DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	3-18-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000477	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR * Note response date by April 15th '08 cc: Ms. Forkner, Deps	[X] Prepare reply for appropriate signature DATE DUE 4-9-08 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Recvd 4/7/08, letter attached.			
2.			
3.			
4.			

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1.			
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3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 14, 2008

Emma Forkner, Director
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202-8206

Dear Ms. Forkner:

This is in response to your request to renew South Carolina's Head and Spinal Cord Injury (HASCI) Home and Community-Based Waiver. This request has been assigned control number 0284.R03. This number should be used in all correspondence pertaining to the renewal. Our review of the request found that it did not conform fully to statutory and regulatory requirements. Our concerns do not seem to warrant a formal request for additional information, which would stop the 90-day review clock. We are, however, requesting you respond to this informal request for information timely, so that we can meet our 90-day review timeline. Please provide the clarifications necessary to respond to the following issues:

1. **Appendix A-7: Distribution of Waiver Operational and Administrative Functions:** (A) The Medicaid agency is ultimately responsible for the overall operation and administration of the waiver program. Therefore, each function should be checked for the Medicaid agency. (B) Also, please explain what role the operating agency (DDSN) has in the execution of the Medicaid provider agreement.

2. **Appendix B-1-a: Target Group(s)** The State indicates that the Aged population group for this waiver has a minimum age and a maximum age of 65 years. Is it the intention of the State to provide waiver services to these individuals for the one year that they are 65 years of age? The State's description in the additional criteria section should clarify the status of these groups.

3. **Appendix B-4-b: Medicaid Eligibility Groups Served in the Waiver:** (A) The currently approved waiver covers the Optional State Supplement recipients. This group is not included in the renewal application. Is this intentional or an oversight? (B) The currently approved waiver indicates that the State covers "all individuals who would be eligible for

Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community." In the renewal application, the State checked "Only the following groups of individuals in the special home and community-based waiver group under 42 CFR 435.217 and checked a special income level equal to 300? Of the SSI Federal Benefit Rate (FBR)" and "Aged and disable d individuals who have an income at 100% of the FPL." Is it the State's intent to change the coverage group?

4. Appendix C-2-f: Open Enrollment of Providers: Please explain where potential providers have ready access to information regarding requirements and procedures to qualify and the timeframes established for qualifying and enrolling in the program.

5. Appendix D-1-e: Risk Assessment and Mitigation: Not all risks to a recipient are able to be classified directly as abuse, neglect or exploitation. There are other potential risks (i.e. physical, medical, financial, developmental, etc.) that exist that should be part of a general risk assessment. The state has not indicated if these are being assessed or reviewed. Please specify (A) How risks are assessed, (B) How strategies to mitigate risk are incorporated into the service plan in a manner sensitive to the person's preferences, including responsibilities and measures for reducing risks, and (C) The types of backup arrangements that are used.

6. Appendix D-2-a: Service Plan Implementation and Monitoring:
Please specify or indicate;
(A) The monitoring methods and frequency to the target population, e.g. including the frequency of direct, in-person contact with the participant.
(B) How monitoring methods address: …

- Services furnished in accordance with the service plan.
- Participant access to waiver services identified in service plan.
- Participants exercise free choice of provider.
- Services meet participants' needs.
- Effectiveness of back-up plans.
- Participant health and welfare.
- Participant access to non-waiver services in service plan, including health services

(C) Methods for prompt follow-up and remediation of identified problems.
(D) How methods for systematic collection of information about monitoring results are compiled, including how problems identified during monitoring, are reported to the state.

7. Appendix E-1-d: Election of Participant-Direction: The additional criteria that the State uses to determine whether a person may direct some or all of their services is not specific or well-defined, includes a blanket exclusion of individuals solely on the basis that they have specific cognitive or other disabilities and appears to exclude participants solely on the basis of an assessment by their service coordinator that the individual, in isolation, is unable to carry out some of the responsibilities associated with participant direction. Please specify and detail the criteria the State uses determine if a waiver service recipient is capable of self directing their services, and the method of evaluation used in this determination.

8. Appendix F-1: Opportunity to Request a Fair Hearing: While the description describes the appeals process for when notice is made to an individual of an adverse action that affects eligibility status and / or receipt of services, it does not address instances of choice of HCBS vs. institutional services and choice of provider. Please elaborate on the process for these two issues.

9. Appendix G-3-b: Medication Management and Follow-Up:
Please specify:
(A) The scope of monitoring (i.e., whether monitoring is designed to focus on certain types of medications or medication usage patterns).
(B) Methods for conducting monitoring.
(C) Frequency of monitoring.
(D) How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices.
(E) Because this waiver serves individuals with cognitive impairments or mental disorders, please describe how second-line monitoring is conducted concerning the use of behavior modifying medications.

Again, this is an informal request for additional information, and the 90 day review clock will not be stopped. However, for CMS to have adequate time to review your responses in accordance with our 90-day review clock, we request a response no later than April 15, 2008. If you should have any questions, please feel free to contact me at (404) 562-7413 or Mark Reed in our Central Office at 410-786-0861. If necessary, a conference call can be arranged.

Thank you,

Kenni Howard RN

Kenni Howard, RN
Health Insurance Specialist

CC: Mark Reed, Central Office

Log #477

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

April 7, 2008

Mr. Jay Gavens
Acting Associate Regional Director
Center for Medicare and Medicaid Services
Division of Medicaid and State Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Ms. Kenni Howard, RN

Dear Mr. Gavens:

This is in response to your request for additional information to renew South Carolina's Home and Community Based Waiver Program for the Head and Spinal Cord Injured (control number 0284.R03). The State response to your questions follows below.

1. **Appendix A-7: Distribution of Waiver Operational and Administrative Functions:** (A) The Medicaid agency is ultimately responsible for the overall operation and administration of the waiver program. Therefore, each function should be checked for the Medicaid agency. (B) Also, please explain what role the operating agency (DDSN) has in the execution of the Medicaid provider agreement.

   State Response:

   A. The state has amended the chart to include each function. Please see changes to the chart in our web-based submission.
   B. The States interpretation of this checkbox was in the broad sense to include any quality assurance and contracting functions being preformed by the operating agency that assist the state in carrying out waiver operations. While the State maintains ultimately administrative authority, DDSN, as the operating agency oversees it's contracted and county board providers by maintaining a quality assurance and contracting process that providers undergo in order to serve participants in the HASCI waiver.

2. **Appendix B-1-a: Target Group(s)** The State indicates that the Aged population group for this waiver has a minimum age and a maximum age of 65 years. Is it the intention of the State to provide waiver services to these individuals for the one year that they are 65 years of age? The State's description in the additional criteria section should clarify the status of these groups.

State Response:

The state's age requirements are related only to waiver eligibility upon entry into the waiver. As long as the participant continues to meet all other eligibility requirements participants will remain eligible in the HASCI waiver even after age 65 as long as they were assessed for eligibility prior to age 65. The State's initial description under the additional information attempted to clarify this and originally was written as:

Participants on the HASCI Waiver before age 65 remain eligible for Waiver services after their 65th birthday if all other eligibility factors continue to be met. Waiver services are limited to participants with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, disease, dementia, or a neurological disorder related to aging, regardless of the age of onset.

Where the individual:

1. Has urgent circumstances affecting his/her health or functional status; and,
2. Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision in order to avoid institutionalization; and,
3. Needs services not otherwise available within existing community resources, including family, private means and other agencies/programs, or for whom current resources are inadequate to meet the basic needs of the individual, which would allow them to remain in the community.

The state has rewritten the additional criteria section and to try and add clarity to this distinction and the waiver document now states:

Participants **must be enrolled prior to age 65 but will** remain eligible for Waiver services after their 65th birthday if all other eligibility factors continue to be met. Waiver services are limited to participants with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, disease, dementia, or a neurological disorder related to aging, regardless of the age of onset. Where the individual:

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3. Needs services not otherwise available within existing community resources, including family, private means and other agencies/programs, or for whom current resources are inadequate to meet the basic needs of the individual, which would allow them to remain in the community.

3. **Appendix B-4-b: Medicaid Eligibility Groups Served in the Waiver:** (A) The currently approved waiver covers the Optional State Supplement recipients. This group is not included in the renewal application. Is this intentional or an oversight? (B) The currently approved waiver indicates that the State covers "all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community." In the renewal application, the State checked "Only the following groups of individuals in the special home and community-based waiver group under 42 CFR 435.217 and checked a special income level equal to 300? Of the SSI Federal Benefit Rate (FBR)" and "Aged and disable d individuals who have an income at 100% of the FPL." Is it the State's intent to change the coverage group?

State Response:

The state does not intend to change covered groups in this waiver renewal. As a result the state has amended the waiver renewal per CMS regional office instructions so that the eligibility remains the same as it has in previous years.

4. **Appendix C-2-f: Open Enrollment of Providers:** Please explain where potential providers have ready access to information regarding requirements and procedures to qualify and the timeframes established for qualifying and enrolling in the program.

State Response:

The state has added language to the waiver document that includes both the operating and administering agencies websites where information on requirements of enrollment, procedures and timeframes can be found. Please see the amended language below.

Potential providers are given the opportunity to enroll/contract with South Carolina Medicaid and/or subcontract with DDSN. Potential providers are made aware of the requirements for enrollment through either the operating or administrating agency by contacting them directly. **All potential providers are given a packet of information upon contacting the agencies that describe the requirements for enrolment, the procedures used to qualify and the timeframes established for qualifying and enrolling providers. Additionally, potential providers can find information regarding enrollment requirements and timeframes for enrollment at the state's website at: http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/BureauofLongTermCareServices BECOMINGAcltcPROVIDER.asp, and at the operating agencies website of http://www.state.sc.us/ddsn/qpl/HowToBecomeQualified.htm .** DDSN/DHHS will validate the provider meets all standards and qualifications and then the Medicaid agency may enroll the provider should they choose to enroll with the Medicaid agency.

5. **Appendix D-1-e: Risk Assessment and Mitigation:** Not all risks to a recipient are able to be classified directly as abuse, neglect or exploitation. There are other potential risks (i.e. physical, medical, financial, developmental, etc.) that exist that should be part of a general risk assessment. The state has not indicated if these are being assessed or reviewed. Please specify (A) How risks are assessed, (B) How strategies to mitigate risk

are incorporated into the service plan in a manner sensitive to the person's preferences, including responsibilities and measures for reducing risks, and (C) The types of backup arrangements that are used.

State Response:

The state has included the following response in the waiver renewal to clarify policies and procedures around risk assessment and mitigation.

A. The operating agency has a comprehensive assessment completed annually by the Service Coordinator prior to completing the participant's Support Plan, which assesses risks, including but not limited to, physical, financial, medical and developmental risks.
B. Policies balancing risk and policies addressing interventions are utilized by Service Coordinators with the operating agency.
C. The Service Coordinator assesses the participant's natural support network during completion of the annual comprehensive assessment. Emergency planning is also part of the participant's Support Plan and the Service Coordinator is cued to assess the "back-up" plan during completion of the planning process.

6. **Appendix D-2-a: Service Plan Implementation and Monitoring:**
Please specify or indicate;
(A) The monitoring methods and frequency to the target population, e.g. including the frequency) of direct, in-person contact with the participant.
(B) How monitoring methods address: ...
   - Services furnished in accordance with the service plan.
   - Participant access to waiver services identified in service plan.
   - Participants exercise free choice of provider.
   - Services meet participants' needs.
   - Effectiveness of back-up plans.
   - Participant health and welfare.
   - Participant access to non-waiver services in service plan, including health services.

(C) Methods for prompt follow-up and remediation of identified problems.
(D) How methods for systematic collection of information about monitoring results are compiled, including how problems identified during monitoring, are reported to the state.

State Response:

A. The participant's Plan must be reviewed at least quarterly and face-to-face contact between the participant or his/her legal guardian and must occur at least once every 365 days.

B. 1. **At least quarterly the services are monitored to assure the services are received and effective, the participant or his/her legal guardian is satisfied with the services and the participant's Plan is current and updated/changes as new needs and interventions are identified. In addition to the Service Coordinator's review of the participant's Plan the Plans are also reviewed by DDSN HASCI Division staff and the quality assurance/quality improvement contracted staff as part of the QA requirement.**
2. The participant's access to services including health care providers is monitored as needed by the Service Coordinator based on the participant's health care needs. The services must be monitored at least quarterly.
3. Participant's are given a list of available providers to choose a provider of Waiver services.
4. Per policy, Service Coordinators are required to monitor services at least quarterly to assure the services are meeting the participant's needs.
5. Service Coordinators monitor all services and needs at least quarterly.
6. The Service Coordinator's monitorship requirement includes inquiring if the participant's health has changed and if his/her needs are being met.
7. The participant's Plan is monitored at least quarterly and the participant's access to a primary health care provider and other health care providers is monitored as needed based on the person's health care needs.

C. **Service Coordinators are required to follow-up promptly if they are notified of a participant's problem or a provider problem.**

*D. **The contracted QA/QI program with the operating agency and the QA program with the agency responsible for administering the Waiver collect and share data and review results.***

7. **Appendix E-1-d: Election of Participant-Direction:** The additional criteria that the State uses to determine whether a person may direct some or all of their services is not specific or well-defined, includes a blanket exclusion of individuals solely on the basis that they have specific cognitive or other disabilities and appears to exclude participants solely on the basis of an assessment by their service coordinator that the individual, in isolation, is unable to carry out some of the responsibilities associated with participant direction. Please specify and detail the criteria the State uses determine if a waiver service recipient is capable of self-directing their services, and the method of evaluation used in this determination.

State Response:

The following information has been added to **Appendix E-1-d** to better clarify the assessment process that interested participants/responsible parties undergo in order to self-direct attendant care services.

Participants interested in self-directed care are prescreened to assure capability utilizing a standardized pre-screen form. If he/she is not capable a responsible party may direct care if he/she passes the pre-screen. The prescreening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction

and assuring the health and welfare of the participant. The three principal areas screened during the assessment are communication, cognitive patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/responsible party to make them understood and the ability of others to understand the participant/responsible party. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the participant/responsible party. Finally the assessment tool reviews the mood and behavior patterns of the participant/responsible party to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the participant/responsible party. If the participant/responsible party disagrees with the results they may appeal the decision. The RN match visit is completed prior to service authorization.

8. **Appendix F-1: Opportunity to Request a Fair Hearing:** While the description describes the appeals process for when notice is made to an individual of an adverse action that affects eligibility status and / or receipt of services, it does not address instances of choice of HCBS vs. institutional services and choice of provider. Please elaborate on the process for these two issues.

State Response:

The State has amended waiver language to include instances of choice of HCBS vs. institutional services and choice of provider. Please see the amended waiver language.

An appeal may be made on behalf of a Waiver participant by a parent or legal guardian or the Waiver participant whenever any decision adversely affects his/her eligibility status and/or receipt of services. The Waiver participant or the parents/legal guardian of the Waiver participant is informed of this decision verbally and in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et.seq.

A Waiver participant or the parent/legal guardian of a Waiver participant who is dissatisfied with a level of care decision by DDSN **and/or DHHS** has the right to request an appeal of the action, as well as the right to request an appeal of DDSN's decision to reduce, suspend, deny or terminate a waiver service. **Waiver participants may also appeal any issues of choice of provider and choices of HCBS vs. institutional services.**

A request for reconsideration of an adverse decision by DDSN must be sent in writing to the State Director at SCDDSN. A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. In order for Waiver benefits/services to continue during the reconsideration/appeal process, the Waiver participant or the Waiver participant's parent/legal guardian's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision.

The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

If the Waiver participant or the Waiver participant's parent/legal guardian continues to be dissatisfied with decision a request for appeal can be made to SCDHHS. The Waiver participant or the Waiver participant's parent/legal guardian must write a letter requesting an appeal within 30 days of the date of the official written notification issued by DDSN. If the appeal is filed within ten (10) days, services may continue pending the outcome of the hearing. If the adverse action is upheld, the Waiver participant or the Waiver participant's parent/legal guardian may be required to repay Waiver benefits received during the reconsideration/appeal process.

Information regarding the right to appeal and instructions for initiating an appeal are printed on the Notice of Suspension, Denial, Reduction and Termination Forms and the formal letter of denial from DDSN for eligibility. Also included on these forms is the information on continuation of services and possible liability if the participant elects to continue receiving services.

9. Appendix G-3-b: Medication Management and Follow-Up:

Please specify:

(A) The scope of monitoring (i.e., whether monitoring is designed to focus on certain types of medications or medication usage patterns).
(B) Methods for conducting monitoring.
(C) Frequency of monitoring.
(D) How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices.
(E) Because this waiver serves individuals with cognitive impairments or mental disorders, please describe how second-line monitoring is conducted concerning the use of behavior modifying medications.

State Response:

A. Medication Error/Event Reporting Policy (100-29-DD) focuses on all medications and reporting errors regarding Waiver participants receiving residential or day services. DDSN Directive 603-11-DD focuses on psychopharmacologic and anti-epileptic medication for side effects. DDSN Directive, 100-09-DD, focuses on the reporting of any critical incidents, which would also include medication administration errors resulting in serious adverse reactions/poisoning. Providers of residential habilitation are required to meet all the above policies.

B. Medication errors/events will be tracked using the definition and procedures contained in Policy Directive 100-29-DD. Three categories of errors/events will be analyzed: a) medication errors, b) transcription/documentation errors and c) red flag events. Policy Directive 603-11-DD, Monitoring Psychopharmacologic and Anti-epileptic Medication for Side Effects, conducts monitoring using the Psychotropic Medication Monitoring Scale or (PMMS). Critical incidents occurring at DDSN facilities, DSN Board facilities, other service provider locations, or while a Waiver

participant is under the supervision of staff or a contracted employee from the aforementioned provider must be reported to DDSN and is monitored by DDSN.

C. Medication errors/event reporting (100-29-DD) is monitored by provider staff and their overall risk management program. Critical incidents (Policy Directive 100-09-DD) are reported to the operating agency. Quality management staff with the operating agency will review critical incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. Policy Directive 603-11-DD, Monitoring Psychopharmacologic and Anti-epileptic Medication for Side Effects, the monitoring shall begin with a baseline Psychotropic Medication Monitoring Scale (PMMS) evaluation performed prior to initiation of the medication and then will occur at the next quarterly nursing assessment and then every six months after that. Residential Standards of the operating agency require the residential provider to have available a health care professional that can assess a resident's health condition, intervention needed and provide staff instruction regarding the intervention. The Residential Standards also address medications and/or treatments including how they are administered (by a licensed nurse, unlicensed staff as allowed by law or independently by the resident when he/she is assessed as independent). For those residents that are not independent in taking their own medication/treatments, a medication/treatment log must be maintained and the medication log is reviewed at a minimum monthly for accuracy and completeness. If the review of the medication log indicates an error, actions must be taken to alleviate future errors following operating agency policies.

D. DDSN and providers develop and use their data collection system to track, monitor and analyze potentially harmful practices and follow up to address any problems.

E. The monitoring of psychopharmacologic and anti-epileptic medication for side effects is noted by nursing staff at any time that a suspected side effect is detected. This is in addition to the regularly scheduled monitoring that occurs every six months.

Thank you for your continued assistance with the Head and Spinal Cord Injury waiver renewal (control number 0284.R03). Should you have questions or comments regarding our responses, please submit them to Jonathan Tapley at (803) 898-2702 or if you prefer you may e-mail him at Tapley@SCDHHS.GOV.

Sincerely,

Emma Forkner
Director

EF/wsmd

SC Department of Health and Human Services
Transmittal for Director's Signature

Item(s) to be signed:

Indicate reason Director's signature is needed:

Log Number 477

DATE REQUESTED BY:	CONTACT PERSON & PHONE #:

APPROVALS

1) DIVISION DIRECTOR/BUREAU CHIEF SIGNATURE: Sam Waldrep	Date: 4/4/08
2) DEPUTY DIRECTOR'S SIGNATURE:	Date: 4/7/08
3) OTHER (Please indicate) Roy Smith	Date:
George Maky	Date: 4/2/08
Jon Tapley	Date: 4-2-08

FOR DIRECTOR'S USE ONLY

DATE RETURNED:	___ APPROVED	___ DISAPPROVED

Rev: 07/03

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

Mr. Jay Gavens
Associate Regional Director
Center for Medicare and Medicaid Services
Division of Medicaid and State Operations
Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Ms. Kenni Howard, RN

Dear Ms. Howard:

This is in response to your request for additional information to renew South Carolina's Home and Community Based Waiver Program for the Head and Spinal Cord Injured (control number 0284.R03). The State response to your questions follows below.

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   A. The state has amended the chart to include each function. Please see changes to the chart in our web-based submission.
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Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202 -8206
(803) 898-2504 • Fax (803) 898 -4515

2. **Appendix B-1-a: Target Group(s)** The State indicates that the Aged population group for this waiver has a minimum age and a maximum age of 65 years. Is it the intention of the State to provide waiver services to these individuals for the one year that they are 65 years of age? The State's description in the additional criteria section should clarify the status of these groups.

State Response:

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State Response:

The state does not intend to change covered groups in this waiver renewal. As a result the state has amended the waiver renewal per CMS regional office instructions so that the eligibility remains the same as it has in previous years.

4. **Appendix C-2-f: Open Enrollment of Providers:** Please explain where potential providers have ready access to information regarding requirements and procedures to qualify and the timeframes established for qualifying and enrolling in the program.

State Response:

The state has added language to the waiver document that includes both the operating and administering agencies websites where information on requirements of enrollment, procedures and timeframes can be found. Please see the amended language below.

Potential providers are given the opportunity to enroll/contract with South Carolina Medicaid and/or subcontract with DDSN. Potential providers are made aware of the requirements for enrollment through either the operating or administrating agency by contacting them directly. **All potential providers are given a packet of information upon contacting the agencies that describe the**

requirements for enrolment, the procedures used to qualify and the timeframes established for qualifying and enrolling providers. Additionally, potential providers can find information regarding enrollment requirements and timeframes for enrollment at the state's website at: http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/BureauofLongTermCareServices/BECOMINGAcltcPROVIDER.asp, and at the operating agencies website of http://www.state.sc.us/ddsn/qpl/HowToBecomeQualified.htm . DDSN/DHHS will validate the provider meets all standards and qualifications and then the Medicaid agency may enroll the provider should they choose to enroll with the Medicaid agency.

5. **Appendix D-1-e: Risk Assessment and Mitigation:** Not all risks to a recipient are able to be classified directly as abuse, neglect or exploitation. There are other potential risks (i.e. physical, medical, financial, developmental, etc.) that exist that should be part of a general risk assessment. The state has not indicated if these are being assessed or reviewed. Please specify (A) How risks are assessed, (B) How strategies to mitigate risk are incorporated into the service plan in a manner sensitive to the person's preferences, including responsibilities and measures for reducing risks, and (C) The types of backup arrangements that are used.

State Response:

The state has included the following response in the waiver renewal to clarify policies and procedures around risk assessment and mitigation.

A. The operating agency has a comprehensive assessment completed annually by the Service Coordinator prior to completing the participant's Support Plan, which assesses risks, including but not limited to, physical, financial, medical and developmental risks.
B. Policies balancing risk and policies addressing interventions are utilized by Service Coordinators with the operating agency.
C. The Service Coordinator assesses the participant's natural support network during completion of the annual comprehensive assessment. Emergency planning is also part of the participant's Support Plan and the Service Coordinator is cued to assess the "back-up" plan during completion of the planning process.

6. **Appendix D-2-a: Service Plan Implementation and Monitoring:**
Please specify or indicate;
(A) The monitoring methods and frequency to the target population, e.g. including the frequency of direct, in-person contact with the participant.
(B) How monitoring methods address: ...
   - Services furnished in accordance with the service plan.

- Participant access to waiver services identified in service plan.
- Participants exercise free choice of provider.
- Services meet participants' needs.
- Effectiveness of back-up plans.
- Participant health and welfare.
- Participant access to non-waiver services in service plan, including health services

(C) Methods for prompt follow-up and remediation of identified problems.

(D) How methods for systematic collection of information about monitoring results are compiled, including how problems identified during monitoring, are reported to the state.

State Response:

A. The participant's Plan must be reviewed at least quarterly and face-to-face contact between the participant or his/her legal guardian and must occur at least once every 365 days.

B. 1. At least quarterly the services are monitored to assure the services are received and effective, the participant or his/her legal guardian is satisfied with the services and the participant's Plan is current and updated/changes as new needs and interventions are identified. In addition to the Service Coordinator's review of the participant's Plan the Plans are also reviewed by DDSN HASCI Division staff and the quality assurance/quality improvement contracted staff as part of the QA requirement.

2. The participant's access to services including health care providers is monitored as needed by the Service Coordinator based on the participant's health care needs. The services must be monitored at least quarterly.
3. Participant's are given a list of available providers to choose a provider of Waiver services.
4. Per policy, Service Coordinators are required to monitor services at least quarterly to assure the services are meeting the participant's needs.
5. Service Coordinators monitor all services and needs at least quarterly.
6. The Service Coordinator's monitorship requirement includes inquiring if the participant's health has changed and if his/her needs are being met.
7. The participant's Plan is monitored at least quarterly and the participant's access to a primary health care provider and other health care providers is monitored as needed based on the person's health care needs.

C. Service Coordinators are required to follow-up promptly if they are notified of a participant's problem or a provider problem.

D. The contracted QA/QI program with the operating agency and the QA program with the agency responsible for administering the Waiver collect and share data and review results.

7. **Appendix E-1-d: Election of Participant-Direction:** The additional criteria that the State uses to determine whether a person may direct some or all of their services is not specific or well-defined, includes a blanket exclusion of individuals solely on the basis that they have specific cognitive or other disabilities and appears to exclude participants solely on the basis of an assessment by their service coordinator that the individual, in isolation, is unable to carry out some of the responsibilities associated with participant direction. Please specify and detail the criteria the State uses determine if a waiver service recipient is capable of self-directing their services, and the method of evaluation used in this determination.

   State Response:

   The following information has been added to **Appendix E-1-d** to better clarify the assessment process that interested participants/responsible parties undergo in order to self-direct attendant care services.

   Participants interested in self-directed care are prescreened to assure capability utilizing a standardized pre-screen form. If he/she is not capable a responsible party may direct care if he/she passes the pre-screen. The prescreening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare of the participant. The three principal areas screened during the assessment are communication, cognitive patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/responsible party to make them understood and the ability of others to understand the participant/responsible party. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the participant/responsible party. Finally the assessment tool reviews the mood and behavior patterns of the participant/responsible party to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the participant/responsible party. If the participant/responsible party disagrees with the results they may appeal the decision. The RN match visit is completed prior to service authorization.

8. **Appendix F-1: Opportunity to Request a Fair Hearing:** While the description describes the appeals process for when notice is made to an individual of an adverse action that affects eligibility status and / or receipt of services, it does not address instances of choice of HCBS vs. institutional services and choice of provider. Please elaborate on the process for these two issues.

   State Response:

The State has amended waiver language to include instances of choice of HCBS vs. institutional services and choice of provider. Please see the amended waiver language.

An appeal may be made on behalf of a Waiver participant by a parent or legal guardian or the Waiver participant whenever any decision adversely affects his/her eligibility status and/or receipt of services. The Waiver participant or the parents/legal guardian of the Waiver participant is informed of this decision verbally and in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et.seq.

A Waiver participant or the parent/legal guardian of a Waiver participant who is dissatisfied with a level of care decision by DDSN **and/or DHHS** has the right to request an appeal of the action, as well as the right to request an appeal of DDSN's decision to reduce, suspend, deny or terminate a waiver service. **Waiver participants may also appeal any issues of choice of provider and choices of HCBS vs. institutional services.**

A request for reconsideration of an adverse decision by DDSN must be sent in writing to the State Director at SCDDSN. A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. In order for Waiver benefits/services to continue during the reconsideration/appeal process, the Waiver participant or the Waiver participant's parent/legal guardian's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

If the Waiver participant or the Waiver participant's parent/legal guardian continues to be dissatisfied with decision a request for appeal can be made to SCDHHS. The Waiver participant or the Waiver participant's parent/legal guardian must write a letter requesting an appeal within 30 days of the date of the official written notification issued by DDSN. If the appeal is filed within ten (10) days, services may continue pending the outcome of the hearing. If the adverse action is upheld, the Waiver participant or the Waiver participant's parent/legal guardian may be required to repay Waiver benefits received during the reconsideration/appeal process.

Information regarding the right to appeal and instructions for initiating an appeal are printed on the Notice of Suspension, Denial, Reduction and Termination Forms and the formal letter of denial from DDSN for eligibility. Also included on

these forms is the information on continuation of services and possible liability if the participant elects to continue receiving services.

9. **Appendix G-3-b: Medication Management and Follow-Up:**
Please specify:
(A) The scope of monitoring (i.e., whether monitoring is designed to focus on certain types of medications or medication usage patterns).
(B) Methods for conducting monitoring.
(C) Frequency of monitoring.
(D) How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices.
(E) Because this waiver serves individuals with cognitive impairments or mental disorders, please describe how second-line monitoring is conducted concerning the use of behavior modifying medications.

State Response:

A. Medication Error/Event Reporting Policy (100-29-DD) focuses on all medications and reporting errors regarding Waiver participants receiving residential or day services. DDSN Directive 603-11-DD focuses on psychopharmacologic and anti-epileptic medication for side effects. DDSN Directive, 100-09-DD, focuses on the reporting of any critical incidents, which would also include medication administration errors resulting in serious adverse reactions/poisoning. Providers of residential habilitation are required to meet all the above policies.

B. Medication errors/events will be tracked using the definition and procedures contained in Policy Directive 100-29-DD. Three categories of errors/events will be analyzed: a) medication errors, b) transcription/documentation errors and c) red flag events. Policy Directive 603-11-DD, Monitoring Psychopharmacologic and Anti-epileptic Medication for Side Effects, conducts monitoring using the Psychotropic Medication Monitoring Scale or (PMMS). Critical incidents occurring at DDSN facilities, DSN Board facilities, other service provider locations, or while a Waiver participant is under the supervision of staff or a contracted employee from the aforementioned provider must be reported to DDSN and is monitored by DDSN.

C. Medication errors/event reporting (100-29-DD) is monitored by provider staff and their overall risk management program. Critical incidents (Policy Directive 100-09-DD) are reported to the operating agency. Quality management staff with the operating agency will review critical incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. Policy Directive 603-11-DD, Monitoring Psychopharmacologic and Anti-epileptic Medication for Side Effects, the monitoring shall begin with a baseline Psychotropic Medication Monitoring Scale (PMMS) evaluation performed prior to initiation of the medication and then will occur at the next quarterly nursing assessment and then every six months after that. Residential Standards of the operating agency require the residential provider to have available a health care professional that can assess a resident's health condition, intervention needed and provide staff instruction regarding the intervention.

The Residential Standards also address medications and/or treatments including how they are administered (by a licensed nurse, unlicensed staff as allowed by law or independently by the resident when he/she is assessed as independent). For those residents that are not independent in taking their own medication/treatments, a medication/treatment log must be maintained and the medication log is reviewed at a minimum monthly for accuracy and completeness. If the review of the medication log indicates an error, actions must be taken to alleviate future errors following operating agency policies.

D. DDSN and providers develop and use their data collection system to track, monitor and analyze potentially harmful practices and follow up to address any problems.
E. The monitoring of psychopharmacologic and anti-epileptic medication for side effects is noted by nursing staff at any time that a suspected side effect is detected. This is in addition to the regularly scheduled monitoring that occurs every six months.

Thank you for your continued assistance with the Head and Spinal Cord Injury waiver renewal (control number 0284.R03). Should you have questions or comments regarding our responses, please submit them to Jonathan Tapley at (803) 898-2702 or if you prefer you may e-mail him at Tapley@SCDHHS.GOV.

Sincerely,

Emma Forkner
Director

EF/wsmd