DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Waldrup	12-1-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101247	[X] Prepare reply for the Director's signature DATE DUE 2-15-10
2. DATE SIGNED BY DIRECTOR cc: Ms Forkner, Depp, CMS file	[ ] Prepare reply for appropriate signature DATE DUE [ ] FOIA DATE DUE ~~[X] Necessary Action~~

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. SAM WALDROP			
2. MSI JACOMIS			
3.			
4.			

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

November 17, 2010

Emma Forkner, Director
SC Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

Dear Ms. Forkner:

The Centers for Medicare and Medicaid Services (CMS) is conducting a quality review of South Carolina's Home and Community Based Waiver for Individuals Dependent on Mechanical Ventilation, CMS control number 40181.R03. This review will be used to evaluate the overall performance of this waiver program throughout the currently approved period (December 1, 2007 – November 30, 2012) and to identify the need for any modifications or technical assistance necessary to continue successful operation this waiver program. The results of this review will serve to inform both the State and CMS of the State's compliance with waiver assurances in anticipation of the waiver's renewal. The expiration date of this waiver is November 30, 2012.

The CMS requests States to demonstrate adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis. Enclosed with this letter is a listing of the types of evidence-based information CMS must review in order to determine the State's implementation of its quality management and improvement strategy – that is discovery, remediation and improvement activities with regard to all of the waiver assurances. We request you submit the information identified in the enclosure to this office within **ninety** days of receipt of this letter. To expedite the review process, we ask that you provide concise, specific information that demonstrates your State's implementation of your quality management and improvement strategy.

While we recognize the value of State policies and procedures with regard to oversight activities, this evaluation focuses on the extent to which the policies and procedures have been implemented, and the results of the State's oversight activities. That is, how does the state identify quality issues, and how does the State address these issues on an individual and systemic basis when they are identified? As you will see in the enclosure, we are requesting evidence as to the implementation of the quality management and improvement strategy.

After reviewing the requested submissions, Connie Martin will contact your staff to discuss any necessary follow-up activities. Please feel free to contact her at (404) 562-7412 with any questions related to this request.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure: HCBS Quality Review Worksheet
cc: Mark Reed, Central Office Analyst

HCBS Quality Review Work Sheet

I. Level of Care (LOC) Determination

The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating a waiver applicant or participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.		
Sub Assurances	CMS Expectations	Types of Evidence
An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	State submits evidence that is has reviewed applicant files to verify that individual levels of care evaluations are conducted.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.	State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted at least annually or as specified in the approved waiver.	
The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.	State submits that it regularly reviews participant files to verify that the instrument described in the approved waiver is used in all level of care re-determinations, the person(s) who implement level of care determinations are those specified in the approved waiver, and the process/instruments are applied appropriately.	

II. Service Plans

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.		
Sub Assurances	CMS Expectations	Types of Evidence
Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.	State demonstrates that service plans are reviewed periodically to assure that all of participant needs are addressed and preferences considered.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The state monitors service plan development in accordance with its policies and procedures	State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.	
Service plans are update/revised at least annually or when warranted by changes in the waiver participant's needs.	State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures.	

II. Service Plans (Continued)

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.		
Sub Assurances	CMS Expectations	Types of Evidence
Services are delivered in accordance with the service plan, including the type, scope, amount, and frequency specified in the service plan.	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
Participants are afforded choice: 1) Between waiver services and institutional care; and 2) Between/among waiver services and providers	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	

III. Qualified Providers

The State demonstrates it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.		
Sub Assurances	CMS Expectations	Types of Evidence
The State verifies that providers initially and continually met required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.	State provides documentation of periodic review by licensing/certification entity.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements	State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants.	
The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	State provides documentation of monitoring and training and actions it has taken when providers have not met requirements (e.g., technical assistance, training).	

IV. Health and Welfare

The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.		
Sub Assurances	CMS Expectations	Types of Evidence
The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	State demonstrates that, on an ongoing basis, abuse, neglect and exploitation are identified, appropriated actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect and exploitation trends and strategies it has implemented for prevention.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

V. Administrative Authority

The State demonstrates it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.		
Sub Assurances	CMS Expectations	Types of Evidence
The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.	State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

VI. Financial Accountability

The State demonstrated that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.		
Sub Assurances	CMS Expectations	Types of Evidence
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver. State submits results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver reimbursement methodology. State demonstrates that interviews with State staff and providers are periodically conducted to verity that any identified financial irregularities are addressed. Stat demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreements/contracts.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

April 29, 2011

Ms. Jackie Glaze
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Connie L. Martin

Dear Ms. Glaze:

Enclosed is South Carolina's Submission of Evidentiary-Based Information with regard to oversight activities of the South Carolina's Home and Community Based Waiver for Individuals Dependent on Mechanical Ventilation, CMS control number 40181.R03. We look forward to your evaluation of South Carolina's performance.

Please contact Sam Waldrep, (803) 898-2725 should you need additional information regarding this waiver assessment.

Sincerely,

Sam Waldrep
Deputy Director

Enclosures

CC: Sam Waldrep, Bureau Chief
Vanessa Busbee, Department Head

Evidentiary-Based Information
South Carolina Home and Community Based Waiver for Individuals Dependent on Mechanical Ventilation (#40181.R03)

P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2580 • Fax (803) 898-8235

Introduction

The Mechanical Ventilation Waiver offers a variety of services to address participants' needs. The services offered are designed to provide participants the choice of remaining in their homes, instead of seeking nursing home placement. As of January 21, 2011 thirty-four (34) participants are enrolled in this waiver.

State nurse consultant staff performs the case management function for these waiver applicants and participants. As of January 21, 2011, the following twelve (12) offices have mechanical ventilator dependent participants. The number of participants is indicated in parenthesis.

Greenville (1); Spartanburg (2); Greenwood (1); Rock Hill (4); Columbia (8); Aiken (1); Sumter (5); Florence (5); Conway (1); Charleston (3); Ridgeland (2); and Anderson (1)

Program operations are based on State policies and procedures that address Federal assurances. Due to evidentiary based requirements, the chart review data collection process changed during the waiver review period. In March 2008 an on-site visit, under the National Quality Contractor, was held with Medstat staff. Compliance rates were increased to reflect a requirement of 94% or 100% compliance on all, except one (89%), indicators. Also, in 2009 a compliance score of 100% was required for most QA indicators and all indicators directly related to Federal Assurances. Additionally, Phoenix (our new case management/nurse web based data collection system) was implemented in April 2010. Data for many QA indicators accumulated on a daily basis, thus, allowing an on-going review of these indicators (i.e. timeliness of re-evaluations, level of care determinations).

Lastly, as a result of Medstat staff training in 2005 a Quality Assurances Task Force of pertinent SCDHHS Central Office staff was developed in February 2006. The Task Force is scheduled to meet every other month to discuss the following information: quality assurance chart review results (regional office and central office); service providers' (i.e. LPN, RN, personal care, home delivered meals, etc) growth and/or concerns; Care Call system reports, Adult Protective Services reports, appeals and other QA activities. This information is used to make program enhancements, policy changes and identify training needs; and pertinent information is shared with appropriate regional office staff.

This Evidentiary-based report identifies the automated reporting and data collection processes, which include Case Management Systems (CMS), Phoenix and Care Call. Case Management language referenced through out the three automated systems refers to case managers and nurse consultants.

The automated Case Management System (CMS) kept automated records of all intake, assessment, and care planning activities since 1991. There were a number of features of CMS available to case managers including automated reports which list their caseloads, when assessments are due, services provided to consumers and cost out reports of the services. There were also emergency preparedness reports that indicated which consumers were most vulnerable in cases of natural disasters. Another feature of CMS is the Service Plan Wizard. The Wizard was used when developing a plan of care.

CMS was featured by the Centers for Medicare & Medicaid Services in one of its Promising Practices Papers in Long Term Care. The Service Plan Wizard was featured in a separate Promising Practices Paper.

Phoenix is the most recent version of this software. It was implemented in 2010 and is designed to be used with tablets so case managers and nurses can obtain electronic signatures and work toward a completely paperless system. The tablets download critical data and upload it to the web as needed. Data input can be done through the tablets or directly to the web.

There are a number of features available for workers. These include a dashboard showing all assigned

cases, activities due and performed, and notifications. There is a database of medications allowing them to indicate current and former medications being taken by participants. There is also an automated way to identify need for home repairs and electronically send them to a specialist who will do a home assessment and provide specifications for providers. Providers electronically accept these referrals and view pertinent information related to the services provide.

Additional features of Phoenix include a section for home assessment, one for caregiver supports, one measuring quality indicators and reporting out by individual worker and CLTC office for a number of measures and a feature that pulls data from various source in Phoenix to ensure the service plan reflects all identified needs and goals. There are also edits to ensure compliance with federal regulations (e.g., waiver admission is within 30 days of the most recent level of care determination) as well as state policies. There is also a means to identify waiver participants most at risk for missed in-home visits and those most at risk in the event of natural disasters.

Lastly, the South Carolina Care Call system is an automated system used to document in-home service delivery. It offers web-based reporting and billing. Workers call a toll free number upon commencing and ending services. The system monitors the phone being used to make the call. Services documented are compared with the prior authorization to determine if the service was provided appropriately.

On a weekly basis, the database generates electronic billing to MMIS for services provided. Only authorized services and the total units provided are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services.

I. Level of Care (LOC) Determination:

Sub Assurances:

A. An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

State's Evidence: All waiver referrals go through an intake process. Intake criteria are applied by a Nurse Consultant and the case is assigned to a Nurse Consultant for assessment. Prior to April 2010 assessments were keyed in to the SCDHHS's Case Management System (CMS) and after this date assessments are keyed into Phoenix. Individuals that met the eligibility requirements may enroll for Mechanical Ventilation Dependent Waiver. A Nurse Consultant verifies that the participant is Medicaid eligible, meets Level of Care (LOC) and elects to participate. Justification for LOC determination is documented in the narrative and/or narrative checklist and on the assessment form.

A manual review of all files for the review period of December 1, 2007 forward indicate that 94% of Mechanical Ventilator Dependent applicants had a LOC on file within thirty (30) days of waiver enrollment. Of the 15 enrollees reviewed, only one (1) did not have a level of care determination within thirty (30) days of waiver enrollment. However, the participant met LOC criteria at the next assessment and continues to meet LOC criteria. The following documents are provided as evidence to support that an evaluation of LOC is provided to all applicants:

- **Attachment #1**: Samples of Nurse Consultant completed assessments to support level of care determination

Remediation: This error occurred in a regional office that appropriately entered four (4) other applicants into the waiver during the review period. Therefore, this error was viewed as an isolated incident when it occurred in 2009. To ensure future accuracy, all nurse consultant staff was required to attend mandatory Case Management and HCBS Waiver Training written by Center for Medicare and Medicaid Services and University of Southern Maine, Muskie School of Public Health.

- **Attachment # 2**: Attendance sheets for nurse consultants attending mandatory Case Management and HCBS Waiver training written by CMS and University of Southern Maine, Muskie School of Public Health

Also, the April 2010 implementation of Phoenix (computerized case management/nurse system) will aide in accuracy of this waiver assurance. Applicants with LOC determinations not within thirty (30) days cannot be enrolled in the waiver.

- **Attachment #3**: Phoenix Feature: Waiver enrollment denial due to LOC determination beyond thirty (30) days

B. The level of care of enrolled participants is re-evaluated at least annually or as specified in its approved waiver.

State's Evidence: Enrolled participants are re-evaluated at least annually or more frequently if warranted. The assigned nurse consultant completes the assessment within 365 days of the last completed assessment. The same assessment tool used for initial assessments and LOC determination is used for re-evaluations.

A manual review of all participants (34) files indicates that 92% of all re-evaluations (58 of 65) were completed within 365 days during the December 1, 2007 – January 31, 2011review period. All participants (100%) continued to meet LOC criteria when re-evaluations were conducted within 3- 14 days of the original due date. The following documents are provided as evidence to support that the LOC of all applicants is re-evaluated at least annually or more frequently are as follows:

- **Attachment #4**: Copy of Statewide Summary for Central Office 2007 - 2011 Quality Assurance Review. Indicator 1C address re-evaluation requirements. Compliance requirements for indicators 1C is 100%.

Remediation: The errors were not redundant in any particular regional office and occurred over a three year period (2008 – 2010); therefore, instances were viewed as isolated situations. However, to ensure future compliance, all nurse consultants were required to attend Case Management and HCBS Waiver Training written by CMS and University of Southern Maine, Muskie School of Public Health.

- **Attachment #2**: Attendance sheets for Nurse Consultants that attended-mandatory Case Management and HCBS Waiver Assurances Training written by CMS and University of Southern Maine, Muskie School of Public Health

Also, as of Phoenix implementation, nurse consultants are notified of required monthly activities for each participant on his/her caseload. Upon logging into Phoenix, each nurse consultant's "Dashboard" lists all required current and future month activities (i.e. re-evaluations). Additionally, Phoenix has two QA features to assist in monitoring re-evaluation timeliness. One feature will display the percentage of evaluations conducted timely. Through out the month the other feature shows the number of activities completed versus the number of activities remaining. Both features will daily produce data, based on specified time period. Thus, allowing daily monitoring of re-evaluation timeliness. Finally, on-going QA reviews will be conducted in 2011 for quality improvement.

- **Attachment #5** : Sample of Nurse Consultant's Phoenix "Dashboard"
- **Attachment #6**: Sample QA feature reflecting percentage of timely re-evaluations
- **Attachment #7** : Sample QA feature reflecting number of completed monthly activities verse number of remaining activities

C. The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

State's Evidence: The approved assessment instrument is part of the CMS program and Phoenix. Both programs ensure that the approved assessment form is used for 100% of applicants. All assessments must be selected from our computerized system. And, each system (CMS, prior to April 2010 or Phoenix, after April 2010) only allows the appropriate waiver assessment to be selected. Central Office chart reviews included a 100% of mechanical ventilator dependent files. The state has a 100% statewide average for using the appropriate process and 100% statewide average for appropriate level of care determinations. The following documents are provided as evidence that process and

instruments are applied appropriately and according to the approved description to determine participant level of care.

- **Attachment #4**: Copy of Statewide Summary for Central Office 2007- 2011 Quality Assurance Reviews (indicators 5 and 6)

- **Attachment #1**: Samples of Nurse Consultant completed assessments to support level of care determination

II. Service Plans:

Sub Assurances:

A. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

State's Evidence: SCDHHS is responsible for developing participant service plans based on the comprehensive assessment of the participant's medical needs, activities of daily living, psycho behavioral information and instrumental activities of daily living. Each problem addressed on the service plan includes a goal, objective and interventions. The State CMS program had a component (referred to as the "Wizard") that links problems identified in the assessment to the service plan. Phoenix has a component that links assessment deficits to the service plan, and identified deficits cannot be removed from the service plan. Quality Assurance reviews of service plans ensure participant needs are met. The following documents are provided as evidence that individual service plans are reviewed to assure that all participant needs and personal goals are addressed:

- **Attachment #8**: Copy of service plans and service plan wizard requirements

- **Attachment #9**: Copy of Phoenix assessment and Service Plan

- **Attachment #4** : Copy of Statewide Summary for Central Office 2007 – 2011 Quality Assurance Reviews (indicators 4A and 4B)

Remediation: All nurse consultants, though only three regional offices showed need for improvement, attended mandatory Case Management and HCBS Waiver Training.

- **Attachments #2**: Attendance sheets for Nurse Consultants that attended-mandatory Case Management and HCBS Waiver Assurances Training written by CMS and University of Southern Maine, Muskie School of Public Health

With Phoenix automatically linking assessment deficits to the service plan, the number of errors in addressing each participant's needs should be less. Phoenix will also list all appropriate interventions for specific problems/goals noted on participant's service plan. To evaluate the effectiveness of these Phoenix components and ensure progress towards future compliance, on-going service plan development QA reviews will be conducted in 2011.

B. The state monitors service plan development in accordance with its policies and procedures.

State's Evidence: For the 2007 – 2011 waiver review period, accumulated data indicates that service plan development is conducted in accordance with policy and procedure guidelines

97% of the time. The following documents are provided as evidence that the State monitors service plan development in accordance with its policies and procedures:

- **Attachment #4**: Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Reviews (indicators 4A and 4B)

Remediation: Nurse consultants were required to attend Case Management and HCBS Waiver Training. Also, to continue improvement with this assurance on-going QA reviews will be Conducted in 2011.

Additionally, a Phoenix component requires a State worker's signature for service plan completion and authorization of services

C. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs

State's Evidence: Central Office yearly reviews were used to monitor the updating/revising of service plans at least annually or when warranted by changes in participant's needs. A 100% record review showed a statewide compliance rate of 98%. Of 65 required service plans all participants, except one, had service plans developed annually. And, for this one participant three other required service plans were developed annually. The following documents are provided as evidence to support the monitoring of service plan updates/revisions:

- **Attachment #4**: Copy of Statewide Summary for Central Office 2007-2011 Quality Assurance Reviews (indicators 4A and 4B). Individual regional office findings are not shown in the attached chart but results of the 65 required service plans are reflected in indicators 4A and 4B (shown on the chart).

Remediation: Annual service plan updates were not viewed as an area of concern, because only one of all (65) required service plan updates was omitted. The regional office where this omission occurred successfully updated all other (9) required annual service plans. Thus, this error was viewed as an isolated incident. To ensure continued compliance and improvement all nurse consultants were required to attend Case Management and HCBS Waiver Training.

Additionally, Phoenix has a QA feature that accumulates annual service plan development data. This feature, based on specified review period, displays the percentage of service plans updated annually. To ensure and evaluate the effectiveness of this Phoenix feature on-going QA reviews of service plan updates/revisions will be conducted in 2011.

- **Attachment #10**: Sample QA feature reflecting percentage of annual service plan updates/revisions

D. Services are delivered in accordance with the service plan, including the type, scope, amount, and frequency specified in the service plan.

State's Evidence: The CMS program (prior to 2010) and Phoenix (after 2010) will not allow service authorizations that do not contain, amount, duration, scope, and frequency criteria. Care Call reports monitor service delivery. Regional office management staff monitors care call activities and narrate concerns in participants file. Nurse Consultants share provider choice information if a participant expresses a desire to change providers. Also, the CO annual QA reviews ensure monitoring of Care Call activities (indicators 3 and 3A). The

following evidence supports the monitoring of service plan delivery:

- **Attachment #11**: Sample Care Call Reports

- **Attachment #4**: Copy of Statewide Summary for Central Office 2007-2011 Quality Assurance Reviews (indicator 3,and 3A)

Remediation: Two regional offices show a need for improvement in reviewing Care Call activity reports and documenting care call activity dates reviewed, and four regional offices only show a need for improvement in documenting Care Call activity dates reviews. Quality assurance reviews will be conducted in 2011 to monitor improvement of care call activity reviews and documentation of review dates. Also, the narrative checklist feature in Phoenix has been modified to require documentation of dates of Care Call activities reviewed.

- **Attachment #12**: Copies of Phoenix generated narrative checklist that include Care Call review dates

E. Participants are afforded choice: (1) between waiver services and institutional care; and (2) between/among waiver services and providers.

State's Evidence: **1.** Each participant or responsible party signs and dates a LOCUS form prior to program entry. Prior to April 2010 the LOCUS form was in hard copy. Since April 2010 the LOCUS form is generated and signed in Phoenix. The LOCUS form indicates participant's choice of community care or institutional care. Signature and Date on LOCUS forms are monitored during quality assurance reviews. The following documents serve as evidence that each participant is afforded choice between waiver services and institutional care:

- **Attachment #4**: Copy of Statewide Summary for Central Office 2007- 2011 Quality Assurance Review (indicator 2B). The State was 100% compliant with this assurance.

Remediation: All participants, except one had required LOCUS form signed. However, upon discovery of this error, a LOCUS form was signed by participant. Thus, the state is at 100% compliance. Phoenix QA is being developed to monitor compliance with this assurance.

- **Attachment #13**: Copy of Phoenix LOCUS QA feature

State's Evidence: **2. Nurse** Consultants discuss service provider options with participants. Initial service provider selections are noted on provider choice forms by the nurse consultant. The participant signs and dates the choice form confirming verbal provider selections, at the nurse consultant's first visit. Subsequent selections for additional or changes in provider services are narrated in the participants chart. Participants also have choices regarding who directs his/her care. Proper documentation of provider choice is monitored during QA reviews. Participant and/or responsible party dissatisfaction with provider or services reported through the CLTC complaint system is addressed by CLTC Central Office staff and with the appropriate nurse consultant for resolution. Also, a phone interview with all participants is surveyed yearly for participants' satisfaction with services. Results of 2008 and 2009 surveys show overall satisfaction with CLTC services. Findings from the 2010 survey are being analyzed. The following documents serve as evidence that each participant is afforded choice between waiver services and providers:

- **Attachment #4:** Copy of Statewide Summary for Central Office 2007 -2010 Quality Assurance Review (indicators 2A).

- **Attachment #14**: Sample Provider Choice List

- **Attachment #15**: Copy of 2008 and 2009 Annual Survey of Community Long Term Care (CLTC) Consumer Experience and Satisfaction Report

Remediation: The statewide compliance score was 97%. One regional office compliance score showed a need for improvement. Therefore, in addition to nurse consultant's attending the mandatory Case Management and HCBS Waiver Training, on-going QA reviews will be conducted in 2011.

General Summary regarding assurances I and II: Quality Assurance review findings show that the majority of the State's regional offices have one – two areas of noncompliance. Monitoring will continue to ensure improvement and/or the need for additional intervention (i.e. training). Only one office showed more than two areas requiring improvement. Central Office continues to meet with Sumter office management staff to identify work flow and performance issues. Additional plans are being developed to monitor and ensure improvement.

III. Qualified Providers:

Sub Assurances:

A. The State verifies that providers initially and continually met required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.

State's Evidence: The state verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards. The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State employs a licensed Registered Nurse to conduct on-site reviews periodically based on past performance of the following services:

- Personal Care II
- Personal Care I
- Medicaid Nursing

The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other requirements as outlined in the contract. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, emergency backup plans, policy and procedure manuals, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

Other services are reviewed by different means.

Home delivered meals are monitored by the State Unit on Aging, since all but three providers are part of the aging network. SCDHHS has a formal memorandum of agreement with the State Unit on Aging to perform this function.

Environmental modification services require a contractor's license. Along with ensuring that providers have these licenses, the State employs a reviewer who conducts on-site reviews of a sample of modifications and is available upon request.

Attendant care services are provided by individuals directly employed by participants. SCDHHS has a contract with the University of South Carolina to ensure that these attendants meet all requirements to provide services. The University employs registered nurses to assess attendants and determine that they are capable of providing all needed care. In addition, the case manager consults with the participant at least monthly to ensure that services are being provided appropriately.

B. The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

State Evidence: The CLTC Compliance Review Officer monitors contracted providers to ensure compliance with contractual requirements. This person identifies and rectifies situations where providers do not meet requirements.

For services monitored by the compliance registered nurse, a report is generated listing all deficiencies identified. The report will also score the review based on a sanctioning scale; the scores will determine if they will receive a sanction and if so, the level of the sanction. The scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed. Currently only Personal Care II reviews are being scored. For the other services, a report is generated listing all deficiencies identified. Based upon the severity and number of the deficiencies and results of prior reviews, sanctions may take place. These range from requiring a corrective action plan to recoupment to suspending new referrals to termination of the contract.

Following is a chart that outlines how the reviews will be scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=secondary, 2 = serious, 3 = major

Client Service Questions	Possible Answers	Severity level
Was supervisory visit made within 30 days after PC II services initiated?	Y,N,NA	3
Was the initial supervisory visit documented in Care Call?	Y,N,NA	3
Does provider maintain individual client records?	Y,N	2
Did provider give participant written information regarding advanced directives?	Y,N,NA	1

There are five types of sanctions:

- Corrective Action Plan – This is the least severe sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a corrective action plan for correcting deficiencies and avoiding recurrence.

- 30-day suspension – This sanction level is moderate, at this level, new referrals are suspended for 30 days. The provider is required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 30-day period.

- 60-day suspension – This sanction level is substantial, at this level, new referrals are suspended for 60 days. The provider is required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 60-day period.

- 90-day suspension – Indicates major and/or widespread deficiencies. The 90-day suspension of new referrals will only be lifted after an accepted corrective action plan. In addition, an acceptable follow-up review visit will be conducted if warranted prior to reinstatement.

- Termination – Indicates major and substantial, generally coupled with a history of reviews with repeated moderate to major deficiencies. Termination is a last resort.

The system scores reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews are scored:

Calculating process

- The level of sanction is decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.
- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.
- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted basic points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted basic points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (secondary)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the review score:

Determine sanction

Score scale & Sanction Level

Sanction Type	Final score - Standard	Final Score – Positive History
Correction Plans	1-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449

Termination	**400+**	**450+**

Good History is determined based on previous review scores. For example, if a provider's previous year review had a score that did not include a suspension, but required them to submit a corrective action plan and the current review score warrants a 30-day suspension, the current review will be scored using the Positive History scoring scale and the provider will be required to only submit a corrective action plan rather than be subject to a 30-day suspension based on the previous review.

For environmental modification services, identified deficiencies could result in suspension of new referrals for a period of time or recoupment of funds depending on the severity of the deficiency. Environmental modification providers will be given the opportunity to correct the deficiencies when warranted. If corrections are not done timely, this may result in recoupment of funds and/or termination.

For attendants participants may terminate services for any reason at any time. Any allegations of inappropriate actions would be investigated and could result in termination from the Medicaid program and/or recoupment of payments.

C. The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

State Evidence:

The state implements its policies and procedures for verifying that training is provided in accordance with state requirements in the approved waiver. Training requirements are monitored as part of the reviews conducted by the compliance registered nurse as described above. These include all pre-service requirements, competency evaluations for personal care aides and all ongoing in-service annual requirements. These requirements are specific to the individual services and are included in the service monitoring review. Sanctions taken would include deficiencies in meeting training requirements.

IV. CMS Assurance: Health and Welfare

Sub Assurance:

A. The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation.

State Evidence: An APS Powerpoint has been developed and placed on the internal website for training purposes. The Powerpoint stresses State Law, mandatory reporting and the importance of referrals and narration. There is also a "Memorandum of Agreement (MOA) between South Carolina Department of Health and Human Services and South Carolina Department of Social Services". This MOA ensures the sharing of information and data. The CLTC complaint system (in Phoenix) is used to notify Central Office of reported allegations of abuse, neglect and/or exploitation. All reports of abuse, neglect and/or exploitation are monitored for resolution outcomes. Reported allegations that are not resolved at the regional office level are discussed for resolution at Quality Assurance Task Force Meetings. The following evidence supports that the State identifies, addresses and seeks to prevent occurrences of abuse, neglect, and exploitation on an ongoing basis:

- **Attachment #16**: APS information (State Law)
- **Attachment #17**: Copy of APS internal website power point

- **Attachment #18**: "Memorandum Of Agreement Between South Carolina Department Of Health and Human Services And South Carolina Department Of Social Services"

- **Attachment #19**: Copies of CLTC Complaint Forms generated in Phoenix

Remediation: The State did not receive complaints regarding abuse, neglect and/or exploitation during the December 1, 2007 – January 31, 2011 review period. Neither has there been knowledge of unreported allegations of abuse, neglect and/or exploitation.

V. CMS Assurance: Administrative Authority

Sub Assurance:

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

State Evidence: SCDHHS retains administrative authority and responsibility for operation of the mechanical ventilator dependent waiver program. Waiver functions are performed in twelve of thirteen SCDHHS offices. Each area and satellite office has state employees (Area Administrators, Lead team case managers and Lead team nurse consultants and other nurse consultants) that manage and supervise the daily operations of the waiver. Initial assessments and level of care determinations, service plan development and on-going waiver services are performed by state nurse consultant staff. Services provided by nurse consultants are monitored by area office supervisory staff and central office staff. Area office state employees are monitored by supervisors and during Central Office quality assurance reviews.

- **Attachment #4**: Copy of Statewide Summary for Central Office 2007 -2010 Quality Assurance Review

VI. CMS Assurance: Financial Accountability

Sub Assurance:

A. State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

State Evidence: As noted, the State Medicaid Agency serves as both the Administrative and Operating Authority for the mechanical ventilator dependent waiver program. As such, the agency has direct responsibility for ensuring financial accountability. This is done in a number of ways.

First, South Carolina's Care Call system is used for almost all waiver service claims. This is a system in which providers of in-home services make a call to a toll-free number to document service delivery. When payment is based upon the length of stay (personal care, attendant care, etc.), two calls are made to document the start and end time of the service. Nurse Consultants and non-reimbursed nurse supervision of personal care aides must also document service delivery from the home, even though the call does not generate payment.

Care Call generates claims based upon these documented visits. The claim will be based upon authorized services and will be the lesser of the delivered and authorized time (e.g., two hours authorized and 1.5 hours delivered = a claim for 1.5 hours; two hours authorized and three hours delivered = a claim for two hours). This ensures that provider billings do not exceed authorized amounts. It also provides a check to see if the phone call was made from the authorized

location.

In cases where the service is not provided in the home and/or where no in-home documentation is required (e.g. environmental modifications, home delivered meals), the Care Call system allows claims entry through the phone or web. In these cases, the service is documented and, as before, compared with the authorized amount to ensure that billings do not exceed authorized limits and that services were performed as authorized (e.g., services authorized for Monday, Wednesday and Friday will not give payment for service performed on Tuesday).

At this time, Personal Care II, Personal Care I, Nursing, Attendant, Care Nursing, Home Delivered Meals, Pest Control and all home modifications are billed through the Care Call system. In all cases, no claim can be submitted that is not supported by a service authorization.

It is planned that within 18 months all waiver claims will come through the Care Call system. Currently, for services not part of the system, South Carolina has developed a system which checks to ensure that the participant was enrolled in the waiver and Medicaid eligible at the time of the service. Nurse Consultants review service delivery with participants on a monthly basis to ensure that claims are appropriate and that authorized services are being delivered.

In addition to the financial accountability offered by the Care Call system, the State also employs a licensed Registered Nurse who conducts on-site reviews with personal care, respite and nursing providers. The reviews consist of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other requirements contractually specified (e.g., background checks). The administrative review determines that all agency administrative requirements (liability insurance, list of officers, emergency back-up plans, etc.) have been met. The participant review pulls a sample of participants and verifies that all requirements relating to the actual conduct of service have been met. As an example, personal care service reviews would identify documentation of nurse supervision (including appropriate on-site visits), nurse sign-off on aide task sheets, nurse consultant notification of any problems/changes in condition and other required elements.

These reviews have been automated for a number of years. Since April, 2008, personal care reviews have been scored based upon number of and seriousness of deficiencies. Provider sanctions are based upon these scores. Since then, approximately 10% of providers have received sanctions which included suspension of new referrals. Many more providers have had to submit written corrective action plans. Review schedule is based upon results of prior reviews. Every provider receives an on-site review at least every 18 months.

Also, the Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to CLTC service providers. Recoupments are made when provider records do not support billings of services.

Finally, CLTC and Program Integrity work closely with the Medicaid Fraud Control Unit of the South Carolina Attorney General's Office. Any suspected fraud is referred to this unit for investigation. This unit has used data given to them to initiate criminal investigations against several providers.

Evidentiary-Based information
South Carolina Mechanical Ventilation Dependent
Home and Community Based Waiver Program (#40181.R03)

Attachment 1 - Samples of Nurse Consultant completed assessments to support level of care determinations

Attachment 2 - Attendance sheets for nurse consultants attending mandatory Case Management and HCBS Waiver training written by CMS and University Southern Maine, Muskie School of Public Health

Attachment 3 - Phoenix waiver enrollment denial due to LOC beyond 30 days

Attachment 4 - Copy of Statewide Summary for Central Office 2007-2011 Quality Assurance Review

Attachment 5 - Sample of Nurse Consultants' Phoenix "Dashboard"

Attachment 6 - Sample QA feature reflecting percentage of timely re-evaluations

Attachment 7- Sample QA feature reflecting number of completed monthly activities verses number of remaining activities

Attachment 8 - Copy of service plans and service plan wizard requirements

Attachment 9 - Copy of Phoenix service plan

Attachment 10 - Sample QA feature reflecting percentage of annual service plan updates/revisions

Attachment 11 - Sample Care Call Reports

Attachment 12 - Copies of Phoenix generated narrative checklist that include care call review dates

Attachment 13 - Copy of Phoenix LOCUS QA feature

Attachment 14 - Sample Provider Choice List

Attachment 15 - Copy of 2008 and 2009 Annual Survey of Community Long Term Care (CLTC) Consumer Experience and satisfaction Report

Attachment 16 - APS information (State Law)

Attachment 17 - Copy of APS internal website power point

Attachment 18 - Memorandum of Agreement Between South Carolina Department of Health and Human Services and South Carolina Department of Social Services

Attachment 19 - Copies of CLTC Complaint Form generated in Phoenix

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	12-1-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-0247	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Ms Forkner, Deps, CMS file Extend per Richard's e-mail see attached.	[X] Prepare reply for appropriate signature DATE DUE 3-11-11 [ ] 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. Cleared 4/29/11 attached.	letter		
2.			
3.			
4.			

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

November 17, 2010

Emma Forkner, Director
SC Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

Dear Ms. Forkner:

The Centers for Medicare and Medicaid Services (CMS) is conducting a quality review of South Carolina's Home and Community Based Waiver for Individuals Dependent on Mechanical Ventilation, CMS control number 40181.R03. This review will be used to evaluate the overall performance of this waiver program throughout the currently approved period (December 1, 2007 – November 30, 2012) and to identify the need for any modifications or technical assistance necessary to continue successful operation this waiver program. The results of this review will serve to inform both the State and CMS of the State's compliance with waiver assurances in anticipation of the waiver's renewal. The expiration date of this waiver is November 30, 2012.

The CMS requests States to demonstrate adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis. Enclosed with this letter is a listing of the types of evidence-based information CMS must review in order to determine the State's implementation of its quality management and improvement strategy – that is discovery, remediation and improvement activities with regard to all of the waiver assurances. We request you submit the information identified in the enclosure to this office within **ninety** days of receipt of this letter. To expedite the review process, we ask that you provide concise, specific information that demonstrates your State's implementation of your quality management and improvement strategy.

While we recognize the value of State policies and procedures with regard to oversight activities, this evaluation focuses on the extent to which the policies and procedures have been implemented, and the results of the State's oversight activities. That is, how does the state identify quality issues, and how does the State address these issues on an individual and systemic basis when they are identified? As you will see in the enclosure, we are requesting evidence as to the implementation of the quality management and improvement strategy.

After reviewing the requested submissions, Connie Martin will contact your staff to discuss any necessary follow-up activities. Please feel free to contact her at (404) 562-7412 with any questions related to this request.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure: HCBS Quality Review Worksheet
cc: Mark Reed, Central Office Analyst

HCBS Quality Review Work Sheet

I. Level of Care (LOC) Determination

The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating a waiver applicant or participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.		
Sub Assurances	CMS Expectations	Types of Evidence
An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	State submits evidence that is has reviewed applicant files to verify that individual levels of care evaluations are conducted.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.	State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted at least annually or as specified in the approved waiver.	
The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.	State submits that it regularly reviews participant files to verify that the instrument described in the approved waiver is used in all level of care re-determinations, the person(s) who implement level of care determinations are those specified in the approved waiver, and the process/instruments are applied appropriately.	

II. Service Plans

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.		
Sub Assurances	CMS Expectations	Types of Evidence
Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.	State demonstrates that service plans are reviewed periodically to assure that all of participant needs are addressed and preferences considered.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The state monitors service plan development in accordance with its policies and procedures	State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.	
Service plans are update/revised at least annually or when warranted by changes in the waiver participant's needs.	State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures.	

II. Service Plans (Continued)

·The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.		
Sub Assurances	CMS Expectations	Types of Evidence
Services are delivered in accordance with the service plan, including the type, scope, amount, and frequency specified in the service plan.	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
Participants are afforded choice: 1) Between waiver services and institutional care; and 2) Between/among waiver services and providers	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	

III. Qualified Providers

The State demonstrates it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.		
Sub Assurances	CMS Expectations	Types of Evidence
The State verifies that providers initially and continually met required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.	State provides documentation of periodic review by licensing/certification entity.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements	State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants.	
The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	State provides documentation of monitoring and training and actions it has taken when providers have not met requirements (e.g., technical assistance, training).	

IV. Health and Welfare

The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.		
Sub Assurances	CMS Expectations	Types of Evidence
The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	State demonstrates that, on an ongoing basis, abuse, neglect and exploitation are identified, appropriated actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect and exploitation trends and strategies it has implemented for prevention.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

V. Administrative Authority

The State demonstrates it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.		
Sub Assurances	CMS Expectations	Types of Evidence
The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.	State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

VI. Financial Accountability

The State demonstrated that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.		
Sub Assurances	CMS Expectations	Types of Evidence
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver. State submits results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver reimbursement methodology. State demonstrates that interviews with State staff and providers are periodically conducted to verity that any identified financial irregularities are addressed. Stat demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreements/contracts.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: √ Record Reviews, on-site √ Record Reviews, off-site √ Training verification records √ On-site observations, interview, monitoring √ Analyzed collected data (including surveys, focus group, interview, etc.) √ Trends, remediation actions proposed / taken √ Provider performance monitoring √ Operating agency performance monitoring √ Staff observation / opinion √ Participant / family observation and opinion √ Critical events and incident reports √ Mortality reviews √ Program logs √ Medication administration data reports, logs √ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

Log #247

From: Richard Kluender
To: Sam waldrep
CC: Brenda James; Vanessa Busbee
Date: 2/14/2011 2:45 PM
Subject: Log #247

Sam Vanessa and Sherry need two more days on the subject log, per Brenda, you may grant the extension. Brenda by copy of this email, this is notice that we are requesting a 2 day extension on log#247.

Rich