South Dakota

Home Again SD Operational Protocol – A Money Follows the Person Demonstration Project

OPERATIONAL PROTOCOL VERSION 2

GRANT 93.791

March, 2026

Contents of the MFP OP template

HOW TO USE THE MONEY FOLLOWS THE PERSON OPERATIONAL PROTOCOL TEMPLATE

Purpose

The Operational Protocol (OP) is the operational guide that outlines the Demonstration and addresses how the state or territory will meet the objectives of the Money Follows the Person (MFP) Demonstration. The OP describes how the state or territory will operationalize processes to ensure that the state or territory's Demonstration is equipped with the tools, infrastructure, systems, and policies to make MFP Demonstration goals and initiatives successful.

The state or territory must review and amend the OP every three years, or more frequently as needed, in response to changes in (1) federal, state, or territory law, regulation, or policy impacting MFP eligibility, enrollment, or program operations; and (2) MFP operations, inclusive of changes to any of the required MFP OP elements. Refer to MFP Program Terms and Conditions (PTC) 36 for specific requirements around amending the OP.

While the OP describes "how" the state or territory operates the MFP program, "what" the state or territory plans to do to advance MFP and Medicaid home and community-based services (HCBS) is included in the state or territory's unique MFP Work Plan. Reporting on progress is included in the state or territory's Semi-Annual Progress Report (SAR).

Instructions

The OP template consists of 13 sections. Section A is an overview of the state or territory's MFP Demonstration; sections B through M are the required operational elements of the state or territory's MFP Demonstration. Each section contains prompts for information that are labeled by section and prompt number order (for example, section A.1, prompt A.1.1). The state or territory is required to respond to prompts in each section. Each prompt provides:

- Guidance on how to insert information
- Displays and tools for formatting and inserting information:
  - **Text response boxes.** Information may be entered in multiple lines of text and, where applicable, an external document may be uploaded into a text box.
  - **Table shells.** Table shells display the layout of tables without the information or data. Some table shells contain example entries in red text. Table shell rows may be added if needed. Table shells titled "Example Table" can be modified.
  - **Checkboxes.** Checkboxes are displayed as a checklist in which to place a checkmark to make a selection.

The yellow line at left indicates instructional text and is followed either by a text response box, checkbox, or a table shell.

A few tips for entering information

- Text insertions must be clear, concise, and consistent.
- Directly address each prompt.
- Use the "Other Information" text box when additional information is necessary to further support, explain, or justify a response to a prompt.
- Limit text responses to no more than three pages.

- Use bullet points, tables, flow charts, and diagrams to help break up long sections of text and to briefly summarize information.
- Use preferred terms and spell out first use of acronyms.
- Do not leave prompts blank. Enter “Not Applicable” for OP prompts that are not relevant to the state or territory’s MFP program.

Using hyperlinks and embedding documents

- Use hyperlinks to link to external documents that are relevant to the MFP program, including MFP marketing and educational materials, service-related documents such as assessments and program checklists, and information contained on external websites.
- Hyperlinks must be documented in Appendix A.1 of the OP.
- If you are embedding external documents within the template, follow these instructions and select “Display as icon.” This Word feature allows documents to be embedded as clickable icons and may be a preferable alternative to pasting long documents in the appendix or hyperlinking to a document.
- Accessibility features can be maintained by assigning alt text to the icons representing embedded objects.

Before submitting the OP, complete the following three steps:

1. Ensure that all hyperlinks work.
2. Update the contents of the MFP OP template above by right-clicking anywhere within the field and selecting “Update field.” This will automatically update the page numbers in the contents list.
3. If amending or updating the OP, complete the change log.

Change log

If amending or updating the OP, complete the change log by inserting entries into Table 1. The first two lines of the table provide examples of how to populate the change log.

Table 1. Change log

Section	Prompt	Date of OP submission	Changes made since last revision of OP
A	A.1.1	04/01/2025	Updates to the Gap analysis to include information from 2024 assessments.

SECTION A. MFP PROGRAM OVERVIEW

This section briefly describes how the state or territory's MFP Demonstration is designed to meet unique state or territory long-term services and supports (LTSS) system reform efforts to increase the use of HCBS, rather than institutional LTSS. Use the prompts in this section to report on the state or territory's LTSS system assessment and gap analysis and to identify the state or territory's MFP Demonstration target population and geographic area(s) of service.

A.1. State or territory system and gap analysis

A.1.1. Summary of state or territory LTSS system and gap analysis

The summary must address these components:

- Identify LTSS population needs
- Identify geographic area(s) of need
- Identify ways the state or territory can test new approaches and flexibilities in its Medicaid programs to strengthen HCBS through the MFP Demonstration
- Identify ways to provide opportunities to furnish MFP Demonstration services in a more equitable manner
- Identify and determine measurable, attainable, and timely MFP Demonstration goals and outcomes

In 2007, South Dakota conducted a Gap analysis through House Bill 1156. The bill required a study of the long-term care system to include;

- Long-term care financing, including long-term care insurance;
- Costs of providing long-term care;
- Alternative approaches to providing long-term care;
- Barriers to the provision of quality long-term care services;
- Programs and techniques employed in other states for providing long-term care; and
- Other issues appropriate to the study of the continuum of care.

The study concluded in November 2007 and resulted in a series of key findings. Among those findings were:

- Growth in the elderly population will fuel a rising demand for services;
- South Dakota needs to rebalance and replace nursing facility capacity;
- South Dakota needs to target assisted living capacity towards growing regions;
- South Dakota needs to expand home health care services; and
- South Dakota needs to expand Home and Community-based Services (HCBS)

The findings were evaluated, and the following recommendations were made:

- South Dakota needs to develop a single point of entry system to make access to information, assessment and referral to appropriate service providers easier;

- The Task Force recommends the State of South Dakota expand existing home and community-based services in order to better meet the needs of seniors throughout the state by supporting them to stay in their own homes and communities as long as possible;
- The Task Force recommends the State of South Dakota enhance existing home and community-based services to ensure services are comprehensive and meet the needs of the elderly in South Dakota; and
- South Dakota should right size the nursing facility industry by realigning moratorium bed levels to reflect projected demand for nursing facility services.

Since the recommendations were released in 2008, the State has addressed and completed many of the task force recommendations including implementation of the Aging and Disability Resource Center model and right sizing the nursing home industry via Senate Bill 196.

Additionally, the State formally implemented the Money Follows the person rebalancing demonstration project to further enhance existing Home and Community-Based Services (HCBS).

The State has not conducted another formal gap analysis but continues to utilize qualitative and quantitative data to support necessary changes and enhancements to HCBS including:

- LTSS Needs Assessment – Targeted Completion Summer 2025
- CMS Onsite Review and Corrective Action Plan – 2024
- Access Rule Self-Assessment – 2024

The State utilizes resources such as those listed above for informed decision making when enhancing the Home Again SD program.

A.2. Service areas and target groups of the MFP program

A.2.1. Service areas

Specify the service area(s) in which the MFP Demonstration operates.

☒ State or territory-wide

☐ If not state or territory-wide, indicate specific jurisdictions:

South Dakota

A.2.2. Target groups

Complete Table A.2.2 to indicate the MFP target population(s) included in the state or territory's Demonstration and indicate the corresponding state or territory operating agency administering Medicaid HCBS. Please note that target groups falling into the "Other" category must be defined here and throughout the OP.

Table A.2.2. MFP target population groups

Select all that apply	Target group of eligible individuals	State or territory operating agency
☒	Older adults	SD Department of Human Services
☒	Individuals with physical disabilities (PD)	SD Department of Human Services

Select all that apply	Target group of eligible individuals	State or territory operating agency
☒	Individuals with intellectual and developmental disabilities (I/DD)	SD Department of Human Services
☐	Individuals with mental health and substance use disorders (MH/SUD)	
☐	Other, please specify (e.g., HIV/AIDS, brain injury)	

Describe reasons for targeting certain MFP populations. Include geographic strategies, considerations specific to rural areas, provider network considerations, and alignment with state or territory Olmstead plans and rebalancing strategies.

The State utilizes HCBS 1915(c) waivers to identify target populations for Home Again SD to ensure all recipients receiving MFP demonstration services have on-going community-based supports. This requirement emphasizes recipient safety and well-being and provides a sustained support system to help the recipient remain in the community of their choosing longer.

A.3. Other information

If needed, provide other information regarding the state or territory's service area(s), target populations, or reporting that is not addressed elsewhere in the template.

N/A

SECTION B. PROJECT ADMINISTRATION

B.1. Administrative structure

B.1.1. Organizational chart

Provide an organizational chart that shows the entity responsible for the management of the MFP cooperative agreement and the Authorized Organizational Representative;[1] how the management entity relates to all other departments, agencies, and service systems providing HCBS to MFP participants; and the relationship of the organizational structure to the state or territory Medicaid agency and state or territory Medicaid director (SMD).

Upload the organizational chart into either the appendix or text box or provide an external link.

The South Dakota Department of Social Services (DSS), Division of Medical Services (Medicaid) serves as the single State Medicaid Agency (SMA). As such, Medicaid is the entity responsible for the management of the cooperative agreement and the Authorized Organizational Representative. A copy of the Organizational Chart may be found in Appendix A.3.

B.1.2. Administrative structure

Describe how the state or territory will structure the administration of the MFP program, including how roles and responsibilities will be coordinated across state or territory operating agencies and managed care plans (MCP) (if applicable). Clearly indicate how the organizational and structural administration will function to implement, operate, and monitor the OP elements of the Demonstration.

Example Table B.1.2. Administrative structure

Administrative entity (state/territory, other government entity, MCP or contractor/consultant)	OP element(s)	MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)	Formal commitments (for example, Memorandum of Understanding)
South Dakota Medicaid	All	Lead Entity responsible for implementation and oversight of the MFP Rebalancing Demonstration.	

South Dakota Medicaid serves as the lead entity for the MFP Rebalancing Demonstration. South Dakota Medicaid operates as a fee-for-serve agency with no managed care organizations. The MFP Demonstration Coordinator (Program Director) will be responsible for general project administration and reporting to CMS. The Division of Medical Service's Policy Strategy Manager will provide direct oversight of the Program Director and MFP Rebalancing Demonstration. Data collection and analytics will be handled by the Division's data analytics team with direct supervision by the Deputy Director. The State's Medicaid Director will retain primary oversight responsibility for the program, ensuring strategic alignment with departmental goals and compliance with regulatory standards.

[1] The Authorized Organizational Representative is defined in the MFP Demonstration Program Terms and Conditions (PTC 25).

B.2. Staffing

B.2.1. Project director and data and quality analyst

Upload the job description and performance evaluation criteria for these positions into the appendix or provide an external link.

B.2.2. Other project staff

Complete Example Table B.2.2 for all non-contract positions. Describe the MFP role, responsibilities, and relevant OP element(s) for each position in the last column on the table. Responses for the last column may be provided as table text, embedded documents, external links, or text indicating where the response has been added in the appendix. The relevant OP element(s) for each role are the MFP program components (as defined by the major section headers of this document; for instance, D. Community Engagement, E. Benefits and Services, and H. Reporting) on which the staff person in that position will work.

Example Table B.2.2. MFP Demonstration staff

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
MFP Program Director – Sara Spisak	100%	Administrative	Non-contract	Elements B-M: Serves as the program administrator and main point of contact for the MFP Grant
Data Analyst – Zachary King	25%	Administrative	Non-contract	Elements H-I: Collect and analyze data for reporting measures and establishing benchmarks.
Policy Strategy Manager – Ashley Lauing	10%	Administrative	Non-contract	Element B-C: Provides administrative oversight of the MFP program director, implements marketing and recruitment, serves as liaison to Medicaid administration in SD.
Administrative Assistant – Katie Stager	10%	Administrative	Non-contract	Element B: Processes invoices and claims for recipients and transition coordinator agencies

B.2.3. In-kind support

Describe positions providing in-kind support (that is, support from non-MFP staff) to the MFP Demonstration. Indicate the percentage of time each individual or position is dedicated to the grant and the roles and responsibilities of each position. Indicate the OP element(s) the positions will support. If a large number of staff provide in-kind support to the MFP Demonstration, describe the staff in general or aggregate terms, such as contracting specialists, fiscal staff, etc.

N/A

B.2.4. Staffing and contract execution timeline

Provide a hiring timeline (start and end date) for non-contract staff. For contract, consultant, or subrecipient positions, provide the contract execution date and expected expiration/end date.

Contracts for Transition Coordinator Agencies run annually from June 1 – May 31.

Non-contracted staff are on an as-needed basis, during periods where staff positions are vacant other non-contracted staff absorb duties on a temporary basis.

B.3. Billing and reimbursement

B.3.1. Billing and reimbursement procedures

Describe how the state or territory will establish billing and reimbursement procedures to link Medicaid claims to MFP individuals. Include the following:

- Description of MFP identifier codes in the Medicaid Management Information System (MMIS) and if applicable in the state or territory accounting system
- Description of procedures for ensuring against duplication of payment for the Demonstration and Medicaid programs
- If the state or territory operates a managed long-term services and supports (MLTSS) program, description of your state or territory's managed care claiming methodology to determine the portion of the capitation rate that is attributable to qualified HCBS listed in Attachment A of the MFP PTC
- Procedures for fraud control and monitoring

Medicaid has programming in MMIS that looks at claims history that would match the current claim. If there is a claim already on file for the same date of service and procedure billed by the same provider, the claim will more than likely deny for a duplicate. The system also checks the procedure code to make sure another provider hasn't been billed for the services on the same date. That claim may pend as possible duplicate. When all validations have passed, MMIS assigns a budgetary account code (BAC) that is reported to finance and allows for those Medicaid claims to be linked directly the MFP individual.

Account Code: 52041300

Center User Codes:

31201 Demonstration Services (general MFP budget, EFmap)

31202 Qualified Waiver Services (general MFP budget, Efmap)

31203 Capacity Building Services (Capacity Building Budget, Grant Funding)

31204 Supplemental Services (general MFP budget, Grant Funding)

The State has processes in place for fraud control and monitoring. Those processes can be found in the General Coverage Principles billing and policy manual on pages 6-7 located at https://dss.sd.gov/docs/medicaid/providers/billingmanuals/General/General_Coverage_Principles.pdf.

B.4. Budget process

B.4.1. Budget development process

Describe how the state or territory will prepare the MFP budget. Include the following:

- Process for projecting annual expenditures
- Cross-agency roles and responsibilities for developing, reviewing, and approving the budget
- Procedures for adjusting or reconciling the budget

The State utilizes a structured, data-driven approach to prepare the Money Follows the Person (MFP) budget. Annual expenditure projections are based on historical data and spending trends from prior program years, adjusted for anticipated program changes, enrollment growth, and other relevant factors.

The State Medicaid Agency (SMA) holds sole responsibility for developing, reviewing, and approving the MFP budget. However, the SMA collaborates closely with the Department of Human Services (DHS), which administers the 1915(c) Home and Community-Based Services (HCBS) waivers. While the SMA maintains final budget authority, it takes into consideration projected costs and planned activities shared by DHS to ensure alignment across programs and services that impact MFP participants.

The State employs a standardized process for budget adjustments and reconciliation. This includes regular reviews of actual expenditures against projections, with mid-year and end-of-year reconciliation procedures in place to identify and implement necessary budget modifications. Adjustments are documented and justified in accordance with State financial policies and federal reporting requirements to ensure fiscal integrity and program compliance.

B.5. Other information

If needed, provide other information regarding the state or territory's MFP Demonstration administration that is not addressed elsewhere in the template.

N/A

SECTION C. RECRUITMENT, ENROLLMENT, OUTREACH, AND EDUCATION

C.1. MFP-qualified inpatient facility recruitment

C.1.1. MFP-qualified inpatient facility types

In Table C.1.1, describe how the state or territory will collect and verify that MFP participants are transitioning to the community from an MFP-qualified inpatient facility. Describe the process for each target population and inpatient facility type. If there are multiple "other" populations to note, illustrate the type(s) of inpatient facilities separately for each "other" population with a new row.

Table C.1.1. MFP-qualified inpatient facility type by target group

Target population(s)	MFP-qualified inpatient facility types from which the target population will transition	Description of data collection and verification procedures
Older adults	☒ Nursing facility ☒ ICF/IID ☒ Hospital ☐ IMD	MFP program administration requires verification of in-patient stay meeting the length of stay requirements using MMIS Level of Care data before forwarding the referral to the appropriate 1915(c) HCBS Waiver.
Individuals with PD	☒ Nursing facility ☒ ICF/IID ☒ Hospital ☐ IMD	MFP program administration requires verification of in-patient stay meeting the length of stay requirements using MMIS Level of Care data before forwarding the referral to the appropriate 1915(c) HCBS Waiver.
Individuals with I/DD	☒ Nursing facility ☒ ICF/IID ☒ Hospital ☐ IMD	MFP program administration requires verification of in-patient stay meeting the length of stay requirements using MMIS Level of Care data before forwarding the referral to the appropriate 1915(c) HCBS Waiver.
Individuals with MH/SUD	☐ Nursing facility ☐ ICF/IID ☐ Hospital ☐ IMD	
Other, please specify in text box below (e.g., HIV/AIDS, brain injury) Click or tap here to enter text.	☐ Nursing facility ☐ ICF/IID ☐ Hospital ☐ IMD	

Note: MFP programs transitioning MFP participants from an IMD (see PTC 14) must provide a description in section C.1.2 of the OP of how the state or territory will verify certain requirements, such as that the individual meets MFP individual eligibility criteria.
ICF/IID = Intermediate Care Facility for Individuals with Intellectual Disabilities; IMD = Institution for Mental Diseases.

C.1.2. Institution for mental diseases (IMD) exclusion

For MFP programs transitioning MFP participants from an IMD (see PTC 14), provide a description of how the state or territory will verify that the:

- Individual meets the MFP individual eligibility criteria

- Individual is receiving one of these benefits:
  - Services for individuals ages 65 and older in an IMD, referred to as “IMD over 65”
  - Inpatient psychiatric services for individuals younger than 21, referred to as “psych under 21”
  - Medicaid beneficiaries ages 21 through 64 residing in an IMD who are receiving services that are covered under a Substance Use Disorder or Serious Mental Illness section 1115 demonstration

N/A

C.1.3. Strategies for recruiting MFP-qualified inpatient facilities

Describe strategies for recruiting MFP-qualified inpatient facilities to engage in the development and implementation of person-centered transition programs that offer residents the choice of leaving the facility to return to the community. Include geographic strategies, considerations specific to rural areas, alignment with state or territory Olmstead plans and rebalancing strategies, and facility access and engagement approaches.

The program employs a multi-faceted outreach and recruitment approach to engage MFP-qualified inpatient facilities in the development and implementation of person-centered transition programs. These strategies aim to provide facility residents with the informed choice to transition back to the community, aligning with the state’s Olmstead plan and rebalancing goals.

- Outreach Events and Conferences: The program actively participates in statewide and regional healthcare conferences, long-term care association meetings, and community health expos to promote awareness of the Home Again SD program. These events serve as platforms to engage facility administrators, care managers, and social workers, providing them with information on the benefits of participating in Home Again and encouraging them to make Home Again SD part of every discharge plan.
- Directed Facility Outreach: A targeted outreach campaign identifies and engages MFP-qualified inpatient facilities across the state. Outreach efforts include direct communication through personalized letters and toolkits highlighting the benefits of collaboration such as improved resident outcomes and funding for transition supports.
- Site Visits: Conducted by program representatives to establish relationships, assess facility readiness, and address potential barriers to engagement.
- Facility Access and Engagement Approaches: To facilitate access and engagement the program utilizes resource sharing where facilities are provided with toolkits, success stories, and case studies that highlight the program’s impact on residents and participating facilities. The program also establishes partnerships with professional organizations, advocacy groups, and state agencies to reinforce the importance of facility participation

C.2. MFP participant recruitment and enrollment

C.2.1. Eligibility criteria for participation in MFP

Describe any state or territory-specific MFP eligibility criteria. For example, describe your state or territory’s requirements for individuals’ length of stay in an MFP-qualified inpatient facility if more than 60 consecutive days. See section IV of the MFP PTC for a description of MFP eligibility criteria.

Recipients must meet all of the following eligibility criteria to receive Home Again SD services:

- Age 18 or older.
- A resident of South Dakota.

- Enrolled in Medicaid or has a pending Medicaid application.
    - Recipients may not transition prior to Medicaid approval but referrals will be accepted for those with a pending Medicaid application.
- Resides in nursing facility, ICF/ID or other qualifying institution for 60 or more consecutive days.
- Meets South Dakota Medicaid HCBS 1915(c) waiver level of care with financial eligibility criteria at least one day prior to transition.
- Will reside in qualified housing upon transition in one of the following:
    - A home either owned or leased by the participant or his/her family;
    - An apartment with an individual lease that has lockable access and its own living, sleeping, bathing, and cooking areas;
    - A group home with no more than four unrelated individuals residing together and;
    - An assisted living facility that meets the criteria of an apartment.
- Is willing to enroll in and can be supported in the community through the provision of an existing 1915(c)HCBS waiver.
- Expresses a desire to live and receive services in a home and community-based setting.

C.2.2. Participant recruitment and enrollment process

Describe the MFP participant recruitment and enrollment process, indicating differences as applicable for each target group and inpatient facility type identified in C.1.1. Include the following:

- Describe the process to identify eligible individuals interested in transitioning from an inpatient facility to a qualified residence.
- Describe the role of No Wrong Door (NWD) systems to recruit and enroll MFP participants.
- Describe how the state or territory will verify MFP individual eligibility criteria.
- Describe the provider(s) rendering services to recruit and enroll individuals into MFP.
- Describe how the state or territory will ensure a person-centered planning process during the MFP recruitment and enrollment process. The person-centered planning process must include a person-centered service plan that identifies the individual's needs and individualized strategies and interventions for meeting those needs and be led by the individual and the individual's legally authorized representative if applicable.

When a referral is sent to the MFP/Home Again program, the program director (PD) will review the eligibility criteria noted previously in C.2.1.

- The PD checks Medicaid eligibility via MMIS.
    - If MMIS does not show current eligibility, the PD contacts the Division of Economic Assistance (EA) – the division responsible for Medicaid enrollment – to confirm an application for Medical Assistance has been filed. In instances where an application for Medical Assistance is not on file with EA, the PD will inform the referring entity that an application for Medical Assistance will need to be completed.
- To confirm level of care, the PD utilizes MMIS to verify the LOC on file is a Home Again allowable level of care (LOC).
    - If the LOC in MMIS is not a Home Again approved LOC, the PD requests a preliminary review of LOC by the DHS Division of Long Term Services and Supports (LTSS).
- The PD confirms the number of days in a qualified institution before transition activities occur.

    - The PD may utilize MMIS, or a medical records review, or a combination of both to confirm the recipient has had continuous confinement in a(n) eligible institution(s) for 60 or more days.
        - In some circumstances, the PD may assign the recipient to a Transition Coordinator (TC) before 60 days has been reached when the PD has been informed a recipient will exceed 60 days of continuous confinement but will be eligible to move home sometime after the 60 days. In those circumstances, the Transition Coordinator may perform some services to facilitate a move back to Home Again eligible housing as soon as the recipient is medically discharged.

Referrals may come from any source, including self-referral, family/friend referrals, institutional level referrals, or referrals submitted to the State's NWD system, Dakota at Home. Dakota at Home reviews all calls, inquiries, and referrals and forwards all recipients who may be eligible for Home Again services to the PD. All referrals are reviewed and considered by the PD for services. Referrals are only denied if the recipient will not meet eligibility requirements or if the transition is deemed unsafe by State waiver staff.

- A transition would be considered unsafe in the following circumstances, this is not an all-inclusive list, and each case is determined on a case-by-case basis to ensure the safety and well-being of the recipient:
    - If the recipient is unable to receive care in the community of choice due to provider shortages and is unwilling to relocate to another community (e.g., tracheostomy care).
    - If the recipient is unwilling to participate in a 1915(c) HCBS waiver upon discharge.
    - If the recipient's required care would place them at high risk of reinstituionalization despite receiving cares in the community (e.g., high fall risk).

Recruitment is the sole responsibility of the SMA. The SMA utilizes comprehensive marketing efforts across the State to outreach and recruit new participants. Additionally, the PD and other staff attend multiple conferences throughout the year to provide education to facilities, providers, and care givers about the program.

Person-Centered Planning is at the core of all Home Again transitions and starts as soon as a referral is received with the initial question "Do you wish to live and receive services in the community"? Once the recipient confirms they wish to live and receive services in the community, the TCs begin utilizing a person-centered planning approach to transition the recipient from an institutional setting to the community of their choosing. The TCs are required to submit a copy of the person-centered plan to the PD for review and are required to provide a warm handoff to the waiver specialist who will be overseeing the recipient's participation in the HCBS waiver.

C.2.3. Data sources for recruiting MFP participants

Describe how the state or territory will process and organize data sources to identify and recruit MFP participants. The description must include the use of the Minimum Data Set (MDS) Section Q and must describe any variability among MFP target populations, MFP-qualified inpatient facilities, and state or territory operating agencies.

South Dakota utilizes a variety of data sources to identify and recruit individuals eligible for participation in the Money Follows the Person (MFP) program, beyond the federally mandated use of the Minimum Data Set (MDS) Section Q. Section Q of the MDS is used to identify nursing facility residents who express a desire to return to the community. These referrals are routed to the state's NWD system, Dakota at Home.

In addition to MDS Section Q, South Dakota uses the following data sources:

- Pre-Admission Screening and Resident Review (PASRR):
    - The PASRR process is used to evaluate individuals prior to or upon admission to a nursing facility. PASRR Level II assessments often identify individuals who are appropriate for community-based care and may benefit from transition supports under MFP. Recipients who would be considered good candidates for MFP are referred by the state's PASRR nurse directly to the program.
- Long-Term Services and Supports (LTSS) Assessment Data:
    - Functional assessments conducted for eligibility determinations under the ADLS, CHOICES, Family Support 360, and HOPE waivers are used to identify individuals who are eligible for HCBS and may be appropriate for MFP transition. These assessments include indicators of individual preferences, support needs, and potential community supports. Case managers refer MFP eligible recipients to the state's NWD system.
- Referral and Case Management Systems:
    - Case managers serving the ADLS, CHOICES, FS360, and HOPE waivers are in regular contact with institutionalized individuals and receive referrals from nursing facilities, state hospitals, family members, and community-based organizations. These case managers are often the first point of contact for individuals expressing interest in transitioning to the community and play a central role in assessing readiness, coordinating transition planning, and referring individuals to the MFP program. Case managers refer MFP eligible recipients to the state's NWD system.

To enhance its identification and recruitment strategies, South Dakota may consider integrating Medicaid Management Information System (MMIS) data to systematically flag individuals with extended institutional stays or those experiencing frequent re-admissions. MMIS data can help proactively identify MFP-eligible individuals based on claims history and service utilization patterns.

Additionally, the state may consider using nursing facility quality review data, such as rates of Section Q referrals or indicators of facility readiness to support discharge planning. This would allow South Dakota to target outreach to facilities with high transition potential and strengthen quality improvement efforts.

These strategies will be refined and aligned with the state's broader LTSS and waiver data systems to ensure that all MFP participants remain enrolled in a 1915(c) waiver, and that outreach and enrollment processes are tailored to the needs of each target population and setting type.

C.3. Outreach and marketing to participants, providers, and the community

C.3.1. Marketing plan

Describe how the state or territory will develop and implement a marketing plan to recruit and enroll MFP participants. Include a description of the following:

- Strategy or strategies to provide cultural, linguistic, and disability competency in the production and dissemination of marketing materials
- Types of marketing materials and tools
- Types of media approaches (print, radio, television, direct mail, social media, search engine, and so on)

Upload printed marketing materials or provide an external link to the materials in the appendix, as appropriate.

The State's marketing, outreach, and education plan can be found in Appendix A.6.

C.3.2. Outreach and education plan

Describe how the state or territory will develop and implement an outreach and education plan to recruit MFP-inpatient providers, service providers, affordable and accessible housing providers, community-based organizations, and other relevant entities. Include a description of the following:

- Methods and tools
- Collaboration opportunities
- Types of events and trainings

Upload outreach and education materials into the appendix or provide an external link.

The State's marketing, outreach, and education plan can be found in Appendix A.6.

C.3.3. Stevens Amendment and accessibility requirements

Select the boxes below to confirm the state or territory adheres to the requirements regarding the Stevens Amendment and complies with accessibility laws.

☒ The state or territory affirms that it has established procedures for complying with the requirement in Section 26.G and 26.H of the CMS Standard Terms and Conditions (STC) regarding the Stevens Amendment, which describes actions federal award recipients must take when engaging in public reporting and acknowledgement of sponsors.

☒ The state or territory acknowledges responsibility for complying with federal laws regarding accessibility (Attachment B of CMS STC).

C.4. Informed consent

C.4.1. Informed consent criteria

Describe how the state or territory will implement procedures for obtaining informed consent. Include the following:

- Process for ensuring that each eligible individual or the individual's legally authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP Demonstration
- Process for ensuring that each eligible individual or the individual's legally authorized representative will have input into, and approve the selection of, the qualified residence in which the individual will reside and the setting in which the individual will receive HCBS
- Process for ensuring individuals are informed about all aspects of the transition process; have full knowledge of the services and supports that will be provided both during and after the program year; and are informed of their rights and responsibilities as a participant, including the right to file reports or complaints regarding violation of their rights or other critical incidents
- Method(s) for obtaining informed consent (written, verbal, digital, and so on)

Provide an external link to informed consent forms and informational material. Alternatively, paste or embed those materials into the appendix or the text box below. If using the appendix, use the text box to indicate where in the appendix these materials can be found.

The State implements a comprehensive, person-centered process to ensure that all eligible individuals or their legally authorized representatives (LAR) are fully informed and able to make voluntary decisions about participation in the MFP Demonstration. Informed consent is obtained in writing through a standardized consent form signed by the individual or LAR.

- Ensuring Informed Choice Regarding Program Participation:

  All individuals who meet initial eligibility criteria for MFP are provided detailed information about the program prior to enrollment. This includes:

  - A clear explanation of MFP goals, services available during the 365-day demonstration period, and the voluntary nature of participation
  - A review of eligibility requirements, transition process, and any risks or benefits
  - Confirmation that participation is not required to receive Medicaid services and can be declined at any time

  Consent is not obtained until this information is discussed and the individual or LAR demonstrates understanding.

- Ensuring Choice of Qualified Residence and HCBS Setting

  Each individual or LAR has input into the selection of the qualified residence to which they will transition and the HCBS settings where services will be provided.

  - The transition plan includes documented evidence of the individual's or LAR's approval of the chosen residence and HCBS providers
  - The individual's choice is central to the planning and is revisited prior to finalizing the move

- Ensuring Full Understanding of Transition Process, Services, and Rights

  Prior to giving informed consent, individuals and/or LARs are provided with comprehensive information about:

  - The services and supports they will receive during the transition and throughout the MFP demonstration period
  - Their rights as an MFP participant, including the right to receive services in the least restrictive setting, the right to file grievances or critical incident reports, and protections under the state's HCBS and Medicaid policies

- Method for Obtaining Informed Consent

  Informed consent is primarily obtained in written form, using the State's standardized MFP informed consent document. This document is signed by the eligible individual or the LAR prior to transition. The consent form affirms that the individual has received and understands all relevant information and voluntarily agrees to participate.
  Alternative formats such as verbal or digital consent may be used in limited circumstances (e.g., during telehealth interactions or where written consent is not immediately feasible), provided that consent is documented and followed by a signed written version as soon as practicable. All forms of consent must be documented in the individual's file.

A copy of the standardized authorization and informed consent document is attached in Appendix A.7.

C.5. Legally authorized representative

C.5.1. Procedures for MFP engagement with a legally authorized representative

Describe how the MFP Demonstration will engage with a legally authorized representative and how the process aligns with state or territory policy. Include the following:

- Procedures for engaging with a legally authorized representative as part of an individual's person-centered planning process during the transition period and the 365-day MFP enrollment period
- Specific strategies and approaches when working with inpatient facility administrators who are serving as a legally authorized representative, particularly around identifying and eliminating conflict of interest concerns
- Process for verifying that an MFP participant's legally authorized representative has (1) a known relationship with the individual; (2) ongoing interaction with the individual; and (3) recent knowledge of the individual's welfare
- Engagement of LARs During the Transition and 365-Day Enrollment Period: When applicable, the State ensures that legally authorized representatives (LARs) are fully engaged throughout the individual's transition from an institutional setting into a qualified community residence, and throughout the 365-day MFP demonstration period.
    - Upon identification of an eligible individual, the MFP transition coordinator confirms the presence of an LAR, defined per South Dakota law (SDCL § 34-12H and § 34-12C for guardianship and health care consent statutes), and obtains documentation of the representative's legal authority (e.g., guardianship orders, power of attorney, or court orders).
    - LARs are included in all planning meetings and are involved in the person-centered service planning process, consistent with the individual's preferences and consent.
    - The LAR is expected to support decision-making that reflects the individual's values, preferences, and best interests, consistent with both MFP and state person-centered planning policy.
    - Communication with the LAR is documented in the participant's case file and includes all major transition and service planning decisions.

- Addressing Conflict of Interest When Inpatient Facility Staff Act as LARs: In rare cases where an inpatient facility administrator or staff member is serving as the LAR (such as emergency guardianship under SDCL § 29A-5-312), the State takes additional steps to identify and address potential conflicts of interest:
    - The MFP transition team prioritizes efforts to identify and engage an alternative, less conflicted, representative—preferably a relative or someone with a personal connection to the individual.
    - When a facility staff member serves as a temporary guardian, the State ensures decisions are independently reviewed and consistent with the individual's expressed wishes, if known.
- Verifying the Appropriateness of the LAR Relationship: To ensure that an MFP participant's LAR is a suitable and informed decision-maker, the following verification procedures are in place:

- Known Relationship: The transition coordinator verifies that the LAR has a documented legal relationship with the participant through guardianship, medical power of attorney, or other applicable legal designation recognized by South Dakota statutes.
- Ongoing Interaction: The transition coordinator confirms, through interviews and collateral documentation, that the LAR has maintained regular contact or interaction with the individual (e.g., visits, phone calls, written communication) prior to and during the transition process.
- Recent Knowledge of Welfare: The LAR must demonstrate a current understanding of the individual's needs, preferences, health status, and goals. This is assessed through direct conversations and their active involvement in transition and care planning meetings. Documentation of this verification is maintained in the participant's file.

C.5.2. Re-enrollment

Describe the state or territory's MFP re-enrollment policy (1) for individuals who have been re-institutionalized or hospitalized prior to completing their 365-day MFP enrollment period, and (2) for individuals who have been re-institutionalized after completing their 365-day MFP enrollment period. Include actions that occur at 30- and 60-day intervals during an individual's institutional or hospital stay.

Recipients who have been reinstitutionalized prior to completing their 365-day MFP enrollment period for less than 30 days remain enrolled on the program with no changes to enrollment or eligibility. For those recipients who are institutionalized for more than 30 days are disenrolled from the program but remain eligible for reenrollment if they meet MFP eligibility criteria.

Recipients who have been reinstitutionalized after completing their 365-day MFP enrollment period are eligible to reapply for the program if they meet eligibility criteria.

C.6. Other information

If needed, provide other information regarding the state or territory's approach to recruitment, enrollment, outreach, and education that is not addressed elsewhere in the template.

N/A

SECTION D. COMMUNITY ENGAGEMENT

Describe how the state or territory will engage the broad community, including but not limited to, Medicaid agency leadership, participants in HCBS programs, residents in long-term care facilities, long-term care facility staff, family members and other caregivers, HCBS providers, the aging and disability network, MCPs, housing providers, and the direct care workforce, to inform the state or territory's approach to the design of the MFP Demonstration and how the state or territory can leverage the MFP Demonstration to expand and enhance the HCBS system. Include a description of the state or territory's strategy(s), structure of the engagement process, engagement tools, communication process, and how the process will be strengthened throughout the MFP program period of performance.

The state employs a comprehensive and inclusive approach to community engagement to inform the design and implementation of the Money Follows the Person (MFP) Demonstration. Key strategies include leveraging existing advisory structures and fostering collaboration across stakeholders to shape policies and enhance the HCBS system.

Engagement Strategies and Structures:

- Advisory Committees: The state utilizes the Medicaid Advisory Committee (MAC) to gather input from Medicaid participants, beneficiaries, and other stakeholders.
- Tribal Consultation: Ongoing tribal consultations ensure the inclusion of tribal perspectives and alignment with the unique needs of tribal communities.
- Collaborative Meetings: Regular engagement with agencies administering 1915(c) HCBS waivers, which rely on their advisory boards and committees, ensure consistent alignment with broader HCBS policy goals.

Engagement Tools and Communication Processes:

- Engagement Tools: the State utilizes stakeholder groups, virtual and in-person advisory meetings, and participant surveys to ensure accessible and varied participation opportunities.
- Communication Processes: Transparent communication is maintained through newsletters, public meetings, and updates to state websites.

Strengthening the Process:

Throughout the performance period the State and Home Again SD will:

- Actively engage the Beneficiary Advisory Council (BAC) to inform policy decisions and changes to the MFP program.
- Foster cross-agency collaboration to integrate diverse perspectives into policy development.
- Monitor engagement effectiveness and adjust approaches as necessary to ensure inclusivity and meaningful participation.

By leveraging advisory structures, fostering partnerships, and maintaining transparent communication, the state will ensure a community-informed approach to designing the MFP Demonstration and enhancing the HCBS system.

D.1. Community engagement process

States or territories may use Example Table D.1 to list those engaged in the design and implementation of the MFP Demonstration; to indicate the related OP element(s); and a brief description of the engagement structure, including the type and frequency of engagement and role(s) in the engagement process.

Example Table D.1. Description and frequency of community engagement

Entities	OP elements	Description of the engagement process
Medicaid Advisory Committee	All	Substantive changes made to the administration of the MFP grant and Home Again programs are presented for comment and input from the Medicaid Advisory Council (MAC). The MAC meets on a quarterly basis.
Tribal Consultation	All	Substantive changes made to the administration of the MFP grant and Home Again programs are presented for comment and input during Tribal Consultation meetings. Tribal consultation meetings are held on a quarterly basis.
Division of Human Services	All	As the entity responsible for administering HCBS waivers, the Division of Human services is frequently engaged in the design of the Home Again program. This helps ensure a seamless transition from the transition coordinators to waiver supervisors and HCBS staff.

D.2. Other information

If needed, provide other information regarding the state or territory's approach to engagement that is not addressed elsewhere in the template.

N/A

SECTION E. BENEFITS AND SERVICES

Describe how the MFP Demonstration will provide opportunities for MFP participants to receive high-quality services in their own homes or community rather than institutions. The state or territory must describe qualified HCBS (PTC 16 and Attachment A in the PTC), Demonstration services (PTC 17), and supplemental services (PTC 24) that it will provide under the MFP Demonstration.

E.1. Qualified HCBS

The qualified HCBS program is the Medicaid service package(s) that the state or territory will make available to an MFP participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based state plan services and HCBS waiver program services. MFP-qualified HCBS are listed and described in Attachment A to the MFP PTC.

The state or territory must describe:

- Qualified HCBS available to MFP participants
- Target population
- Any proposed Medicaid coverage strategy to amend and implement changes to the state plan or HCBS waiver program(s) to carry out the Demonstration; these descriptions must indicate:
  - The specific HCBS program that will be changed or amended
  - Which authority the HCBS program operates under
  - When the change or amendment will occur

The state or territory may insert information using (1) Example Table E.1, (2) a description in the text response box below, or (3) a combination of both a table and a separate text description.

Example Table E.1. MFP-qualified HCBS

MFP-qualified HCBS	Qualified HCBS description	MFP target population(s)
HCBS under section 1905(a) state plan services	Not Applicable	Not Applicable

HCBS under sections 1915(c), 1915(i), 1915(j) and 1915(k)	Our state provides services through four existing 1915 (c) waiver programs: 1. Home and Community-Based Options and Person-Centered Excellence or "HOPE" Waiver 2. Assistive Daily Living Services or "ADLS" Waiver 3. Community, Hope, Opportunity, Independence, Careers, Empowerment, Success or "CHOICES" Waiver 4. Family Support 360 Waivers	1. Older adults, ages 65+; or Individuals 18 or older with a qualifying physical disability 2. Loss of use of all four limbs as a substantial functional limitation, 18 or older, able to manage and self-direct services or select a representative to manage and direct 3. Individuals 18 or older with Intellectual or Developmental Disability that manifested before age 22 4. Individuals of any age with Intellectual or Developmental Disability (but must be 18 to also qualify with MFP services)
Other HCBS options (describe)	Not Applicable	Not Applicable

The State operates four (4) 1915(c) waivers. A description of each waiver and covered services can be found in the linked billing and provider manuals.

ADLS: https://dss.sd.gov/docs/medicaid/providers/billingmanuals/HCBS/Assistive_Daily_Living_Services.pdf

CHOICES: https://dss.sd.gov/docs/medicaid/providers/billingmanuals/HCBS/CHOICES.pdf

FS360: https://dss.sd.gov/docs/medicaid/providers/billingmanuals/HCBS/Family_Support_360.pdf

HOPE: https://dss.sd.gov/docs/medicaid/providers/billingmanuals/HCBS/Home_and_Community_Based_Options_and_Person-Centered_Excellence.pdf

E.2. MFP Demonstration services

E.2.1. Demonstration service description

MFP Demonstration services are qualified HCBS that could be provided, but are not currently provided, under the state or territory's Medicaid program. Demonstration services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan. The state or territory is expected to test and evaluate Demonstration services. Demonstration services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. Demonstration service descriptions must include:

- The qualified HCBS Medicaid authority under which the service could be covered

- The target population(s) receiving the service
- For a new Demonstration service not currently covered under the state or territory's HCBS program, a description of the scope of the service including a definition of the discrete service; a complete list and description of any goods and services that will be provided; any conditions that apply to the provision of the service; and eligibility criteria
- For a Demonstration service currently authorized under the state or territory's Medicaid program, a description of how the service complements or supplements the authorized HCBS in an amount, frequency, scope, or duration greater than allowed under the state or territory's Medicaid program
- A description of how the state or territory will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant

The state or territory may insert information using (1) Example Table E.2.1, (2) a description in the text response box, or (3) a combination of both a table and a separate text description.

Example Table E.2.1. Demonstration services

Demonstration services are services provided after the recipient has transitioned from the eligible facility to an eligible housing as defined by CMS. These services may be provided on a one-time basis for up to 365 days post-transition after waiver or state plan limits have been reached. Waiver and State Plan limits may be found at www.DSS.SD.Gov. Service limits provided in the table below are Home Again program limits, exceptions to these limits may be requested and approved on an as needed basis.

Demonstration service title	HCBS Medicaid authority	MFP target population(s)	Amount, duration, and scope of service	Service testing and evaluation
Transitional Supports	1915 (c)	Older adults (ELD); Individuals with PD (PD); Individuals with I/DD (DD)	Transitional supports are offered for up to 365 days post-transition or until fund limits are reached. Transitional supports are not available under the state's Medicaid state plan. The following are services and limits. $5,000 – Necessary Housing Supplies (e.g., dishes, towels, linens, cleaning supplies, essential furniture). $5,000 – Essential appliance repair/replacement* All services and supplies must be for the direct benefit of the recipient and they must be considered necessary to prevent reinstitutionalization. * Denotes a service that requires estimates from at least two vendors and prior approval from the MFP PD before purchase or service delivery. The cost of repair may not exceed the cost of replacement.	The State is currently reviewing mechanisms for testing and evaluating the services.

Home Modifications	1915 (c)	Older adults (ELD); Individuals with PD (PD); Individuals with I/DD (DD)	Home modifications may be paid post transition conditional upon the denial from the applicable HCBS waiver. If the applicable HCBS waiver is able provide home modifications, MFP may provide additional funding after waiver limits have been reached. Each waiver's limits are provisional based on service amounts and recipient needs. The following are services and limits. $12,500 – Home Modifications post-transition* * Denotes a service that requires estimates from at least two vendors and prior approval from the MFP PD before purchase or service delivery. The cost of repair may not exceed the cost of replacement.	The State is currently reviewing mechanisms for testing and evaluating the services.
Assistive Technology Supports	1915 (c)	Older adults (ELD); Individuals with PD (PD); Individuals with I/DD (DD)	Assistive technology supports are ongoing supports for up to 365 days post-transition or until fund limits are reached. Some assistive technologies may be covered under the Medicaid plan. In instances where an assistive technology can be covered under the recipient's waiver or Medicaid state plan, those services must be exhausted before utilizing MFP funding. $7,500 – items that allow the recipient to safely, successfully, and as independently as possible, transition to and/or remain in the community.	The State is currently reviewing mechanisms for testing and evaluating the services.

Assistive Technology is provided for, in a more limited way, in each of the four HCBS waivers. The MFP services for assistive technology are intended to expand its definition as purposely broad to allow for items not included in the waiver that would significantly benefit a participant, as well as allow for advances in technology.

The MFP assistive technologies are available to participants to the extent it is not available as a waiver or state plan service. The waivers are not able to provide these until someone is already in their home within the community and are allowed a nominal amount to provide such. There are numerous participants that are in need of such essential supports so that they are able to transition home. MFP provides those that are essential prior to transitioning, so that they may transition home.

If the participant is able to safely and comfortably wait until they are in the home, they would utilize the waiver supports. If they are not able to even transition from the long-term care facility without having them in place, MFP is utilized. The MFP transition coordinators work closely with waiver specialists to ensure the safety and needs of each participant are met.

E.3. MFP supplemental services

E.3.1. Supplemental service descriptions

Supplemental services are one-time services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Supplemental services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan. Supplemental services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. The state or territory is expected to test and evaluate supplemental services. Supplemental service descriptions must include:

- The target population(s) receiving the service
- The category of the supplemental service (short-term housing assistance, food security, payment for activities prior to transitioning from an MFP-qualified inpatient facility, payment for securing a community-based home)
- The scope of the service, including a definition of the discrete service (for example, if providing payment for activities prior to transitioning from an MFP-qualified inpatient facility, describe each discrete activity under this category, such as home accessibility modifications, vehicle adaptations, and home cleaning)
- An assurance that services are responsive to a person's needs and wants described in a person-centered plan
- A complete list and description of any goods and services that will be provided
- Any conditions that apply to the provision of the service
- How the state or territory will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant
- Under the payment for activities prior to transitioning from an MFP-qualified inpatient facility, please include the following information for each discrete activity:
  - Specify the time period for when payment to a provider for rendering the supplemental service will occur (e.g., up to 15 days prior to discharge/transition to the community date)
  - Specify the time period for when the service will be rendered (e.g., up to 15 days prior to discharge/transition date)

The state or territory must insert information using Example Table E.3.1 and may provide additional information in the text response box below.

Example Table E.3.1. Description of supplemental services

Supplemental services must be provided prior to the date of transition. Services must be paid for by the transition coordinator (not invoiced) prior to transition. Some services outlined below may be provided on the date of transition. These services may be provided on a one-time basis after waiver or state plan limits have been reached. Waiver and State Plan limits may be found at www.DSS.SD.Gov. Service limits provided in the table below are Home Again program limits, exceptions to these limits may be requested and approved on an as needed basis.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Transition Coordination Services	Older adults (ELD); Individuals with PD (PD); Individuals with I/DD (DD)	On-going unlimited services prior to transition and HCBS waiver supports.	Services under this category may be rendered prior to and through date of transition. Transition coordination services may include community integration services such as identifying the participant's preferences related to housing, Assisting participant with finding and securing housing as needed. This may include arranging for or providing transportation. Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings. Identify any additional supports or services needed outside the scope of Community Integration services and address among the team. Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.	The state will ensure that supplemental services are responsive to the individual needs and preferences outlined in the participant's person-centered plan. This will be achieved through a collaborative assessment process, direct participant involvement in service selection, and ongoing monitoring to verify alignment with the participant's goals. All services provided will be documented in the service plan, including the participant's acknowledgment and approval. Adjustments will be made as needed to address any changes in the participant's circumstances or preferences.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Food Security/Pantry Stocking	Older adults (ELD); Individuals with PD (PD); Individuals with I/DD (DD)	One-time funding up to $1,500.* *The state may approve requests over this amount under extenuating circumstances. An exceptions request may be made to the PD. All exceptions are reviewed by a member of executive leadership.	Food security supports are one-time funding supports to help obtain necessary groceries, supplies, and items essential to daily living. These supports must be provided in advance of the recipient transitioning. Perishable goods may be purchased the day of transition to prevent spoiling. $800 – groceries and essential kitchen items (See appendix A.5.1.) $700 – personal care items (See appendix A.5.2.)	The state will ensure that supplemental services are responsive to the individual needs and preferences outlined in the participant's person-centered plan. This will be achieved through a collaborative assessment process, direct participant involvement in service selection, and ongoing monitoring to verify alignment with the participant's goals. All services provided will be documented in the service plan, including the participant's acknowledgment and approval. Adjustments will be made as needed to address any changes in the participant's circumstances or preferences.

Activities Prior to Transition	Older adults (ELD); Individuals with PD (PD); Individuals with I/DD (DD)	One-time funding up to $27,900* *The state may approve requests over this amount under extenuating circumstances. An exceptions request may be made to the PD. All exceptions are reviewed by a member of executive leadership.	Activities prior to transition are one-time funding supports for services not covered by the Medicaid state plan or waiver, but are essential to a safe transition home. Services under this category may be rendered up to transition. This also includes the day of transition, particularly for food/pantry stocking items. All services must be paid by transition coordinators agencies on a cash basis, not through an invoice or reimbursement system. Payment must be received to serving provider no later than the date of transition. Any services provided after the date of transition are not allowable under this category, and any services not paid for by the date of transition will not be eligible for coverage. The following are allowed activities and limits: $12,500 – home modifications necessary for the safety of the recipient prior to their transition home.* $400 – initial deep clean of residence. $5,000 – essential appliance repair/replacement* $300 – clothing essentials $500 – seasonally appropriate clothing $200 – safety/survival kits $2,000 – security deposits, utility deposits, and first month's rent. $5,000 – Necessary Housing Supplies (e.g., dishes, towels,	The state will ensure that supplemental services are responsive to the individual needs and preferences outlined in the participant's person-centered plan. This will be achieved through a collaborative assessment process, direct participant involvement in service selection, and ongoing monitoring to verify alignment with the participant's goals. All services provided will be documented in the service plan, including the participants' acknowledgment and approval. Adjustments will be made as needed to address any changes in the participant's circumstances or preferences.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
			linens, cleaning supplies, essential furniture). Transportation supports are one time services related to the relocation from the institutional setting to home. $2,000 – moving expenses and one-time expenses related to transportation from institutional setting to home. This includes lock and key replacement for previously leased storage units. * Denotes a service that requires estimates from at least two vendors and prior approval from the MFP PD before purchase or service delivery. The cost of repair may not exceed the cost of replacement	

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Assistive Technology	Older adults (ELD). Individuals with PD (PD); Individuals with I/DD (DD)	One-time funding up to $7,500* *The state may approve requests over this amount under extenuating circumstances. An exceptions request may be made to the PD. All exceptions are reviewed by a member of executive leadership.	Assistive technology is not covered under Medicaid state plan while the recipient is living in an institutional setting. Additionally, individuals are not eligible for 1915 (c) waiver services while living in an institutional setting. Supplemental services funding for assistive technology is intended to purchase items in advance of the transition that the recipient will need immediately upon transition. $7,500 – Items that allow the recipient to safely, successfully, and as independently as possible, transition to the community.	The state will ensure that supplemental services are responsive to the individual needs and preferences outlined in the participant's person-centered plan. This will be achieved through a collaborative assessment process, direct participant involvement in service selection, and ongoing monitoring to verify alignment with the participant's goals. All services provided will be documented in the service plan, including the participants' acknowledgment and approval. Adjustments will be made as needed to address any changes in the participant's circumstances or preferences.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Securing a Community Home	Older adults (ELD); Individuals with PD (PD); Individuals with I/DD (DD)	One-time funding up to $350* *The state may approve requests over this amount under extenuating circumstances. An exceptions request may be made to the PD. All exceptions are reviewed by a member of executive leadership.	Funding for securing a community home can be used in advance of a transition to pay for housing related costs. The following services and limits are allowed: $350 – housing application fees, and identification cards, copies of birth certificates, etc. necessary to complete applications for housing.	The state will ensure that supplemental services are responsive to the individual needs and preferences outlined in the participant's person-centered plan. This will be achieved through a collaborative assessment process, direct participant involvement in service selection, and ongoing monitoring to verify alignment with the participant's goals. All services provided will be documented in the service plan, including the participants' acknowledgment and approval. Adjustments will be made as needed to address any changes in the participant's circumstances or preferences.

Click or tap here to enter text.

E.3.2. Supplemental services housing plan and food security plan

If providing short-term housing assistance or food pantry stocking, upload the required housing plan or food security plan that describes how these services will be administered and sustained. See the March 31, 2022 Note to MFP Recipients: Announcement of Certain Changes to Supplemental Services under the MFP Demonstration for specific requirements for the housing and food security plans.

Helping increase the length of time to support rental expenses allows MFP participants to begin to rebuild the supports they need to be successful moving forward.

Document the maximum amount of food assistance available per recipient through MFP-funded supplemental services.

• MFP would provide $800 per individual for groceries, including fruits, vegetables, dairy, meat, and grain products and baking items, food storage options, etc. All grocery items purchased would meet standards for SNAP & WIC approved items. (See Attachment A for a detailed listing of options.)

• An additional $700 each would allow for other pantry necessities such as cleaning supplies; as well as personal care items (shampoo/conditioner, soap, toothbrush/paste, floss, deodorant, tissues, razor, shaving cream, feminine products, & other necessities). (See Attachment B for a detailed listing.)

Describe the strategies for developing, strengthening, & maintaining partnerships food assistance programs.
• The Department of Social Services administers a Supplemental Nutrition Assistance Program (SNAP) to individuals and families across the State. SNAP helps support food costs to stay healthy while regaining financial independence. The amount provided is based on household size, income, and allowable expenses. Participation helps stretch limited budgets, improve nutrition, and reduce the risk of diet-related health problems.
• South Dakota's Adult Nutrition Program targets adults aged 60 and older who are in greatest social and economic need with particular attention to: low income, minority, older individuals in rural communities, with limited English proficiency and who are at risk of institutional care. Local supports and volunteers keep these services running and are provided in numerous areas of the state by both providers and tribal providers.

Describe the recipient's plan for building local outreach & referral networks.
• SD MFP will maintain an agreement with SD DSS to forward all MFP participant's information to the local DSS office for consideration of SNAP, TANF, and other benefits.
• SD MFP will assist transition coordinators and recipients in forwarding a recommendation for Community Health Worker services to the recipient's PCP or provider of choice.

Provide assurance and describe how the state will ensure access to food assistance for MFP participants once the food assistance under the demonstration funding is no longer available.
• Through collaboration with waiver programs in SD, participants who meet qualifying criteria are allowed home delivered meals. Other recipients are allowed homemaker services for meal prep in instances where the recipient lives alone.

E.4. Managed long-term services and supports

Select the box below to indicate whether your state or territory operates an MLTSS program.

☐ Yes, the state or territory operates an MLTSS program that includes providing HCBS to these populations: (select all that apply).

- ☐ Older adults
- ☐ Adults with PD
- ☐ Individuals with I/DD
- ☐ Individuals with MH/SUD
- ☐ Other, please specify (e.g., HIV/AIDS, brain injury)

For states or territories that selected "Yes", describe how the state or territory implements the MFP Demonstration under managed care programs. Clearly indicate the qualified HCBS, Demonstration, and supplemental services that are delivered under managed care. Additionally, describe how the MFP Demonstration supports or complements the state or territory's MLTSS strategy for expanding HCBS, promoting community integration, ensuring quality, and increasing efficiency.

N/A

E.5. Service providers

E.5.1. Qualified HCBS, MFP Demonstration, and supplemental service providers

For each qualified HCBS, MFP Demonstration, and supplemental service, include the following:

- Describe how the state or territory will ensure that providers have sufficient experience and training in the provision of their applicable supplemental services.
- Describe how the state or territory provides access to needed services or manages a waiting list when provider shortages or other barriers prevent timely provision of HCBS, MFP Demonstration, and supplemental services.
- Describe how the MFP program will ensure that MFP participants are offered the choice of a Medicaid-qualified provider under a person-centered planning process or the Medicaid authority limiting participants' choice of provider.

The state or territory may insert information using (1) Example Table E.5.1, (2) a description in the text response box, or (3) a combination of both a table and separate text description.

Example Table E.5.1. Describe HCBS, MFP Demonstration, and supplemental service provider qualifications

Service	Provider qualifications

South Dakota's MFP program provides direct one-on-one training and technical assistance to providers. This individualized approach allows the State to ensure that each provider understands the MFP program requirements, reporting expectations, participant rights, and procedures for coordinating and delivering supplemental services. Trainings are tailored to the provider's service area and experience level.

South Dakota does not utilize a waitlist for MFP participants. Provider contracts include provisions requiring that agencies accept all referrals within their approved service capacity and geographic coverage area. When provider shortages or other barriers arise, the State coordinates directly with the MFP providers to ensures that participants have continuous access to needed demonstration and supplemental supports without delay or interruption.

The State continually monitors provider capacity through provider reporting, and case management feedback to ensure that access to MFP services remains sufficient to meet participant needs statewide.

Each region currently has one Medicaid-qualified MFP provider authorized to deliver the full range of demonstration and supplemental services. While MFP-specific provider choice is limited by regional availability, participants retain full choice of providers for all other Medicaid and waiver services. This approach maintains compliance with federal freedom-of-choice requirements and aligns with the established provisions of South Dakota's 1915(c) waivers

E.6. Other information

If needed, provide other information regarding the state or territory's benefits and services that is not addressed elsewhere in the template.

N/A

SECTION F. TRANSITION AND HOUSING SERVICES

F.1. Transition services

F.1.1. Comprehensive transition coordination services

Describe how the state or territory's MFP Demonstration will implement comprehensive transition coordination services during these three phases: (1) pre-transition, (2) transition, and (3) during an MFP participant's 365-day enrollment period. Include the following:

- Description of transition coordination activities
- Description of person-centered planning in the transition coordination process, including:
  - How the state or territory's MFP Demonstration will ensure that each MFP participant's service plan is individualized to provide the services and supports needed to live in the community
  - How MFP participants and their legally authorized representative (if applicable) will lead the development of their service plan
- Steps in the transition coordination process
- Communication process between MFP transition coordination and Medicaid HCBS programs
- How transition coordination services advance health for all people served
- How transition coordination services promote community integration

Use discrete descriptions for each target population.

South Dakota's transition coordination services were developed with the participants' needs and desires to live in and receive services in a location of their choosing. This is met by providing necessary supports throughout all phases of the transition process. This includes: the (1) pre-transition phase, (2) transition phase, and (3) 365-days of enrollment phase. Transition services do not vary by target population. There are some additional requirements based on the appropriately assigned HCBS waiver.

Transition Coordinators are advocates for the participants and are employed by Centers for Independent Living or other agencies on aging. They are contracted positions with the state to provide specific transition coordination services. These include:

(1) The **pre-transition phase** includes helping to prepare a potential participant for the transition process. The participant is determined to be Medicaid eligible by the Division of Economic Assistance, housed within the Department of Social Services. The Division of Economic Assistance determines eligibility for all Medicaid and 1915 () HCBS Waiver participants. Upon referral, all potential participants are reviewed for Medicaid eligibility, as well as eligibility for the MFP program. Once each is verified, the program director refers the participant to a transition coordinator who will meet with the participant. This meeting is held in person whenever possible, or via video or conference call, which is open to any guardian to participate as well. During this meeting, there will be a review of the program and participation requirements. The participant (and their guardian, as appropriate) would sign and date the consent to participate form. The transition coordinator would also complete an interview questionnaire to gather more information, identify any next steps and build a transition team.

(2) Next, in the **transition phase**, the Person-Centered Service Plan is developed based on information received in the interview process when the transition coordinator initially met with the recipient. Any identified members of the transition team, as requested by the recipient, the transition coordinator, and a waiver specialist, would assess the participant's capacity to succeed in the community with the support of MFP to get there and HCBS waiver supports to help them maintain their independence and success in

the community. The transition coordinator will review a 24/7 backup plan with the recipient during their transition. During the transition process, services as appropriate would be provided to the participant. These include demonstration services such as transitioning (securing housing, setting up a residence, and home modifications), transportation, and assistive technology. These also include supplemental services such as food security and pantry stocking, an initial deep cleaning of the residence, and any essential appliances, in addition to clothing, winter gear, and survival safety kits in the event of a power outage or other disaster. Sometimes it is necessary to provide these services in advance of the transition so that they are already established by the time the participant returns home.

(3) During an MFP participant's **365-day enrollment period**, the transition coordinator and the waiver specialist are actively involved in the participant's life, at established intervals and through methods determined by the participant with the input of the transition team, ensuring the participant has ongoing supports and information needed to remain in the community beyond the 365-days enrollment period. The transition coordinators reach out at six months to again review the 24/7 backup plan, and at 11 months to complete the post qualify of life survey. The waiver specialist takes the lead during this phase, reaching out to the transition coordinator when necessary, or such support may be needed. Also, during this phase, the transition coordinator would document any adverse event that may occur during this phase such as being hospitalized or re-institutionalized, or the death of a participant. This also helps to identify if the participant was absent from the community for 30 days or more. (If more than 30 days, the participant would end their 365 days of services at that time. They may be re-referred to the program again as necessary, following the verification that the same eligibility requirements are met for the program.)

F.1.2. Transitions under managed care plans

If MFP participants are required to enroll in a managed long-term care or comprehensive managed care plan, clearly describe how the MFP Demonstration will coordinate the delivery of comprehensive transition coordination services with the MCP. Include the following:

- Describe the roles and responsibilities for the MCP during each transition phase: (1) pre-transition, (2) transition phase, and (3) during an MFP participant's 365-day enrollment period
- Describe how the MFP program will ensure that MCPs provide all data and related documentation necessary to monitor and evaluate MFP transition coordination services, including identifying MFP managed care encounters through the Transformed Medicaid Statistical Information System (T-MSIS).

N/A

F.1.3. Housing-related services and supports

Describe how the state or territory will structure, organize, and implement housing-related supports and services to increase affordable and accessible housing opportunities for MFP participants. Account for any differences between target population groups and geographic service areas, specifically in rural service areas.

Click or tap here to enter text.

Select the following housing-related services and supports available to MFP participants. See the State Health Official letter #21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH) for a description of housing-related services and supports.

☒ Home accessibility modifications (provide a dollar amount available per participant)

Recipients are eligible for up to $12,500 for housing accessibility modifications costs. Those costs may include temporary modifications such as the installation of a wheelchair ramp outside the home or

grab bars in the shower. It may also include permanent modifications such as enlarging the doorway to allow wheelchair passage or bathroom renovations. All services and supports must be specific to the individual's needs based on his or her disabilities and/or health conditions and not of general utility in the home.

☒ One-time community transition costs (provide a dollar amount available per participant)

Recipients are eligible for up to $10,000 for one-time community transitions costs. Those costs may include necessary expenses to establish a beneficiary's basic living arrangement, such as security deposits, utility activation fees, and essential household furnishings.

☒ Pre-tenancy supports

Home Again transition coordinators will help assist the recipient with the following under pre-tenancy supports:

- Completion of applications for housing assistance and for the residence,
- Review lease and rental agreements,
- Ensure housing units are safe and ready for move-in utilizing an approved checklist,
- Arranging for support moving in to include but not limited to:
  - Moving expenses
  - Transportation expenses related to the move when necessary

☒ Tenancy supports

Home Again transition coordinators will help assist the recipient with the following under tenancy supports:

- Connecting the individual to community resources to maintain housing stability
- Individualized support as outlined in the person-centered plan

F.2. Partnerships with state or territory and local housing entities

Describe how the state or territory will develop and sustain partnerships with state or territory and local housing agencies to increase access to affordable and accessible housing for MFP participants. Include the following:

- How the state or territory will put in place partnership arrangements with state or territory and local housing entities
- How the state or territory will work with those entities to assist MFP participants to obtain affordable and accessible housing
- Description of the proposed infrastructure expenditures to support housing partnerships; examples of infrastructure expenditures include:
  - Housing specialist position(s)—responsible for developing/maintaining system-level partnerships with state or territory and local housing entities
  - Technology—for example, electronic referral systems, shared data platforms, screening tool, case management systems, databases/data warehouses, housing registry
  - Workforce development—for example, training, housing coordination certification, cultural competency training
  - Outreach, education, and convenings—for example, design and production of outreach and education materials, translation, investments in community convenings

The State recognizes the critical importance of cross-sector partnerships in increasing access to affordable and accessible housing for MFP participants. While the State has not yet established formal partnerships with state or local housing agencies, it is committed to initiating and developing these relationships as part of its MFP infrastructure planning.

F.3. MFP-qualified residence

Describe how the state or territory will verify and document the type of MFP-qualified residence (see PTC 15) an MFP participant resides in during the 365-day enrollment period. Use discrete descriptions for each target population if applicable. Include the following:

- Description of the process for identifying MFP-qualified residences
- Description of the provider(s) responsible for verifying and documenting the type of MFP-qualified residence
- Assessments or tools for screening MFP-qualified residences, including:
  - Name and description of the assessments of tools
  - Embed any assessments or tools below or in the appendix, or provide a link to the source

The State follows a structured process to identify and verify that residences selected by Home Again participants meet the federal definition of a “qualified residence” as outlined in the MFP Demonstration Program requirements. A qualified residence is defined as one of the following:

- A home owned or leased by the individual or the individual's family member;
- An apartment with an individual lease, with lockable entry and exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or family has domain and control;
- A residence in a community-based residential setting, in which no more than four unrelated individuals reside.

During the transition planning process, Home Again transition coordinators work closely with the individual and, where applicable, their legally authorized representative, to explore housing options that reflect the individual’s preferences, needs, and goals.

Once a potential residence is identified, Home Again staff verify that the setting meets the definition of a qualified residence before the transition occurs.

This data element is not currently captured through T-MSIS for South Dakota. At present, verification and documentation of MFP-qualified residence types are reviewed internally by the Program Director during periodic T-MSIS/TAF corrections and data quality reviews. These reviews ensure that the housing type aligns with the federal definition of a qualified residence, based on transition documentation maintained by the MFP transition coordinators.

The State is actively working to update its Medicaid Management Information System (MMIS) to support the accurate collection and reporting of residence type data in alignment with MFP reporting requirements. Once implemented, these system enhancements will enable the State to routinely capture and submit "Transitions by Housing Type" data through T-MSIS as part of ongoing reporting and monitoring.

F.4. Other information

If needed, provide other information regarding the state or territory’s transition coordination and housing processes and services that is not addressed elsewhere in the template.

Click or tap here to enter text.

SECTION G. SELF-DIRECTION AND INFORMAL CAREGIVING

G.1. Self-direction

Describe any opportunities for MFP participants to receive HCBS as self-directed services.

Self-direction in South Dakota's MFP demonstration will be offered to the extent it is offered in the 1915(c) HCBS Waiver the individual enters upon transition. Two of South Dakota's four waivers – the ADLS Waiver and the Family Support 360 Waiver – offer self-direction opportunities. Both waivers that offer self-direction provide participants with the opportunity to direct some or all of their services, including services received during the transition period through Home Again SD staff.

G.1.1. Termination of self-direction

Describe how the state or territory accommodates a participant who voluntarily terminates self-direction to receive services through an alternate service delivery method, including how the state or territory assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method. Describe the circumstances under which the state or territory will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Specify procedures for switches from self-direction to provider-managed or other service delivery systems.

Recipients who voluntarily terminate self-direction are transitioned off of the ADLS or FS360 waiver and are transitioned on to the HOPE waiver via warm handoff.

When a participant's cognitive ability has decreased to the extent the participant cannot manage and self-direct services, or if they refuse to manage and self-direct services to the extent that it affects their health, safety and welfare, the participant will be presented with possible service options. One would be to have a family member, friend, or non-legal representative manage and direct their services for them. If the participant does not have someone who wants to assist with management and self-direction, options will be explored by the participant's DHS Service Coordinator, in consultation with the ADLS Waiver Manager. Other options may include the Home and Community Based Waiver within the DHS Long Term Services and Supports program, one of two waivers in the Division of Developmental Disabilities, if eligible, or possibly skilled nursing care.

Regardless of who is managing and self-directing the service, the provider agency and the ADLS Waiver Manager must assure that all health, safety and welfare assurances are being met while on the waiver while transitioning to another more suitable program. The ADLS Waiver Manager and DHS Service Coordinator ensure that the transition occurs on a timely basis and does not compromise the health and waiver of the participant. Transition of supports will be seamless from one state program to another. Accessing additional natural supports and/or accessing community resources such as mental health agencies, the Department of Social Services, or Law Enforcement may be used as interventions if the participant's health or welfare is in jeopardy.

If the participant refuses to consider options for alternative services for management and self-direction, then the ADLS waiver program termination process will begin. The provider agency works closely with the ADLS Waiver Manager in these situations to gather all pertinent information and documentation to support the provider's termination decision. The program provider notifies the participant thirty days prior to the termination of services. If there are no other providers willing or able to work with the participant, and they refuse to utilize an in-home health agency approach for personal attendant care, then the ADLS Waiver termination process will begin.

A revised level of care is sent to the Department of Social Services, who issues a Notice of Adverse Action. This Notice of Action explains the process for requesting a fair hearing if the participant does not agree with the decision to terminate ADLS waiver services.

G.2. Other information

If needed, provide other information regarding self-direction and informal caregiving that is not addressed elsewhere in the template.

N/A

SECTION H. REPORTING

H.1. Reporting plans and procedures

Describe how the state or territory will develop and implement a reporting plan and procedure for data collection, reporting, and participation in the MFP evaluation effort. The reporting plan must include data collection plans and procedures that demonstrate the state or territory's capacity to collect and share data for reporting the required program, expenditure, and financial information. States or territories must include a description of their T-MSIS data submission status and must address how identified T-MSIS data quality issues are being addressed.

Describe the reporting procedures for ensuring timely and complete data submissions to CMS, including quarterly, semi-annual, and annual reporting requirements; performance indicators and program outcome metrics; and continuous quality improvement and quality measures reporting.

Describe the strategies for ensuring that all partners and participants—including all affiliated departments, agencies, and providers—will participate in the project's evaluation.

South Dakota's data reporting requirements are currently met by our 1915(c) HCBS Waiver teams and our claims submission system. South Dakota submits T-MSIS data quarterly and has a dedicated team of database analysts and engineers who work on improvements and fixes for South Dakota's T-MSIS system. The South Dakota MFP team has been working closely with the T-MSIS team to ensure improvements in the quality of South Dakota's MFP data are planned and executed. Currently, through T-MSIS and our existing experience of care surveys, South Dakota is poised to meet all MFP reporting requirements.

As a program under the SMA, South Dakota's MFP program Data Quality Analys (DQA) is able to easily access claims, demographic, and financial information through MMIS. The DQA has been involved in the following ways: developing novel technology implementations; assessing existing data pipelines to meet reporting requirements; advising on improvements to existing pipelines, including T-MSIS, to meet MFP reporting needs; and tracking and reviewing data from the state's MMIS system. This allows the team to analyze financial, claims, and demographic data in compliance with CMS guidelines and industry standards accurately and efficiently.

South Dakota follows a structured reporting calendar to ensure compliance with all CMS submission deadlines, including quarterly, semi-annual (MFP SAR), and annual (MFP Annual Report) submissions. These reports are compiled internally by the MFP Program Director, with support from the DQA and department financial team to ensure completeness, accuracy, and alignment with CMS guidance.

Coordination with 1915(c) HCBS Waivers ensures the state obtains consumer experience of care surveys, which are directly reported to CMS. This partnership between the MFP program and 1915(c) HCBS Waivers is collaborative and ongoing, with shared responsibilities for survey administration and data interpretation.

The DQA has identified a number of MFP-specific data points that are not currently being reported via the T-MSIS file and are therefore not transformed in the TAF files. The DQA has worked with South Dakota's database engineers to identify where the issue exists in the reporting pipeline and potential solutions. These fixes are under review by South Dakota Medical Services leadership to ensure alignment with broader business strategies. Implementation of solutions will proceed once the selected approach is approved.

SECTION I. QUALITY MEASUREMENT, ASSURANCE, AND MONITORING

I.1. Quality assurance and improvement

I.1.1. Quality management strategy

Provide as an appendix a comprehensive and integrated quality management strategy. Describe how the state or territory assures quality and continuously improves the quality of HCBS under the state or territory Medicaid program, and assures the health and welfare of individuals participating in the MFP Demonstration. In the Work Plan, include state or territory initiatives to improve the quality of services received by individuals receiving HCBS through the MFP Demonstration and the systems that serve them. Include how the state or territory monitors and evaluates the quality of services provided to MFP participants (including supplemental services), the roles and responsibilities of all agencies involved, and remediation and improvement processes.

Describe the program's targeted system performance requirements, including that (1) the state conducts level-of-care need determinations consistent with the need for institutionalization, (2) plans of care are responsive to participants' needs, (3) qualified providers serve participants, (4) health and welfare of participants is protected, (5) state or territory Medicaid agency retains administrative authority over the program, and (6) the state or territory provides financial accountability of the program.

If the state or territory plans to integrate the MFP program into a new or existing section 1915(c) HCBS waiver program, section 1915(i) state plan HCBS, section 1915(j) self-directed personal care services, section 1915(k) Community First Choice, or a section 1115 demonstration, provide a link to the approved quality improvement system (QIS), for example as found in:

- Appendix H of the section 1915(c) HCBS waiver application
- QIS information provided in the section 1915(i) state plan application
- The quality assurance and improvement plan used to monitor and evaluate the section 1915(j) self-directed option
- The quality assurance and improvement strategy used to monitor the section 1915(k) Community First Choice State Plan option
- Section IV of the section 1115 demonstration application, describing how delivery system reforms will impact quality, access, cost of care, and health status of the covered populations

Describe how the HCBS state plan, section 1115 demonstration, or waiver program's existing QIS is or will be modified to ensure adequate oversight and monitoring of the MFP program.

As outlined in the Work Plan, South Dakota will work to develop a quality improvement plan to support the tracking of performance indicators and program outcomes. This plan will align with CMS priorities and MFP demonstration goals and will be informed by data from MMIS and experience of care surveys. It will also support South Dakota's continuous quality improvement (CQI) efforts and identify metrics that are meaningful, measurable, and actionable. All agencies, contractors, and provider partners engaged with the MFP program are expected to participate in evaluation activities.

Quality assurance attestation

☒ Select this box to indicate the state or territory will cooperate in carrying out activities to develop and implement continuous quality assurance and quality improvement systems for HCBS and LTSS.

I.1.2. HCBS quality measures

Describe how your state or territory plans to select an experience of care survey or surveys for each of the major population groups included in the state or territory's HCBS program from the HCBS Quality Measures and report on the survey data.

The State will continue to utilize the NCI-AD and NCI-ID experience of care surveys for each of the major HCBS population groups.

Describe any limitations in the data sources, sampling strategy, or calculations used to report the HCBS Quality Measure Set, as well as any other anticipated challenges for reporting.

Limitations for sampling include the limited population served in South Dakota due to the low population of the state. Future stratification of sampling may be difficult to ensure minimum statistical representation due to the small size of groups in the potential stratification. As a result, South Dakota intends to continue its current practice of collecting consumer care surveys and claims data from all participants who are able to complete such questionnaires.

Describe how HCBS Quality Measure Set data will be used to support MFP program monitoring and improvement.

The State will utilize the HCBS Quality Measure Set to support the MFP program by enabling systematic program monitoring and driving targeted improvement initiatives.

- Monitoring Program Performance
    - Tracking Outcomes: The measure set provides standardized metrics to evaluate the quality of services and health outcomes of MFP participants, ensuring they align with program goals.
    - Identifying Trends: Regular data analysis can reveal trends in service utilization, participant satisfaction, and health outcomes, highlighting areas for further investigation or action.
- Driving Quality Improvement
    - Establishing Benchmarks: The data provides benchmarks for quality improvement initiatives, allowing the program to set realistic, measurable goals for improvement.
- Enhancing Accountability and Reporting
    - Demonstrating Impact: Aggregated data can be used to demonstrate the program's effectiveness.
    - Compliance Monitoring: The data supports compliance with federal and state quality assurance standards, safeguarding participant well-being.

Please list the responsible party and any key partners for reporting on the HCBS Quality Measure Set and driving improvement.

South Dakota Department of Social Services, Division of Medical Services (SMA) will be responsible for overseeing the reporting of HCBS Quality Measure Set. The SMA will work in collaboration with the Department of Human Services to contract for experience of care surveys which are reported directly to CMS.

Both divisions will work collaboratively to ensure quality measures are reviewed on a regular basis to seek opportunities to improve.

I.2. Additional MFP quality assurance requirements

Describe how the state or territory will address the three additional MFP quality assurance requirements for (1) 24-hour backup systems for crucial services, (2) risk assessment and mitigation, and (3) incident management. For each requirement, describe how the state or territory will monitor its use and effectiveness and explain any variations by target population, geography, or any other factor. Describe the protocol for the reporting of incidents to the state or territory's critical incident systems for the state or territory's HCBS program(s).

I.2.1. 24-hour backup systems for critical services

Using the table shell below, describe any 24-hour backup systems accessible by Demonstration participants, as well as how participants can access the systems (for example, toll-free telephone number or website). The state or territory should describe, at a minimum, the backup systems related to (1) critical services, (2) transportation, (3) direct care workers, (4) repair and replacement for durable medical equipment (DME) and other equipment (including provision of loaning equipment while repairs are being made), and (5) access to medical care (including how participants are assisted with initial appointments, how to make appointments, and how to deal with appointment or care issues). Add as many rows as needed to capture all backup systems available to Demonstration participants.

Table I.2.1. 24-hour backup systems

Backup system	Description of system	Participant access
Critical services	ADLS Waiver: Participants receive services from enrolled provider agencies contracted with the Department of Human Services. ADLS Services are self-directed. Participants develop a backup plan during the service planning process. The back up plan contains names and contact information for Personal Care attendants, a family member, friend, neighbor, and the ADLS Provider Agency. In addition, the phone number for the local Adult Protective Services, fire department, police department and poison control, A copy of this plan is provided to the participant and the ADLS Provider Agency. The ADLS Provider agencies assist with ensuring uninterrupted critical services, including personal care and health-related tasks, through on-call staff and emergency protocols.	ADLS Waiver: Participants utilize their back up plan. In the event their back-up plan fails they contact their assigned provider agency directly. Provider staff are on call 24/7. Emergency procedures and contacts are shared during service planning.
	CHOICES Waiver: Community Support Providers (CSPs) develop comprehensive care plans that integrate necessary services. CSPs are required to have contingency plans to address service interruptions, ensuring that critical services are maintained without disruption.	CHOICES Waiver: Participants reach out to their assigned Community Support Provider (CSP), which maintains an on-call system. Emergency contact info is provided in their person-centered support plan.

Backup system	Description of system	Participant access
	Family Support 360 Waiver: Community Support Providers (SPs) are mandated to have emergency response plans to maintain critical services. These plans include backup staffing arrangements and coordination with families to ensure continuity of care.	Family Support 360 Waiver: Families contact their assigned Service Coordinator, who can initiate emergency provider response. Some providers offer a 24/7 contact number.
	HOPE Waiver: The LTSS Case Management Specialist works with the participant to develop a critical service back-up plan which outlines how critical services will be provided when the usual caregiver(s) are unavailable, including during inclement weather or other disruptions to scheduled care. In provider-owned settings, staff are available 24/7 to ensure critical service needs are met. Providers are required to have protocols in place to ensure that critical services continue uninterrupted during unforeseen events.	HOPE Waiver: Participants receive a copy of their Individual Support Plan (ISP) which contains the critical service back-up plan. Participants are informed of how to activate their back-up services and who to contact in the event of a caregiver's absence or other emergency. Participants and caregivers may request a copy of the critical service back-up plan by contacting DHS' toll-free number or the participant's Case Management Specialist.
Transportation	ADLS Waiver: Transportation services are assessed during the service planning and are arranged through natural supports or local transportation providers to ensure participants can attend medical appointments and access community resources. Backup transportation options are identified in participants' care plans.	ADLS Waiver: Participants utilize natural supports or call the local transportation provider agency to arrange backup transportation. Medical Transportation is a Medicaid Service and not provided by the waiver. The waiver does provide information and referral services.
	CHOICES Waiver: Transportation is built into each service within the waiver. CSP's are responsible for identifying the participants' needs and utilizing CSP provided transportation in addition to community-based options.	CHOICES Waiver: Participants contact their CSP or designated transportation provider. CSPs assist with arranging alternate transport in case of a service interruption. In addition, Participants work with their Case Manager to identify necessary transportation supports outside CSP provision.
	Family Support 360 Waiver: Transportation services are coordinated by SPs, who work with families to arrange and provide transportation. Backup options are considered in the service planning process to address potential service gaps.	Family Support 360 Waiver: Families coordinate with the Service Coordinator, who helps arrange or identify backup transportation options using waiver funds or community programs.

Backup system	Description of system	Participant access
	HOPE Waiver: Transportation may be provided if necessary for the provision of waiver services. In provider owned-settings, staff are available to assist with facilitation transportation needs. HOPE Waiver. Participants with critical service needs are required to have an emergency back-up plan for waiver services. Providers are expected to have backup transportation arrangements to ensure service continuity.	HOPE Waiver: Case Management Specialists assist participants in identifying transportation providers available in their communities to meet their needs. Participants and caregivers may access transportation resources independently at any time by using the Dakota at Home Resource Directory or visiting the DOT website to locate local providers.
Direct care workers	ADLS Waiver: Participants receive services from enrolled provider agencies contracted with the Department of Human Services. ADLS Services are self-directed. Participants develop a backup plan during the service planning process. The back up plan contains names and contact information for Personal Care attendants, a family member, friend, neighbor, and the ADLS Provider Agency. In addition, the phone number for the local Adult Protective Services, fire department, police department and poison control, A copy of this plan is provided to the participant and the ADLS Provider Agency. The ADLS Provider agencies assist with ensuring uninterrupted critical services, including personal care and health-related tasks, through on-call staff and emergency protocols	ADLS Waiver: Participants utilize their back up plan. In the event their back-up plan fails they contact their assigned provider agency directly. Provider staff are on call 24/7. Emergency procedures and contacts are shared during service planning.
	CHOICES Waiver: CSPs are required to have staffing plans that include backup personnel to cover shifts when regular staff are unavailable, ensuring continuous support for participants.	CHOICES Waiver: Participants or guardians contact the CSP. Staff shortages are covered using on-call or alternate workers scheduled through the agency.
	Family Support 360 Waiver: SPs coordinate with families to arrange for backup direct care workers. Plans are tailored to each participant's needs, considering family involvement and available community resources.	Family Support 360 Waiver: Families work with SPs and the Service Coordinator to initiate a backup worker when the primary caregiver is unavailable. Plans are pre-established.
	HOPE Waiver: Providers develop staffing plans that include provisions for backup direct care workers to ensure uninterrupted services, particularly for participants with critical needs.	HOPE Waiver: Participants or caregivers call the provider agency. The agency deploys backup workers according to their staffing contingency plans.

Backup system	Description of system	Participant access
Repair and replacement for DME and other equipment	ADLS Waiver: Participants work with DME provider agencies to assess and coordinate the repair or replacement of durable medical equipment (DME). ADLS Service Coordinator may assist in expediting services to minimize disruption.	ADLS Waiver: Participants report equipment issues to their DME provider and/or ADLS Service Coordinator, if requested by the participant, the ADLS Service coordinator will coordinate repairs or replacements.
	CHOICES Waiver: CSPs assist participants in obtaining necessary DME repairs or replacements, coordinating with vendors and ensuring timely service to maintain participant safety and independence. Assistive Technology and Specialized Medical Equipment and Drugs are standalone services within the CHOICES Waiver, and each participant has a maximum of $5,000 per ISP year in each category.	CHOICES Waiver: Case Managers initiate the process to identify a need for repair or replacement and work with the CSP to submit authorizations to vendors or the CSP itself.
	Family Support 360 Waiver: SPs support families in arranging for DME maintenance and replacement, working with suppliers and funding sources to address equipment needs promptly.	Family Support 360 Waiver: Participants and families notify the Service Coordinator, who assists in coordinating repairs with vendors and seeking funding.
	HOPE Waiver: When contacted by the participant, DME providers coordinate the repair and replacement of DME, ensuring that participants have the necessary equipment to support their health and daily living activities.	HOPE Waiver: Case managers coordinate DME repairs or replacements by submitting authorizations and working with vendors on behalf of the participant.
Access to medical care	ADLS Waiver participants schedule and access medical care, including arranging transportation and coordinating with healthcare providers to ensure continuity of care. ADLS Service Coordinators may assist as requested by participants.	ADLS Waiver: Participants may contact their ADLS Service Coordinator for help with appointment schedule their and transportation. Emergency medical care follows 911 protocols.
	CHOICES Waiver: Nursing services are provided through the waiver. Each CSP has procedures in place to report each incident to the nursing department and then they respond with appropriate medical attention. Staff at CSP's are trained as Medication Aid's and can use their judgement when emergency medical intervention is needed.	CHOICES Waiver: Participants reach out to their direct care staff, which arranges care or transportation. Emergency services follow standard 911 protocols.
	Family Support 360 Waiver: SPs work with families to arrange medical care, including scheduling appointments and coordinating transportation, to ensure participants' health needs are met.	Family Support 360 Waiver: Families work with the Service Coordinator to ensure access to care, including backup scheduling or emergency referrals.

Backup system	Description of system	Participant access
	HOPE Waiver: The Case Management Specialists work with participants to develop goals and strategies within the ISP to assist the participant in accessing necessary healthcare services. If the participant has elected to receive nursing services, their nurse can assist with scheduling appointments, understanding doctor's orders, and managing medications. If eligible, participants may also have access to PERS to ensure immediate assistance when needed. In provider-owned settings, staff are available 24/7 to assist in arranging required medical care.	HOPE Waiver: Case Management Specialists provide a copy of the ISP to the participant, which includes goals and strategies related to accessing medical care. If nursing is authorized, the participant can contact their nurse to request assistance with scheduling appointments. Emergency services follow standard 911 protocols.
Other (describe):	ADLS Waiver: Participants may have access to emergency response systems, such as personal emergency response systems (PERS), coordinated through provider agencies to ensure immediate assistance when needed.	ADLS Waiver: Participants are provided with personal emergency response devices (PERS) if applicable. Devices can be activated during emergencies.
	CHOICES Waiver: CSPs may include emergency response systems in participants' care plans, providing devices and services that allow participants to summon help during emergencies.	CHOICES Waiver: CSPs install and monitor PERS or other emergency tech. Participants activate devices to summon help.
	Family Support 360 Waiver: SPs can coordinate the provision of emergency response systems for participants, enhancing safety and providing peace of mind for families.	Family Support 360 Waiver: SPs help families acquire PERS or other safety devices. Families are trained on use, and devices connect directly to emergency contacts or dispatch.
	HOPE Waiver: Providers may offer emergency response systems as part of the service package, ensuring that participants have immediate access to assistance in case of emergencies.	HOPE Waiver: Emergency response systems (e.g., call buttons) are provided by providers. Participants can use devices or call emergency contacts listed in their care plan.

Describe the organization of 24-hour backup systems. Explain which state, territory, or local agencies are responsible for providing 24-hour, seven day per week emergency backup in all geographical areas in which the MFP Demonstration will operate and for each target group if it varies.

Home Again recipients are required to participate in HCBS waiver services, as such, 24-hour backup systems are uniquely identified under each waiver and outlined above.

Waiver	Responsible Agency	After-Hours Contact System
ADLS	Division of Rehabilitation Services	DHS Service Coordinators are required to complete a Personal Attendant Back-Up Plan form during the planning process. The plan includes information

		for contacts in the event that a back-up attendant is needed for personal attendant services. The plan also includes who to contact in an emergency, and may include the telephone numbers for family, natural supports and their healthcare providers.
CHOICES	Division of Developmental Disabilities (DDD)	Provider on-call systems
FS 360	Division of Developmental Disabilities (DDD)	Case manager contact + family
HOPE	Division of LTSS	Provider and LTSS on-call systems

Participant Access to Backup Systems

- Participant Orientation: Upon enrollment, participants and their families are provided with contact information for their case managers, providers, and emergency systems.
- ISP and Service Plan Inclusion: Backup systems are documented in each participant's ISP, which includes step-by-step instructions for emergencies.
- Provider Responsibility: Providers are contractually required to maintain emergency contact systems and ensure uninterrupted service delivery.
- After-Hours Protocols: Each division maintains an on-call system for responding to emergencies outside of normal business hours, ensuring that participants never face service disruptions without access to immediate assistance.

Describe the process for receiving and resolving participant complaints when the backup systems and supports do not work.

Complaint and Resolution Process for Backup System Failures

Initial Reporting of the Complaint

- Participants, family members, guardians, or providers may report a failure in the backup system—such as missed critical services, unavailable direct care staff, lack of transportation, or malfunctioning DME—to one of the following entities:
    - ADLS: The participant contacts their provider agency directly or their assigned case manager. Contact info is included in their person-centered service plan.
    - CHOICES: Complaints are typically reported to the Community Support Provider (CSP) staff or team leader, or directly to the assigned case manager and Division of Developmental Disabilities (DDD).
    - Family Support 360: The family may report issues to their Family Support Coordinator or the Department of Human Services (DHS).
    - HOPE: Participants contact their LTSS Case Management Specialist to report a complaint.

Documentation and Triage

- All reported complaints are documented by the receiving staff using internal complaint tracking tools or formal grievance logs. The severity of the complaint is assessed immediately to determine whether it involves:
    - Health and safety risks
    - Repeated system failure
    - Provider noncompliance
- If an urgent health or safety issue is identified, emergency services or immediate alternative supports may be dispatched.

Follow-Up and Investigation

- A staff member—typically the case manager, service coordinator, or a state staff person—initiates an investigation into the cause of the failure, which may involve:
    - Contacting the provider to determine staffing or equipment issues
    - Reviewing service records or logs
    - Assessing the participant's service plan for adequacy of backup supports
- Each waiver ensures that a staff person is responsible for ensuring the follow-up is completed promptly.

Resolution and Remediation

- Once the root cause is identified, the following steps are taken:
    - ADLS & HOPE: The case manager works with the provider agency to ensure corrective action, such as adding additional staff coverage or updating the service plan.
    - CHOICES: The CSP may submit a remediation plan to DDD and notify the participant of changes.
    - Family Support 360: The Service Coordinator may convene a team meeting to revise the support plan and put new contingencies in place.
- If the complaint reveals a pattern of service failure, state oversight staff may initiate a formal review or corrective action plan for the provider.

Participant Notification and Appeal Rights

- Participants are informed of the outcome of the complaint and any action taken. If the participant is dissatisfied with the resolution, they are advised of their rights to:
    - File a formal grievance with the provider
    - Appeal through the Medicaid Fair Hearing process
    - Contact South Dakota's Division of Developmental Disabilities, LTSS, or DHS, depending on the waiver

Ongoing Monitoring and Quality Improvement

- Complaints related to backup system failures are tracked as part of the state's Continuous Quality Improvement (CQI) process. Waiver staff analyze complaint trends to identify:
    - Systemic gaps in coverage or emergency planning
    - Training needs for providers or case managers
    - Opportunities to revise service planning procedures
- These findings are used to inform waiver oversight and may lead to updates in policy, training, or provider requirements.

I.2.2. Risk assessment and mitigation

Describe the organization of risk assessment and mitigation processes for all program participants, including monitoring.

Home Again recipients are required to participate in HCBS waiver services, as such, risk assessment and mitigation processes are uniquely identified under each waiver.

ADLS Waiver

- Initial Risk Identification: Conducted by the case manager during the Level of Care (LOC) determination and initial person-centered service planning process.
- Risk Mitigation Plan: Integrated into the participant's Service Plan, including backup plans for critical services such as personal care or equipment failure.
- Ongoing Monitoring:
    - Case managers conduct quarterly contacts (phone or in-person) and annual home visits.
    - Service utilization and health outcomes are tracked via MMIS.
- Critical Incident Reporting: Required within 24 hours of incident, with follow-up and remediation documented and reviewed by waiver administrators.

CHOICES Waiver

- Risk Assessment Tools: Use of standardized assessment forms during service planning and reassessment periods.
- Risk Mitigation Strategies:
    - Development of individualized backup staffing plans for participants receiving 24-hour supports.
    - Collaboration with residential providers to ensure contingency planning.
- Monitoring:
    - Quarterly review of services and risks by the case manager.
    - On-site visits at least twice per year; more frequently if risk factors increase.
    - Monitoring of incident reports and implementation of corrective action plans (CAPs) as needed.

Family Support 360 Waiver

- Unique Considerations: Given the focus on children and young adults with developmental disabilities, risks are often identified in collaboration with families and school systems.
- Risk Planning:
    - Risks related to behavioral health, mobility, and caregiver stress are documented.
    - Supports such as respite services and emergency contacts are built into the Family Service Plan.
- Monitoring:
    - Monthly family contact and quarterly reviews by the case manager.
    - Mandatory follow-up within 5 days of any critical incident involving child safety or well-being.
    - Close coordination with Child Protection Services when appropriate.

HOPE Waiver

- Risk Assessment Tool: Use of a standardized assessment during service planning and reassessment periods.
- Risk Mitigation Strategies:
    - Development of a person-centered care plan which addresses areas of improvement as identified by the standardized assessment.
- Mitigation:
    - Incorporation of home modifications, personal emergency response systems (PERS), and in-home services and supports.
- Monitoring:
    - Quarterly case management contact and semi-annual in-home reassessment.

Cross-Waiver Monitoring & Oversight

- Data Review: Risk data is collected and analyzed through the state's MMIS system, critical incident reporting system, and provider documentation.
- Interdisciplinary Review: Complex cases may be escalated to an inter-agency review team or clinical consultant for deeper analysis.
- Continuous Quality Improvement (CQI):
    - Risk trends are reviewed quarterly by program administrators and annually as part of the waiver's CQI process.
    - System-level risks are addressed via Performance Improvement Projects (PIPs) or policy revisions.

I.2.3. Incident management system

Assure that MFP critical incidents are reported through the state or territory's incident management systems for Medicaid HCBS. Describe the organization of the incident management system used to monitor the health and welfare of MFP participants. Identify the state or territory entity responsible for receiving, reviewing, and responding to MFP critical incident reports and investigating consumer complaints regarding violation of their rights. If applicable, clearly describe how the policy differs by situation (for instance, by participant population group, qualified institutional setting, or operating division).

South Dakota's incident management system for Money Follows the Person (MFP) participants is integrated within the state's 1915(c) Home and Community-Based Services (HCBS) waivers—ADLS, CHOICES, Family Support 360, and HOPE. Since all MFP participants are enrolled in one of these waivers, they are subject to the incident management protocols outlined therein.

- Incident Management System Structure
    - The incident management system is designed to monitor the health and welfare of MFP participants by ensuring timely reporting, review, and resolution of critical incidents. Key components include:
    - Reporting Mechanism: Providers and case managers are required to report critical incidents—such as abuse, neglect, exploitation, or serious injuries—through the state's online reporting system, where available, within specified timeframes.
    - Review and Investigation: Upon submission, incidents are reviewed by designated state entities to determine the need for further investigation. Investigations are conducted promptly to ensure participant's safety and compliance with program standards.

    - Data Analysis and Quality Improvement: Incident data is analyzed to identify trends and inform quality improvement initiatives aimed at preventing future occurrences.
- Responsible Entities
    - The responsibility for receiving, reviewing, and responding to critical incident reports varies by waiver:
    - ADLS: The Division of Rehabilitation Services within the Department of Human Services (DHS) oversees incident management activities.
    - HOPE waiver: The Critical Incident Review Team within The Division of Long-Term Services and Supports (LTSS) oversees incident management activities.
    - CHOICES and Family Support 360 Waivers: The Division of Developmental Disabilities (DDD) within DHS is responsible for managing incidents, including the operation of the online reporting system and coordination of investigations.
    - In addition, the Office of the Long-Term Care Ombudsman serves as an external entity that participants can contact regarding complaints or concerns about their rights and services.
- Policy Variations by Population and Setting
    - While the core incident management framework is consistent across waivers, certain policies are tailored to specific populations:
    - Children and Young Adults (Family Support 360): Additional safeguards are in place to coordinate with child protection services when incidents involve minors.
    - Individuals with Intellectual or Developmental Disabilities (CHOICES): Enhanced monitoring protocols are implemented to address the unique needs of this population, including regular interdisciplinary team meetings to review incidents and outcomes.
    - Older Adults and Individuals with Physical Disabilities (HOPE): Risk assessments focus on the participant's individual needs, with corresponding incident response strategies.
- Monitoring and Continuous Improvement
    - The state conducts regular audits and reviews of incident reports to ensure compliance with reporting requirements and to identify areas for system-wide improvements. Findings from these reviews inform training programs for providers and case managers, as well as updates to policies and procedures to enhance participant safety and program effectiveness.

I.3. Other information

If needed, provide other information regarding the state or territory's approach to quality that is not addressed elsewhere in the template.

SECTION J. CONTINUITY OF CARE POST-DEMONSTRATION

In accordance with section 6071(c)(2) of the Deficit Reduction Act of 2005, the MFP Demonstration must operate in connection with a qualified HCBS program to assure continuity of services for eligible individuals.

Select this box.

☒ The state or territory affirms that it has established procedures and processes for ensuring that the provision of HCBS will continue for an MFP participant at the conclusion of the 365-day enrollment period for as long as an individual remains eligible for medical assistance.

SECTION K. PUBLIC HEALTH EMERGENCIES

K.1. Program adaptations in response to Public Health Emergencies

K.1.1. Program adaptations

Describe adaptations your state or territory's MFP Demonstration made in response to a Public Health Emergency (PHE), such as the COVID-19 PHE, declared at either the state, territory, or federal level. For instance, these could include protocols for MFP participants living in the community who test positive for COVID-19, plans to prevent COVID-19 spread among participants, modifying recommendations related to infection control or immunizations (such as the COVID-19, flu, and shingles vaccines), or ways the MFP Demonstration has expanded access to or incorporated services delivered through telehealth technology. Identify adaptations that have ended and those that are ongoing. Describe how any MFP Demonstration adaptations in response to PHEs align with and use policies and procedures from the state or territory's HCBS program(s).

During the COVID-19 PHE, the State implemented a number of emergency adaptations within its Money Follows the Person (MFP) Demonstration to safeguard participant health and safety, ensure continuity of services, and comply with federal and state emergency guidelines. These adaptations were made in alignment with state Medicaid HCBS flexibilities, including those approved through Appendix K amendments.

- Virtual and Remote Transition Activities
    - Transition coordination, person-centered planning meetings, and assessments were conducted via telephone or secure video platforms to reduce in-person contact.
    - Digital or verbal consent processes were temporarily accepted to ensure continuity of care planning.
    - Virtual housing searches and remote lease negotiations were supported where possible.
- Telehealth Services
    - MFP participants were allowed to receive a broader range of HCBS services via telehealth, including case management, behavioral health, and some habilitation services.
    - Transition coordinators helped participants and caregivers access and use devices or platforms needed for virtual care.
- Infection Control and Vaccination Support
    - Participants received education on infection prevention and access to personal protective equipment (PPE) when needed.
    - MFP teams promoted access to COVID-19 testing and vaccination.

Ongoing Adaptations Post-COVID

Several strategies introduced during the COVID-19 PHE have demonstrated long-term value and have been incorporated into standard MFP procedures:

- Telehealth for Service Delivery: Continued use of telehealth for care coordination, behavioral health services, and participant check-ins, where clinically appropriate and supported by Medicaid billing policy.
- Remote Person-Centered Planning: Ongoing flexibility for participants and families to engage in planning meetings remotely if preferred.

- Emergency Preparedness: Enhanced focus on emergency and contingency planning has been retained in the transition process and incorporated into person-centered service plans.

K.2. Future PHEs

Describe if and how your state or territory is planning for future PHEs in its HCBS systems and MFP Demonstration. For instance, this may include permanent adoption of measures implemented for the COVID-19 PHE.

The State's MFP Demonstration maintains flexibility to adapt its operations in response to public health emergencies (PHEs) declared at the state, territorial, or federal level. Adaptations are implemented in alignment with broader state Medicaid and Home and Community-Based Services (HCBS) policies and are designed to ensure participant safety, continuity of care, and compliance with emergency public health guidelines. The following outlines the types of adaptations that may be activated during a PHE, including examples of modifications that originated during the COVID-19 emergency but are applicable across other emergency scenarios.

- Participant Safety and Infection Control Protocols: In response to a declared PHE, the MFP program adopts enhanced infection prevention and control procedures that reflect guidance from the Centers for Disease Control and Prevention (CDC), the South Dakota Department of Health, and other relevant public health authorities. These may include:
    - Recommending or facilitating access to vaccinations (e.g., COVID-19, influenza, shingles)
    - Distributing infection control supplies (e.g., masks, disinfectants, gloves) to transition coordinators and participants
    - Providing education to participants, caregivers, and direct service providers on infection prevention practices
    - These procedures are adapted to meet the needs of individuals in community settings and are integrated with HCBS provider protocols during the demonstration period.
- Flexibility in Transition and Service Delivery: To minimize disruption to transitions during a PHE, the MFP program may temporarily adjust procedures, such as:
    - Allowing virtual or telephonic assessments, care planning meetings, and transition coordination
    - Permitting remote signatures or documentation in place of in-person meetings
    - These adaptations are aligned with flexibilities authorized through Appendix K amendments to the 1915(c) HCBS waivers and are implemented in coordination with the Department of Human Services and the State Medicaid Agency.
- Telehealth Integration: The MFP program supports the continued use of telehealth to promote access to services during and after a PHE. Temporary flexibilities initiated during a PHE may include:
    - Supporting remote delivery of behavioral health, case management, and other HCBS services
    - Equipping participants or caregivers with technology or training to enable virtual visits
    - Encouraging provider use of telehealth platforms for service delivery, consistent with Medicaid billing guidance

- Communication and Coordination: During a PHE, the MFP program coordinates closely with HCBS administrators and transition coordinators to ensure consistent messaging and participant support. Activities may include:
    - Disseminating real-time updates and guidance to transition teams and providers
    - Updating person-centered service plans to reflect emergency-related needs and contingencies
    - Maintaining emergency contact procedures for participants experiencing service disruption
- Alignment with State HCBS Programs: All PHE-related adaptations are reviewed to ensure consistency with South Dakota's HCBS waiver authorities and Medicaid State Plan policies. Whenever appropriate, MFP leverages state-wide policies enacted during emergencies—such as those authorized through Appendix K—to ensure a unified response across long-term services and supports systems.

K.3. Other information

If needed, provide other information regarding the state or territory's approach to PHEs that is not addressed elsewhere in the template.

Click or tap here to enter text.

APPENDIX A. HYPERLINKS AND GLOSSARY

States or territories may include additional information and documents that do not fit in the other template sections in the Appendix. The template provides default appendix section and subsection headings that states or territories may rename, delete, or otherwise modify as needed. States or territories may also modify the appendix section titles to meet their needs. States or territories that include hyperlinks in the OP must collect all links in the reference table below.

App A.1. Summary of Hyperlinks

Copy all hyperlinks used in the OP into the table below, by OP section. For each link, provide a brief description (for example, "educational materials provided to participants").

Appendix Table A.1. Summary of Hyperlinks

OP section	Link	Brief description
How to use	Embed or link to a file in Word Make your Word documents accessible to people with disabilities	Instructions for embedding a file in a Word document Accessibility instructions for Word documents
A. MFP program overview		
B. Project administration		
C. Recruitment, enrollment, outreach, and education		
D. Community engagement		
E. Benefits and services	March 31, 2022 Note to MFP Recipients	Note to MFP Recipients: Announcement of Certain Changes to Supplemental Services under the MFP Demonstration
F. Transition and housing services	https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf ADLS Waiver Manual CHOICES Waiver Manual FS360 Waiver Manual HOPE Waiver Manual	State Health Official letter #21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH) Billing and Provider Manuals outlining the services provided under each 1915(c) HCBS Waiver.
G. Self-direction and informal caregiving		
H. Reporting	ADLS Waiver Manual CHOICES Waiver Manual FS360 Waiver Manual HOPE Waiver Manual	Billing and Provider Manuals outlining the services provided under each 1915(c) HCBS Waiver.
I. Quality measurement, assurance, and monitoring	HCBS Quality Measure Set	Information about the HCBS Quality Measure Set
J. Continuity of care post-Demonstration	Section 6071(c)(2) of the Deficit Reduction Act	Requirement that the MFP project must operate in conjunction with a qualified and operational HCBS program
K. Equity	Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government	Definition of equity
L. Tribal Initiative		

OP section	Link	Brief description
M. Public health emergencies		
Appendix A		
Appendix B		

App A.2. Glossary

Use the glossary section of the appendix to provide a comprehensive list of acronyms used by the state or territory in responses throughout the OP. Commonly used acronyms are already defined in the glossary table. As demonstrated in the example table shell below (Appendix Table A.2), the glossary can also be used to provide additional context for certain acronyms through brief descriptions.

Appendix Table A.2. Glossary

Acronym	Meaning	Brief description (optional)
ADLS	Assistive Daily Living Services	South Dakota 1915 (c) HCBS waiver
CHOICES	Community, Hope, Opportunity, Independence, Careers, Empowerment, Success	South Dakota 1915 (c) HCBS waiver
CMS	Centers for Medicare & Medicaid Services	
FS 360	Family Support 360	South Dakota 1915 (c) HCBS waiver
HOPE	Home and Community-Based Options and Person-Centered Excellence	South Dakota 1915 (c) HCBS waiver
I/DD	Intellectual and developmental disabilities	
IMD	Institution for Mental Diseases	
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	
LGBTQ+	Lesbian, gay, bisexual, transgender, and queer	
LTSS	Long-term services and supports	
MCP	Managed care plan	
MMIS	Medicaid Management Information System	
MLTSS	Medicaid managed long-term services and supports	
MH/SUD	Mental health and substance use disorders	
MDS	Minimum Data Set	
MFP	Money Follows the Person	
OP	MFP Operational Protocol	
PD	Physical disabilities	
PTC	MFP Program Terms and Conditions	
PHE	Public health emergency	
QIS	Quality improvement system	
SAR	MFP Semi-Annual Progress Report	
SDOH	Social determinants of health	

Acronym	Meaning	Brief description (optional)
SMD	State Medicaid director	
SPA	State Plan Amendment	
STC	Standard Terms and Conditions	CMS's standard grant/cooperative agreement terms and conditions, which can be used as a reference for definitions for key terms.
T-MSIS	Transformed Medicaid Statistical Information System	
Examples of state or territory -specific acronyms		
DMS	Division of Medical Services	Responsible for daily operations of MFP program
DSS	Department of Social Services	Administers Medicaid in the state or territory
FFS	Fee-for-service	

App A.3. Department of Social Services Organizational Chart

B.1.1. Organizational Char

App A.4. Program Staff Job Descriptions

App A.4.1. Program Director – Sara Spisak

Program Director Job Description.pdf

App A.4.2. Data Analyst – Zachary King

Data Analyst Job Description.pdf

App A.5. Supplemental Services

App A.5.1. Pantry Stocking

Supplemental Services Food Supp

App A.5.2. Personal Items

Supplemental Services Personal Ite

App A.6. Marketing, Outreach, and Education Plan

HomeAgain_2025Marketing Strategy_Fir

App A.7. Informed Consent

DSS24_HA_Form_InformedConsent&Authori

APPENDIX B. OPTIONAL SECOND APPENDIX

App B.1. Appendix Section

App B.1.1. Appendix subsection

App B.2. Appendix Section

App B.2.1. Appendix subsection

App B.3. Appendix Section

App B.3.1. Appendix subsection

App B.4. Appendix Section

App B.4.1. Appendix subsection

App B.5. Appendix Section

App B.5.1. Appendix subsection

App B.5.1.1. Appendix sub-subsection