



**CHOICES WAIVER AMENDMENT
CONFLICT-FREE CASE MANAGEMENT
JANUARY 26, 2016**

Appendix C

C-1 a: Waiver Definition

Case Management services require the facilitation and development of a comprehensive person-centered individualized support plan (ISP) written by the case manager and reviewed/approved by the state. Case management includes the ongoing monitoring of the participant's provision of services, health and welfare. Case management assists people in gaining access to necessary services including, but not limited to, State Plan services, educational, employment, social, medical, individual budget or other services. The case manager will help people in obtaining needed services with an emphasis on non-paid natural supports. Case managers initiate a comprehensive assessment and periodic reassessment of individual needs to develop, revise and update the participant's ISP as well as advocate on behalf of the participant in all respects including but not limited to individual choice and independence. Case management includes assistance in accessing supports to transition from an institutional setting, the family home or from one provider to another. Case management includes the development of a 24-hour individual back-up plan with paid and natural supports. The case manager will observe and monitor the implementation of the ISP at least quarterly, and the plan will be reviewed by the entire ISP team at least annually or more frequently as requested by the participant or as circumstances dictate. Providers of direct-support HCBS for the individual, or those who have an interest in or are employed by a provider of direct-support HCBS for the individual, shall not provide case management or develop the person-centered service plan.

C-2 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:

Pursuant to ARSD Article 67:54, to participate in the delivery of HCBS, providers shall be approved by DHS according to ARSD Article 46:11. Providers shall have a signed provider agreement with DHS and DSS. These agreements must be renewed annually.

Pursuant to ARSD Article 67:54, to receive reimbursement for covered medical services which are medically necessary and which are provided to eligible recipients, a provider must have a provider agreement with DSS. The agreement must be signed by the individual who is requesting to become a participating provider or by an agent of the facility or corporation that is requesting to become a participating provider and approved and signed by DSS. Only those individuals or facilities which meet licensure and certification requirements listed in this article may be participating providers.

A qualified provider of CHOICES waiver services is defined in SDCL 27B-1-17(3) Community Services Provider (SP) and 27B-1-17(4) Community Supports Provider (CSP). CSPs must be nonprofit corporations incorporated according to SDCL chapters 47-22 to 47-28, inclusive. CSPs must meet the definition for tax exemption status according to § 501(c)(3) of Title 26 of the Internal Revenue Code, October 22, 1986, as in effect on December 20, 1995. SPs may be non-profit or for profit organizations. The requirements for certification of CSPs and SPs are contained in ARSD Article 46:11.

Agencies seeking to become qualified providers of CHOICES waiver services may contact the Division of Developmental Disabilities to inquire about provider enrollment and receive instructions regarding the enrollment process. Additionally, the information governing provider enrollment is readily available on the DHS/DDD website.

Appendix D

D-1 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:

~~Qualified providers shall initially and annually provide a statement to the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any, of full disclosure of the potential conflict of interest that exists due to the qualified provider furnishing other direct waiver services and service plan development.~~

~~Qualified providers~~ Case managers shall initially and annually provide the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any, a list of all qualified providers and a list of the full range of waiver services furnished by all qualified providers in the State.

~~The qualified provider~~ case manager shall provide support to each participant who desires to develop their own plan or choose the individual of their choice to develop their plan. ~~If the service coordinator is responsible for any direct implementation of the participant's plan, another service coordinator or qualified provider staff member shall conduct monitoring of those services provided directly to the participant by the participant's service coordinator.~~

The DHS/DDD conducts a review of a representative random sample of participant files to evaluate each of the above requirements.

D-1 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):

The ~~service coordinator~~ case manager is responsible for ISP development. The DHS/DDD allows for the use of a provisional service plan, as described in Appendix B, to get services initiated until a more detailed service plan can be finalized. The ~~service coordinator~~ case manager and participant must identify an ISP development team within fifteen calendar days of initiation of services. The team must include the participant and the participant's ~~service coordinator~~ case manager, and the following individuals shall have the opportunity to participate in the development of the service plan: the participant's parent if the participant is under 18 years of age, the participant's guardian or conservator if any, and any other individual desired by the participant. The ~~service coordinator~~ case manager, the participant and the participant's team develop the ISP within thirty days of initiation of services. The ISP is implemented within forty-five days of initiation of services. The ISP team must meet at least annually to review the ISP; however the participant or any other member of the team may request an ISP team meeting at any time or as the participant's needs change. All ISP team meetings shall be scheduled and conducted in a manner which facilitates the active participation of all ISP team members, especially the participant and the family, guardian, conservator, adult foster care provider, or advocate. The ~~service coordinator~~ case manager shall encourage the participant to choose the location of the meetings and shall document if the participant is unable or unwilling to participate in any meeting.

Prior to the initiation of services and at least annually thereafter, the participant and the identified ISP team shall review existing assessment information and complete new assessments or reassessments if appropriate. The initial and annual ISP shall include documentation of the results of the ISP team's review of the assessments. The assessments shall include: physical examination performed by a licensed physician or a specially trained physician's assistant or a nurse practitioner who is supervised by a licensed physician; dental examination; social evaluation; psychological evaluation by a qualified examiner; personal outcome assessment to identify and prioritize each participant's preferences; adaptive behavior or independent living skills; a developmental, educational or vocational evaluation; medication and immunization

history; nutritional, vision, auditory, speech and language screenings; assistive technology assessment; and a safety assessment that addresses the participant's safety risks in the areas of environment, health, and personal vulnerability. ~~An Inventory for Client and Agency Planning (ICAP) The case manager shall be completed~~ complete an Inventory for Client and Agency Planning (ICAP) initially and annually to assess the participant's functional limitations and identify corresponding need for services. As appropriate, additional assessments may be conducted.

Initially and annually thereafter ~~service coordinators~~ case managers will provide participants a choice of providers by providing a list of qualified providers and participants will also receive a list of the full range of CHOICES waiver services. Participants shall also receive information on how to request a fair hearing pursuant to ARSD ~~Chapter~~ Article 67:17:02 if choice of services or qualified provider is denied.

The ISP shall include the participant's goals including preferences and priorities; actions to be taken to attain the goals; and a personal outcome assessment to demonstrate how each participant's preferences are identified and prioritized. Each participant's ISP must be reviewed at least annually in terms of its relevance to the current needs of the participant. Each qualified provider is required to be accredited by a national quality assurance organization. The accreditation process will promote promising practices that shall ensure the ISP process addresses participant desired outcomes, needs and preferences.

The ~~service coordinator~~ case manager shall be responsible for the oversight and monitoring of the ISP plan and shall complete the quarterly ISP assessment. The quarterly ISP assessment shall include information in the following areas:

- (1) The monitoring and coordinating of implementation of the ISP;
- (2) The observation and documentation of the ISP services;
- (3) Any intervention necessary to ensure the appropriate delivery of services and necessary revisions of the ISP;
- (4) Any review of substantiated instances of abuse, neglect, or exploitation;
- (5) Monitoring of the participant's health, welfare, and safety; and
- (6) Monitoring of the participant's progress toward goals or changes to the participant's health, safety, or behavior intervention plans.

The ~~service coordinator~~ case manager shall provide the quarterly assessment to the ISP team and document the outcome of the review and any recommendations regarding the status of the ISP. ~~If the participant's service coordinator provides a service directly to the participant, another service coordinator shall complete a quarterly assessment regarding that service.~~

The participant, the participant's parent if the participant is under age 18, or the participant's guardian if any designates responsibility for implementing the service plan, and collaborates with the ~~service coordinator~~ case manager to coordinate waiver and other State Plan services. That is, the participant and/or legal representative work with the ~~service coordinator~~ case manager to coordinate State Plan Services with waiver services.

DHS/DDD provides oversight regarding the ISP development process, implementation and monitoring through the representative random sample review of participant records. In the event that a problem is discovered, the qualified provider is required to respond to the problem within 10 days of discovery. The DHS/DDD monitors the remediation efforts of the qualified provider until the problem is fixed.

The DHS/DDD participates in the National Core Indicators (NCI) project every three years. As part of this survey, the DHS/DDD is able to obtain data on participant and family satisfaction of the ISP development process. Data gathered through the participation of NCI enhances the State's ability to monitor ISP development performance, incorporate the findings into decision making processes, and use the data in systemic quality improvement.

D-1 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.

~~An~~ The case manager shall complete an ICAP ~~is completed~~ initially and annually for each participant. The ICAP assesses the participant's functional limitations and needed assistance. Risk factors address the areas of motor skills, social and communication skills, personal living skills, community living skills and maladaptive behaviors. If appropriate, other risk assessments such as a safety assessment that addresses the participant's safety risks in the areas of environment, health, and personal vulnerability are completed.

The participant and the participant's ISP team determine the amount of time, if any, that the participant may be at home without any supports. Supports must be provided when supervision of the participant is required. The ISP shall include documentation of the amount of time a participant can remain unsupervised. Each qualified provider shall deliver training in accessing on-call supports and emergency services to each participant.

The participant's ~~service coordinator~~ case manager shall monitor the participant's health, safety and welfare in a manner that is sensitive to the participant's preferences. Each participant and the participant's team shall determine and document that the participant's living and work environments are safe. If unsafe conditions are identified, the team shall develop a plan which will immediately rectify the situation to ensure that the participant is safe.

Any critical services upon which the participant depends for health, welfare and safety are accompanied by a backup plan for provision of services when the qualified provider staff are unavailable. If the need for a backup plan is identified it is included within the ISP.

Pursuant to ARSD ~~Article 46:11:06:01~~ each CSP must have a health, safety, sanitation, and disaster plan approved by the DDD. ~~each qualified provider must have a health, safety, sanitation, and disaster plan approved by the DDD.~~ The plan must include specific procedures which ensure the health and safety of the participants at all times. Pursuant to ARSD Article

46:11:05:15 the participant's ISP team must determine and document the maximum amount of time, if any, the participant may be left unsupervised. A staff member must be on duty when supervision of the participant is required. Pursuant to ARSD Article 46:11:05:16 each CSP qualified provider of direct HCB services must have a policy which specifies how participants can access staff assistance when they are unsupervised. Assessment and training in accessing on-call staff and emergency services must be provided to each participant as indicated by each participant's needs and documented in the ISP. Policy is reviewed by the DDD initially and ongoing as changes are made to the policy. A representative random sample of participant records is reviewed for ISP documentation requirements.

D-2 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.

Pursuant to ARSD Article 46:11:05:05, each participant must have a designated service coordinator case manager. The service coordinator case manager conducts quarterly and annual reviews of each participant's ISP and may be contacted by a participant or their legal representative at any time to address changes. The service coordinator case manager is also responsible for identifying issues/concerns with waiver or other services and supports the participant in taking appropriate action steps. If at any time a service coordinator case manager believes that a participant's safety is at risk, the service coordinator case manager will immediately rectify the situation to ensure the participant's safety. The participant's service coordinator case manager is responsible for monitoring and coordinating the implementation of his/her ISP. The service coordinator case manager shall be responsible to complete a quarterly ISP assessment. The quarterly ISP assessment shall include information in the following areas:

- (1) The monitoring and coordinating of implementation of the ISP including appropriate backup plans and access to non-waiver services;
- (2) The observation and documentation of the ISP services;
- (3) Any intervention necessary to ensure the appropriate delivery of services and necessary revisions of the ISP based on the participants needs;
- (4) Any review of substantiated instances of abuse, neglect, or exploitation;
- (5) Monitoring of the participant's health, welfare, and safety; and
- (6) Monitoring of the participant's progress toward goals or changes to the participant's health, safety, or behavior intervention plans.

The service coordinator case manager shall provide the quarterly assessment to the ISP team and document the outcome of the review and any recommendations regarding the status of the ISP. ~~If the participant's service coordinator provides a service directly to the participant, another service coordinator shall complete a quarterly assessment regarding that service.~~ The service coordinator case manager shall ensure the participant acknowledges his/her right to exercise free choice of qualified providers of waiver services.

The DHS/DDD conducts a quality assurance review of a representative random sample of participant ISPs. The statistically valid sample is based upon a 95% confidence level, a 5% margin of error, and a response distribution based upon the results of the previous year's review

cycle. When a participant's ISP is randomly selected for DHS/DDD quality assurance review, the ~~service coordinator~~ case manager shall collect all information about ISP monitoring and implementation, including how problems identified during the monitoring was resolved, and submits the documentation to the DHS/DDD. All quality assurance review results are submitted to the SSMA for review and approval.

D-2 b: Monitoring and 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:

~~Qualified providers shall initially and annually provide a statement to the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any, of full disclosure of the potential conflict of interest that exists due to the qualified provider furnishing other direct waiver services and monitoring ISP implementation and participant health and welfare.~~

~~Qualified providers~~ Case Managers shall initially and annually provide the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any, a list of all qualified providers and a list of the full range of waiver services furnished by all qualified providers in the State.

The ~~qualified provider~~ case manager shall provide support to each participant who desires to monitor their own ISP or choose the individual of their choice to monitor their plan. ~~If the service coordinator is responsible for any direct implementation of the participant's plan, another service coordinator or qualified provider staff member shall conduct monitoring of those services provided directly to the participant by the participant's service coordinator.~~

The DHS/DDD conducts a quality assurance review of a representative random sample of participant records to evaluate each of the above requirements. The SSMA is provided with the results of the reviews for review and approval.

D bi: Methods for Remediation/Fixing Individual Problems

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.

If a participant's ISP is determined to not address all the participant's needs pursuant to ARSD Article 46:11:05:02, found not to assess and address the participant's health and safety risk factors per ARSD Article 46:11:05:02, 46:11:05:15, 46:11:05:16, 46:11:06:08, and 46:13:01:15, discovered not to be reflective of the participant's personal preferences and goals according to ARSD 46:11:05:03, found to not to have used the approved process for service plan development 46:11:05:03, or is not monitored as required by ARSD 46:11:05:05, ARSD Article 46:11 addresses a participant's needs, health and safety risk factors, personal preferences and goals as addressed in the ISP. If the ISP is found not to have addressed the participant's needs, not to have assessed and addressed the participant's health and safety, not to be reflective of the participant's personal preferences and goals, not to have used the approved process for service plan development, or have been monitored, the qualified provider case manager has 10 days from the date of discovery to respond to the DHS/DDD indicating how the problem will be fixed. If the solution meets the approval of the DHS/DDD the qualified provider case manager has 30 days from the date of discovery to reconvene the ISP team to update the ISP. If the problem takes longer than 30 days from the date of discovery to fix, the qualified provider case manager must receive approval from the DHS/DDD for an extension and ensure the participant's health and safety are intact during the remediation process. Once the problem is fixed, the updated ISP is submitted to the DHS/DDD for approval. This entire process is documented in the SMART system and submitted to reports for trend analysis. If a significant amount of individual problems related to the participant's ISP surface during the DHS/DDD quality assurance review process, the qualified provider case manager is required to submit a plan of enhancement to the DHS/DDD that address systemic level issues for DHS/DDD and SSMA approval. If at any point during this process it is discovered that the participant's health and safety are in immediate jeopardy, the DHS/DDD, and if necessary, in collaboration with other state agencies (i.e. the DSS Division of Adult Services & Aging, the DSS Child Protection Services, State Attorney's Medicaid Fraud Control Unit) and/or law enforcement, shall immediately conduct an onsite investigation to ensure participant safety. If the investigation substantiates the immediate health and safety of the participant, the qualified provider shall submit to the DHS/DDD a plan of correction and may be placed on probationary status, until the criteria of the plan of correction is met, or is decertified.

Pursuant to ARSD Article 46:11, if a participant's ISP is found not to be updated within 12 months of the previous ISP pursuant to ARSD 46:11:05:01, found to not contain annual documentation of the choice of providers or choice of waiver services, or found not to be updated when the needs of the participant have changed ARSD 46:11:05:03, the qualified provider case manager has 10 days from the date of discovery to respond to the DHS/DDD indicating how the problem will be fixed. If the solution meets the approval of the DHS/DDD the qualified provider case manager has 30 days from the date of discovery to reconvene the ISP team to update the ISP or provide evidence that the problem has been fixed. If the problem takes longer than 30 days from the date of discovery to fix, the qualified provider case manager must receive approval from the DHS/DDD for an extension and ensure the participant's health and safety are intact during the remediation process. Once the problem is fixed, the updated ISP or

supporting documentation is submitted to the DHS/DDD for approval. This entire process is documented in the SMART system and submitted to reports for trend analysis. If a significant amount of individual problems related to the participant's ISP surface during the DHS/DDD quality assurance review process, the ~~qualified provider~~ case manager is required to submit a plan of enhancement to the DHS/DDD that address systemic level issues for DHS/DDD and SSMA approval.

Per ARSD 67:16:34:02 qualified providers must keep legible medical and fiscal records that fully justify and disclose the extent of waiver services provided and the billings made to DHS. Per DHS Service Record Review Requirements, if it is determined that documentation maintained by the qualified provider is inadequate to support the activities reported in the participant's ISP (including type, scope, amount, duration and frequency), the participant's daily rate will be recalculated based on available documentation. If the participant's daily rate requires revision, the qualified provider will receive an adjusted consumer service authorization indicating the new daily rate and its associated effective dates. The provider qualified provider must submit a copy of the Medicaid remittance advice, indicating all claims during the review period were adjusted, to the DHS. The qualified provider must submit the required adjustments within 60 days from the receipt of the review report. If the qualified provider is not able to comply with the 60-day requirement, the provider must submit a written request for an extension to the DHS for consideration. The qualified provider must also submit any updates made to the participant's ISP to the DHS/DDD for review and approval. This entire process is documented in the SMART system and submitted to reports for trend analysis. If a significant amount of individual problems related to the participant's waiver services surface during the review, the qualified provider is required to submit a plan of enhancement to the DHS/DDD that addresses systemic level issues for DHS/DDD and SSMA approval.

The CHOICES Waiver Manager will complete a 100% quality assurance review of initial LOC applications for participants new to the waiver. If it is determined that the choice of institution, choice of provider, or choice of waiver services are missing from a LOC the DHS/DDD will immediately notify the qualified provider request the documentation be submitted prior to the start of waiver services. The DHS/DDD will evaluate the LOC upon receipt of this information for compliance. The CHOICES Waiver Manger will conduct additional training with the DHS/DDD staff responsible for processing the LOC on LOC requirements.

SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD review of compliance with federal requirements and aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvement. SMART engages qualified providers in the remediation of problems discovered and systemic improvement of their certification requirements. It is also available to DHS/DDD staff, the SSMA and qualified providers as a tool to generate qualified provider specific reports to monitor and trend improvement progress.

The DHS/DDD is responsible for conducting a one hundred percent review of all qualified provider policies and a biennial onsite review is conducted for the review of the implementation of policies. A statistically valid sample of participant files is reviewed on a continuous and ongoing basis to assure participant's health and welfare. Individual problems discovered during

the review must be fixed within a reasonable timeframe specified by the DHS/DDD. Systemic issues are addressed biennially through a qualified provider plan of enhancement process. The waiver manager is responsible for aggregating quarterly and annual information for analysis by the Internal Waiver Review Committee (IWRC) and the Core Stakeholders Group. Their findings and recommendations are reported to the DDD Director and the SSMA for remediation.

Appendix F

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.

As described in Appendix B, the DHS-DD-717 Home and Community-Based Services Choice/Rights/Fair Hearings Form is a required component of the LOC application criteria.

Regarding Choice of Institutional Care, applicants are informed verbally by the ~~service coordinator~~ case manager and in writing via the DHS-DD-717. The DHS-DD-717 Form provides information on how to request a fair hearing if not given the choice of Home and Community-Based Services as an alternative to institutional care and is signed by the applicant and/or legal representative and the ~~service coordinator~~ case manager prior to the initiation of services. This form is maintained by the ~~service coordinator~~ case manager and by the DHS/DDD. The applicant receives a written copy of the DHS-DD-717.

Regarding Choice of Services and Providers, applicants are informed verbally by the ~~service coordinator~~ case manager and in writing via the DHS-DD-717 Form. The DHS-DD-717 Form provides information on how to request a fair hearing if denied a Home and Community-Based Waiver Service or denied the provider of choice and is signed by the applicant and/or legal representative and the ~~service coordinator~~ case manager prior to the initiation of services. This form is maintained by the ~~service coordinator~~ case manager and by the DHS/DDD. The DHS-DD-717 Form is accompanied with a listing all qualified waiver providers and waiver services. Annually, participants and/or legal representatives are provided in writing of their choice of qualified waiver providers and waiver services and the right to a fair hearing pursuant to ARSD ~~chapter Article~~ Article 67:17:02 if choice of qualified waiver provider and waiver services is denied.

Regarding a Reduction or Termination of Services, documentation of the decision made by the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any, and the participant's team shall be included in the participant's file. Information about the fair hearing process must be provided at least ten days prior to the reduction of services when the reduction in services adversely affects the participant or the participant opposes the reduction in services. Information about the fair hearing process shall be provided to the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any at least 30 days prior to the termination of services pursuant to ARSD Article 46:11:03:03. The participant shall continue receiving services during the appeal process until a decision is reached after a hearing pursuant to SDCL Chapter 1-26 unless to do so would pose a danger to the participant or others, in which case the qualified provider shall make alternative arrangements for the participant approved by the DHS/DDD. Additionally, the DHS-DD-717 Form provides information on how to request a fair hearing if the waiver participant feels that any of his or her rights have been violated or not honored in any way.

Regarding Timely Application Processing, Denial, Termination, participants/applicants are informed in writing by DSS via the DSS-EA-266 Notice of Action of their right to a fair hearing. This form is maintained electronically by DSS and a paper copy is maintained by the DHS/DDD. A copy is also provided to the applicant/participant, the participant's guardian/rep, and the provider.

The CHOICES waiver has no provision for suspension of services. Waiver services continue pending a fair hearing decision.

F-3 b: Operational Responsibility

Specify the State agency that is responsible for the operation of the grievance/complaint system:

All qualified providers are required to maintain a grievance/complaint system as specified in ARSD Article 46:11:03:06 which contains minimum procedures for grievance. A participant may register a grievance directly to the DHS/DDD as the state agency responsible for the operation of the grievance/complaint system at any time. If a grievance is registered directly with the state, several state agencies, including the DSS Adult Services & Aging, the DSS Child Protection Services, and the SD Medicaid Fraud Control Unit within the SD Attorney General's Office work collaboratively with the DHS/DDD whenever the need arises. All participants who file a grievance are afforded due process pursuant to South Dakota Codified Law Chapter 1-26.

F-3 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).

Each participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian (also referred to in this section as the complainant) may register a grievance/complaint regarding any action or decision by the qualified provider which may adversely affect the provision of the participant's waiver services. Registering a grievance/complaint is not a prerequisite or substitute for a fair hearing.

Each qualified provider must have written grievance procedures pursuant to ARSD Article 46:11-03:06 approved by the DHS/DDD whereby a participant, a participant's parent if the participant is under 18 years of age, or a participant's guardian is informed at the time of application and annually thereafter of their right to appeal any decision or action by the qualified provider that affects the participant. The qualified provider may not process a grievance until a participant has the opportunity to obtain an advocate if so desired. Advocates may not represent a participant in a grievance procedure unless requested by that participant and with the participant present. The qualified provider must ensure that assistance is provided for those who do not understand the grievance procedure.

At any time, a grievance/complaint may be submitted in writing, via e-mail or verbally to the DHS/DDD. Qualified Providers are required to provide participants initially and annually with information on how to contact the DHS/DDD. Participants seeking to file a grievance/complaint shall receive priority attention of available DHS/DDD staff. The DHS/DDD staff receiving the grievance/complaint should gather adequate information to assess the immediate safety of the participant(s) involved in the grievance/complaint. If the grievance/complaint involves the alleged abuse, neglect, or exploitation (ANE) of a person with intellectual/developmental disabilities, the first duty of the DHS/DDD staff person receiving the complaint is to take reasonable actions to ensure the health and safety of the person. DHS/DDD staff must ensure that any suspected illegal activity is reported to law enforcement and other appropriate state agencies.

A DHS/DDD Program Specialist shall contact the complainant within one (1) working day of receipt of all grievances/complaints to acknowledge receipt of the complaint/grievance. The DHS/DDD Program Specialist will gather information necessary to review the complaint/grievance. Information sources include but are not limited to qualified provider policies, qualified provider staff, people supported, guardians, individual files, etc. If the grievance/complaint involves medical or health issues the review should include an evaluation of a DHS/DDD Program Specialist who is also a registered nurse. If the complaint/grievance involves an allegation of ANE or the immediate jeopardy of the health and safety of the participant, the DHS/DDD Program Specialist should immediately notify a DHS/DDD supervisor and take reasonable actions to ensure the health and safety of the participant. The DHS/DDD Program Specialist should utilize available/applicable resources such as DHS/DDD management and nursing staff, state/federal laws, statements from parties involved, the implementation of the investigation process, etc. to make a determination on the complaint. The DHS/DDD Program Specialist will summarize the complaint, determination and any follow-up actions/resolution regarding the complaint and provide to a DHS/DDD supervisor for approval. This information will be provided to the complainant within 14 working days of the receipt of the complaint. If applicable, the DHS/DDD Program Specialist shall monitor the qualified provider action plan. A log of the complaint, including the timeline, summary and resolution, will be provided to the DHS/DDD Director, the SSMA and the Internal Waiver Review

Committee for trend analysis. Throughout the process of registering any type of grievance/complaint, the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian may at any time request a fair hearing pursuant to SDCL Chapter 1-26.

Appendix G

G-1 b: State Critical Event or Incident Reporting Requirements

Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All qualified providers as required in ARSD ~~Article 46:11:03:01~~ must have a policy on abuse, neglect and exploitation, approved by DHS/DDD which:

- 1) Defines abuse, neglect and exploitation pursuant to SDCL 22-46-1;
- 2) Requires report to DHS/DDD pursuant to ARSD ~~Article 46:11:03:02~~;
- 3) Requires report to DSS pursuant to SDCL 22-46, 26-8A-3 to 26-8A-8, inclusive;
- 4) Includes a procedure for an internal investigation, including the issuance of the investigation findings to the DHS/DDD within 30 calendar days and if allegation is substantiated, distribution if investigation results to the participant, the participant's parent if under 18 years of age, or the guardian, if any;
- 5) Includes a procedure for remediation to ensure health and safety of participants;
- 6) Includes a procedure for disciplinary action to be taken if staff has engaged in abusive, neglectful, or exploitative activities;
- 7) Includes a procedure to inform the guardian, the parent if the participant is under 18 years of age, and the participant's advocate if any of the alleged incident or allegation and any information not otherwise prohibited by court order about any action taken within 24 hours after the incident or allegation, unless the person is accused of the alleged incident;
- 8) Includes a requirement, upon substantiating the incident, to document the actions to be implemented to reduce the likelihood of or prevent repeated incidents of abuse, neglect or exploitation;
- 9) Includes a procedure for training provided in an accessible format to the participant, the guardian if any, and family members as identified by the participant upon admission and annually thereafter on how to report to the qualified provider and DHS/DDD any allegation of abuse, neglect, or exploitation; and
- 10) Includes a requirement that retaliation against a whistle blower is forbidden pursuant to SDCL 27B-8-43.

The critical events or incidents that qualified providers are required by ARSD Article ~~46:11:03:02~~ to report to DHS/DDD for review and follow-up action by the appropriate authority are:

1. Deaths;
2. Life-threatening illnesses or injuries;

3. Alleged instances of abuse, neglect, or exploitations against or by any participant;
4. Changes in health or behavior that may jeopardize continued services;
5. Serious medication errors;
6. Illnesses or injuries that resulted from unsafe or unsanitary conditions;
7. Any illegal activity involving a participant that involves law enforcement;
8. Any use of physical, mechanical, or chemical intervention that is not part of an approved plan;
9. Any bruise or injury resulting from the use of a physical, mechanical or chemical intervention;
and
10. Any diagnosed case of a reportable communicable disease involving a participant.

The qualified provider must provide verbal notice of any critical event or incident to the DHS/DDD no later than the end of the next working day from the time the qualified provider becomes aware of the incident. The qualified provider must submit a written critical incident report utilizing the DHS/DDD online reporting system within seven (7) calendar days after the verbal notice is made. The written report must contain a description of the incident, specifying what happened, when it happened and where it happened. The report must also include any action taken by the qualified provider necessary to ensure the participant's safety and the safety of others and any preventative measures taken by the qualified provider to reduce the likelihood of similar incidents occurring in the future. Further information relating to the incident not available when the initial written report was completed may be submitted in the form of a follow-up to the online report. The DHS/DDD may request further information or follow-up related to the critical event.

South Dakota Senate Bill 14 was introduced during the 2011 Legislative session. SB 14 was drafted in collaboration with and supported by the Department of Health, the Department of Human Services, AARP, the Advisory Council on Aging, the Council of Mental Health Centers, Association of Community Based Services, the South Dakota Association of Healthcare Organizations, South Dakota Health Care Association and the Network Against Family Violence & Sexual Assault. SB 14 entitled an Act to require the mandatory reporting of abuse or neglect of elderly or disabled adults. With its passing, SB 14 amended SDCL Chapter 22-46 to establish a mandatory reporting system for abuse and neglect of elders or adults with disabilities similar to the mandatory reporting process that exists for child abuse.

DHS/DDD conducts continuous and ongoing reviews of qualified providers to ensure compliance with ARSD ~~Article 46:11:03:01~~ and ~~46:11:03:01~~. A report that identifies statewide information regarding critical incident reports is available at the DHS/DDD website: <http://dhs.sd.gov/dd/Division/publications.aspx>

G-1 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.

Each qualified provider is required pursuant to ARSD Article 46:11:03:01 to provide each participant, any family members as identified by the participant, and the legal guardian if any with information or training in an accessible format regarding protection from abuse, neglect and exploitation which includes how to report incidents. This information will be provided at the time of admission and annually. The qualified provider must document the date, time, and content of this training. The DHS/DDD reviews this information for compliance of ARSD Article 46:11:03:01 during a representative random sample of review of participant records.

Each qualified provider is required to add the following statement to each participant's ISP that informs each participant/family/guardian/advocate how to contact the DHS/DDD if they have concerns or would like to self-report an incident. "I understand that if I have any questions, comments, or concerns about my services, I can contact a program specialist at the Division of Developmental Disabilities, c/o 500 East Capitol, Pierre, SD 57501. Toll free in SD: 1-800-265-9684 or (605) 773-3438. Email info: <http://dhs.sd.gov/dd/contactinfo.aspx> "

G-1 d: Responsibility for Review of and Response to Critical Events or Incidents

Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Upon receiving the verbal report of a critical event required by ARSD Article 46:11:03:02, the DHS/DDD Program Specialist will consult with the qualified provider to ensure the immediate safety of the participant and others; ensure appropriate notification to the guardian if any, parent if the participant is under 18 years of age, the DSS Child Protective Services, the DSS Adult Services and Aging, and/or law enforcement; and provide any other technical assistance appropriate for the situation.

Upon receiving the written report of a critical event required by ARSD Article 46:11:03:02, the DHS/DDD Program Specialist will conduct a review of the report within two (2) working days if due to abuse, neglect, exploitation and death, or within five (5) working days if related to any other incident-type described in G-1a. to ensure appropriate reporting/notification as described above; if indicated by the MOU with the Attorney General, forward the report to the Medicaid Fraud Control Unit (MFCU); conduct follow up with collaborating state agencies as described above; assess the current situation to ensure the health, welfare and safety of the participant; assess the qualified provider's investigation of the incident; and conduct further review of the incident if determined that the qualified provider is not compliant with any provision of ARSD and waiver requirements. Any incident that involves alleged abuse, neglect or exploitation of a participant by a qualified provider staff person, is reported to MFCU for potential investigation and prosecution as appropriate.

The DHS/DDD conducts internal and external quality assurance reviews of all critical incidents. One hundred percent of incidents received by DHS/DDD are reviewed by a DHS/DDD Program Specialist and by a peer reviewer. The DHS/DDD Program Specialist assigned to the qualified provider receives the critical incident report and conducts the initial review. Peer reviewers review the critical incident reports that have not been submitted to them in the capacity as the

provider's assigned Program Specialist. Peer reviewers review each critical incident report to ensure that all reporting requirements were met and assess if appropriate follow-up was taken. Recommendations are provided to the provider's assigned Program Specialist as appropriate. The internal Critical Incident Review Committee (comprised of at least three Program Specialists, a DHS/DDD nurse and the Waiver Manager) reviews critical incident reports to identify potential provider trends and identify if DHS/DDD internal review timelines are not met. Recommendations are made to the appropriate Program Specialists for corrective action. The DHS/DDD also conducts a representative random sample of participant records to ensure reportable incidents not reported pursuant to ARSD Article 46:11:03:04 or reported incidents not in compliance of ARSD Article 46:11:03:02 are discovered and immediately remediated. This process is explained further in G-1-e.

For purposes of ensuring compliance with certification, the DHS/DDD may survey the qualified provider at any given time without prior notice pursuant to ARSD Article 46:11:02:04. The DHS/DDD may impose probation, not to exceed one year, if a qualified provider has deficiencies which seriously affect the health, safety, welfare, or rights of a participant pursuant to ARSD Article 46:11:02:12. The qualified provider must complete, in a period approved by DHS/DDD, but not to exceed 1 year, a plan of corrective action approved by DHS/DDD pursuant to ARSD Article 46:11:02:13. All relevant parties are notified in writing of the results of an investigation within 15 days of the completion of an investigation.

A qualified provider's certification may be revoked pursuant to ARSD Article 46:11:02:14 on any of the following grounds:

- 1) Permitting, aiding, or abetting the commission of any unlawful act;
- 2) Engaging in any practices which seriously affects the health safety, welfare, rights, or habilitation of the participants;
- 3) Failure to comply with all licensing and other standards required by federal or state laws, rules, or regulations that result in practices which are detrimental to the welfare of the participants;
- 4) Falsifying information provided to the DHS/DDD for certification purposes; or
- 5) Failure to comply with a probationary plan of corrective action.

The Internal Waiver Review Committee is comprised of the each state waiver manager as well as representatives from the SSMA and the DHS Budget and Finance Office. The Core Stakeholders Group is comprised of participants, participant family members, qualified provider staff, non-profit disability organizations, and other state agency staff. The Internal Waiver Review Committee and the Core Stakeholders will conduct an external review of critical incidents to identify trends and areas of concerns and provide recommendations to the DHS/DDD.

G-1 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.

DHS/DDD conducts annual ARSD/HCBS participant record review that is a representative, random sample of all waiver participant service plans. The statistically valid sample size is based upon historical data from the previous annual ARSD/HCBS participant record review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results. This review process ensures that reportable incidents not reported pursuant to ARSD ~~Article 46:11:03:01~~ or that reported incidents not in compliance of ARSD ~~Article 46:11:03:02~~ are discovered and remediated. Any discovery of noncompliance in these areas will result in the qualified provider creating and submitting a Plan of Enhancement to the DHS/DDD for review, approval and continued monitoring.

The internal Critical Incident Review Committee compiles and analyzes aggregate data from the CIR reporting process to identify red flags for further follow up and trends that may indicate training needs and/or service enhancements on a quarterly basis. Quarterly data is presented to the Internal Waiver Review Committee and the Core Stakeholders Group to provide oversight of critical incidents received by DHS/DDD and work with DHS/DDD to identify how this oversight is conducted to be beneficial to participants, providers and DHS/DDD. An annual report of critical incidents statewide is provided to qualified providers and stakeholders and is placed on the DHS/DDD website.

All qualified providers must meet the certification requirements set forth in ARSD 46:11. DHS notifies the SSMA when and why a provider is placed on probation, when a provider satisfactorily completes a probationary plan of corrective action and/or when and why a provider's certification is revoked.

G-2 ai: Safeguards concerning restraints and restrictive interventions

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).

The use of restraints may be applied only if a person with an intellectual/developmental disability exhibits destructive behavior and if alternative techniques including positive behavior support techniques have failed.

South Dakota Codified Law 27B-8-50 Aversive behavioral techniques --Findings. The Legislature hereby finds that:

- 1) Research does not support the long-term efficacy of aversive behavioral intervention;
- 2) The use of aversive or abusive treatment raises disturbing legal and ethical issues, and may well deprive the recipient of constitutional or statutory rights and be outside the ethical guidelines imposed upon the treatment professional;
- 3) Any person with a disability has the same right to be treated with dignity and respect as any other citizen; and

4) The use of aversive and abusive treatments on any person with a disability diminishes the dignity and humanity of the treatment professional and the person with a disability. The South Dakota Legislature opposes any treatment or practice which violates the right to freedom from harm. The South Dakota Legislature promotes activities that lead to implementation and dissemination of positive intervention alternatives.

The use of aversive intervention techniques is prohibited. No person may use aversive intervention techniques on a person with an intellectual/developmental disability. The rights of any person with an intellectual/developmental disability receiving services may only be restricted as a result of due process in accordance with statute and the rules of the South Dakota Department of Human Services. The rights of any person with an intellectual/developmental disability may be suspended to protect that person from endangering self or others. In order to provide specific services or supports to the person with an intellectual/developmental disability, such rights may be suspended only by due process that will promote the least restriction on the person's rights.

The use of any highly restrictive procedures, including restraints and time-out, shall be described in written behavior support plans. Use of restraints shall be applied only in an emergency if alternative techniques have failed. Physical restraint intended to restrict the movement or normal functioning of a portion of a person's body through direct contact by staff, shall be employed only if necessary to protect the person with an intellectual/developmental disability from immediate injury to self or others. No physical restraint may be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports. Physical restraint shall be applied only after alternative techniques have failed and only if such restraint is imposed in the least possible restriction consistent with its purpose. Mechanical restraint using mechanical devices intended to restrict the movement or normal functioning of a portion of a person's body is subject to special review and oversight, as defined in rules promulgated pursuant to South Dakota Codified Law Chapter 1-26. Any mechanical restraint shall be designed and used so as not to cause physical injury to the person with an intellectual/developmental disability and so as to cause the least possible discomfort. No chemical restraint and medication may be used excessively, as punishment, for the convenience of staff, as a substitute for a program, or in quantities that interfere with a person's developmental program.

In accordance with statute and the rules promulgated pursuant to SDCL Chapter 1-26, due process shall be assured pursuant to SDCL § 27B-8-52 for the use of physical, mechanical, or chemical restraints, including their use in an emergency or on a continuing basis.

A behavior support plan is designed to increase the participant's socially adaptive behaviors and to modify the participant's maladaptive or challenging behaviors. The outcome is to replace maladaptive or challenging behaviors with behaviors and skills that are adaptive and socially productive. A behavior support plan shall use, develop, and promote positive, respectful approaches for teaching in every aspect of life. Behavior support plans may only be implemented following the completion of a comprehensive functional analysis if alternative nonrestrictive procedures have been proven to be ineffective, and only with the informed consent of the person with an intellectual/developmental disability, if eighteen years of age or over and capable of giving informed consent, or the person's parent or legal guardian. Behavior support

plans shall be developed in conjunction with the interdisciplinary team and implemented in accordance with South Dakota Codified Law § 27B-8-52.

Time-out rooms used for separating a person with an intellectual/developmental disability from other persons receiving services and group activities may be employed only under close and direct staff supervision and only as a technique in behavior support plans. No time-out room may be used in an emergency situation. Behavior support plans utilizing a time-out procedure may be implemented only if it incorporates a positive approach designed to result in the acquisition of appropriate behavior.

Each qualified provider of direct HCB services must have a human rights committee or participate in a multiagency committee pursuant to ARSD Article 46:11:05:13 which ensures that each participant's rights are supported. The committee's membership is appointed and selected by the qualified provider and its composition must meet the following criteria:

- (1) Committee membership must include at least one participant or a participant's representative;
- (2) At least one-third of the committee's members may not be affiliated with the qualified provider; and
- (3) At least one member of the committee must have training or experience with issues and decisions regarding human rights.

The human rights committee must use the following procedures:

- (1) Review and approve or disapprove all behavior support plans which use any ~~of the~~ highly restrictive procedures ~~listed in § 46:11:05:06~~. The review must ensure the opportunity for the informed consent of and participation by the participant, the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any, or advocate in the development of highly restrictive supports;
- (2) Review and approve or disapprove at least every six months all behavior support plans which use any ~~of the~~ highly restrictive procedures ~~listed in § 46:11:05:06~~;
- (3) Review each participant's restrictions of rights and restoration plan;
- (4) Review and approve the qualified provider's policies, procedures, and practices in limiting rights of participants; and
- (5) Provide the committee with training in individual rights, disability awareness, and the qualified provider's philosophy and mission.

Each qualified provider of direct HCB services must have policies approved by the DHS/DDD addressing the use of highly restrictive procedures. Such procedures include physical or chemical intervention, medications to manage behavior, time-out rooms, or other techniques with similar degrees of restriction or intrusion. The policy shall include:

- (1) Procedures to ensure compliance with SDCL 27B-8-51, 27B-8-52, 27B-8-54, and 27B-8-55;
- (2) A description of the ISP team's process including plan development, identifying the most appropriate restrictive procedure for the participant's needs and restoration plan, and consent by the participant, or the participant parent, if the participant is under 18 years of age, or the participant's guardian, if any;
- (3) Procedures for review, approval, and right to appeal, the highly restrictive procedures by the participant, or the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any;

- (4) A review and approval by the human rights committee and behavior support committee prior to implementation and at least every six months thereafter;
- (5) A description of circumstances under which a time-out room may be used, the maximum time it may be used, and the procedures to be followed;
- (6) A requirement that the participant's plan include timelines for notifying the participant's parent, if the participant is under 18 years of age, or the guardian, if any, when highly restrictive procedures are used;
- (7) A requirement to address emergency rights restrictions pursuant to ARSD §46:11:03:08, including time-lines of team meetings and review by the human rights committee and the behavior support committee; and
- (8) Procedures to ensure regular oversight of implementation and staff training.

Each qualified provider of direct HCB services must have a behavior support committee pursuant to ARSD Article 46:11:05:12, that is appointed and selected by the qualified provider, which reviews the technical adequacy of and approves all behavior support plans which use any of the highly restrictive procedures listed in ~~§ 46:11:05:06~~.

The behavior support committee must be composed of a person with experience or training regarding behavior support and a physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications to manage behavior. The behavior support committee must be provided with training in the effectiveness of behavior support techniques, the qualified provider's mission and philosophy, behavior changing medication, and disability awareness.

The participant's case manager will review and approve all rights restrictions.

ARSD Article 46:11:05:07 refers to a A time-out room as an enclosed area in which the participant is placed contingent upon the exhibition of a maladaptive behavior, in which reinforcement is not available and from which egress is denied until appropriate behavior is exhibited. A time-out room may only be used under continuous observation of the participant by a qualified provider staff, may not be locked with a key, and must allow for immediate staff entry. A time-out room may only be used as part of a behavior support plan approved by both the qualified provider's human rights and behavior support committees. A time-out room may not be used in a punitive fashion. Each use of the time-out room may not exceed 15 minutes. If after 15 minutes, the participant continues to exhibit a maladaptive behavior that poses a threat to the participant or others, the use of the time-out room may continue for another 15 minutes. The maximum amount of time a participant may be in the time-out room shall not exceed one continuous hour. The CSP shall document any use of the time-out room.

The individual service plan of a consumer who exhibits maladaptive behavior must include provisions to teach the consumer the circumstances, if any, under which the behavior can be exhibited adaptively; to teach the consumer how to channel the behavior into similar but adaptive expressions; or to replace the behavior with behavior that is adaptive.

G-2 aii: 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:

The DHS/DDD is responsible for general oversight and monitoring the use of highly restrictive procedures, including restraints and time-out, used by qualified providers of direct HCB services. DHS/DDD will review the use of highly restrictive procedures through an ARSD/HCBS quality assurance review of the qualified provider's policies specified in § 46:11:05:06. Biennially the DHS/DDD will review the implementation of the requirements specified in ARSD Article 46:11:05:12 regarding the qualified provider's Behavior Support Committee, and Human Rights Committee composition, § 46:11:05:14 Human Rights Committee—Procedures and procedures. The DHS/DDD will conduct a review of a representative random sample of participant files which shall include a review of any restraint procedure and behavior support plan used by the qualified provider.

The DHS/DDD prohibits the use of seclusion.

The DHS/DDD also completes internal investigations upon receipt of a concern or complaint from participants, family members, guardians, and/or community members regarding highly restrictive procedures.

DHS/DDD's incident reporting database will also be used to identify any unauthorized use, over use or inappropriate use of highly restrictive procedures and follow-up will occur as appropriate.

If applicable, the DHS/DDD will collaborate with other state agencies, such as the Department of Social Services Child Protection Agency, the Department of Social Services Division of Adult Services & Aging, or the Attorney General's Medicaid Fraud Control Unit, to investigate the use of highly restrictive procedures that are not, or suspected to not be, in compliance with due process and the requirements specified in South Dakota Codified Law or Administrative Rules of South Dakota.

G-2 bi: 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.

Unless modified by court order, a person with an intellectual/developmental disability has the same legal rights and responsibilities guaranteed to all other persons under the federal and state constitutions and federal and state laws. No person with an intellectual/developmental disability may be required to perform any act or is subject to any procedure which is contrary to the person's religious beliefs, and each person has the right to practice personal religious beliefs and to be accorded the opportunity for religious worship. No person may be coerced into engaging in or refraining from any religious activity, practice, or belief. Any person with an

intellectual/developmental disability has the right to receive publicly supported educational services in accordance with federal and state education laws. Any person with an intellectual/developmental disability has the right to access to appropriate dental and medical care and treatment for any physical ailments and for the prevention of illness or disability. Surgery and any other medical procedures may be performed without consent or court order only if the life of the person with an intellectual/developmental disability is threatened and there is not time to obtain consent or a court order. Documentation of the necessity for the surgery shall be entered into the record of the person as soon as practicable. No person with an intellectual/developmental disability is subject to any experimental research or hazardous treatment procedures without the consent of:

- (1) The person with an intellectual/developmental disability, if eighteen years of age or over and capable of giving informed consent. If any person's capacity to give informed consent is challenged, the person, a qualified intellectual disability professional, physician, or interested person may file a petition with the court to determine competency to give consent;
- (2) The guardian of the person with an intellectual/developmental disability, if the guardian is legally empowered to execute such consent; or
- (3) The parent or guardian of the person with an intellectual/developmental disability, if the person with an intellectual/developmental disability is less than eighteen years of age.

No person with an intellectual/developmental disability who is subject to an order of guardianship may be subjected to experimental research or hazardous treatment procedures without prior authorization of the circuit court.

The receipt of services and supports pursuant SDCL Chapter 27B-8 does not operate to deprive any person with an intellectual/developmental disability of any other rights, benefits, or privileges, does not cause the person with an intellectual/developmental disability to be declared legally incompetent, and may not be construed to interfere with the rights and privileges of parents or guardians regarding the minor child. No agency, community service provider, facility, school, or person who receives public funds and provides services to persons with intellectual/developmental disabilities may engage in the following practices:

- (1) Corporal punishment--physical or verbal abuse, such as shaking, screaming, swearing, name calling, or any other activity that would be damaging to a person's physical well-being or self-respect; and
- (2) Denial of food--preventing a person from having access to a nutritionally adequate diet as a means of modifying behavior. Persons enrolled in residential programs or living units are expected to partake in meals at a predetermined scheduled time.

Any person with an intellectual/developmental disability receiving services has the right to:

- (1) Communicate freely and privately with others of the person's own choosing;

- (2) Receive and send sealed, unopened correspondence. No person's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;
- (3) Receive and send packages. No person's outgoing packages may be opened, delayed, held, or censored by any person;
- (4) Reasonable access to telephones, both to make and to receive calls in privacy, and reasonable and frequent opportunities to meet with visitors; and
- (5) Suitable opportunities for interaction with others of the person's own choosing.

No person may use aversive intervention techniques on a person with an intellectual/developmental disability. The rights of any person with an intellectual/developmental disability receiving services may only be restricted as a result of due process in accordance with statute and the rules of the Department of Human Services. The rights of any person with an intellectual/developmental disability as specified in this chapter may be suspended to protect that person from endangering self or others. In order to provide specific services or supports to the person with an intellectual/developmental disability, such rights may be suspended only by due process that will promote the least restriction on the person's rights.

Pursuant to ARSD ~~Article 46:11:03:08~~ the rights of the participant may only be restricted to protect the consumer from endangering self or others or to provide specific services or supports as provided in SDCL 27B-8-52. Any restriction of rights shall promote the least restrictive alternative appropriate to meet the needs of the participant. Prior to restricting a participant's rights, the qualified provider shall require the participant, the participant's ISP team the participant's parent, if the participant is under 18 years of age or the participant's guardian, to review and approve each restriction. The qualified provider's human rights committee shall act as an impartial party to review and approve or deny each restriction prior to implementation and at least annually thereafter. If the participant displays behavior that endangers self or others and requires an emergency rights restriction, the qualified provider shall notify the human rights committee and the participant's parent if the participant is under 18 years of age or the legal guardian within 24 hours of implementation of the restriction.

The participant's case manager will review and approve restrictions approved by the Human Rights Committee.

The human rights committee must use the following procedures:

- (1) Review and approve or disapprove all behavior support plans which use any ~~of the~~ highly restrictive procedures ~~listed in § 46:11:05:06~~. The review must ensure the opportunity for the informed consent of and participation by the participant, the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any, or advocate in the development of highly restrictive supports;
- (2) Review and approve or disapprove at least every six months all behavior support plans which use any ~~of the~~ highly restrictive procedures ~~listed in § 46:11:05:06~~;

- (3) Review each participant's restrictions of rights and restoration plan;
- (4) Review and approve the qualified provider's policies, procedures, and practices in limiting rights of participants; and
- (5) Provide the committee with training in individual rights, disability awareness, and the qualified provider's philosophy and mission.

Appendix I

I-2 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).

In a format prescribed by DHS, qualified providers submit a cost report (Statement of Expenses & Revenues) within their required annual independent audit. The cost report format prescribes the listing of accounts with actual and allocated costs for each service center.

Qualified providers must ~~complete~~ submit an annual ICAP (The Inventory for Client and Agency Planning is a standardized tool that assesses an individual's adaptive skills and maladaptive behaviors) for each person they ~~support~~ provide direct HCB services. ~~Qualified provider staff~~ Case managers completing ICAPs are trained by DHS/DDD staff utilizing supplemental guidelines developed by DHS/DDD in conjunction with agency representatives. DHS/DDD staff reviews a sample of completed ICAPs ~~from each qualified provider~~. The sample is weighted in that it targets people with significant changes or ~~qualified provider~~ trends that identify potential issues. That sample is broadened if the qualified provider does not meet established standards. This audit process is completed prior to rate calculation so issues/problems are corrected prior to payments being made.

Qualified Providers utilize an internet based information system (Service Record) to identify the services provided to each person. The Service Records are audited onsite, as described in the Quality Improvement section of this appendix, by DHS fiscal staff to ensure that people are receiving the services reported on the Service Record.

Activity Logging (time study) Data is gathered in anticipation of creating a new Individual Resource Allocation (IRA) model. Qualified Providers utilize an internet based application to submit activity logging information that reports the number of units of each service provided to each waiver participant. This information is gathered for a statistically representative time period. The internet application has on-line edits that prevents errors. Summary edits also identify potential issues that prompt providers to review information prior to submission.

DHS/DDD staff conduct on-site visits to provide technical assistance to qualified providers during activity logging and review the information that is gathered and reported. Activity logging is gathered in anticipation of re-modeling, approximately once every five years.

Developing a Model

The IRA model draws information from five sources:

1. Cost Reports from qualified provider agencies
2. ICAP
3. Service Record
4. Activity Logging Data
5. Economic measures – Data compiled by geographic region, specific to each locale.

Qualified Providers committed significant time to participate in a workgroup that developed the model. All information regarding model development is accessible to the public.

Step 1

Cost reports from each qualified provider agency are used to compile the system-wide average cost per service.

Each qualified provider is required to submit an annual independent audit. Within the audit is a Statement of Expenses & Revenues which serves as the agency cost report. The DHS/DDD prescribes the format for the Statement of Expenses & Revenues. This information is validated and compiled by DHS fiscal staff.

Step 2

Activity logging is used to identify the number of units of services provided to each person. That amount is multiplied by the average cost of each service to determine a cost of service for each person.

Step 3

Multiple regression is used to formulate a model which predicts the cost of services an individual will need based on the services they receive and their needs as assessed by the ICAP. Cost per person serves as the dependent variable. Information from Service Records, ICAPs and economic measures serve as potential independent variables.

Step 4

The model generates an individualized rate for each person that is either increased or decreased by the agency specific gain/loss quotient as indicated by the historical costs incurred by each agency.

Using the Model

The model currently in use supports people and qualified providers to utilize person-centered planning to determine an appropriate array of services and supports. Waiver services and individualized information can then be entered into the model to generate a rate for services and supports.

If a person experiences a temporary additional but significant need, the qualified provider may request Extraordinary Needs Funding (ENF). These requests require supporting documentation and are reviewed by DHS/DDD staff for approval/denial and are paid using state general fund dollars.

If a person's needs or preferences change, providers can make a significant change request (SCR) that could adjust the daily service rate to accommodate the change. The SCR requires supporting evidence that the change is person-centered and are reviewed by DHS/DDD staff.

The conflict-free case management rate was derived from the Community Support Provider cost report data from salaries, benefits, taxes, and overhead for existing case managers. South Dakota Department of Labor wage statistics were used to validate the cost report data. Rate increases will be calculated using the inflationary rate approved for qualified providers by the South Dakota State Legislature, unless the qualified provider and State mutually agree the inflationary rate cap is unrealistic or unfair. The State may grant rate increases during all subsequent years in which the State elects to renew SP contracts.

I-2 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:

Appendix I-2a describes how each participant's daily rate and case management rate are determined. Each person's daily rate is calculated by the IRA model described in Appendix I-2-a. The qualified provider is certified as an OHCDs by the DHS/DDD pursuant to ARSD Article 46:11:02. The qualified provider is notified of the person's daily rate and the rate file is uploaded to the DSS MMIS. All waiver services are billed by the qualified provider via an electronic billing submitted by the qualified provider to the DSS MMIS. Once a claim is submitted to the DSS MMIS, the claim goes through a pricing process and the DSS MMIS calculates payment based upon information within the rate file. The DSS MMIS computes service level expenditures prior to processing claims and generating qualified provider remittance advices. Service level expenditures are assigned budgetary coding and are queried from the DSS MMIS for reporting purposes.

HCBS waiver dollars are used only to fund the approved services in the waiver. If an individual is eligible for both special education services and HCBS, the Individual Education Plan (IEP) team can choose to receive supports from a qualified provider. All waiver participants receiving special education services are documented within the MMIS with a specific and unique identifier indicating they are a child eligible for CHOICES waiver services. This identifier means educational services are calculated separately for the rates that will be provided to the child, thus preventing duplication of payment for waiver services and Individuals with Disabilities Education Act (IDEA) related services. The rate for waiver services is then uploaded to the MMIS which only allows the qualified provider to bill for the authorized federal amount of waiver services. All existing checks for Medicaid waiver services within the MMIS are applied.

All IDEA-related services and the non-federal matching share for individuals under the age of 21 are funded by the South Dakota Department of Education and payments are attested prior to the expending of FFP as described in Appendix I-4-a.

Supplies and equipment participants receive from vendors who are not qualified providers must be authorized through the plan of care. The qualified provider purchases the supplies/equipment and makes arrangements for delivery to the participant. The qualified provider bills the DSS MMIS for the supplies/equipment.

DSS exercises administrative authority and oversight of the waiver and authorizes and pays all waiver claims through the DSS MMIS.

I-3 gii: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:

Entities are designated as an OHCDS when they meet the criteria outlined in ARSD Article 46:11:02. This includes being certified as a CSP or SP, having a signed provider agreement with the SSMA and the DHS/DDD, and provide at least one service covered under the provisions of ~~article~~ ARSD Article 67:16.

If a provider does not voluntarily agree to contract with an OHCDS the provider may contract directly with the SSMA and the DHS/DDD and meet the requirements of ARSD Article 46:11:02:02 to become a certified agency.

Each participant is informed upon application and annually of their right to choose their provider. The DHS/DDD ensures this information is provided to each participant at the time of application during review of the application for waiver services. To ensure this information is provided to the participant annually the DHS/DDD reviews for this during the representative random sample participant file review process.

The OHCDS is accountable for ensuring that the individual providers delivering services meet all of the state's applicable waiver standards. The DHS/DDD monitors OHCDS compliance of waiver requirements by way of quality assurance reviews.

Financial accountability is maintained at several levels. The OHCDS is required to complete an annual contract with the DHS that provides detailed instructions as to how waiver funding may be utilized. Participant plans are reviewed at the state level to ensure that waiver funding is assigned to participants to pay for supports and services that meet waiver requirements. Each OHCDS is required to conduct and submit an annual audit, undergo a representative random sample review of all claims, and submit to monitoring conducted by DHS as a component of the PERM. All claims adjudicated through the MMIS fall under the authority of the DSS Surveillance and Utilization Review System. This system is staffed with investigators who seek and review paid claims to find inappropriate or incorrect payment to providers.