assisted Living, the Specialist determines if the provider has reported the critical incident to the Department of Health. DSS is working with DOH to further improve and formalize the process for identifying trends and patterns of critical incidents to ensure the health and safety of the consumer.

- 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 ASA 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 ASA 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 Social 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 ASA 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 orally or in writing to the state's attorney of the county in which the elder or disabled adult resides or is present, to the Department of Social Services, or to the law enforcement (LE) officer. The state's attorney or LE officer, upon receiving a report, shall immediately notify DSS. The three entities work together to follow-up on reports, including reports received from the 9 SD reservations, to determine next steps. In DSS, the Specialist or Supervisor receives the reports.

The Medicaid Fraud Control Unit at the Office of the Attorney General investigates and prosecutes acts of abuse, neglect or exploitation perpetrated upon any resident in a health care facility that receives federal funding.

For Specialists, reports of abuse, neglect, and exploitation are addressed in a timely manner according to the nature of the report. Timeframes for initiating a face-to-face assessment and interview with the consumer are based on the severity and immediacy of the real or potential harm. The purpose of an assessment is to determine if the reported situation does exist and to what extent it adversely affects the alleged victim. Reported conditions fall into several general categories which drive the investigation protocol and timeframe:

A report of life or health threatening condition or criminal activity exists: suspected death of an alleged victim due to suspected abuse or neglect; report of physical abuse (fractures, burns, other injuries); report of domestic abuse; sexual abuse; report of an individual who is a danger to himself or others; threat of serious injury or death by a caretaker; threat of suicide; and report of need for immediate medical attention to prevent irreversible physical damage (unconsciousness, acute pain, severe respiratory distress). These situations require immediate action and immediate notification to a law enforcement agency. Collateral contacts and a face to face contact with the individual will be made within 24 hours of receipt of the report by the department, unless LE assumes total responsibility for investigation. If law enforcement assumes total responsibility for the investigation the Specialist will update the SAMS as a referral for other public services. The Specialist may accompany LE upon request. Reporters are also directed to call LE to report their concerns since they have first-hand knowledge of the situation. Regardless of the referring party's action, the Specialist reports to LE.

A report in which a life or health threatening condition does not exist: reports of medical noncompliance which does not include a life-threatening condition; report of inadequate attention to physical needs; report of intimidation by a caretaker; report of exploitation of resources, and report of serious, but not life threatening, self-neglect. In these situations, collateral contacts must be made within 72 hours of receipt of the referral and a face to face contact with the alleged victim must be made within 7 business days of receipt of the referral. If the result of collateral calls is a referral to other public services such as law enforcement, then a face to face visit is not necessary and a case will not be opened.

A report of abuse, neglect and exploitation perpetrated against an adult with developmental disabilities: ASA receives reports concerning individuals with developmental disabilities as the Adult Protection agency for the state. Many of these alleged victims are involved with supportive programs. 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 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 local law enforcement and will also follow up with law enforcement and the Department of Human Services to ensure the report was received.

A report involving licensed facilities: ASA may also receive reports concerning individuals who reside in facilities licensed by the Department of Health. Investigations of abuse, neglect, exploitation, or other critical incidents involving a facility licensed by the Department of Health are coordinated with a Department of Health 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.

A report of exploitation: Reporting of exploitation is not mandatory per South Dakota law; however, when a Specialist receive a report, he/she follows up as appropriate. 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 of receipt of the referral and a face to face contact with the alleged victim is made within 7 business days of receipt of the referral.

A face to face visit with the adult must be completed if an APS case is opened. The Specialist may make collateral contacts to obtain further information regarding the alleged abuse, neglect, exploitation, self-abuse or self-neglect. In most cases and especially when the adult's decision making is in question, the Specialist will complete a Mini-Mental Status Exam or contact the 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 Department policy, the Department 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 two visits at different times of the day 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 at any time during the course of the investigation 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. There are many different outcomes that can occur in an APS case. The ultimate goal is to protect the elder or adult with disabilities from any further abuse, neglect or exploitation.

Specialists receive notification of critical incidents, including death, missing person, and serious injury from a variety of sources including providers, family members, consumers, obituaries, etc. When a Specialist receives a report of death, missing person or serious injury for a consumer the information must be documented in SAMS.

ALCs are required to report incidents of death, missing person or serious injury of waiver consumers to the Department of Health's Office of Licensure and Certification within the timelines noted in G-1b. When a consumer chooses an ALC to receive services, a partnership between ASA and the ALC is developed to ensure the health, safety, and welfare of the individual. If a Specialist discovers a provider is not reporting incidents involving ASA consumers as required, he/she informs the provider of their responsibility to report such incidents. In the event a report is not made to ASA at the time of the critical incident, documentation and appropriate follow up is completed by the Specialist once the report is received.

Critical Incident/Death: When a Specialist receives a report of critical incident/death resulting from natural causes that occurred in an Assisted Living Center, 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 Assisted Living Center, the Specialist must determine if the death has been reported to DOH. If the death has not been reported to DOH, the Specialist must direct the provider to report the incident. This is to ensure DOH is aware of the death and appropriate protocol was followed.

When a Specialist learns that a consumer died in another setting, 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 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.

Critical Incident/Missing Person: When a Specialist receives a report of critical incident/missing person involving a consumer who lives in an ALC, the Specialist must determine if the incident has been reported to DOH. If the incident has not been reported to DOH, the Specialist directs the provider to report the incident. This is to ensure DOH is aware of incidents and appropriate protocols are being followed. Reports must be documented in SAMS and referred to the State Long Term Care Ombudsman.

The Specialist must follow up with law enforcement regarding the status of the missing person 48 hours after receiving the report and complete a "critical incident/follow-up" SAMS database journal note to document information received. If the individual is still missing after 48 hours, the Specialist must follow up with law enforcement one week from the date of the report. 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 must document this information in SAMS.

Critical Incident/Serious Injury: When a Specialist receives a report of critical incident/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, the Specialist must determine if the incident has been reported to DOH. If the

incident has not been reported to DOH, the Specialist directs the provider to report the incident. This is to ensure that DOH is aware of incidents and appropriate protocols are being followed. Reports must be documented in SAMS.

When a Specialist receives a report of critical incident/serious injury involving a consumer who lives in a home/apartment 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.

When a Specialist receives a report of critical incident/ missing person or serious injury and abuse and/or neglect is suspected, the Specialist must refer to APS 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 Social Services' Division of Adult Services and Aging (ASA) 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 ASA Regional Offices as they conduct investigations and coordinate with law enforcement.

A Critical Incident Review Team (CIRT) consisting of Division of Adult Services and Aging 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 and serious injury that occurred the previous month were responded to according to Critical Incident Reporting and Adult Protective Services Policies. Reports created from SAMS and Ombudsmanager 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 complete the required follow up and/or document the follow up 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 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. 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 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 by the State or Local Long-Term Care Ombudsmen, the Ombudsman documents the report in the Ombudsmanager database and makes a referral to the Office of

Health Facilities Licensure & Certification. 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, providing training on resident rights to residents and Assisted Living Center staff. The South Dakota Long Term Care Ombudsman Policy specifies that Assisted Living Centers will be visited at a minimum on a quarterly basis.

The Division of Adult Services and Aging 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 ASA 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 ASA 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). Also during the initial home visit and at least annually thereafter ASA 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 ASA 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, ASA 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 ASA 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 ASA Specialist will follow the Adult Protective Services Policy. Additionally the ASA 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. The Office of Health Facilities Licensure & Certification receives information about the unauthorized use of restrictive interventions through complaints. The Office of Health Facilities Licensure & Certification conducts on-site reviews at Assisted Living Centers and through these unannounced surveys and on-site record reviews identify incidents of unauthorized use of restrictive interventions. Surveyors may make unannounced visits and on-site record reviews in follow up to complaints received. Also, when reports are received by the State or Local Long-Term Care Ombudsmen, the Ombudsman documents the report in the Ombudsmanager database and makes a referral to the Office of Health Facilities Licensure & Certification. The Ombudsman and the Office of Health Facilities Licensure & Certification staff collaborate to follow-up on unauthorized use of restrictive interventions to ensure residents' rights are being protected. The State and Local Long-Term Care Ombudsmen regularly visit Assisted Living Centers, providing training on resident rights to residents and Assisted Living Center staff. The South Dakota Long Term Care Ombudsman Policy specifies that Assisted Living Centers will be visited at a minimum on a quarterly basis.

The Division of Adult Services and Aging is responsible for detecting the unauthorized use of restrictive interventions including, but not limited to restricting a consumer's rights, access to others or activities, restraints, restriction of movement, seclusion, in a consumer's home. The use of restrictive interventions in the home setting is uncommon, however the ASA 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 the consumer's home. At the six month review the ASA 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). During the initial home visit and at least annually thereafter the Community Health Assessment (CHA) is completed for each consumer.

The ASA 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 ASA Specialist will follow the Adult Protective Services Policy. Additionally the ASA 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 seclusion in Assisted Living Centers. The Office of Health Facilities Licensure & Certification receives information about the unauthorized use of seclusion through complaints. The Office of Health Facilities Licensure & Certification conducts on-site reviews at Assisted Living Centers and through these unannounced surveys and on-site record reviews will identify incidents of unauthorized use of seclusion. Surveyors may make unannounced on-site visits and record reviews in follow up to complaints received. Also, when reports are received by the State or Local Long-Term Care Ombudsman, the Ombudsman documents the report in the Ombudsmanager database and makes a referral to the Office of Health Facilities Licensure & Certification. The Ombudsman and the Office of Health Facilities Licensure & Certification staff collaborate to follow-up on unauthorized use of seclusion to ensure residents' rights are being protected. The State and Local Long-Term Care Ombudsmen regularly visit Assisted Living Centers, providing training on resident rights to residents and Assisted Living Center staff. The South Dakota Long Term Care Ombudsman Policy specifies that Assisted Living Centers will be visited at a minimum on a quarterly basis.

The Division of Adult Services and Aging 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 ASA 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 ASA 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 ASA Specialist will follow the Adult Protective Services Policy. Additionally the ASA 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.

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. 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 or registered pharmacist 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. Unlicensed staff must also receive ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the Assisted Living Center. Assisted Livings that admit or retain a resident with cognitive impairment must have the resident's physician, physician assistant, or nurse practitioner determine and document if services offered by the facility continue to enhance the resident's functioning in activities of daily living and identify if other disabilities and illnesses are impacting the resident's cognitive and mental functioning. The Assisted Living Center is required to be approved for medication administration by the Department of Health (DOH). Each Assisted Living Center staff member is required to attend specific in-service training within one month after employment.

Assisted Living Centers 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 disposition 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.

In an 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 resident's ability to self-administer medications.

- 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.

Surveys of Assisted Living Centers, licensed facilities, are completed by the Department of Health, Office of Health Facilities Licensure & Certification. Surveys are conducted for state licensure per South Dakota Codified Law (SDCL) 34-12-13 and Administrative Rules of South Dakota (ARSD) 44:04.

According to Administrative Rules of South Dakota (ARSD) 44:70:04:15, each Assisted Living Center provides for on-going evaluation of the quality of services provided to residents. Components of the quality assessment evaluation includes establishment of Assisted Living Center standards; review of resident services to identify deviations from the standards and actions taken to correct deviations; resident satisfaction surveys; utilization of services provided; and documentation of the evaluation and report to the governing body that is legally responsible for the overall conduct of the Assisted Living Center. Additionally, unannounced surveys are conducted by the Department of Health consisting of a team of one to three surveyors, dependent on the Assisted Living Center's history and size. The survey team includes one registered nurse to identify potential residents over level of care. Other team members include a generalist, a sanitarian, and/or an engineer.

PRE-SURVEY PREPARATION

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); 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 prior to entering.

SURVEY PROCEDURES

An Entrance Conference is held by the DOH survey team with the Assisted Living Center(s) 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 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 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 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 disposition 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 describing how the requirements and findings are not in compliance and technical assistance is provided to the Assisted Living as needed.

Assisted Living Centers are surveyed more than once each year if warranted by the identification of potentially harmful medication administration practices through reports or if there is an ongoing investigation. The Office of Health Facilities Licensure & Certification also requests Assisted Living Centers provide documentation as needed.

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).

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 (assisted living centers). As noted in the Medication Management and Follow-Up section of Appendix G-3 the following Department of Health Administrative Rules apply to Assisted Living Centers for monitoring self-administration of medication and medication administration by non-medical providers.

Per Administrative Rules of South Dakota (ARSD) 44:70:07:07, if any 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 per ARSD 44:70:04:14(3), the Assisted Living Center 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 Assisted Living Center and relevant to the residents receiving the medication. If any resident is permitted to self-administer medications, the Assisted Living Center'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 Assisted Living Center's staff. The Assisted Living Center must also follow procedures to provide written educational materials to the resident and the resident's family explaining the resident's rights and responsibilities associated with medication self-administration.

In an Assisted Living Center approved for medication administration, a resident may self-administer drugs if the registered nurse (if applicable) and physician, physician assistant, 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 resident's ability to self-administer medications. Additionally, in an Assisted Living Center 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 Assisted Living Center to establish and practice methods and procedures for medication control that include the following: 1) A requirement of the Assisted Living Center 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 Assisted Living Center 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 Assisted Living Center 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 Assisted Living Center 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.

In-home nursing services must be performed by a registered nurse or a licensed practical nurse 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 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.

According to ARSD 20:48:04.01:01, the Registered Nurse is responsible for the nature and quality of nursing care that a resident of an Assisted Living Center and a consumer living at home receives under the nurse's direction. To achieve full utilization of the services of a registered nurse or a licensed practical nurse, 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.

Per 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 registered nurse 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.

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:

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.

In-home providers 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 Adult Services and Aging 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 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.

The Department of Social Services, Division of Adult Services and Aging conducts an on-site review for each in-home provider prior to initial enrollment and annually thereafter. On-site reviews are performed by ASA Regional Supervisors and Regional Managers, or the HCBS Program Manager 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 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 Department of Health Office of Health Care Facilities Licensure & Certification (OLC) has oversight responsibility for monitoring the performance of waiver providers in the administration of medications to waiver consumers residing in Assisted Living Centers. Monitoring is conducted through on-site, unscheduled surveys. Additionally, the OLC 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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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, off-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%, +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

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:

Database generated list of abuse, neglect and exploitation investigations

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of critical incidents where appropriate follow-up occurred.
Numerator = Number of critical incidents 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):
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

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

Data Aggregation and Analysis:

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

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

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 receive educational information regarding preventative health care. Numerator = Number of consumers who received preventative health care information. Denominator = Number of consumers reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

		Confidence Interval = 95%, +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants receiving age appropriate preventative health care. Numerator = Number of consumers that received 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):
	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%, +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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 Adult Services and Aging (ASA) Regional Supervisors during quarterly Care Plan reviews using

the same random sample utilized for the Care Plan assurances. Following the conclusion of the quarter, each ASA 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. All Care Plans are stored electronically in the State of South Dakota's FileDirector system, a digital document reviewing program, which allows the ASA Regional Supervisors to review consumer Care Plans remotely on their office computers.

Abuse, neglect and exploitation reports made to the Division of Adult Services and Aging on behalf of elders and adults with disabilities are assigned to an ASA Specialist. The ASA Specialist follows the policies and procedures for investigating reports and documenting all pertinent information in the Social Assistance Management System (SAMS) consumer database and in Ombudsmanager for Assisted Living Centers. The Critical Incident Review Team (CIRT) reviews all Adult Protective Services (APS) cases involving waiver consumers on a monthly basis to ensure cases were initiated according to timeframes specified in policy. Data for APS cases involving waiver consumers is collected from a report generated from the Social Assistance Management System (SAMS).

The data reviewed to ensure waiver consumers receive educational information regarding abuse, neglect and exploitation is contained on the consumer Care Plans. This performance measure is reviewed quarterly by the ASA Regional Supervisors as part of Care Plan Reviews utilizing the Care Plan assurances random sample.

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

During the quarterly review of Care Plans, Regional Supervisors also 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 the incidents of abuse, neglect and exploitation were followed up according to the Adult Protective Services (APS) Policy.

The data for critical incidents regarding waiver consumers is collected from a report generated from the Social Assistance Management System (SAMS). The report, along with 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 collected from responses provided by waiver consumers on the Quality of Life Survey. Responses are reviewed each month by the Critical Incident Review Team (CIRT) and any reports of restraint and seclusion become an APS case opened for investigation. Responses are collected, compiled, and analyzed for trends.

Data to ensure waiver consumers receive educational information regarding preventative health care is contained in the consumer Care Plans. This performance measure is reviewed on a quarterly basis and is reviewed by the ASA Regional Supervisors during quarterly Care Plan reviews using the same random sample utilized for Care Plan assurances.

To determine if waiver consumers have received appropriate preventative health care, Regional Supervisors utilize the same random sample utilized to complete Care Plan reviews. Specifically, the Community Health Assessment, which has several questions involving appropriate preventative health care the consumer received, is reviewed. ASA Regional Supervisors review the answers to these questions to determine if age appropriate preventative health care has been received by the consumer.

For performance measures reviewed along with the Care Plan on a quarterly basis, the HCBS Program Manager provides an Excel Spreadsheet to the ASA Regional Supervisors to identify which consumers to review. ASA Regional Supervisors record the results of each performance measure on the spreadsheet and forwards it to the HCBS Program Manager once the reviews are complete. 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 other ASA State

Office Program Specialists.

For the performance measures reviewed by the Critical Incident Review Team, reports are pulled and reviewed each month and results of the review are recorded on Excel Spreadsheets. This process notates which Performance Measures were met for each occurrence of abuse, neglect, exploitation, complaint restraint and seclusion and critical incident and which require remediation. Those requiring remediation are forwarded to the ASA Regional Supervisors to work with the ASA Specialists to remediate and ensure the health and welfare of waiver 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 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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

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 ASA 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 ASA Specialists not conducting follow up when signs of abuse, neglect and exploitation are identified, the ASA 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 ASA 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 ASA 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 ASA 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 ASA Specialist and the ASA Regional Supervisor review the process and determine what prevented the incident from being addressed appropriately. If additional follow-up is needed, it is conducted

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 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 ASA 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 ASA 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 ASA Regional Supervisors who then work with ASA 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 ASA Specialist is not following procedures, the ASA 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.

Quarterly Webinars are held to inform and educate ASA Specialists by reviewing recommendations for improvements. Recommendations are reviewed in detail with ASA Specialists who are provided an opportunity to ask questions during the Webinar. ASA Specialists can also access the recorded Webinar presentations on the Department of Social Services Intranet.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
 Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services

that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

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 Adult Services and Aging Director and Deputy Division Director, ASA Nurse Consultant Program Manager, Social Assistance Management System (SAMS) Program Manager, ASA Training Coordinator, ASA Regional Managers, two ASA Regional Supervisors, and two ASA 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 ASA Specialists, ASA Regional Supervisors, ASA Regional Managers, and State Office Program staff as needed. Guidance and training will be provided following each quarterly Waiver Review Committee meeting to Division of Adult Services and Aging 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 ASA staff.

If, over time, a trend is identified where an individual or a group of ASA 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 ASA 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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

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 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. 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.

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 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 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 Adult Services and Aging. 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%.

Finally, when the Home and Community-Based Services Program Manager, Regional Managers or Regional Office Supervisors conduct the annual on-site review 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Aggregation and Analysis:

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

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

b. **Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

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

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

Performance Measure:

Number and percent of provider payment rates that are consistent with the rate methodology approved in the waiver application. Numerator = Number of payment rates consistent with the rate methodology approved in the waiver application. Denominator = Number of payment rates 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

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

Data Aggregation and Analysis:

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

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

Data for the performance measures in the Financial Accountability assurance is obtained through quarterly reports generated from the Medicaid Management Information System (MMIS). The HCBS Manager reviews a random sample of claims paid with waiver funds to ensure paid waiver claims are for consumers enrolled in the waiver on the date the service is delivered, the service incurred is an approved waiver service and the payment rates are consistent with the rate methodology approved in the waiver application. The universe is all claims paid with waiver funds. The number of waiver claims for the quarter is entered into the Raosoft sample calculator to determine the sample size. The data is tracked in Excel spreadsheets.

b. Methods for Remediation/Fixing Individual Problems

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

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 a Department of Social Services (DSS) Adult Services and Aging Specialist

incorrectly authorized services, the Adult Services and Aging 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.

ii. Remediation Data Aggregation

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

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

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 services, nursing, adult day services, meals, and assisted living are prospective rates modeled using historical costs as the basis. Cost report information is submitted annually to assess the adequacy of payment models implemented.

The Department of Social Services (DSS) utilizes stakeholder workgroups to develop rate-setting methodologies. The workgroups both informal and formal include representation from providers and agencies, fiscal, program and service delivery. The workgroup process supports a comprehensive and 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 and final legislative appropriation.

DSS 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 and corresponding revenue. Aggregation and analysis of data submitted in cost reports by providers from across the state, allows DSS to ensure rates are reflective of the actual cost of service provision.

Provider reimbursement rates are available to the public online at <http://dss.sd.gov/asa/>.

The information below includes specific information regarding each service, the rate methodology, entities responsible for rate setting, opportunities for public comment, and frequency of rate updates.

Rate Determination Methods by Service (Appendix I-2a)

1)Homemaker, Personal Care, Respite, Adult Companion, Chore Services

a)Methods employed to establish provider payment rates

i)Utilizing stakeholder input, the rate methodology that established a prospective rate based on historical cost is developed. The rate model includes cost components including salary and benefits and operating costs.

ii)Cost reports are submitted by providers on an annual basis so the cost of providing the service can be analyzed and compared to modeled rate. If the rate is sufficient according to the cost reports, the proposed rate for the upcoming fiscal year in an increase based on inflation. If cost reports show that the cost of providing the service exceeds the modeled rate, the information is used to develop the budget for the following fiscal year.

iii)Rate is tiered based on whether or not provider offers health care coverage for direct service employees.

b)Entities responsible for rate determination

i)DSS Division of Adult Services and Aging (ASA), DSS Office of Provider Reimbursement and Audits

c)Opportunity for public comments

i)Rate methodologies are developed in collaboration with providers and associations with representation from provider groups including the Assisted Living Association of South Dakota, the South Dakota Association of Healthcare Organizations, and the South Dakota Health Care Association.

ii)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 and testify in support of or opposition of the proposed budget changes each year. Additionally, any proposed changes to the Administrative Rules of South Dakota are approved by the legislative hearing process and subject to public input and testimony.

iii)There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Wavier Renewal.

d)Frequency of rate updates

i)Evaluated annually. Last rate update in 2016.

2)Nursing Services and Adult Day Services

a)Methods that are employed to establish provider payment rates

i)Utilizing stakeholder input, the rate methodology that established a prospective rate based on historical cost is developed. The rate model includes cost components including salary and benefits and operating costs.

ii)Cost reports are submitted by providers on an annual basis so the cost of providing the service can be analyzed and compared to modeled rate. If the rate is sufficient according to the cost reports, the proposed rate for the upcoming fiscal year in an increase based on inflation. If cost reports show that the cost of providing the service exceeds the modeled rate, the information is used to develop the budget for the following fiscal year.

b)Entities responsible for rate determination

i)DSS ASA, DSS Office of Provider Reimbursement and Audits (OPRA)

c)Opportunity for public comments

i)Rate methodologies are developed in collaboration with providers and associations with representation from provider groups including the Assisted Living Association of SD, the SD Association of Healthcare Organizations, and the SD Health Care Association.

ii)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 and testify in support of or opposition of the proposed budget changes each year. Additionally, any proposed changes to the Administrative Rules of SD are approved by the legislative hearing process and subject to public input and testimony.

iii) There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Waiver Renewal.

d) Frequency of rate updates

i) Evaluated annually. Last rate update in 2016.

3) Medical Equipment and Medical Supplies

a) Methods that are employed to establish provider payment rates

i) When the State Plan has been exhausted, the rate of payment for ASA Medical Equipment is limited to the lesser of the provider's usual and customary fee or the fee contained on the department's website located at <http://dss.sd.gov/medicaid/providers/feeschedules/dss/>.

b) Entities responsible for rate determination

i) ASA and Medical Services

c) Opportunity for public comments

i) There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Waiver Renewal.

d) Frequency of rate updates

i) Evaluated annually. Last rate update in 2016.

4) Emergency Response System

a) Methods that are employed to establish provider payment rates

i) Provider bills usual and customary charge.

b) Entities responsible for rate determination

i) DSS ASA

c) Opportunity for public comments

i) There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Waiver Renewal.

d) Frequency of rate updates

i) Evaluated annually. Last rate update in 2015. Evaluated as needed based on providers usual and customary provider rate increases.

5) Meals

a) Methods that are employed to establish provider payment rates

i) Cost reports are submitted by providers on an annual basis. This information is utilized to determine if rate adjustments are necessary. In collaboration with providers, DSS is transitioning to a more standardized approach.

b) Entities responsible for rate determination

i) ASA and DSS OPRA.

c) Opportunity for public comments

i) Rate methodologies are developed in collaboration with providers and associations with representation from provider groups including the Assisted Living Association of SD, the SD Association of Healthcare Organizations, and the SD Health Care Association.

ii) 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 and testify in support of or opposition of the proposed budget changes each year. Additionally, any proposed changes to the Administrative Rules of SD are approved by the legislative hearing process and subject to public input and testimony.

iii) There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Waiver Renewal.

d) Frequency of rate updates

i) Evaluated annually. Last rate update in 2016.

6) Nutritional Supplements

- a)Methods that are employed to establish provider payment rates
 - i)Provider bills usual and customary charge.
- b)Entities responsible for rate determination
 - i)ASA and Medical Services
- c)Opportunity for public comments
 - i)There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Wavier Renewal.
- d)Frequency of rate updates
 - i)Evaluated annually. Last rate update in 2016.

7)Environmental Accessibility Adaptations

- a)Methods that are employed to establish provider payment rates
 - i)Provider bills usual and customary charge.
- b)Entities responsible for rate determination
 - i)ASA
- c)Opportunity for public comments
 - i)There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Wavier Renewal.
- d)Frequency of rate updates
 - i)Evaluated as needed based on provider feedback.

8)Assisted Living

- a)Methods that are employed to establish provider payment rates
 - i)Cost reports are submitted by providers on an annual basis so the cost of providing the service can be analyzed and compared to the modeled rate. If the rate is sufficient according to cost reports, the proposed rate for the upcoming fiscal year is an increase based on inflation. If cost reports show that the cost of providing the service exceeds the modeled rate, the information is used to develop the budget for the following fiscal year.
- b)Entities responsible for rate determination
 - i)ASA and DSS Office of Provider Reimbursement and Audits.
- c)Opportunity for public comments
 - i)Rate methodologies are developed in collaboration with providers and associations with representation from provider groups including the Assisted Living Association of South Dakota, the South Dakota Association of Healthcare Organizations, and the South Dakota Health Care Association.
 - ii)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 and testify in support of or opposition of the proposed budget changes each year. Additionally, any proposed changes to the Administrative Rules of SD are approved by the legislative hearing process and subject to public input and testimony.
 - iii)There are opportunities for public comment during the Waiver Application Renewal process including meetings of the Tribal Consultation, Medicaid Advisory Council, and Advisory Council on Aging as well as communication with providers, stakeholders and consumers regarding the Wavier Renewal.
- d)Frequency of rate updates
 - i)Evaluated annually. Last rate update in 2016.

- 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. The report pulls a sample of waiver claims which are then 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 Adult Services and Aging 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. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (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.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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

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

Appendix I: Financial Accountability

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

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

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

Check each that applies:

- Appropriation of Local Government Revenues.**

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

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

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

Appendix I: Financial Accountability

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

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

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**
Check each that applies:
- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

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

Appendix I: Financial Accountability

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

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

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

The methodology used by the Department of Social Services (DSS) Office of Provider Reimbursement and Audits to set reimbursement rates for Assisted Living clearly establishes the delineation between Assisted Living 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 to that the rate methodology for services does not include these costs.

When a consumer is evaluated by the DSS Division of Economic Assistance for financial eligibility for Assisted Living under the waiver, a needs allowance of the standard SSI benefit plus \$20 is deducted from their income. The needs allowance is to be used by the consumer to cover the cost of room and board in the Assisted Living.

The Department of Social Services issues an annual letter to qualified providers of Assisted Living on behalf of each waiver consumers. The letter clearly separates the services that will be reimbursed through the Waiver and the amount of money the Assisted Living must collect directly from the consumer for room and board.

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	7780.09	6485.87	14265.96	29737.22	9588.80	39326.02	25060.06
2	8371.88	6998.25	15370.13	30896.97	10461.38	41358.35	25988.22
3	8437.38	7551.11	15988.49	32101.95	11413.37	43515.32	27526.83
4	8705.90	8147.65	16853.55	33353.93	12451.99	45805.92	28952.37
5	8978.18	8791.32	17769.50	34654.73	13585.12	48239.85	30470.35

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	1776		1776
Year 2	1834		1834
Year 3	1895		1895
Year 4	1957		1957
Year 5	2022		2022

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 for these estimates is as follows:

Factor D was projected by utilizing data from the 372 lag reports for FY11, FY12, FY13 and FY14 for unduplicated recipients, average units, and average expenditures. The initial projections were compared to currently budgeted expenditures and adjusted as necessary. The historical average growth was applied to determine unduplicated recipients for each waiver year. Average cost was adjusted for anticipated inflationary increases.

- 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 FY11, FY12, FY13 and FY14 were used to identify historical expenditures. The average increase (7.9%) was applied to each year of this waiver.

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

372 lag reports for FY11, FY12, FY13 and FY14 were used to identify historical expenditures. The average increase (3.9%) was applied to each year of this waiver.

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

372 lag reports for FY11, FY12, FY13 and FY14 were used to identify historical expenditures. The average increase (9.1%) was applied to each year of this waiver.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Services	
Homemaker	
Personal Care	
Respite Care	
Specialized Medical Equipment	
Specialized Medical Supplies	
Adult Companion Services	
Assisted Living	
Chore Services	
Emergency Response System (ERS)	
Environmental Accessibility Adaptations	
In-Home Nursing Services	
Meals	
Nutritional Supplements	

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	
Homemaker Total:						1037548.08
Homemaker	1 hour	522	79.00	25.16	1037548.08	
Personal Care Total:						603236.16
Personal Care	1 hour	444	54.00	25.16	603236.16	
Respite Care Total:						
GRAND TOTAL:						13817434.00
Total Estimated Unduplicated Participants:						1776
Factor D (Divide total by number of participants):						7780.09
Average Length of Stay on the Waiver:						274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						831110.28
Respite Care	1 hour	77	429.00	25.16	831110.28	
Specialized Medical Equipment Total:						256206.48
Specialized Medical Equipment	each	237	8.00	135.13	256206.48	
Specialized Medical Supplies Total:						689661.00
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:						9185420.92
Assisted Living	1 day	1118	273.50	30.04	9185420.92	
Chore Services Total:						77291.52
Chore Services	1 hour	64	48.00	25.16	77291.52	
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	
In-Home Nursing Services Total:						666624.00
In-Home Nursing Services	1 hour	420	32.00	49.60	666624.00	
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	
GRAND TOTAL:						13817434.00
Total Estimated Unduplicated Participants:						1776
Factor D (Divide total by number of participants):						7780.09
Average Length of Stay on the Waiver:						274

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:						39241.61
Adult Day Services	1 hour	13	524.06	5.76	39241.61	
Homemaker Total:						1108809.24
Homemaker	1 hour	539	79.00	26.04	1108809.24	
Personal Care Total:						645427.44
Personal Care	each	459	54.00	26.04	645427.44	
Respite Care Total:						893692.80
Respite Care	1 hour	80	429.00	26.04	893692.80	
Specialized Medical Equipment Total:						463402.16
Specialized Medical Equipment	each	299	8.00	193.73	463402.16	
Specialized Medical Supplies Total:						712047.00
Specialized Medical Supplies	1 month	827	12.00	71.75	712047.00	
Adult Companion Services Total:						131111.40
Adult Companion Services	1 hour	53	95.00	26.04	131111.40	
Assisted Living Total:						10146467.10
Assisted Living	1 day	1155	273.50	32.12	10146467.10	
Chore Services Total:						159989.76
Chore Services	1 hour	128	48.00	26.04	159989.76	
Emergency Response System (ERS) Total:						70560.00
Emergency Response System (ERS)	1 month	245	9.00	32.00	70560.00	
Environmental Accessibility Adaptations Total:						68000.00
Environmental Accessibility Adaptations	each	17	1.00	4000.00	68000.00	
GRAND TOTAL:						15354026.85
Total Estimated Unduplicated Participants:						1834
Factor D (Divide total by number of participants):						8371.88
Average Length of Stay on the Waiver:						274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Nursing Services Total:						723287.04
In-Home Nursing Services	1 hour	434	32.00	52.08	723287.04	
Meals Total:						112538.85
Meals	each	123	145.00	6.31	112538.85	
Nutritional Supplements Total:						79452.45
Nutritional Supplements	each	99	114.65	7.00	79452.45	
GRAND TOTAL:						15354026.85
Total Estimated Unduplicated Participants:						1834
Factor D (Divide total by number of participants):						8371.88
Average Length of Stay on the Waiver:						274

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:						40604.17
Adult Day Services	1 hour	13	524.06	5.96	40604.17	
Homemaker Total:						1184560.76
Homemaker	1 hour	557	79.00	26.92	1184560.76	
Personal Care Total:						689044.32
Personal Care	1 hour	474	54.00	26.92	689044.32	
Respite Care Total:						958540.44
Respite Care	1 hour	83	429.00	26.92	958540.44	
Specialized Medical Equipment Total:						478900.56
Specialized Medical Equipment	each				478900.56	
GRAND TOTAL:						15988829.38
Total Estimated Unduplicated Participants:						1895
Factor D (Divide total by number of participants):						8437.38
Average Length of Stay on the Waiver:						274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		309	8.00	193.73		
Specialized Medical Supplies Total:						735294.00
Specialized Medical Supplies	1 month	854	12.00	71.75	735294.00	
Adult Companion Services Total:						140657.00
Adult Companion Services	1 hour	55	95.00	26.92	140657.00	
Assisted Living Total:						10466691.84
Assisted Living	1 day	1152	273.50	33.22	10466691.84	
Chore Services Total:						170565.12
Chore Services	1 hour	132	48.00	26.92	170565.12	
Emergency Response System (ERS) Total:						72864.00
Emergency Response System (ERS)	1 month	253	9.00	32.00	72864.00	
Environmental Accessibility Adaptations Total:						76000.00
Environmental Accessibility Adaptations	each	19	1.00	4000.00	76000.00	
In-Home Nursing Services Total:						772997.12
In-Home Nursing Services	1 hour	448	32.00	53.92	772997.12	
Meals Total:						120249.95
Meals	each	127	145.00	6.53	120249.95	
Nutritional Supplements Total:						81860.10
Nutritional Supplements	each	102	114.65	7.00	81860.10	
GRAND TOTAL:						1598829.38
Total Estimated Unduplicated Participants:						1895
Factor D (Divide total by number of participants):						8437.38
Average Length of Stay on the Waiver:						274

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:						41966.72
Adult Day Services	1 hour	13	524.06	6.16	41966.72	
Homemaker Total:						1264632.00
Homemaker	1 hour	575	79.00	27.84	1264632.00	
Personal Care Total:						736646.40
Personal Care	1 hour	490	54.00	27.84	736646.40	
Respite Care Total:						1027128.96
Respite Care	1 hour	86	429.00	27.84	1027128.96	
Specialized Medical Equipment Total:						494398.96
Specialized Medical Equipment	each	319	8.00	193.73	494398.96	
Specialized Medical Supplies Total:						759402.00
Specialized Medical Supplies	1 month	882	12.00	71.75	759402.00	
Adult Companion Services Total:						150753.60
Adult Companion Services	1 hour	57	95.00	27.84	150753.60	
Assisted Living Total:						11182977.40
Assisted Living	1 day	1190	273.50	34.36	11182977.40	
Chore Services Total:						181739.52
Chore Services	1 hour	136	48.00	27.84	181739.52	
Emergency Response System (ERS) Total:						75168.00
Emergency Response System (ERS)	1 month	261	9.00	32.00	75168.00	
Environmental Accessibility Adaptations Total:						84000.00
Environmental Accessibility Adaptations	each	21	1.00	4000.00	84000.00	
In-Home Nursing Services Total:						826140.16
In-Home Nursing Services	1 hour	463	32.00	55.76	826140.16	
Meals Total:						128216.25
GRAND TOTAL:						17037437.72
Total Estimated Unduplicated Participants:						1957
Factor D (Divide total by number of participants):						8705.90
Average Length of Stay on the Waiver:						274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals	each	131	145.00	6.75	128216.25	
Nutritional Supplements Total:						84267.75
Nutritional Supplements	each	105	114.65	7.00	84267.75	
GRAND TOTAL:					17037437.72	
Total Estimated Unduplicated Participants:					1957	
Factor D (Divide total by number of participants):					8705.90	
Average Length of Stay on the Waiver:						274

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						43329.28
Adult Day Services	1 hour	13	524.06	6.36	43329.28	
Homemaker Total:						1351468.80
Homemaker	1 hour	594	79.00	28.80	1351468.80	
Personal Care Total:						786931.20
Personal Care	1 hour	506	54.00	28.80	786931.20	
Respite Care Total:						1099612.80
Respite Care	1 hour	89	429.00	28.80	1099612.80	
Specialized Medical Equipment Total:						509897.36
Specialized Medical Equipment	each	329	8.00	193.73	509897.36	
Specialized Medical Supplies Total:						784371.00
Specialized Medical Supplies	1 month	911	12.00	71.75	784371.00	
Adult Companion Services Total:						161424.00
GRAND TOTAL:					18153871.89	
Total Estimated Unduplicated Participants:					2022	
Factor D (Divide total by number of participants):					8978.18	
Average Length of Stay on the Waiver:						274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Companion Services	1 hour	59	95.00	28.80	161424.00	
Assisted Living Total:						11946113.51
Assisted Living	1 day	1229	273.50	35.54	11946113.51	
Chore Services Total:						193536.00
Chore Services	1 hour	140	48.00	28.80	193536.00	
Emergency Response System (ERS) Total:						77760.00
Emergency Response System (ERS)	1 month	270	9.00	32.00	77760.00	
Environmental Accessibility Adaptations Total:						92000.00
Environmental Accessibility Adaptations	each	23	1.00	4000.00	92000.00	
In-Home Nursing Services Total:						884119.04
In-Home Nursing Services	1 hour	479	32.00	57.68	884119.04	
Meals Total:						136633.50
Meals	each	135	145.00	6.98	136633.50	
Nutritional Supplements Total:						86675.40
Nutritional Supplements	each	108	114.65	7.00	86675.40	
GRAND TOTAL:					18153871.89	
Total Estimated Unduplicated Participants:					2022	
Factor D (Divide total by number of participants):					8978.18	
Average Length of Stay on the Waiver:						274