



## 2023 CHOICES Waiver Renewal – Short Version

This document was created by the SD Council on Developmental Disabilities by taking information from the 198-page Waiver Renewal Application and inserting into this document for easier reading.

The Waiver Renewal Public Comment period is open from January 9, 2023, until February 8, 2023. A Town Hall Conference Call on the Waiver Renewal will be held January 19, 2022.

Links to the Waiver Renewal Application and Town Hall Conference Call are available on the Division of Developmental Disabilities' website.

<https://dhs.sd.gov/developmentaldisabilities/default.aspx>

### Page 4, Brief Waiver Description –

The CHOICES (Community, Hope, Opportunity, Independence, Careers, Empowerment, Success) waiver program is a 1915(c) waiver designed to provide community-based services and supports to South Dakotans with intellectual/developmental disabilities who would otherwise require institutional level of care. The goal of the CHOICES waiver is to assist individuals in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the state of South Dakota; and promote the integrity of their families.

The objectives of CHOICES are to:

- Deliver services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of safeguards;
- Offer an alternative to institutionalization through the provision of an array of services and supports that promote community inclusion and individuality by enhancing and not replacing existing natural supports;
- Encourage individuals and their families to exercise their rights and share responsibility for the provision of their services and supports; and
- Offer a platform for a person-centered system based on the needs and preferences of the individual.

The Department of Human Services, Division of Developmental Disabilities (DHS/DDD), through a Memorandum of Understanding with the Single State Medicaid Agency (SSMA), operates CHOICES. The SSMA in South Dakota is the Department of Social Services, Division of Medical Services. CHOICES provides services and payment for those services that are not offered under the State Medicaid Plan. CHOICES services are offered statewide. Case management is provided by qualified Medicaid providers that do not provide direct supports to the same individual. The individual's Case Manager assures that the individual's needs are assessed and identified for each service.

**Page 1, Significant changes to this renewal include:**

- 1) Revised the reimbursement methodology in appendix I to align with the fee-for-service methodology outlined in the 2021 rate study
- 2) Revised service definitions for the following services: Residential Habilitation, Day Services, Career Exploration, Individual Support Employment to align with the fee-for-service methodology outlined in the 2021 rate study
- 3) Nursing and Other Medically Related Services- Speech, Hearing & Language were removed as standalone services to align with the fee-for-service methodology outlined in the 2021 rate study
- 4) Added the following services: Assistive Technology, Group Supported Employment, Group Supported Employment- Enclave, Shared Living Residential Habilitation
- 5) Clarified the DHS/DDD response to allegations of ANE;
- 6) Revised the waiver projections for the 5-year cycle of this waiver;
- 7) Updated the ICAP and LOC assessment process; and
- 8) Adjusted certain Performance Measures as suggested by CMS during the Evidence Report process.

**Revision 1) Revised the reimbursement methodology in appendix I to align with the fee-for-service methodology outlined in the 2021 rate study (Appendix I, Financial Accountability)**

Page 169, I-1, Financial Integrity and Accountability  
Page 176, Rates, billing and Claims

a. Rate Determination Methods

*An independent rate build-up approach was used to develop payment rates for covered services. The foundation of the independent rate build-up is direct care*

*worker wages and benefits, which comprise the largest percentage of costs for these services. This approach:*

- Uses a variety of data sources to establish rates for services that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic area.*
- Relies primarily on credible data sources and reported cost data (i.e., costs are not audited, nor are rates compared to costs after a reporting period and adjusted to reflect those costs).*
- Makes additional adjustments to rates to reflect state-specific policy goals – for example, incenting specific kinds of services*

*This approach yields a more transparent rate methodology compared to the current SBR A3 model, by allowing DHS to clearly delineate the components that contribute to rates and make adjustments as needed.*

*The values for each component of the rate models were calculated, and rates were built from the bottom up for each of the waiver services included in the rate study. Costs were determined for each component associated with the direct care provided for a service (for example, direct service professional wages and benefits), identified the corresponding payment amount(s), and added on payment amounts reflecting administration and program support costs required to deliver the service.*

*The independent rate model build-up approach incorporates assumptions about types of employees, wage rates, benefit costs, program support and administration costs, supervisor span of control, staffing patterns, and direct care worker productivity factors. Some of these components vary among services (e.g., staffing patterns) while others are the same across the services (e.g., administrative factor).*

*A two-pronged stakeholder engagement approach involved the formation of a Rate Methodology Workgroup and Steering Committee. DHS communicated the operating norms and scope of the engagement at the start of the rate study process and clarified that the Rate Methodology Workgroup and Steering Committee would work to accurately capture the costs of service delivery in South Dakota and to determine the common principles and parameters that will apply to the future rate setting methodology. The Rate Methodology Workgroup provided subject matter expertise on provider survey and rate methodology development and reviewed and validated rate model factors and assumptions, including wages, benefits, administration, program support and staffing. The Steering Committee validated decision-making processes and reviewed the rate methodology approach.*

*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.*

*The conflict-free case management rate was derived in October 2015 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 adjustments will be calculated using the inflationary rate approved for qualified providers by the South Dakota State Legislature.*

*The fee schedule will be updated with rates for services upon approval of this renewal and will be made available on the DSS website.*

**b. Flow of Billings (page 178)**

*Appendix I-2a describes how the fee schedule and case management rate are determined. The qualified provider is certified as an OHCDs (Organized Health Care Delivery System) by the DHS/DDD pursuant to ARSD Article 46:11.*

*All waiver services are billed by the qualified provider via an electronic billing submitted by the qualified provider to the DSS MMIS. 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.*

*The state uses the OHCDs arrangement for qualified providers who are not case managers to purchase supplies/equipment from vendors who are not Medicaid providers. 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.*

**Revision 2)** Revised **service definitions** for the following services: Residential Habilitation, Day Services, Career Exploration, Individual Support Employment to align with the fee-for-service methodology outlined in the 2021 rate study (Appendix C)

### **Page 59, Career Exploration (was Prevocational Services)**

Services are based on the belief that all individuals with developmental disabilities can work in integrated, competitive employment and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. The outcome of the service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Career Exploration services are designed to assist participants in identifying and developing skills to prepare them for integrated competitive jobs and compensation at or above minimum wage, but not less than customary wage and level of benefits paid by the employer for similar work performed by employees without disabilities.

Primarily focusing on the development of competitive worker traits through a trial-work training model, Career Exploration services can be furnished in a variety of community settings and is not limited to fixed-site facilities. Participant training will include learning the expectations of a competitive work environment, problem solving skills and strategies, and general workplace safety and mobility training.

Career Exploration includes occupational training to teach participants skills for the competitive labor market, and personal training designed to develop appropriate worker traits. Occupational training through this service will include teaching concepts such as following directions, attendance, task completion, problem solving, and workplace safety.

Further Career Exploration components will include training participants on benefits management, the financial information needed by participants when they enter employment in the general workforce, and the use of work-related evaluations which involve the use of planned activities, systematic observation, job shadowing, internships, and work trials to accomplish a formal assessment of the participant skills and interests, including identification of service needs and identification of employment objectives.

Career Exploration services are limited to an 18-month delivery window, with a maximum of two three-month extensions available with DHS approval. Upon culmination of Career Exploration, a participant has identified and is prepared to pursue

additional career goals through other Employment-related Services. The DHS/DDD will preauthorize participant access to Career Exploration as well as requests for extension. Access and requests for extension must include ISP team determination of the person's interest in employment, existing work readiness skills and the length of time likely needed to transition successfully to competitive, integrated employment. The DHS/DDD will determine through the preauthorization process if the supports identified by the ISP team are prevocational rather than vocational in nature.

Participants receiving career exploration services must have an outcome to sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

Transportation between the participant's place of residence and the Career Exploration site is provided as a component of Career Exploration and the cost of this transportation is included in this rate. Participants may choose not to use the transportation provided by the Career Exploration location. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.

Providers of Career Exploration will maintain thorough and timely documentation of services demonstrating full compliance with all programmatic and contractual requirements, the Administrative Rules of South Dakota, and all Department of Human Services and Department of Social Services policies.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Page 60, Career exploration services are limited to 18 months, with a maximum of two three-month extensions with approval by DHS/DDD. Career exploration services cannot occur in a residential setting.

Page 11, Transition plan for the waiver: The Department of Human Services/Division of Developmental Disabilities (DHS/DDD) will update the service title of Prevocational Services with Career Exploration and will implement a time limit. Within one year of June 1, 2020, the participant receiving Career Exploration and their team will meet to determine if Career Exploration continues to be the best service option for the participant. The time required to successfully end Career Exploration and transition the participant into competitive employment and/or integrated community activities will also be discussed at that time. The time required will be reviewed and authorized by the DHS/DDD. This process will be monitored via internal tracking systems within the DHS/DDD to ensure all CHOICES participants do not exceed a maximum of 24 months

of Career Exploration supports unless prior authorization from the DDD is granted after receiving additional documentation from the participant's case manager stating necessary steps/changes in supports and approaches to help the participant reach their desired employment outcome. Each participant's time limit will begin on June 1, 2021.

### **Page 65, Day Habilitation / Day Services**

Services shall be intended to assist the person to gain opportunities for meaningful life experiences in coordination with the person's personal goals and supports and agreed upon by the ISP team. Individuals in this service may not be paid a wage for activities in which they participate.

Activities and environments are designed to:

- Build positive social relationships, interpersonal competence, greater independence and personal choice;
- Foster the acquisition of skills;
- Assist in maintaining skills and functioning and preventing or slowing regression for those with degenerative conditions;
- Empower the person to attain or maintain their highest level of self-determination;
- Occur in coordination with any physical, occupational, or speech therapies listed in the person-centered ISP;
- Include personal care/assistance, but these supports may not comprise the entirety of the service.

Day Services may be provided in integrated, community-based settings to promote volunteer activities that include acquiring, retaining, and improving self-help, socialization, and adaptive skills. Day Services settings may also be provided in fixed site facilities or in certain circumstances, virtually. Day Services does not include compensation or the production of goods or services. Meals provided as part of Day Services shall not constitute a full nutritional regimen.

Transportation between the participant's place of residence and the Day Services site is provided as a component of Day Services and the cost of this transportation is included in this rate. Participants may choose not to use the transportation provided by the Day Services location. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.

Delivery of Facility-Based Day Services is largely based on individual participant to staff ratios and are generally based on each individual's Inventory for Client and Agency Planning (ICAP) Assessment score. Each participant's staffing level will fall into one of three levels: Basic, Intermediate and Enhanced. The Day Services support level for

each participant will be outlined in the participant's ISP after a team discussion involving the Case Manager, Day Service Provider and the participant. Support Level is subject to DHS review and approval. The primary difference across support levels is the number of staff required to support a participant as outlined above. The services are generally the same across all Day Service Support Levels.

Community Support encourages integrating participants into activities in a community-based setting. The increased staffing support level (1:4 or 1:2) allows for appropriate supervision of participants while in the community depending on the needs of the participant. Any participant can receive Community Support Day Services while they are receiving Day Services outside of the facility property and in support of the participant's goals. The level of support required will be identified through the ISP process. In addition to Facility-Based and Community Support, Day Services are also offered through Virtual-Based settings and with additional Behavioral Support Services. Day Services in these additional settings may only be billed under specific circumstances and should be included in the participant's ISP.

Virtual-Based Day Services are reserved for outstanding circumstances that restrict a participant's access to Facility and/or Community Support Day Services. It is not intended for daily use.

Behavioral Support Day Services are reserved for participants who have a demonstrated behavioral need or diagnosis, identified through the ICAP and/or Functional Needs Assessment, and cannot safely participate in Day Services without this additional support. The participant must also have a Behavior Support plan in place prior to receiving Behavioral Support Day Services.

Providers of Day Services will maintain thorough and timely documentation of services demonstrating full compliance with all programmatic and contractual requirements of the South Dakota Administrative Rule and Department of Social Services policy.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

This service excludes room and board costs and maintenance other than assuring health and safety. Facility, Community, and/or Virtual Day Services cannot be billed concurrently.

### **Page 73, Residential Habilitation**

Residential Habilitation services are provided to participants living in their own home, which may include a group home or supervised apartment. Residential Habilitation services shall provide the participant with the opportunity to live as independently as possible, with the supports needed to maintain their safety. Services may include, but are not limited to, assistance in acquiring, retaining, and improving skills related to activities of daily living, such as oral and personal hygiene, bathing, toileting, dressing,

personal grooming and cleanliness, bed making, dusting, vacuuming, cleaning, laundry and housekeeping chores, simple home maintenance tasks, eating, cooking and the preparation of food, shopping, money management, budgeting, safety and self-help, recreation and socialization, and adaptive skills necessary for the person's health and welfare.

Payments for Residential Habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of participants, or to meet the requirements of the applicable life safety code. Payments will not be made for the routine care and supervision which would be expected to be provided by a family (i.e., activities that would be performed ordinarily for an individual without a disability and/or chronic illness of the same age) or for activities or supervision for which a payment is made by a source other than Medicaid.

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

Group home participants receive services and supports from a setting staffed 24 hours daily. When necessary, the provider will accompany participants and facilitate their participation in visits for medical care, therapies, personal shopping, recreation and other community activities.

**Supervised Living:** Residential settings offering services that support a person in his or her home or apartment, when the provider does not have round-the-clock responsibility for the person's health and welfare. These services can be provided in other community settings, but are primarily furnished in a person's home or apartment. Supervised Living model assumes that residential staff are not needed during nighttime hours as well as daytime hours when residents are employed outside the home or participating in day services.

**Monitored Living:** Residential settings offering services that support a person in his or her home, shared family home, or apartment, when the provider furnishes services intermittently to the individual. These services can be provided in other community settings, but are primarily furnished in a person's home or apartment. This service may include supervision, socialization, and assistance for a participant to maintain safety in the home and community, and to enhance independence. This service may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements. Remote support is the provision of community residential services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology that utilizes live two-way communication. Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health,

safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time. The use of remote supports must receive prior authorization by DHS/DDD.

Transportation between the participant's place of residence and other service sites or places in the community is provided as a component of Residential Habilitation services and the cost of this transportation is included in the rate. Participants may choose not to use the transportation provided by the group home. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.

Transportation to/from Day Services, Employment-related Services and appointments w/ physicians are included in the rate for those services.

This service excludes room and board costs and maintenance other than assuring health and safety.

### **Page 78, Supported Employment / Individual**

Services are based on the belief that all individuals with developmental disabilities can work in integrated, competitive employment and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change.

Supported Employment services are supports to a participant to obtain and maintain a job in integrated competitive employment, customized employment, or self-employment. Services include job coaching, job support, retention, and follow along. Participants may access Supported Employment regardless of whether Pre-Employment services have been previously accessed. Supported Employment is defined as:

- Integrated work setting in the general workforce.
- Compensation at or above the minimum wage for individual supported employment.
- Must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
- Goals and/or supports related to employment are outlined within the person-centered ISP.

Participants receiving Supported Employment services must have an outcome to sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

Discovery: Development of an employment profile as the desired outcome

Job Development: Coordination between the job seeker and employer to identify and negotiate job responsibilities

Stabilization: Provision of necessary supports that result in the person learning job responsibilities, building relationships with supervisor(s) and coworkers, and achieving professional growth as identified by the person

Long-Term Support: Provision of on-going supports as identified by the team or person to sustain long-term employment, which may include re-engagement of additional supports if needed. The delivery of Supported Employment services may include personal care type services as long as those supports do not encompass the entirety of the service.

Supported Employment should not be billed for transportation purposes only, including for pick up and/or drop off assistance when a participant cannot secure transportation to an employment or service site. Transportation between the participant's place of residence and the employment or service site is allowable only when the provider remains onsite to provide Supported Employment services.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

**Revision 3)** Nursing and Other Medically Related Services- Speech, Hearing & Language were removed as standalone services to align with the fee-for-service methodology outlined in the 2021 rate study (Appendix C)

**Revision 4) Added the following services:** Assistive Technology, Group Supported Employment, Group Supported Employment- Enclave, Shared Living Residential Habilitation (Appendix C)

**Page 68, Supported Employment / Group Supported Employment - Enclave**  
Services are based on the belief that all individuals with developmental disabilities can work in integrated, competitive employment and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change.

Unlike Individual and Group Supported Employment, which seeks to provide participants with the supports and training necessary to maintain a job in an integrated competitive employment environment, Group Supported Employment – Enclave services are designed to create a pathway towards integrated community-based employment for those who are not yet ready to receive Group or Individual Supported

Employment services. Participants receiving group supported employment services must have an outcome to sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

Group Supported Employment – Enclave services are expected to specifically involve strategies that enhance a participant's employability in integrated, community settings, but in a separate and distinct area of the business, away from non-disabled workers. Specifically, Enclaves provide structured environments in which individuals can work in the community to develop appropriate work skills and habits that include initiating interaction with coworkers, taking direction from supervisors, making transportation arrangements, and managing time and money.

Successful outcomes for Enclave participants include demonstrated improvement of work skills and employment habits, and/or a Provider recommendation that the Participant advance to Group Supported or another higher tier of Career and Employment services.

Transportation between the participant's place of residence and the employment site is allowable and the cost of this transportation is included in the rate paid to providers of supported employment services. Participants may choose not to use the transportation provided as part of this service. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Between 2-8 individuals supported at a time. Crew work is not limited or excluded from this service.

### **Page 70, Supported Employment / Group Supported Employment**

Services are based on the belief that all individuals with developmental disabilities can work in integrated, competitive employment and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change.

Similar to Individual Supported Employment, the outcome of Group Supported Employment is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Participants receiving group supported employment services must have an outcome to

sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

Group Supported Employment services are supports to a group of participants to obtain and maintain a job in integrated competitive employment, customized employment, or self-employment. Services include job coaching, job support, retention, and follow along. Participants may access Supported Employment regardless of whether Pre-Employment services have been previously accessed. Group Supported Employment is defined as:

- Work setting in the general workforce.
- Compensation at or above the minimum wage for individual supported employment.
- Group Supported Employment can be provided to a group of (2) to (4) individuals.
- Must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
- Goals and/or supports related to employment are outlined within the person-centered ISP.

Participants receiving Supported Employment services must have an outcome for competitive, integrated employment included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

Transportation between the participant's place of residence and the employment site is allowable and the cost of this transportation is included in the rate paid to providers of supported employment services. Participants may choose not to use the transportation provided as part of this service. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.

Between 2-4 participants supported in a group at a time.

### **Page 75, Residential Habilitation / Shared Living Residential Habilitation**

An arrangement of services provided to a participant in private home of a community member or friend. Shared living services are meant to provide a more person-centered approach to supports and are built on the foundation of life sharing, developing natural supports, and being an active member of the community. The Shared Living Provider (SLP) shall provide services, including assistance, support, and guidance in life domain areas such as daily living, safety and security, community living, healthy lifestyle, social interactions, spirituality, citizenship, and advocacy. The SLP shall provide age-appropriate services to the participant as specified in the participant's Individualized

Service Plan (ISP). Family members are allowed to provide Shared Living Residential Habilitation services as an SLP.

This service excludes the cost of room and board.

**Page 81, Other Service / Assistive Technology**

Assistive Technology means a device, item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of the participant.

Assistive Technology service is available to those participants whose Individualized Service Plan (ISP) specifies a need for the assessment of adaptive functioning needs and/or specifies the use of particular assistive technology is necessary to ensure the participant's health, welfare, and safety.

Assistive Technology service includes:

1. The evaluation of the Assistive Technology needs of the participant, including a functional evaluation of the impact of the provision of appropriate Assistive Technology and appropriate services to the participant in the customary environment of the participant.
2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology devices for the participant.
3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology devices.
4. Coordination and use of necessary therapies, interventions, or services with Assistive Technology devices, such as therapies, interventions, or services associated with other services in the participant's ISP.
5. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant in the operation and/or maintenance of the AT device.
6. Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants in the operation and/or maintenance of the AT device.

This service provides an eligible participant with an annual maximum benefit of five thousand dollars (\$5,000/year), calculated relative to the participant's current benefit year.

**Revision 5)** Clarified the DHS/DDD response to allegations of **ANE**; (Appendix F, Participant Rights and Appendix G, Participant Safeguards)

Page 132, G-1, b, State Critical Event or Incident Reporting Requirement

All qualified providers as required in ARSD Article 46:11 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;
- 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 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.

Page 133, G-1, c, Participant Training & Education

Each qualified provider is required pursuant to ARSD Article 46:11 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 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/developmentaldisabilities/default.aspx>

#### Page 134, G1, d, Responsibility for Review of and Response to Critical events or Incidents

Upon receiving the written report of a critical event required by ARSD Article 46:11, the DHS/DDD 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-1b. 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. Pursuant to ARSD 46:11:03:01 Provider policy on abuse, neglect, and exploitation a provider shall have a policy approved by the DHS/DDD containing the follow procedures for an internal investigation: (a) Initiation of the investigation within 48 hours or the next business day, whichever is later; (b) Issuance of preliminary investigation findings to the division within seven calendar days of initiation of the investigation; (c) Issuance of the final investigation findings to the DHS/DDD within 30 calendar days of initiation of the investigation.

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 Specialist. The DHS/DDD Specialist assigned to the qualified provider receives the critical incident report and conducts the initial review. The DHS/DDD Quality Assurance Manager reviews a representative random sample of the critical incident reports. The DHS/DDD Quality Assurance Manager reviews each critical incident report to ensure that all reporting requirements were met and assess if appropriate follow-up was taken by the DHS/DDD Specialist and provider. Recommendations are provided to the provider's assigned DHS/DDD Specialist as appropriate.

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. 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. 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. 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 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 Internal Waiver Review Committee will conduct an external review of critical incidents to identify trends and areas of concerns and provide recommendations to the DHS/DDD. The DHS/DDD Investigation Unit is responsible for investigating instances of alleged abuse, neglect, or exploitation when there is a high likelihood that the life of the participant is in jeopardy, a repeat incident is imminent, or there is a chronic or systemic pattern of abuse, neglect, or exploitation.

The DHS/DDD investigation Unit is responsible for investigation the following situations:

- Allegations of physical, sexual, and emotional abuse and neglect that result in serious or repeated harm to service recipients;
- Allegations of repeated financial exploitation that result in serious harm to participants
- Deaths that occurred unexpectedly and that appear or are alleged to be due to provider or case manager misconduct, abuse, or neglect
- Incidents that result in potentially life-threatening or serious injury or illness that appear or are alleged to be due to provider or case manager misconduct, abuse, or neglect or that occurred under suspicious circumstances (e.g., repetitive ER visits, multiple uses of physical restraints per day);
- Incidents that result in potentially life-threatening or serious injury that were due to environmental hazards (e.g., fires, drownings, serious automobile accidents, weather emergencies); and
- Incidents that result in criminal charges or incarceration related to abuse, neglect, and exploitation of service recipients or employees

The DHS/DDD Investigation Unit will present investigation findings in a standardized template to include: • Findings and observations associated with all completed investigative activities, • The investigation's conclusions, and • The investigation's recommended corrective actions. After the provider receives notice of the investigation findings, the agency will prepare a Plan of Action within 15 days detailing the steps and interventions they plan to put in place to address the concerns identified during the

investigation. The DHS/DDD may impose probation if the investigation findings show that the provider failed to demonstrate substantial compliance with both waiver and administrative rule requirements.

Page 135, G1, e, Responsibility for Oversight of Critical Incidents and Events  
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 or that reported incidents not in compliance of ARSD Article 46:11 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 DHS/DDD Quality Assurance Manager 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 DDD Advisory 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.

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.

**Revision 6)** Revised the waiver projections for the 5-year cycle of this waiver; (Appendix B)

Page 35-36, Number of Participants

Year 1	2741
Year 2	2796
Year 3	2852
Year 4	2909
Year 5	2967

**Revision 7)** Updated the **ICAP and LOC assessment process**; (Appendix B, Participant Access and Eligibility)

**Page 37- B-3, f, Selection of Entrants to the Waiver.**

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

Significant risk means:

Individuals at imminent risk of being homeless or institutionalized;

Individuals who are homeless or institutionalized;

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

Individuals whose health, welfare or safety is in jeopardy.

Individuals in "priority status" will be placed at the top of the waiting list and receive services on a first come first serve basis. An individual who is at risk of abuse, neglect, or exploitation will be prioritized on the priority level list. A referral will be made to the Department of Human Services, Division of Long-Term Services and Supports as the State's Disability Protection Agency and other programs will be explored. Individuals in "applicant status" will receive services on a first come first serve basis but after those in priority status.

#### **Page 46, B-6, d, Level of Care Criteria**

The criteria for entrance into an ICF-ID/DD are as follows:

1. The individual must be developmentally disabled as defined in ARSD 67:54:03:03 (criteria for determining developmental disability); and
2. The QIDP or qualified DHS/DDD staff must determine that the individual is in need of ICF-ID/DD services pursuant to ARSD 67:54:03:04 (determination of need for ICF-ID/DD services).

The Level of Care criteria used to evaluate whether an individual needs CHOICES waiver services are:

1. ICAP (Inventory for Client and Agency Planning) eligibility with a minimum of 3 functional limitations;
2. Psychological examination to determine intellectual or developmental disability;
3. HCBS Waiver Rights Form (DHS-DD-717) to inform the applicant that services are available from the Home and Community Based Services Waiver. This form also assures each applicant is provided with a list of HCBS providers, informed of the appeal process for denial of services if the applicant is determined not eligible, and provided with contact information to request a fair hearing; and
4. A provisional plan of care that designates the specific waiver services that the participant will receive. The Level of Care criteria used to reevaluate whether an individual has a continued need for CHOICES waiver services is ICAP eligibility with a minimum of 3 functional limitations.

**Page 46, B-6, f, Process for Level of Care Evaluation/Reevaluation)**

The process used for evaluating/reevaluating the level of care for waiver participants is as follows:

Initial Evaluation: The individual's selected case manager gathers all forms and information listed below and submits to DHS/DDD for initial evaluation. These forms are:

1. ICAP eligibility with a minimum of 3 functional limitations;
2. Psychological examination to determine developmental disability or intellectual disability; and
3. HCBS Waiver Rights Form (DHS-DD-717) to inform the applicant that services are available from the Home and Community Based Services Waiver. This form also assures each applicant is provided with a list of HCBS providers, informed of the appeal process for denial of services if the applicant is determined not eligible, and provided with contact information to request a fair hearing; and
4. A provisional plan of care that designates the specific waiver services that the participant will receive. The Office of Waiver Management QIDP or qualified DHS/DDD staff determines initial level of care eligibility. The QIDP or qualified DHS/DDD staff then completes the DHS-DD-730 form (recommending to the SSMA the effective date of initial level of care eligibility). This form is sent to the individual's chosen providers and SSMA.

Re-evaluation: Re-evaluation is performed annually. From the Level of Care criteria described above, the state uses a completed ICAP that results in a minimum of three functional limitations assessed by a QIDP or qualified DHS/DDD staff to reevaluate whether an individual has a continued need for CHOICES waiver services.

**Revision 8)** Adjusted certain **Performance Measures** as suggested by CMS during the Evidence Report process. (not included in this document)

**OTHER SECTIONS THAT MIGHT BE OF INTEREST**

**Page 99, HCBS 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.

All residential and non-residential settings were assessed by DHS/DDD to ensure compliance with the HCBS Settings Rule. The results of settings assessments are entered into an online review system used to compile and calculate Qualified Provider compliance.

SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD review of compliance with Qualified Provider requirements including all certification standards and provider training.

SMART 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. Providers are expected to submit a plan for remediation of any identified issues within 10 days.

DHS/DDD specialists conduct onsite validation assessments to ensure that remediation activities meet the requirements of the rule.

All new provider settings are subject to meeting the requirements of the HCBS Settings Rule prior to the delivery of services at the location. Providers are required to complete a self-assessment. DHS/DDD specialists conduct onsite visits to ensure that the provider assessment was accurate. If the DHS/DDD specialists identifies any issues while onsite, the provider is responsible to remediate those issues prior to the delivery of services at the location. After the completion of the remediation, DHS/DDD specialists will validate the setting to ensure remediation activities meet the requirements of the rule.

Additionally, DHS/DDD reviews all provider policies to ensure compliance with the HCBS Settings Rule.

**Page 129, Procedures for Offering Opportunity to Request a Fair Hearing. (not revised)**

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 DHS/DDD Intake Specialist 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 prior to the initiation of services. This form is maintained 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 DHS/DDD Intake Specialist 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 prior to the initiation of services. This form is maintained 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 Article 67:17 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. 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.

**Page 130, State Grievance/Complaint System (not revised)**

All qualified providers are required to maintain a grievance/complaint system as specified in ARSD Article 46:11 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 DHS Long-Term Services and Supports, 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.

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.

Each qualified provider must have written grievance procedures pursuant to ARSD Article 46:11 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 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 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 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 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 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 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.