hey to Kara George

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
*OFFICE OF DIRECTOR*

## ACTION REFERRAL

| TO | DATE |
|---|---|
| Waldrop | 7-8-11 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 10-021 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>cc: Mr. Keck, Deps, CMS file<br>Cleared 8/18/11, Dee attached letter | [X] Prepare reply for appropriate signature<br>DATE DUE 8-29-11<br>[ ] FOIA<br>DATE DUE _____<br>[ ] 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. George Maky | | | |
| 3. Kara Lewis | | | |
| 4. | | | |

**From:** "Howard, Kenni L. (CMS/SC)" <Kenni.Howard@cms.hhs.gov>
**To:** Waldrep@scdhhs.gov; Lewis@scdhhs.gov
**Date:** 7/21/2011 10:10 AM
**Subject:** SC 0676 report

Kara:

It was a pleasure speaking with you earlier this morning regarding your concerns with the attached report. For clarification on the date issue, CMS' current Quality Interim Procedural Guide (IPG) states that for new waivers, draft reports are issued 12 months prior to expiration, a response is due from the State 11 months prior to expiration and the final reports are issued 9 months prior to expiration. (This allows the State 9 months to work on any issues/concerns or required changes before submitting the renewal application.) For renewed waivers, draft reports are issued 17 months prior to expiration, a response is due 14 months prior to expiration and the final reports are issued 12 months prior the expiration of the program. (This allows the State a full year to make any necessary corrections/changes before submitting the renewal application.)

I am in full agreement with you that the State should not issue a quick response and that along with the operating agency, you should investigate our concerns and provide clarification and/or additional evidence. In order for the State to have adequate time to do such, we agreed to an August 19, 2011 date for submission of your response. This date should still allow CMS adequate time to review any additional information submitted and meet our timeframe for issuance of the final report.

As discussed, I have attached an electronic copy of the draft report so that you can insert responses directly into the areas of concern. As you work on your response, feel free to contact me if you need clarification on anything.

Thank you,

Kenni

Kenni Howard, RN |Health Insurance Specialist |Division of Medicaid and Children's Health |Centers for Medicare and Medicaid Services|61 Forsyth St. S.W., Suite 4T20 | Atlanta, GA 30303-8909 |404-562-7413 | kenni.howard@cms.hhs.gov



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**CC:** Connie.Martin@cms.hhs.gov; Shantrina.Roberts@cms.hhs.gov; Jackie.Glaze@cms.hhs.gov

South Carolina Department of Health & Human Services

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

August 18, 2011

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

Attn: Kenni Howard

Dear Kenni,

The State of South Carolina is in receipt of the Centers for Medicare and Medicaid Services (CMS) draft report for the review of our Community Supports (CS) waiver (#0676).

Please know we have taken your findings under serious consideration. In preparing our response, we realize that evidentiary information presented in previous reports as acceptable may no longer be considered as such. We are eager to make meaningful enhancements to our waiver programs through quality oversight efforts.

The format we have elected to use for this response is to include separate Roman numeral sections for each waiver assurance, followed by numbered performance measures and the State's Evidence with any labeled documentation. Additionally, the State has included points of clarification in areas where we felt there was misinterpretation or misunderstanding of our original submission. We hope this is a straight forward way of presenting our response.

**1915© Home and Community-Based Waiver Assurances**

**I. State Conducts Level of Care (LOC) Need Determinations Consistent with the Need for Institutionalization**

*Performance Measures*

1. Proportion of new enrollees whose LOC completion date is not within 30 days prior to waiver enrollment.

The State's Evidence: As noted in bullet #5, page 2 of the LOC section of the State's original Evidence Report, the SCDHHS controls the MMIS entry process for all CS waiver participants. Enrollment request dates are carefully monitored to ensure new enrollments only occur within 30 days of the LOC Determination. The evidence originally provided as LOC Document #6, indicates that 0 out of 146 new enrollees (0%) for July 2009 had a LOC completion date that was not within 30 days prior to waiver enrollment. For State Fiscal

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Year 2010 (SFY10), 0 out of 1911 (0%) of new enrollees had a LOC completion date that was not within 30 days prior to waiver enrollment. Based on this evidence, the State determined that remediation activities were not necessary.

2. Proportion of participants whose LOC re-evaluation does not occur prior to the 365th day of the previous LOC evaluation.

   The State's Evidence: As noted in Bullet #13 of the LOC Section of the State's original Evidence Report, DDSN utilizes the Quality Contractor Delmarva Foundation to conduct on-site reviews of Service Coordination providers. Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report (LOC Document #15). Indicator G11-04 measures if the LOC Determination was completed within 365 days of the previous determination. Based on data from the Delmarva Annual Report for SFY10 (LOC Document #20), this indicator was met with 100% compliance; therefore, the percentage of participants whose LOC redetermination did not occur within 365 days of the previous LOC is 0%. The State determined that remediation activities were not necessary.

3. Proportion of LOC Determinations that were conducted using the appropriate criteria and instruments.

   The State's Evidence: Bullet #13 of the LOC Section of the State's original Evidence Report indicates DDSN utilizes the Quality Contractor Delmarva Foundation to conduct on-site reviews of Service Coordination providers. Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report (LOC Document #15). Indicator G11-06 measures if the LOC is completed appropriately. Based on data from the Delmarva Annual Report for SFY10 (LOC Document #20), this indicator was met with 100% compliance; therefore, the percentage of participants whose LOC was conducted using incorrect instruments is 0%. The State determined that remediation activities were not necessary.

4. Proportion of participants whose LOC outcome was appropriately determined.

   The State's Evidence: The State provided a copy of a report prepared by the Quality Improvement Organization (QIO), Qualis, to demonstrate adherence to this performance measure (original Evidence Report LOC Document #9A). We note this document was missing the "even numbered" pages and are resubmitting the (same) *full* page document at this time (see LOC Document #9A). The QIO reviewed LOC Determinations issued by DDSN's Consumer Assessment Team (CAT) for all four (4) DDSN waivers, as well as TEFRA eligibility cases, and adverse LOC cases, and subsequently issued a monthly report to SCDHHS summarizing the findings. LOC Document #9A indicates the QIO reviewed a total of 82 ICF/MR LOC Determinations during the month of November 2009. Of these, 23 were for CS waiver candidates. The report indicates the QIO agreed with each of the LOC Determinations made by the CAT, therefore, the State determined no remediation activities were needed since 0% of the LOC Determinations were disputed by Qualis.

Bullet #13 of the LOC Section of the State's original Evidence Report indicates DDSN utilizes the Quality Contractor Delmarva Foundation to conduct on-site reviews of Service Coordination providers. Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report (LOC Document #15). Indicator G11-05 measures if the LOC is supported by the assessment/ documents indicated on the LOC Determination form. Based on data from the Delmarva Annual Report for SFY10 (LOC Document #20), this indicator was met with 100% compliance; therefore, the percentage of participants whose LOC was appropriately determined is 100%. The State determined that remediation activities were not necessary.

5. Proportion of participants whose initial and/or subsequent LOC evaluation was denied appropriately.

   The State's Evidence: The State reviewed the Qualis report originally provided as LOC Document #9A (the complete document submitted per #4 above). It indicates three (3) adverse LOC Determinations for the CS waiver during November 2009. It further notes that Qualis accepted all LOC findings performed by the CAT. Therefore, the State determined 100% compliance and no remediation activities were needed.

   As previously stated, Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report as LOC Document #15. In addition to the compliance reviews conducted by Delmarva, State waiver policy requires that decisions to deny LOC for waiver participants must be confirmed and issued by the CAT. That LOC policy is included as New LOC Document #1.

## II. Service Plans are Responsive to Waiver Participant Needs

*Performance Measures*

1. Proportion of participants whose plans include services and supports that are consistent with needs and personal goals identified in the comprehensive assessment.

   The State's Evidence: As noted in the State's original Evidence Report, DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-02 measures the proportion of participants whose plans include services and supports that are consistent with needs and personal goals identified in the comprehensive assessment. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 98%. When cited by Delmarva, the provider is required to complete a plan of correction and a follow-up review is conducted to assure that needed corrections have been made.

2. Proportion of participants who received assessments in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G11-01 measures the proportion of participants who received assessments in accordance with State policy. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 100%. Therefore, the State determined that remediation activities were not necessary.

3. Proportion of participants whose plans were completed in a timely fashion.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-01 measures the proportion of participants whose plans were completed in a timely fashion. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 95%.

   As an example of remediation conducted by DDSN, we have included Minutes from a Service Coordinator Supervisors Meeting on May 27, 2010. The topic of overdue plans was discussed at this meeting (see New Plan of Care Document #1). Also, SCDHHS is in the process of completing the ongoing CS waiver record review. Once finalized, a decision will be made about a referral to SCDHHS Program Integrity for recoupment of Federal Financial Participation (FFP). CLTC waiver staff will determine at that time if any additional remediation activities or policy changes are necessary.

4. Proportion of participants who received an annual re-assessment in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G11-01 measures the proportion of participants who received annual re-assessments in accordance with State policy. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 100%. Therefore, the State determined that remediation activities were unnecessary.

5. Proportion of participants whose plans were re-written in a timely fashion.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-01 measures the proportion of participants whose plans were re-written in a timely fashion. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 95%.

As an example of remediation conducted by DDSN, we are including Minutes from a Service Coordinator Supervisors Meeting on May 27, 2010. The topic of overdue plans was discussed at this meeting (see New POS Document#1). Also, SCDHHS is in the process of completing the ongoing CS waiver record review. Once finalized, a decision will be made about a referral to SCDHHS Program Integrity for recoupment of FFP. CLTC waiver staff will decide at that time if any additional remediation activities or policy changes are necessary.

6. Proportion of participants whose plans were updated as needs changed.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-04 measures the proportion of participants whose plans were updated as needs changed. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 85%.

   When determined to be out of compliance, the provider was required to submit a Plan of Correction. A follow-up review was conducted to determine if the correction had been made. The data regarding this finding was reviewed by DDSN and submitted to SCDHHS.

   DDSN and DHHS discussed these findings and believe the high error rate is related to new waiver start-up, rather than an on-going concern. Therefore, remediation activities are not warranted at this time.

7. Proportion of participants whose plans were monitored in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-05 measures the proportion of participants whose plans were monitored in accordance with State policy. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 80%. In addition to the Plans of Correction submitted and follow-up reviews conducted by Delmarva, Technical Assistance was provided by DDSN District Office staff to address the issue of plan monitoring. Three examples of Technical Assistance Reports are provided as New Plan of Care Document #2.

8. Proportion of participants who received contact with the case manager in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. Indicators G2-01 (contact in excess of the minimum requirements is completed as defined by the Plan) and G2-02 (face-to-face contacts occur as required) are used to measure the proportion of participants who received contact with the case manager in accordance with State policy. The compliance rates for these indicators during SFY10 were 94% and 99% respectively. Based on this, the State determined that remediation activities were not warranted.

To clarify some points made in the Service Plan section of the June 30, 2011 Draft Report of the CS Waiver, the State provides following additional information:

- SCDHHS wishes to address the CMS concerns noted regarding the SCDHHS review of case records (CMS Draft Report, page 5). SCDHHS/CLTC waiver staff perform record reviews per the terms of the MOA as documented in the original CS Evidence Report (page 2, bullet 2, original Plan of Care Document #2). The CS Record Review originally submitted as evidence was in the initial stages at the time of data collection for the CMS Evidence Request. This record review remains ongoing. Soon after the record review was announced to SCDDSN, both SCDHHS/CLTC Waiver Quality Assurance (QA) Staff personnel assigned to coordinate QA for the DDSN waivers left employment with SCDHHS on the same day. One of these positions has been refilled and the other position is pending. This has left gaps in traditional QA activities.

  The State is aware the CS Record Review submitted for evidence included approximately half of the required records needed to complete the confidence level for waiver year one. It was the intent of the State to follow-up with an additional statewide record review to complete the confidence requirement. At this time, we are in the process of completing an intensive training for the recently hired QA staff person assigned to coordinate SCDDSN waiver issues, and we will initiate an additional CS waiver record review by October. Additionally, we are in the process of completing the ongoing CS waiver record review with a target date of October. Once the review is finalized, a decision will be made about the need for referral to SCDHHS Program Integrity for recoupment of FFP. Also, based on the final report, CLTC staff will determine if remediation activities or policy changes are necessary.

  Related to some points raised in this section of the CMS draft report, the State is providing additional documentation: 1) a copy of the cover letter from SCDHHS/CLTC waiver staff to SCDDSN (New Plan of Care Document #3); and 2) a copy of the SCDDSN response to the CS Record Review findings (New Plan of Care Document #4).

- It was noted that no data was associated with Plan of Care documents #5, 6, 7, 8, and 9 in the State's original Evidence Report to show the State or the quality contractor has completed an analysis to determine if the freedom of choice is being adequately and/or properly applied. Indicator G11-03 is used to determine if Freedom of Choice is present and completed appropriately. For SFY10, the compliance rate for G11-03 was 98%.

## III. Qualified Providers Serve Waiver Participants

*Performance Measures*

1. Proportion of providers that meet required licensing, certification, and other state standards prior to the provision of waiver services by provider type.

   The State's Evidence: For Day Activity, Career Preparation, Employment, Support Center, Community Services and Respite, a license is issued only after an application is submitted to DDSN. A completed application must include pre-licensing inspections (State Fire Marshall Inspection, HVAC, and electrical inspection). An on-site inspection is conducted only when

all pre-licensing requirements have been met. These inspections are conducted by the SC Department of Health and Environmental Control (DHEC). Licenses are only issued when no deficiencies are noted at the time of the on-site inspection. If deficiencies are noted, corrections must be made and verified by the licensing agency prior to the issuance of a license. Once the license is issued, the provider's name is added to the Qualified Provider's List.

For Specialized Medical Supplies, Equipment, Assistive Technology and Appliances, Private Vehicle Modifications, and Environmental Modifications, the provider must present to DHHS a valid license number in order to enroll with the Medicaid Agency. This information is explained on the agency website, www.scdhhs.gov, and a copy of the webpage is included as New Qualified Provider Document #1.

The process for contracting to provide Personal Care 1 or Personal Care 2 services is explained in the State's original Evidence Report, Qualified Provider Documents #3. The process for enrollment to provide Adult Day Health Care services is explained in the State's original Evidence Report, Qualified Provider Documents #4 and #5. Additionally, providers of Adult Day Health Care must present to SCDHHS a valid license number in order to contract as a provider.

Therefore, because of the pre-contractual compliance requirements, 100% of providers meet the required licensing, certification or other state standard prior to the provision of waiver services.

2. Proportion of waiver providers that continue to meet required licensing, certification, and other state standards.

The State's Evidence: For Day Activity, Career Preparation, Employment, Support Center, Community Services and Respite, a license is issued on an annual basis. Licensing inspections for all day program and respite facilities occur annually on a schedule determined by the state licensing agency, DHEC. Upon receipt of the licensing inspection report, the provider must submit a Plan of Correction to DHEC, who will then issue an acceptance letter to the POC and forward a copy of all documentation to DDSN. Exceptions may occur when the provider is cited with a Class I deficiency, which requires an immediate Plan of Correction. In the event of a Class I deficiency, DHEC alerts DDSN of the citation and the subsequent resolution. DDSN also notifies SCDHHS whenever there is a Class I deficiency; however, there have been no Class I deficiencies cited during the review period. 100% continue to meet Licensing Standards.

Upon receipt of an application for a license, the DHEC inspects the ADHC. When determined to be in compliance with the requirements, a license is issued. During SFY10, DHEC did not revoke any Adult Day Health Care licenses. All of the providers (100%) continued to meet the standards.

3. Proportion of non-licensed/non-certified providers that meet waiver requirements.

   The State's Evidence: For Behavior Support and Psychological Services, in order to become a provider, applicants must complete the DDSN Application Form (New Qualified Provider Document #2). This application requires submission of a resume and work sample relevant to the type of services for which the applicant is applying. The application is screened by DDSN for compliance with requirements and additional information is requested from the applicant when needed. Once screening is completed, an interview is conducted with experts in the field and based on the applicant's ability to meet the criteria. Based on the results, a recommendation is made to SCDHHS regarding the applicant's enrollment with Medicaid (see New Qualified Provider Document #3). Additionally, providers are reviewed periodically to determine if they continue to meet the specified criteria in the services provided to waiver recipients. This review is conducted by experts in the field using the Quality Assurance Review Form (see New Qualified Provider Document #4). These results are shared with the provider, a plan of correction is requested and a follow-up review is conducted using the same form. If corrections are not made at the time of follow-up review, it is recommended that the provider's Medicaid enrollment be ended. During SFY10, 5 of 11 applicants (45%) were qualified as providers of these services. During SFY10, 8 of 59 providers (13.5%) were removed from the list because they failed to continue to meet qualifications.

   To become a provider for Personal Care 1 or Personal Care 2 services, applications must be submitted for review and approval by SCDHHS in order to receive a contract. This process was described in the State's original CS Evidence report (see page 2, bullets #2 and 3, and Qualified Provider Documents #3, 4, 5 and 6). All applications are reviewed for completeness by the SCDHHS Provider Compliance Officer through a 100% pre-contractual review. Attached for additional evidence is a copy of an entire provider packet submitted by a personal care business seeking to obtain a Medicaid contract to provide: Personal Care 1, Personal Care 2, HASCI Attendant Care, HASCI Respite, Companion and Medicaid Nursing services. This business owner was successful and thus obtained a Medicaid contract as is noted by the email in the packet announcing his addition to the resource directory for choice of providers. Once the provider begins accepting waiver client referrals, he is entered into the SCDHHS Review schedule for compliance reviews. Those reviews are conducted by a SCDHHS Registered Nurse to ensure compliance with the waiver service scopes and contract requirements. The entire enrollment packet is labeled New Qualified Provider Document #5.

   The State does not currently have a licensure process for personal care. However, this past legislative session a licensure bill was passed. Regulations are being developed. Once licensure is in place, SCDHHS will be able to redirect much of its compliance efforts away from these items that will be included in licensure, to other enhancement activities.

4. Portion of providers that meet training requirements in the waiver.

   The State's Evidence: During SFY10, 9 providers of Day Services (Day Activity, Community Services, Career Preparation, Employment and Support Center) received citations related to staff training issues during their annual licensing inspection. The SC Department of Health and Environmental Control completed a licensing inspection for 45

providers, operating a total of 85 day program facilities. DDSN uses this data to determine the need for technical assistance or other support from the DDSN District Office. The procedures require the provider to submit a Plan of Correction for each and every citation.

During SFY10, 3 providers of Respite Services received citations related to staff training issues during their annual licensing inspection. The SC Department of Health and Environmental Control completed a licensing inspection for 11 providers, operating a total of 17 respite facilities. DDSN uses this data to determine the need for technical assistance or other support from the DDSN District Office. The procedures require the providers to submit a Plan of Correction for each and every citation.

For Psychological Services and Behavior Support Services, providers are required to submit to DDSN evidence of the completion of Continuing Education Units (CEUs) every two years. Providers not complying with the requirements are removed from the provider choice list. During SFY10, all providers were compliant with the completion of CEU; therefore the percentage of providers that met was 100%. New Qualified Provider Document #6 includes a memorandum to providers regarding CEU requirements for continued participation, the forms used for reporting CEUs, and an example of the information in the database that is maintained to track submissions.

To become a provider for Personal Care 1, Personal Care 2 or Adult Day Health Care services, applications must be submitted for review and approval by SCDHHS in order to receive a contract. This process was described in the State's original CS Evidence report (see page 2, bullets #2 and 3 and Qualified Provider Documents #3, 4, and 5). All applications are reviewed for completeness by the SCDHHS Provider Compliance Officer through a 100% pre-contractual review. One of the requirements is that potential candidates attend a mandatory pre-contractual training conducted by SCDHHS Staff. Providers who fail to attend the training are not offered a contract with SCDHHS, thus the training requirement for contracted providers is met at 100%. These pre-contractual trainings are extensive, covering many areas such as scopes of services, direct staff training requirements, expectations for business conduct and administrative requirements such as liability insurance, worker's compensation insurance, policy and procedures manual, and requirements for staff background checks, tuberculin skin test requirements, first aid certification, and service documentation. Attached for additional evidence is a copy of the power point presentation used for the April 2011 Training for potential new providers along with the sign-up sheet to document attendance for that training. These items are labeled New Qualified Provider Documents #7 and #8.

To clarify some points made in the Qualified Providers section of the June 30, 2011 Draft Report of the CS Waiver, the State provides the following additional information:

- Regarding the current Request for Proposal used by potential providers to request permission to be placed on the Qualified Provider Listing (Qualified Provider Documents #1 and #2 from the State's Original Evidence Report), each proposal is reviewed by two teams of reviewers to assure that applicants are qualified and meet the terms of the solicitation. Evaluator Reports for Team 1 and Team 2 are included to show the areas that must be evaluated by each team (see New Qualified Provider Document # 9). To qualify, the applicant's proposal must receive from

each reviewer a score no less than 2 in each category. 100% of applicants are reviewed with only those receiving the required number of points in each category being awarded a contract. Once awarded, a contract the name of the provider is added to the list of qualified providers of the specific service. During SFY10, 10 new service providers were approved out of 14 applicants (71.4%). New providers must attend a mandatory training. A training outline and an attendance roster are included as evidence (see New Qualified Provider Document # 10).

- CMS has noted there was no formal approval letter for the Plan of Correction for the Jasper and Orangeburg Day Program Licensing Reports included with the original evidence. The practice of the state licensing agency, DHEC, is to hold the individual Licensing Inspection Reports until the provider has submitted a satisfactory Plan of Correction. The Plans of Correction are due to DHEC within 15 days. An exception to this applies to Class I deficiencies, which require an immediate Plan of Correction with remediation while the licensing inspection team is on-site with the provider. In the case of the Orangeburg report, DHEC received the POC and forwarded the report to DDSN after their review of the POC, although there was no formal letter indicating this approval. Formal approval letters have since been a topic of discussion at management meetings between the two agencies and DHEC now provides formal approval letters for all POCs. As an additional measure of review, DDSN was able to verify that there have been no critical incident reports or consumer complaints related to any issues cited in the Day Program Licensing Reports for Orangeburg.

  Regarding the Jasper Plan of Correction, a formal POC approval letter was provided, noting exceptions to citation corrections for water temperature and occupancy violations. The occupancy violations are addressed below. DDSN staff conducted the 2008 licensing inspection at the JH Hill Center and allowed a variance in the standard of +/- 2.5%. As an overall system's improvement strategy and to enhance objectivity with the inspections, in August of 2009, DDSN began contracting with the state licensing agency, DHEC, to conduct all licensing inspections for all residential habilitation, day services, and respite locations. The water temperature variance that had been previously accepted was then cited at the JH Hill Center in November 2009. The management staff at the JH Hill Center has been monitoring and will continue to monitor the water temperature and testing at least monthly. In addition, an independent contractor has been consulted to make adjustments to the temperature setting. Verification of these measures is included as New Qualified Provider Document #11. As an additional measure of review, DDSN was able to verify that there have been no critical incident reports or consumer complaints related to any issues cited in the Day Program Licensing Reports for the JH Hill Center.

- CMS has noted a concern regarding the Day Program at the J. H. Hill Center, operated by the Jasper County Disabilities and Special Needs Board. In response, DDSN provides the following information:
  On 1/21/09, the annual Licensing Inspection resulted in a report of "No Deficiencies" at JH Hill Center. On 1/23/09, The Ridgeland Fire Department completed an inspection of the JH Hill Center and determined the maximum occupancy was 42. (DDSN did not receive a copy of this report.) It is of note that the Ridgeland Fire Department does not have any jurisdiction regarding day programs: rather the Day Program Licensing Standards, which are based on SC Code of Law, require an annual inspection from the State Fire Marshal, and not a local fire department. On 8/12/09, The State Fire Marshal's Office completed an annual inspection of the JH Hill

Center and did not cite any occupancy issues. There were several other citations which were corrected within appropriate time frames. (DDSN did receive a copy of this report.)

As required by the Day Program Licensing Standards, the state licensing department, DHEC, completed its next annual licensing inspection for JH Hill Center on 11/25/09 and cited the facility for exceeding licensed occupancy and State Fire Marshal occupancy. The State Fire Marshal reference was in error, as this citation was based on the Ridgeland Fire Department's report and on the JH Hill Center's attendance logs. DHEC did not conduct any actual measurements of the facility on the date of the inspection. Attendance on the date of inspection was 42 people, well within their current licensed capacity of 46 (see New Qualified Provider Document # 12). Although 50 were "enrolled", Licensing Standards and SC Code of Law require 50 square feet per person in attendance, not simply enrolled. Based on the square footage of 3193 usable space for day program activities, which excludes office space, restrooms and other areas primarily used by staff, the actual occupancy capacity could be as high as 63.

We also looked at the November 2009 attendance logs for the JH Hill Center. These reflect program "attendance" rates that varied from 42 to 47 adults on any date of service. This does not mean all consumers were on site at the JH Hill Center. On the two dates that "attendance" was over the licensed capacity, as well as other dates of service throughout the month, 25 of the adults were receiving services outside the building in "enclaves" and "mobile work crews." For reporting purposes, the JH Hill Center does not differentiate what type of day service the person is receiving. The attendance logs are used for reporting service delivery, not necessarily the location.

Note: DHEC did not communicate their concerns regarding exceeding the occupancy rates to DDSN during this time period. This communication issue between the two agencies has since been addressed through the management of both agencies. DDSN is also working with DHEC to develop an automated reporting system for Licensing Inspection Reports that will increase efficiency, improve timeliness of receiving reports, and improve data analysis functions.

To ensure that the health and safety of those attending the day program were not in jeopardy, Ann Dalton, DDSN Director of Quality Management, confirmed with Joan Cooper, DDSN Architect and Director of Planning and Design, on 3/22/10 that she had been on-site and was familiar with the building and it posed no obvious safety hazards. Ms. Cooper further stated that the building was far from its capacity level for those in attendance and confirmed that based on the square footage of 3193 for space used for day program activities, the capacity could accommodate 63 people and remain in compliance with the licensing standards and Code of Laws.

On 7/7/10, the State Fire Marshal's office completed their next required annual inspection of JH Hill Center. There were no citations related to occupancy or otherwise. In addition, on 10/21/10, DHEC completed their next annual Licensing Inspection for JH Hill Center. There were no citations related to occupancy issues.

- As a point of clarification, the State would like to address the comment raised by CMS in the draft report (page 8) regarding the Jasper/JH Hill and "poor oversight authority" by the Medicaid Agency. DHHS is aware of the confusing turn of events in this situation. The State is also

aware there were no injuries to waiver participants and no critical incidents filed related to this matter. State staff discussed this matter with DDSN and they agreed to investigate the break-down in receipt of report information from the licensing agency, DHEC, taking steps to improve the communication process.

- As a point of clarification, the State would like to address an issue raised in the CMS draft report regarding the State not conducting follow-up reviews prior to lifting suspensions (page 8). The SCDHHS Compliance Officer and Compliance Registered Nurse review providers to ensure compliance with scopes of services and contact requirements. The Registered Nurse makes on-site visits to review waiver client records. She generates a report of findings if she identifies circumstances where providers do not meet the scope or contract requirements. As outlined in the provider contracts, based on the severity and number of deficiencies as well as the results of prior compliance reviews, one (1) of five (5) sanctions may be applied. These range from requiring a new corrective action plan, to something more serious such as suspending new client referrals for various periods of time, or even contract termination. The first three (3) sanctions do not require a follow-up visit by the Registered Nurse prior to reinstatement; however, they do require approval of an acceptable corrective action plan by the Compliance Officer. The 4th sanction, 90 days suspension and approval of an acceptable corrective action plan, does require a follow-up review visit by the Registered Nurse. The 5th sanction is provider contract termination.

- For additional information, SCDHHS is in the process of adding SCDDSN to its CareCall/Phoenix electronic provider tracking and payment system. Having SCDDSN as a part of this system will greatly enhance reporting and compliance capabilities for providers. Additionally, it will offer tracking and trending options. SCDDSN is expected to be in CareCall by the summer of 2012.

## IV. Health and Welfare of Waiver Participants

*Performance Measures*

1. Number and proportion of incidents of reported ANE.

   The State's Evidence: For SFY10, 5 of 52 reports (9.6%) of ANE were for participants of this waiver.
   **See the bullets below for information about trend analysis and remediation activities.

2. Number of incidents of ANE that are reported within required timeframes.

   The State's Evidence: For SFY10, 2 of 5 incidents (40%) reported were reported within required timeframes. DDSN has consulted with each provider submitting late reports and provided training/technical assistance in order to increase compliance with this indicator. A copy of this training is submitted as New Health and Welfare Document # 1.

3. Number of incidents of ANE in which the internal review was completed within required timeframes.

The State's Evidence: For SFY10, the internal review was completed within required timeframes for 4 of 5 incidents (80%). DDSN has consulted with each provider submitting late reports and provided training/technical assistance in order to increase compliance with this indicator. A copy of this training is submitted as New Health and Welfare Document # 1.

4. Number and proportion of substantiated incidents of ANE.

   The State's Evidence: For SFY10, 0 of 5 incidents (0%) of ANE for participants of this waiver were substantiated. Based on this the State determined that no remediation was necessary.

5. Proportion of people who report they are treated with dignity.

   The State's Evidence: In accordance with DDSN Policy (see original Health and Welfare Document #10), any occurrence of a staff member using disrespectful or profane language toward a consumer is considered a Critical Incident. For SFY10, there were 10 such critical incident reports out of 1161 statewide reports. Therefore, 99.14% consumers appear to be treated with dignity. For any critical incident reported, the provider is required within 10 days to submit a management review outlining any action taken and quality assurance measures to prevent reoccurrence. These reports are included in the DDSN Incident Management system and provider profile reports.

6. Number and proportion of critical incidents reported (included mortality, injuries, and client to client altercations).

   The State's Evidence: For SFY10, 25 of 1,161 critical incidents (2.4%) were reported for participants of this waiver. The incidents included 0 deaths, 11 injuries, and 8 incidents of client-to-client altercations (see New Health and Welfare Document #2). Also, please see the clarification bullets below for information about trend analysis and remediation activities.

7. Proportion who have a primary care physician of their choice.

   The State's Evidence: Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion who have a primary care physician of their choice. 556 out of 563 (98.7%) people had a primary care physician of their choice.

8. Proportion of people who feel safe in their homes and neighborhood.

   The State's Evidence: Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion who feel safe in their homes and neighborhood. 525 out of 563 (93.3%) people feel safe in their homes and neighborhood.

9. Proportion of participants who receive the recommended preventive dental visits.

   The State's Evidence: : Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion who receive the recommended preventive dental visits . 369 out of 563 (65.5%) receive the recommended preventive dental visits.

10. Proportion of participants whom report that they know their rights.

    The State's Evidence: Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion of participants whom report that they know their rights. 342 out of 563 participants (60.7%) report that they know their rights.

    The Guidelines for Completing the SCDDSN Service Coordination Annual Assessment (see New Health and Welfare Document #3) require a response to each question/item on the assessment (*the Guidelines apply to # 7, 8, 9 and 10 in this section*). Once completed, a decision whether or not to formally address must be made for each need identified by the assessment. To formally address means that the need is included in the Support Plan and services/interventions (Day Activity, Career Preparation, Community Services or In Home Support) in response to the need are authorized. The decision is made by the participant and those chosen by the participant to assist with planning.

    In addition to the services available to formally address identified needs, DDSN offers as a service to its providers, technical assistance from an expert in the area of Quality Management who uses the tenets of the Outcomes Measures © developed by CQL. As part of the technical assistance, providers are assessed on their ability to support people to understand and exercise their rights and assisted to develop a Quality Enhancement Plan to address any shortcomings noted by the assessment in this area.

    DDSN also supports SC IMPACT which is a self-advocacy group whose purpose is to train and support others to learn about their rights and use that information to advocate for themselves.

11. Proportion of participants that report concerns by type.

    The State's Evidence: During SFY10, no concerns were reported for participants of this waiver.

To clarify some points made in the Health and Welfare section of the June 30, 2011 Draft Report of the CS Waiver and provide information about the State's process for trend analysis and remediation, the State provides the following additional information:

- Regarding the absence of findings related to Health and Welfare Documents #2 and #3 in the State's original Evidence Report, DDSN follows the procedures for reporting allegations of ANE according to the SC Code of Laws for Adult/Child Protective services and the Omnibus Adult Protection Act. DDSN has outlined specific reporting procedures in the agency's policy

directive 534-02-DD. By law all allegations of ANE to a vulnerable adult living in a DDSN operated home are reported to the State Law Enforcement Division (SLED). SLED investigates or vets to local law enforcement (LLE) to investigate the allegations. Likewise, all allegations of ANE to a child or to a vulnerable adult not living in a DDSN operated home are reported to the State Department of Social Services (DSS). DDSN receives reports of allegations simultaneous with the reports sent to/called in to SLEDS/DSS and works closely with both investigative entities. We take this a step further by requiring all providers to conduct a management review to determine if any policies, rules, or regulations were violated. When SLED, LLE or DSS finds that abuse occurred, DDSN ensures that appropriate personnel action is taken. DDSN has outlined specific reporting procedures in the agency directive 534-02-DD (Health and Welfare Document#2).

DDSN has a comprehensive system for reporting, collecting & responding to data related to ANE or other critical incidents that do not rise to the threshold of ANE. The agency employs a full-time Incident Management Coordinator who tracks reports throughout the system to ensure compliance with State Law and DDSN policy. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider's management action taken to remediate identified issues such as staff training, staff suspension/termination, updates to risk management and quality assurance procedures and policies and other measures to provide safeguards for the consumers. This data is also reviewed by the SCDDSN Director of Quality Management for trending analysis at both the provider and statewide levels along with corresponding QIO and Licensing data.

Delmarva measures compliance with the established policy and procedures. DDSN developed Administrative Key Indicators to be included with each compliance review conducted by Delmarva. The Administrative Review covers the provider agency to determine if the organization has systems in place, throughout the organization, that identify whether employees are reporting according to state law and DDSN policy and responding appropriately. Three separate indicators address ANE reporting procedures, risk management, and prevention:

> A1-12: Board / Provider follow SCDDSN procedures regarding preventing, reporting and responding to abuse / neglect / exploitation as outlined in 534-02-DD. The compliance rate for this indicator for SFY10 was 85.7%.
>
> A1-13: Board / Provider adhere to procedures regarding initial response to reports of abuse / neglect / exploitation. The compliance rate for this indicator for SFY10 was 97.1%.
>
> A1-14: The Board / Provider follow SCDDSN procedures regarding responding to abuse / neglect / exploitation. The compliance rate for this indicator for SFY10 was 100%.

In addition to the statewide compliance data indicated above (also found in the State's original Evidence Report, Plan of Care Document #16), DDSN has also provided an example of a provider-specific citation regarding ANE reporting. In the attachment, Delmarva has cited the Chester/Lancaster DSN Board for an allegation of abuse on 4/9/09 that was not reported until 4/23/09. The C/L DSNB Plan of Correction is also included to show 100% remediation. The subsequent Delmarva follow-up report includes no repeat citations for this indicator.

- Regarding original Health and Welfare Documents # 4,5,6,7, and the absence of evidence to show that the State analyzed these reports to track or identify trends or patterns and absence of evidence of remediation activities or system improvements identified as a result of State analysis, the State is submitting a detailed report indicating the date of incident, date of initial report, date the final report was due and the date the final report was received (see New Health and Welfare Document #4). This report provides assistance to agency staff in monitoring compliance with timeframes. In addition, DDSN also monitors the compliance indicators reviewed by Delmarva discussed in the previous bullet.

  DDSN continues to track, trend, and analyze all Incident Management data through comprehensive statewide and provider-level profile reports (see New Health and Welfare Document #5 and #6). These reports provide raw data with regard to the number of reports made, cases substantiated and they give a rate per 100 ratio. The rate per/100 information is especially useful in providing a comparative analysis among agencies. This data is often the topic of conversation in statewide Risk Management Meetings and Collaborative DDSN/Quality Assurance Committee Meetings. Copies of these minutes are attached as additional evidence (see New Health and Welfare New Documents #7 and #8).

- Regarding whether appropriate timeframes were met in the reporting of critical incidents, DDSN has mechanisms in place to track, trend, and analyze Critical Incidents. DDSN has the ability to run reports showing the date, time, nature, location, and review outcome, as well as reports to ensure required timeframes are met. An example of this timeline report is included in the State Response (see New Health and Welfare Document #2). In addition, DDSN also monitors the compliance indicators reviewed by Delmarva as previously discussed in the Health and Welfare section. Specifically, indicator A1-15 states that "Board / Provider follows SCDDSN procedures regarding preventing, reporting and responding to critical incidents as outlined in 100-09-DD". The compliance rate for this indicator during SFY10 was 86.1% %, although it should be noted that this rate includes all providers, including multiple Home and Community Based Waiver options and state-only funded services. The POC must address remediation at the individual level.

- As an additional effort towards system improvement, DDSN has also implemented a new, web-based reporting system on its secure provider portal. The automated reporting system went on-line for Critical Incidents July 1, 2009 and on-line for ANE and Death reports on July 1, 2010. The system provides a real-time analysis function and allows the user to pull a variety of reports to assist in tracking and trending information.

- As mentioned above, DDSN has a comprehensive system for collecting data related to ANE or other critical incidents. The agency employs a full-time Incident Management Coordinator that tracks reports throughout the system to ensure compliance with State Law and DDSN policy. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider's management action taken, staff training, risk management and quality assurance activities to provide safeguards for the consumers. This data is also reviewed by the SCDDSN Director of Quality Management, with corresponding QIO and Licensing data. As an additional measure, the Incident Management Coordinator provides on-site training and technical assistance to providers that fall significantly above or below the statewide average for

reporting and the types of incidents. This training is also available to providers upon request (see New Health and Welfare Document #1).

- CMS asked how the State would analyze the database of consumer concerns to identify any trends that might warrant systems improvement if concerns had been reported. Had concerns been reported, DDSN would have reviewed the concerns (annually) to determine if there are identifiable trends. If any trends had been identified, they would be investigated to determine the best course of action to be taken to alleviate future concerns.

## V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

*Performance Measures*

1. Presence of a MOA that includes designated functions.

   The State's Evidence: The State's current Memorandum of Agreement (A50640A) between SCDHHS and SCDDSN is effective for dates July 1, 2010 through June 30, 2015. It was issued to all parties on June 30, 2010. It designates waiver functions and responsibilities for each agency. The presence of a fully executed, current MOA is evidence that the State meets the performance measure for 100% compliance. It was included in the State's original Evidence and labeled Administrative Authority Document #1.

2. Presence of a waiver service contract that includes requirements and responsibilities for the provision of waiver services.

   The State's Evidence: The State's current CS waiver service contract (C14913M) (with amendment) was signed effective July 7, 2010, retroactive to January 1, 2010, and extends thru December 31, 2011. The contract includes requirements and responsibilities for the provision of waiver services, as well as approved service rates. This meets the performance measure for 100% compliance. It was included in the State's Original Evidence and labeled Administrative Authority Document # 17. This amendment is evidence that the State reviews this contract on an ongoing basis and makes the necessary revisions to keep it current.

3. Proportion of ICF/MR LOC validation reviews.

   The State's Evidence: As noted in the State's original Report, the State provided a report submitted by the Quality Improvement Organization (QIO), Qualis, to demonstrate the State's adherence to this performance measure (see Administrative Authority Document # 14). The QIO reviews LOC Determinations issued by the DDSN Consumer Assessment Team (CAT) for all four (4) DDSN waivers, as well as TEFRA eligibility cases, and adverse LOC cases. The QIO then issues a monthly report to SCDHHS summarizing the findings. The example submitted in the State's original Evidence Report (Administrative Authority Document #14) indicates the QIO reviewed 82 ICF/MR LOC Determinations during the month of November 2009. Of these, 23 Determinations were for CS waiver candidates. The report indicates the QIO agreed with each of the LOC Determinations made, therefore, the

State determined no remediation activities were needed since 0% of the LOC Determinations were disputed by Qualis.

With regard to the QIO Quarterly Report for October 2009 – December 2009 for ICF/MR Reviews, also submitted by the State in the original Evidence Report (see Administrative Authority Document #15), this report was produced by the QIO to summarize the monthly reviews conducted by the CAT during the previous 3 months. As noted on the document, it was not intended for public distribution; rather its intent is to serve as an internal quality management tool for staff purposes. However, QA Staff can interpret the information and synthesize the components as needed. For example, pages 4, 5 and 6 of the report, 5th column, indicate the CS waiver ICF/MR LOC Determination reviews that were conducted by the QIO during the 3 months of the summary report. It was also intended to provide specific breakdown information regarding the questions of the LOC instrument. The State uses this report to compare against the information observed in the Plan of Service Documents during CS waiver record reviews. It should be noted that 2 of the 4 LOC findings cited during the CS Record Review (State's original Evidence Report, bullet #7 and Administrative Authority Document # 13) were based on findings from the QIO summary reports compared against waiver participant record documentation. This process has been beneficial to the State in analyzing components of LOC data.

4. Proportion of quality assurance and compliance validation reviews.

The State's Evidence: SCDDSN regularly submits 100% of their final reports to SCDHHS. QA staff review 100% of these final reports. The State has developed a QIO Report Validation Tool to manage and track the receipt and review of these individual provider reviews (see New Administrative Authority Document #1). Additionally, the QIO contract will be amended to provide waiver specific information.

5. Proportion of special focus reviews utilization reviews, and/or suspected fraud investigations.

The State's Evidence: The State included the CS Waiver Record Review in the original Evidence Report (page 3, bullet #7, Administrative Authority Document #13), conducted by SCDHHS/CLTC waiver staff of statewide participants enrolled in the CS Waiver during year 1 of the program. This review focused on LOC, POS and utilization of services/financial accountability. As was stated previously, shortly after the record review was announced to SCDDSN, both SCDHHS/CLTC Waiver Quality Assurance (QA) Staff personnel assigned to coordinate QA for the DDSN waivers left SCDHHS employment on the same day. One of these positions has been refilled and the other position is pending. We are aware that the number of records included in the CS Waiver Record Review was approximately half of those needed to complete the required confidence level for waiver year one. It was the intent of the State to follow-up with an additional state-wide review to complete the confidence requirement. At this time, we are completing an intensive training for the recently hired QA staff person assigned to coordinate SCDDSN waiver issues, and we will initiate an additional CS Waiver Record Review by October of this year. Further, we are in the process of completing the current outstanding CS Waiver Record Review and should have this resolved by October as well. Once finalized, a decision will be made regarding a referral to SCDHHS Program Integrity for recoupment of FFP. At that time, the State will determine if policy

changes or remediation activities are needed. For additional documentation, see the DDSN response to the CS Waiver Record Review, labeled New Administrative Authority Document #2.

Regarding SCDHHS Program Integrity, this unit works cooperatively with waiver staff to investigate complaints, allegations or accept referrals regarding case reviews. They also respond to information from various sources regarding inappropriate billings by Medicaid providers. They collect and analyze data, audit payments to providers and based on record reviews or other audits, recoup payments when provider records do not support the amounts billed for services.

CLTC and Program Integrity also have a relationship with the Medicaid Fraud Control Unit at the South Carolina Attorney General's Office to investigate suspected fraud or initiate criminal investigations.

6. Aggregated discovery and remediation reports submitted by the operating agency, relating to each of the performance measures, for all CMS assurances are reviewed and addressed if applicable.

   The State's Evidence: Information is contained within the QIO reports received to SCDHHS from the operating agency. The State reviews these reports to assure any outstanding irregularities are resolved and follows-up as necessary by requesting corrective action and remediation activities. Waiver specific reports and aggregated reports will be developed during 2012.

7. Meetings are held to discuss specific waiver issues (i.e., review of aggregated reports).

   The State's Evidence: Per the requirements of the MOA, waiver and QA staff from SCDHHS and SCDDSN meet periodically through-out the year to discuss waiver issues. Additionally, frequent, sometimes daily contact is made by phone and email to discuss and resolve concerns. Attached for additional evidence is a copy of the meeting schedule issued by the State for the 2011 meetings. It is labeled New Administrative Authority Document #3.

8. Policy changes are discussed with and/or communicated to the operating agency in a timely manner.

   The State's Evidence: The State frequently issues information and policy changes in the form of Medicaid Bulletins. During CS waiver year one, one such example was the Medicaid Bulletin included in the State's Original Evidence Report (Administrative Authority, page 2, bullet #2). CMS may recall the State submitted amendments to 7 of South Carolina's HCB waivers during the summer of 2010. While awaiting CMS approval, the State issued a Medicaid Bulletin announcing the State's intention regarding Incontinence Supplies. One other note, in the State's original Evidence Report (Administrative Authority, page 2, Document #5) the meeting minutes document the State's instructions to SCDDSN regarding advance preparation for policy manual changes and staff training (see original

Administrative Authority Document #6). We believe this demonstrates 100% compliance with the performance measure.

To clarify some points made in the Administrative Authority section of the June 30, 2011 Draft Report of the CS Waiver, the State provides the following additional information:

- CMS raised issues regarding Administrative Authority Document #12 in the original Evidence Report. The purpose of an appeal log is for the State to quickly and easily determine the number and nature of program appeals. The "outcome" is already identified for 14 of the 15 reconsiderations/appeals that had been submitted at the time of data collection for the original report. These matters were resolved at the DDSN level and did not proceed to DHHS appeal. The State believes this log is an efficient method for tracking any outstanding reconsideration/appeal cases or reviewing the results of current and historical resolved cases. Further, the State is aware that waiver participants/families and attorneys will request reconsideration and/or appeal for almost any issue. Therefore, the State is unsure what value to place on remediation, and to whom the remediation would be offered. However, we can offer the following: in April 2011, the State developed a draft version of a "Hearing Outline Template" and "Hearing Preparation Guidelines" and instructed DDSN staff to use these documents for the next 4-6 months in a test phase. After that time, SCDHHS agreed to take comments for improving the Template document after testing it in actual appeals. Currently, it is scheduled to become a permanent document when it is released by SCDHHS effective October 1, 2011. (See New Administrative Authority Documents #4 and #5). The State hopes these documents will ensure a more consistent process for hearings/appeals across the DDSN waivers, provoking more thorough preparation in advance by DDSN staff.

## VI. State Provides Financial Accountability for the Waiver

*Performance Measure*

1. Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver.

   The State's Evidence: The State's original Evidence Report for Financial Accountability (page 1, bullet #1, and Financial Accountability Document #4) described how the State controls entrance into MMIS by use of "recipient special program" (RSP) codes. These RSP codes further control access to waiver specific procedure codes, which won't pay unless the waiver participant eligibility file contains an appropriate RSP for the dates in question. The RSP entry into participant MMIS files is controlled 100% by the State Medicaid Agency.

   Also noted in the State's original Evidence Report for Financial Accountability (page 2, bullet #5), is information which describes the waiver service authorization process. Service Coordinators authorize waiver services based on need as described in the POS document. Authorizations are forwarded to providers who use the waiver authorization #'s when filing claims for payment in MMIS. SCDDSN uses their QIO, the Delmarva Foundation, to monitor compliance with the authorization indicator during reviews. Indicator G11-14

specifies: "Authorization forms are completed for services as required, prior to service provision." The compliance rate for this indicator for CS waiver year one was 91.4%.

Page 2, bullet #3 of the State's original Evidence Report for Financial Accountability, details the CS Waiver Record Review which has already been referenced in this response. Specific to financial accountability, the State pulled paid claims out of MMIS in accordance with the dates of service for each client in the CS record review. The State looked at multiple items in paid claims and compared them against record documentation, including but not limited to: appropriateness of services billed for payment against services listed in the POS; service rates paid versus service rates approved in the service contract to ensure accuracy of the MMIS system; waiver services incorrectly billed during inpatient hospitalizations; services billed consistent with service authorizations and waiver services billed for noted "absences" at day programs. Included for additional evidence is an example of MMIS Paid Claims from the CS Waiver Record Review for a client identified with findings in the Financial Accountability section of the CS Waiver Record Review. It is labeled New Financial Accountability Document #1. As previously stated, once the CS Waiver Record Review is finalized, a decision will be made regarding a referral to SCDHHS Program Integrity for recoupment of FFP. At that time, the State will determine if policy changes or remediation activities are needed.

The SCDHHS Program Integrity unit works cooperatively with CLTC waiver staff to investigate complaints, allegations or accept referrals regarding case reviews. They also respond to information from various sources regarding inappropriate billings by Medicaid providers. They collect and analyze data, audit payments to providers and based on record reviews or other audits, recoup payments when provider records do not support the amounts billed for services.

Once SCDDSN is added to the SCDHHS's Phoenix/Care Call system, this will provide greater financial accountability for this performance measure. Authorizations will be automated and it will offer enhanced tracking and trending capabilities for service expenditures. SCDDSN is expected to participate in the CareCall Monitoring system by the summer of 2012.

To clarify some points made in the Financial Accountability section of the June 30, 2011 Draft Report of the CS Waiver, the State provides the following information:

- CMS raised the issue that recoupment may be necessary to return FFP based on Delmarva reviews. The State addressed this issue in the original Evidence Report (see original Evidence Report, page 3, bullet 9, Financial Accountability Document #13). For the Chester/Lancaster Delmarva Review submitted, there was no necessary recoupment identified for a CS waiver client. However, there was a necessary recoupment identified for a MR/RD waiver participant within the Chester/Lancaster Delmarva Review so the State submitted that example to demonstrate the process utilized when necessary recoupments are over one (1) year old and unable to use the State's void/replace MMIS system (see original Financial Accountability Document #14).

In addition, the State continues to regularly monitor the void/replace adjustment section of MMIS following Delmarva reviews. To formalize this process we will use the QIO Report Validation Tool for this purpose and will add recoupment tracking data for all necessary Delmarva recoupments to this form. (see New Financial Accountability Document #2).

The State appreciates the opportunity to respond to this CMS Draft Report for the CS Waiver. We are hopeful our many additions of evidence included in this report as well as points of clarification will resolve any outstanding issues. We are grateful for your assistance and any suggestions or recommendations that were included. We will certainly take them under advisement as the State moves toward renewal for the CS waiver. Please contact Kara Lewis, of my staff, at 803-898-2710, with any questions regarding this response.

As we have discussed, I will be glad to provide feedback to CMS on this importance process. I appreciate the opportunity to strengthen the future communication and expectations between CMS and the State.

Sincerely,

Sam Waldrep
Deputy Director

SW/mlh
Enclosure

hey to Kara George

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Waldrep | 7-8-11 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 10021 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>cc: Mr. Keck, Deps, CMS file | [X] Prepare reply for appropriate signature<br>DATE DUE 8-29-11<br>[ ] FOIA<br>DATE DUE _____<br>Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
|---|---|---|---|
| 1. Sam Waldrep | | | |
| 2. George Mary | | | |
| 3. Kara Lewis | | | |
| 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

June 30, 2011



Anthony Keck, Director
South Carolina Department of Health & Human Services
PO Box 8206
Columbia, South Carolina 29202-8206

Dear Mr. Keck:

Enclosed is the draft report of the Centers for Medicare & Medicaid Services' (CMS) review of South Carolina's Community Supports Home and Community Based Waiver, control number 0676. This waiver serves individuals with intellectual and / or related disabilities who meet the criteria for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MF).

We would like to extend our sincere appreciation to all who assisted in the review process. We found the State to not be in compliance with all six of the review components. For those non-compliant assurances, the State must show compliance at the time of renewal in order for CMS to approve the waiver renewal. As such, we included necessary recommendations for program improvements in all six of the assurance areas. We suggest you address these prior to renewal of the waiver in order to meet the assurances and maximize the quality of the waiver program. Please include a detailed plan, with target dates, to show compliance and/or improvements in required waiver performance issues identified in the report.

Please review the draft report and submit your comments within thirty (30) days of receiving this letter. Your response will be incorporated into the final report, which will then become a public document. Should we receive no response from you by the 30th day (July 31, 2011), this draft report becomes a final document. We are available to discuss the report and to provide technical assistance. Please do not hesitate to let us know how we may be of assistance.

We would again like to extend our sincere appreciation to the Division of Community Long Term Care, who provided information for this review. If you have any questions, please contact Kenni Howard at 404-562-7413.

Sincerely,

Jackie Glaze

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

Enclosure

CC: Ellen Blackwell, Central Office

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

# U.S. Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Region IV

# DRAFT REPORT

## Home and Community-Based Services Waiver Review
## South Carolina's Community Supports Waiver
## Control # 0676

**June 30, 2011**

**Home and Community-Based Services**
**Waiver Review Report**

**Executive Summary:**

The South Carolina Department of Community Health and Human Services (DHHS) is the State Medicaid Agency that retains administrative authority of the Community Supports Home and Community-Based Services (HCBS) Waiver. The South Carolina Department of Disabilities and Special Needs (DDSN) is the operating agency. This waiver serves individuals who meet level of care criteria for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and have service needs that can be met with an array of home and community-based services that complement natural supports available in their homes or communities. There is no age restriction and the program operates statewide. The annual cost cap for this program is $10,986 per participant. The State reserves the right to refuse waiver services to individuals who can be reasonably expected to exceed the annual cost cap established for the program. As of June 2011, the State reports the current enrollment at 1987 and an average annual expenditure of waiver plus state plan services at $11,727 per recipient.

As requested per the CMS Interim Procedural Guidance, South Carolina submitted evidence to demonstrate that the State is meeting program assurances as required per 42 CFR 441. In its submission of March 9, 2011, the State provided an introduction to its overall quality management strategy, various examples and summary reports specific to each assurance.

**Summary of Findings**

1. **State Conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.**

   **Required Recommendations:**

   Submitted evidence verifies the State has a level of care determination process in place that ensures applicants meet ICR/MR level of care. However, there is no evidence that the State utilizes currently approved performance measures to aggregate data or utilize results to remediate deficiencies or formulate quality system improvements.

   The CMS requires the state to analyze results of data elements, remediate deficiencies, track and trend findings to determine where system improvements are needed in order to determine full compliance with this assurance.

2. **Service Plans are Responsive to Waiver Participant Needs – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.**

   **Required Recommendations:**

   The CMS requires the State to utilize performance measures to collect, analyze and trend data to develop system improvements that will demonstrate compliance with all service plan assurances and sub-assurances.

3. **Qualified Providers Serve Waiver Participants – The State does not meet this assurance.**

**Required Recommendations:**

While the administering and operating agencies use outside quality contractors for provider reviews, the State is required to conduct follow-up to ensure remediation occurs when negative findings are discovered. CMS requires the State to conduct a full analysis of data submitted by the quality contractors to identify trends and/or potential areas for system improvement. Additional performance measures to ensure direct support staff completes mandatory training, have adequate background and registry checks would help demonstrate compliance with this assurance.

4. **Health and Welfare of Participants – The State does not meet this assurance.**

**Required Recommendations:**

The CMS requires the State to develop a more robust system to demonstrate compliance with this assurance. The State appears to rely heavily on the findings of the quality contractors. The State is required to analyze data submitted by the contracted quality improvement entities, to demonstrate appropriate remediation occurred for negative findings, and results of findings should be used to create system improvements.

5. **State Medicaid Agency Retains Administrative Authority Over the Waiver Program – The State does not meet this assurance.**

**Required Recommendations:**

Although evidence confirmed a MOU and ongoing communication exist between the administering and operating agency, there was no concrete evidence to demonstrate the State Medicaid Agency has retained ultimate authority over the waiver program. The CMS requires the State to use performance measures in the approved waiver to collect and analyze data, to remediate negative findings, to track/trend findings and to develop a strategy for possible system improvement. Additional performance measures related to SCDHHS oversight of the operating agency should be included in the upcoming waiver renewal.

6. **State Provides Financial Accountability for the Waiver – the State does not fully or substantially demonstrate the assurance, but there is evidence that may be clarified or readily addressed.**

**Required Recommendations:**

The CMS requires the State to develop and utilize additional performance measures to demonstrate maintenance of appropriate financial records; claims are coded and paid in accordance with waiver reimbursement methodology; and, that identified financial irregularities are addressed appropriately.

**Introduction:**

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs. CMS must assess each home and community-based waiver program in order to determine that State's assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver.

| | |
|---|---|
| **State's Waiver Name:** | Community Supports Waiver |
| **Operating Agency:** | South Carolina Department of Disabilities and Special Needs (DDSN) |
| **State Waiver Contact:** | Kara Lewis |
| **Target Population:** | Individuals with Mental Retardation and Related Disabilities |
| **Level of Care:** | ICF/MR |
| **Number of Waiver Participants:** | 1987 |
| **Average Annual per capita costs:** | $11,727 |
| **Effective Dates of Waiver:** | July 1, 2009 through June 30, 2012 |
| **Approved Waiver Services:** | Personal Care (Levels I and II); Respite; Adult Day Health Care; Adult Day Health Care Nursing; Adult Day Health Care Transportation; Day Activity; Career Preparation; Employment Services; Support Center; Community Services; Environmental Modifications, Specialized Medical Equipment, Supplies, Assistive Technology and Appliances; In-Home Support; Psychological Services; Private Vehicle Modifications; and, Behavior Support Services |
| **CMS RO Contact:** | Connie Martin<br>Report prepared by Kenni Howard, RN |

## I. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

**The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating / reevaluating an applicant's/waiver participant's level of care (LOC) consistent with care provided in a hospital, nursing facility or ICF/MR.**
*Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5*

**The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.**

**Evidence Supporting This Conclusion:**
*(Evidence that supports this conclusion is weak and not complete. Additional information is required to comply with the assurance.)*

The evidence submitted by the State indicates that they have a level of care determination process in place that assures waiver applicants meet the ICF/MR level of care. The responsibility for LOC determination has been delegated to the operating agency which uses a Consumer Assessment Team (CAT) that consists of clinical licensed psychologists. By the tenth day of each month, the CAT submits a list of initial LOC determinations completed during the previous month to the DHHS waiver staff. The list includes all ICF/MR determinations, as well as any adverse actions. The list is used to determine if the Community Supports waiver requirement of enrollment within thirty days of LOC determination is met.

Re-evaluations are conducted by the Service Coordination/Early Intervention staff which is also responsible for daily operation of the waiver. LOC re-determinations occur at least every 364 days. The DDSN District Office submits a monthly report to each Service Coordination Provider which lists the waiver participant's name and other pertinent information for clients whose previous LOC determination has reached the age of 350 days old. This tickler system assists the Service Coordination Provider in ensuring that re-determinations are completed timely.

The DHHS uses a Quality Improvement Contractor to review all adverse ICF/MR LOC decisions to assure the decisions are appropriate and submitted in the correct format using waiver approved documents.

**Required Recommendations:**
*(CMS recommendations include those areas requiring additional information or clarification prior to approval. The State must provide the requested information to be in compliance prior to renewal.)*

Evidence submitted outlines the process for level of care determinations and re-determinations. However, the State has not utilized the performance measures in the approved waiver to indicate compliance with this assurance. The CMS requires the State to utilize performance measures already in place and report data and outcomes.

The state provided processes, however there is no data to show the percentage of new enrollees whose LOC is not within 30 days of waiver enrollment; the percentage of participants whose level of care re-determinations does not occur prior to the 365$^{th}$ day of the previous LOC

evaluation; and, the percentage of new enrollees whose LOC was conducted using incorrect instruments.

We also require the State to analyze data submitted by the Quality Improvement Contractor to determine if remediation occurred when required and identify trends and develop a system for improvement. The State Medicaid agency should conduct an independent review of the operating agency as a retrospective review of the Quality Improvement Contractor to ensure compliance with the terms of the MOU as well as federal assurance.

Although the State has performance measures in place, it should consider incorporating additional measures to strengthen this assurance area. Below are examples:

- Percentage of new enrollees whose enrollment is no greater than 30 days after LOC completion
- Number of failed MMIS edits checks performed to determine whether submitted claim is valid for newly enrolled participant as measured by a valid LOC date.

## II. Service Plans are Responsive to Waiver Participant Needs

**The State must demonstrate that it has designed and implemented an adequate system for reviewing the reviewing the adequacy of service plans for waiver participants.**
*Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13*

**The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.**

**Evidence Supporting This Conclusion:**
*(Evidence that supports this conclusion is weak and not complete. Additional information is required to comply with the assurance.)*

Evidence submitted by the State is primarily composed of processes and copies of pages from the Memorandum of Agreement (MOA) between the DHHS and DDSN. The description of the processes indicates service plans are developed as outlined in the approved waiver. Plan of Care document #1 is a copy of the MOA page that indicates DHHS will review a sample of waiver case records annually to review plans of care, levels of care, freedom of choice, service notes, and any other supportive documentation to determine appropriateness and adequacy of services that ensure services furnished are consistent with the nature and severity of the individual's disability. Plan of Care document #2 is a copy of a "statewide record review" that summarizes findings of the review. CMS cannot determine if the sampling methodology used is statistically valid for the size of the waiver program, nor is there any evidence of remediation to assure negative findings were corrected. Furthermore, it is unclear who completed the report, to whom it is submitted, if it is analyzed by the Medicaid agency or how it is utilized for system's improvement.

Evidence identified as Plan of Care document #3 is a copy of a review which shows a random sample of participants whose service plans are reviewed to assure all participant needs are addressed. CMS is unable to understand how this document assures participants' needs are being met. There is no explanation of the sampling methodology used, nor is there any data or findings associated with this document.

Plan of Care document #4 list indicators used by the Delmarva Foundation, DDSN's quality contractor. The indicators used by Delmarva appear to address necessary criteria to ensure service plans are timely; justified by the assessment; identify needs and interventions; is amended as needed; monitored at least quarterly; contains the participant's emergency plan; includes the service name, frequency and amount; identifies the provider; documents choice of providers; and, addresses service needs outside the scope of the waiver. There is no data associated with the indicators presented.

Plan of care documents #5, 6, 7, 8, and 9 are copies of the freedom of choice form, Delmarva indicators, an "Acknowledge of Rights and Responsibilities" and a listing of providers respectively, intended to show adherence with the freedom of choice requirement to meet this assurance. However, there is no data associated with these forms showing the State or the quality contractor has completed an analysis to determine if the freedom of choice is being adequately and/or properly applied.

Prior to developing a Plan of Care, the SCDDSN Service Coordinator Annual Assessment is completed. This assessment is needs based and includes a wide range of activities to determine the individual's personal goals and needs in order to develop an accurate and effective Support Plan/Plan of Care. The State presented a completed assessment as evidence of an annual assessment (plan of care document #10), but failed to show how this indicates adherence with the Service Plan development requirements for this assurance.

The State indicates they look at timeliness of POC documents during the record reviews.
Plan of care document #11 is a service plan that was found to be outside the required 364 day time frame from the previous service plan completion. However, there is no evidence of remediation activity for this out of date service plan. Furthermore, the State submitted plan of care document #12 as evidence of a tracking tool that can be created monthly or yearly which allows supervisors to know when plans are due, as well as any plans that are overdue. Again, the State failed to submit an analysis of the failure or remediation activities put into place to prevent future service plans being out of date.

Plans of care document #13 is a copy of a Quality Assurance Review report by Delmarva to the Chester-Lancaster County DSN board which was submitted as evidence of oversight by the DDSN to ensure plans of care are completed in a timely manner and that all needs are identified. The State reports that when errors are found, a plan of correction is submitted and a follow-up review is held within six months. Plan of care document #14 is the plan of correction and document #15 is the follow-up review by Delmarva. The follow-up review indicates a 96% desk review result with a statement indicating that additional follow-up between the provider organization and Delmarva is not required. The report was forwarded to DDSN for their determination regarding technical assistance. There is no evidence indicating further follow-up on this particular plan of correction to determine if individual remediation occurred for items identified, nor was there an analysis presented to determine if the State Medicaid agency followed up with DDSN to ensure the operating agency is in fact following up on their own quality contractor recommendations.

An annual report to the DDSN (submitted by Delmarva) is presented as evidence that they report on all providers reviewed during the previous fiscal year, which includes provider demographics, review methods and statistical information on all indicators. Many indicators in the report are below the 100% expected threshold. There is no evidence of remediation, and there is no State

analysis of this report by either the operating or administering agency. The CMS fails to understand how this document is utilized to identify remediation strategies or implement systems improvements.

**Required Recommendations:**
*(CMS recommendations include those areas requiring additional information or clarification prior to approval. The State must provide the requested information to be in compliance prior to renewal.)*

The CMS requires the State to utilize performance measures in the approved waiver document and provide clear outcomes with a thorough data analysis. In addition, CMS requires the State to identify the specific remediation activities and potential strategies for systems improvement.

## III. Qualified Providers Serve Waiver Participants

**The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.**
*Authority: 42 CFR 441.302; SMM 4442.4*

**The State does not demonstrate this assurance**
*(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)*

**Evidence Supporting This Conclusion:**
*(Evidence that supports the finding that the State does not substantially meet the assurance.)*

The State currently uses four performance measures identified in the approved waiver to measure compliance with the Qualified Provider assurance. However, the State did not submit data that correlates to any of the performance measures in the approved waiver. The majority of evidence submitted was policy and copies of reviews.

Qualified Provider documents #1 and #2 are copies of the current Request for Proposal used by potential providers to request permission to be placed on the Qualified Provider Listing and an explanation of the requirements as explained in the Scope of Solicitation. These documents clearly identify requirements for provider participation in the Community Services waiver. Qualified Provider documents #3, #4 and #5 are copies of documents required by potential providers. The State also requires potential provider attend mandatory training prior to the initiation of a contract. Document #6 is a copy of an email sent by the Compliance Officer to notify staff of a new provider. These documents reflect process only and there is no data presented that shows compliance with the policy.

As evidence of annual provider licensing/certification reviews, the State submitted copies of licensing standards compliance reports and plan of correction (Qualified Provider documents #7-#14) for two County Board of Disabilities and Special Needs and a copy of a renewal letter and certificate for day facilities. There is no indication that the State accepted and/or approved the corrective action plan (CAP) presented, nor is there evidence of any subsequent follow-up review by DHHS to determine if deficiencies were corrected.

Of particular concern, document #12 (Jasper County DSN Day Program-Hill Center CAP) identifies that on the day of inspection, the building held 50 consumers, although licensing capacity is 46. The State Fire Marshall states capacity limit is 42 individuals as referenced by Delmarva finding 1/2/II. Per the report, the building is owned by the waiver operating agency (DDSN) and they are not allowed to deny services to consumers and therefore could not reduce

the number of people at the Hill Center. The CAP also states that staff members at DDSN are aware of the situation. This not only a concern due to lack of remediation, but is also a concern in the Health and Welfare assurance. In addition, this incident is an example of poor oversight authority by the Medicaid agency to allow the continuance of this issue. The documents presented as evidence do not demonstrate compliance with this assurance, nor is there evidence the State analyzed the reports, remediated negative findings or used the information to make improvements.

Qualified Provider document #15 is a copy of a compliance review report conducted by a Registered Nurse on non-licensed/non-certified providers. Documents #16 – #21 are copies of provider suspension letters suspending new client referrals due to negative findings and corresponding emails sent to staff alerting them of the changes in provider status. However, there is no evidence that indicate follow-up reviews were conducted prior to lifting the suspension.

**Required Recommendations:**
*(CMS recommendations must include necessary rectification actions by the State at the time of renewal in order to comply with the assurance when the State does not substantially meet the assurance.)*

The CMS requires the State to utilize the performance measures in the approved waiver and report findings/data on those measures to demonstrate compliance with all waiver assurances. Also, both the administering and operating agencies should conduct follow-up to ensure remediation occurs when negative findings are discovered. The CMS expects full analysis of reports generated by the quality contractor to identify trends and/or potential areas for system improvements. Additional performance measures the State may wish to consider include:

- Number and percentage of agency providers whose direct support staff had timely criminal background and registry checks
- Number and percentage of direct support staff, by agency and individually, who meet all requirements for annual training (i.e. CPR, TB testing, HIPPA, etc.)

## IV. Health and Welfare of Waiver Participants

**The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.**
*Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9*

**The State does not demonstrate this assurance**
*(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)*

**Evidence Supporting This Conclusion:**
*(Evidence that supports the finding that the State does not substantially meet the assurance.)*

Evidence from the State indicates eleven (11) performance measures are being utilized to assess this assurance. However, few data elements for any of the performance measures are included in the evidence package submitted.

The State provided a copy of the Memorandum of Agreement (MOA) with the South Carolina Law Enforcement Division (SLED) outlining abuse, neglect, and exploitation reporting and investigating responsibilities of DDSN (H/W #1). While the MOA is very detailed with identified timelines, there is no activity or results of monitoring to determine if the process is

being correctly followed. Similarly, the DDSN's policy relating to the procedures for preventing and reporting abuse, neglect, and exploitation (ANE) is submitted as evidence (H/W #2 and #3), but there are no findings to indicate the procedures are being followed correctly or timely.

There are critical incident reports from several centers submitted as evidence (H/W # 4,5,6,7), but the reports appear to only capture the number of incidents reported statewide versus by the provider indicated and a breakdown of the type of incident reported and/or substantiated. In the evidence submitted, CMS finds no results of monitoring of the required timelines identified in the MOA. Furthermore, there is no data/evidence the State has analyzed these reports to track or identify trends or patterns, nor is there evidence of remediation activities or system improvements identified as a result of State analysis.

Minutes of the Vulnerable Adult Fatalities Review Committee meeting were submitted as evidence (H/W #8) that the State is compliant with the MOA requirement that the DDSN State Director, or designee, participate in this committee. The minutes of the 9/8/10 meeting presented discusses the resignation of Dr. Clay Nichols, finding his replacement and the possibility of acquiring a pathologist to serve on the committee. They do not reflect any discussion of ANE and therefore does not substantiate the requirement the committee discuss ANE issues.

Health and Welfare Document #9 is pre-service training requirements and orientation for staff employed at local DDSN Boards and qualified service providers. The document does not indicate how the State ensures the pre-service training policy is enforced and there is no evidence to indicate the compliance rate of the percentage of new employees that attend required training.

The Health and Welfare Document #10 submitted as evidence is DDSN directive 100-009-DD which defines a critical incident, outlines reporting and tracking procedures and establishes a feedback system to provide a coordinated internal review process that ensures appropriate action is taken. A copy of the critical incident database log report (H/W #11) is submitted as evidence to show adherence to DDSN policy 100-009-DD. While the report shows the date, time, nature, location, and a review outcome of the reported incident it does not indicate if the appropriate timeframes were met.

The DDSN contracts with Delmarva Foundation as its quality contractor. Health and Welfare document #12 is submitted as evidence to indicate that Delmarva conducts annual assessments of service providers by making on-site visits to review provider records regarding staff training, compliance with ANE and disaster preparedness policies. However, this document only included the indicators used by Delmarva and no assessment results or findings are provided.

The State appears to have a comprehensive Disaster Preparedness Policy and Disaster Preparedness Plan (H/W #13) which was submitted as evidence in assuring health and welfare for waiver participants. However, this policy and plan is at a state level and there is no evidence or indication that the plans are effective at the individual participant level when put into action.

Health and welfare document #14 is a thorough assessment tool which appears to capture appropriate health and wellness issues, knowledge of human and civil rights and asks specific questions pertaining to an emergency/disaster plan. However, as indicated above, there is no evidence submitted that indicates follow-up of individuals if the plan were to be put into action.

Evidence submitted as health and welfare document #15 is results of a survey that surveyed a random sampling of participants in areas of choice of primary physician; do they feel safe in

their home and neighborhood; do they receive preventive dental visits; and, do they report that they know their rights. The percentages of individuals who reported knowing rights are much lower than other indicators of the survey. There is no evidence of the agency's analysis and/or evaluation of the survey results, nor evidence of remediation in respect to the low percentage indicators.

The State indicates they have a process in place for consumers and non-consumers to voice concerns and/or opinions about services and the waiver program. A consumer relations specialist tracks calls/emails by entering information into a database, followed by investigation and follow-up to ensure resolution occurs. Although the State indicates there are currently no concerns reported for this waiver, there is no explanation as to how the State would analyze the database to identify any trends that might warrant systems improvement.

**Required Recommendations:**

*(CMS recommendations must include necessary rectification actions by the State at the time of renewal in order to comply with the assurance when the State does not substantially meet the assurance.)*

The CMS recognizes that the State has multiple electronic systems in place that could be utilized to collect data, identify trends and track remediation. However, the State has failed to submit concrete evidence that these systems are utilized to the fullest extent or that any analysis of reported data has been used to remediate specific issues discovered and create system improvements. CMS requires the State to complete an analysis of data that supports performance measures already in place, which include:

- Number of incidents of ANE that are reported within required timeframes.
- Number of incidents of ANE in which the internal review was completed within required timeframes.
- Percentage of people who report they are treated with dignity.

We require the State develop additional performance measures to capture data that reflects the appropriateness and timeliness of established policies and procedures. Examples of performance measures (with data source) the State may wish to consider include:

- Number and percent of critical incidents for which corrective actions were verified within required timeframe (CI database).
- Average number of critical incidents per waiver recipient (CI database).

## V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

**The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.**

*Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7*

**The State does not demonstrate this assurance**

*(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)*

**Evidence Supporting This Conclusion:**
*(Evidence that supports the finding that the State does not substantially meet the assurance.)*

The document submitted as Administrative Authority #1 is a copy of the Memorandum of Agreement (MOA), which identifies specific functions of the operating agency (DDSN) and the Medicaid agency. The Administrative Authority #2 document (a Medicaid Bulletin) is submitted as evidence that the MOA gives the Medicaid agency authority to issue information or changes in policy. While the MOA clearly delineates duties for each agency, neither it nor the Medicaid Bulletin is sufficient evidence that clearly demonstrate compliance with this assurance.

The MOA states that "DHHS and DDSN shall convene regularly scheduled meetings with state office staff involved with the administration and operation of the HCBS waiver to discuss mutual issues of interest." As evidence to this, the State submitted copies of two meeting agendas and copies of meeting minutes. While the agendas identify multiple topics and the minutes summarize the meetings, there is no clear indication as to how this demonstrates the Medicaid agency maintains administrative authority over the operating agency. There is no indication to define "regularly scheduled meetings", nor are there any indications of discussions on findings, remediation or overall system improvements on the agenda items.

Administrative Authority documents #7 – #12 have been submitted to demonstrate the DDSN has a reconsideration/appeals process in place and that they jointly track these concerns. Document #7 is a copy of the appeals process, documents #8 - #11 are copies of letters requesting reconsideration/appeals, and the decision to those request. Document #12 is an appeal log, which identifies recipients' names, date appeal received, the issue, the response date and outcome. The State failed to submit an analysis of the number of appeals received, outcome or identify trends or remediation activities when appropriate.

Administrative Authority document #13 is a copy of a record review spanning a six month time frame and covers level of care, service plans, and financial accountability. While the report is detailed, there is no indication of the sampling methodology used to determine the number of files reviewed, nor is there any supporting documentation that identifies the outcome of the record review. CMS is unable to determine if remediation occurred, if this provider was in compliance or if a corrective action plan or other sanctions were required.

The document submitted as Administrative Authority #14 is an example of a report submitted by DHHS's Quality Improvement Contractor (Qualis Health) showing their review of adverse level of care determinations. Again, there is no evidence that the State has analyzed the data presented to determine if remediation is necessary, and if so, if it were completed.

The quarterly report identified as Administrative Authority documents #15 and #16 shows all records reviewed during the previous three months, breaking the report down by waiver and institution for all ICF/MR level of care determinations. There are no supporting documents to clarify this report or to identify the headings, and CMS is unable to determine the relevance of the report. There is no analysis of the report by the State submitted to indicate what action the State has taken and how this demonstrates compliance with the administrative authority.

The document identified as Administrative Authority #17 is a copy of a contract for the purchase and provision of home and community-based services for the community supports waiver. Submission of this contract does not demonstrate how the State complies with the assurance.

**Required Recommendations:**
*(CMS recommendations must include necessary rectification actions by the State at the time of renewal in order to comply with the assurance when the State does not substantially meet the assurance.)*

While the approved waiver documents contains performance measures that could help the State demonstrate compliance of this assurance, the State has not shown clear evidence of such. The CMS requires the State to collect, analyze, and report data for performance measures already in place and to clearly identify the schedule of record reviews, trends identified as a result of the reviews, remediation steps taken as a result of the reviews, and identify a process for systems improvement. Additional performance measures could be utilized to help the State demonstrate that the Medicaid Agency maintains administrative authority over the waiver. Some examples include:

- Number and percent of Medicaid-initiated Operating Agency/Contractor remediation actions occurred within the timeframes identified in the MOA.
- Number and percent waiver policies and procedures approved by the Medicaid Agency prior to implementation by the operating agency.
- Number and percent of substantiated cases of abuse, neglect and exploitation for which the operating agency implemented appropriate individual remediation strategies in the timeframes as specified in the MOA.
- Number and percent of findings by the Quality Contractor that was appropriately determined (from a Medicaid look-behind review).

## VI. State Provides Financial Accountability for the Waiver

**The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.**
*Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10*

**The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.**

**Evidence Supporting This Conclusion:**
*(Evidence that supports this conclusion is minimally adequate, however, there are some issues or information that warrant improvement or would benefit from additional information)*

The State submitted enrollment and/or termination forms as well as screen shots to demonstrate that recipients are locked into the Medicaid Management Information System (MMIS) by use of a Recipient Special Program (RSP) indicator. The indicator is determined by the recipient's eligibility status, and the RSP characters affect all aspects of claims processing. Each month DHHS staff receives financial expenditure reports for all waiver programs. The report indicates the number of patients receiving a particular service as well as the net payment amount for the service.

The State submitted Financial Accountability document #6 as evidence that the Medicaid agency conducts waiver record reviews that includes reviewing payment for waiver services. There are several instances throughout the report that indicate payments do not correspond with service authorizations. However, there is no indication of what activities the state undertook with the operating agency and/or providers to remediate the findings. There was no analysis of trending presented to determine if a particular provider was over/under billing or if a particular participant

received services that was not included in their service plan. The State did submit copies of voided claims that show remediation of a random billing irregularity identified by DHHS staff.

Financial Accountability document #8 is a copy of a prior authorization form which establishes the appropriate units of services to be furnished to the participant. The Authorization for Services is completed and sent to the provider of choice. Providers use the prior authorization number when they submit claims to the MMIS in order to receive Medicaid reimbursement. If any of the indicators on the form are missing on the claim submitted, the claim will reject and not pay. The State did not submit a report or analysis of the system to demonstrate the system edits are working appropriately and to ensure that claims are properly adjudicated.

The DDSN utilizes a quality contractor (Delmarva) to monitor compliance that service authorization forms are completed correctly. Submitted evidence (Financial Accountability #9) includes Delmarva indicators used during their review process. Delmarva also conducts an annual assessment of service coordination providers by making on-site visits and reviewing records based on established indicators. Based upon the findings, recoupment may be necessary to return the Federal Financial Participation (FFP). However, the State did not present evidence they have analyzed the Delmarva reports or took any action to remediate negative findings.

The DHHS submits a monthly report to DDSN that shows all services paid by Medicaid during the prior month for participants enrolled in the Community Supports waiver. From this report, a smaller report of direct-billed services is extracted, which shows the amounts paid by Medicaid for each participant by social security number, fund code, service date, participant name, procedure code, units, amount paid, individual provider number, and group provider number. As previously stated, the reports themselves do not indicate compliance with this assurance. The State has not submitted analysis of the reports, trending, nor any remediation activities of discrepancies discovered.

**Suggested Recommendations**:
*(CMS recommendations enable the State to improve upon the process, evidence, or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)*

The CMS expects the State submit results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver. The State should submit results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver reimbursement methodology. The State should submit evidence that interviews with State staff and providers are periodically conducted to verify any identified financial irregularities are addressed, and should demonstrate that site visits are conducted with providers to verify they maintain financial records according to provider agreements/contracts.

CMS suggest the State develop additional performance measures to demonstrate financial oversight exists. Examples of acceptable performance measures the State may wish to consider include:

- Number and percent of claims coded as specified in the waiver application
- Number and percent of claims adhering to reimbursement methodology in the waiver application
- Number and percent of claims paid for services not included in the service plans

- Number and percent of claims denied or suspended for incorrect billing codes an service rates
- Number and percent of paid claims for services delivered to persons in accordance with their approved service plan and with documentation to support the amount, frequency, and duration of services billed.

**From:** "Howard, Kenni L. (CMS/SC)" <Kenni.Howard@cms.hhs.gov>
**To:** Waldrep@scdhhs.gov; Lewis@scdhhs.gov
**Date:** 7/21/2011 10:10 AM
**Subject:** SC 0676 report

Kara:

It was a pleasure speaking with you earlier this morning regarding your concerns with the attached report. For clarification on the date issue, CMS' current Quality Interim Procedural Guide (IPG) states that for new waivers, draft reports are issued 12 months prior to expiration, a response is due from the State 11 months prior to expiration and the final reports are issued 9 months prior to expiration. (This allows the State 9 months to work on any issues/concerns or required changes before submitting the renewal application.) For renewed waivers, draft reports are issued 17 months prior to expiration, a response is due 14 months prior to expiration and the final reports are issued 12 months prior the expiration of the program. (This allows the State a full year to make any necessary corrections/changes before submitting the renewal application.)

I am in full agreement with you that the State should not issue a quick response and that along with the operating agency, you should investigate our concerns and provide clarification and/or additional evidence. In order for the State to have adequate time to do such, we agreed to an August 19, 2011 date for submission of your response. This date should still allow CMS adequate time to review any additional information submitted and meet our timeframe for issuance of the final report.

As discussed, I have attached an electronic copy of the draft report so that you can insert responses directly into the areas of concern. As you work on your response, feel free to contact me if you need clarification on anything.

Thank you,

Kenni

Kenni Howard, RN |Health Insurance Specialist |Division of Medicaid and Children's Health |Centers for Medicare and Medicaid Services|61 Forsyth St. S.W., Suite 4T20 | Atlanta, GA 30303-8909 |404-562-7413 | kenni.howard@cms.hhs.gov



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**CC:** Connie.Martin@cms.hhs.gov; Shantrina.Roberts@cms.hhs.gov; Jackie.Glaze@cms.hhs.gov

South Carolina Department of Health & Human Services

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

August 18, 2011

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

Attn: Kenni Howard

Dear Kenni,

The State of South Carolina is in receipt of the Centers for Medicare and Medicaid Services (CMS) draft report for the review of our Community Supports (CS) waiver (#0676).

Please know we have taken your findings under serious consideration. In preparing our response, we realize that evidentiary information presented in previous reports as acceptable may no longer be considered as such. We are eager to make meaningful enhancements to our waiver programs through quality oversight efforts.

The format we have elected to use for this response is to include separate Roman numeral sections for each waiver assurance, followed by numbered performance measures and the State's Evidence with any labeled documentation. Additionally, the State has included points of clarification in areas where we felt there was misinterpretation or misunderstanding of our original submission. We hope this is a straight forward way of presenting our response.

**1915© Home and Community-Based Waiver Assurances**

**I. State Conducts Level of Care (LOC) Need Determinations Consistent with the Need for Institutionalization**

*Performance Measures*

1. Proportion of new enrollees whose LOC completion date is not within 30 days prior to waiver enrollment.

The State's Evidence: As noted in bullet #5, page 2 of the LOC section of the State's original Evidence Report, the SCDHHS controls the MMIS entry process for all CS waiver participants. Enrollment request dates are carefully monitored to ensure new enrollments only occur within 30 days of the LOC Determination. The evidence originally provided as LOC Document #6, indicates that 0 out of 146 new enrollees (0%) for July 2009 had a LOC completion date that was not within 30 days prior to waiver enrollment. For State Fiscal

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Year 2010 (SFY10), 0 out of 1911 (0%) of new enrollees had a LOC completion date that was not within 30 days prior to waiver enrollment. Based on this evidence, the State determined that remediation activities were not necessary.

2. Proportion of participants whose LOC re-evaluation does not occur prior to the 365th day of the previous LOC evaluation.

   The State's Evidence: As noted in Bullet #13 of the LOC Section of the State's original Evidence Report, DDSN utilizes the Quality Contractor Delmarva Foundation to conduct on-site reviews of Service Coordination providers. Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report (LOC Document #15). Indicator G11-04 measures if the LOC Determination was completed within 365 days of the previous determination. Based on data from the Delmarva Annual Report for SFY10 (LOC Document #20), this indicator was met with 100% compliance; therefore, the percentage of participants whose LOC redetermination did not occur within 365 days of the previous LOC is 0%. The State determined that remediation activities were not necessary.

3. Proportion of LOC Determinations that were conducted using the appropriate criteria and instruments.

   The State's Evidence: Bullet #13 of the LOC Section of the State's original Evidence Report indicates DDSN utilizes the Quality Contractor Delmarva Foundation to conduct on-site reviews of Service Coordination providers. Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report (LOC Document #15). Indicator G11-06 measures if the LOC is completed appropriately. Based on data from the Delmarva Annual Report for SFY10 (LOC Document #20), this indicator was met with 100% compliance; therefore, the percentage of participants whose LOC was conducted using incorrect instruments is 0%. The State determined that remediation activities were not necessary.

4. Proportion of participants whose LOC outcome was appropriately determined.

   The State's Evidence: The State provided a copy of a report prepared by the Quality Improvement Organization (QIO), Qualis, to demonstrate adherence to this performance measure (original Evidence Report LOC Document #9A). We note this document was missing the "even numbered" pages and are resubmitting the (same) *full* page document at this time (see LOC Document #9A). The QIO reviewed LOC Determinations issued by DDSN's Consumer Assessment Team (CAT) for all four (4) DDSN waivers, as well as TEFRA eligibility cases, and adverse LOC cases, and subsequently issued a monthly report to SCDHHS summarizing the findings. LOC Document #9A indicates the QIO reviewed a total of 82 ICF/MR LOC Determinations during the month of November 2009. Of these, 23 were for CS waiver candidates. The report indicates the QIO agreed with each of the LOC Determinations made by the CAT, therefore, the State determined no remediation activities were needed since 0% of the LOC Determinations were disputed by Qualis.

Bullet #13 of the LOC Section of the State's original Evidence Report indicates DDSN utilizes the Quality Contractor Delmarva Foundation to conduct on-site reviews of Service Coordination providers. Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report (LOC Document #15). Indicator G11-05 measures if the LOC is supported by the assessment/ documents indicated on the LOC Determination form. Based on data from the Delmarva Annual Report for SFY10 (LOC Document #20), this indicator was met with 100% compliance; therefore, the percentage of participants whose LOC was appropriately determined is 100%. The State determined that remediation activities were not necessary.

5. Proportion of participants whose initial and/or subsequent LOC evaluation was denied appropriately.

   The State's Evidence: The State reviewed the Qualis report originally provided as LOC Document #9A (the complete document submitted per #4 above). It indicates three (3) adverse LOC Determinations for the CS waiver during November 2009. It further notes that Qualis accepted all LOC findings performed by the CAT. Therefore, the State determined 100% compliance and no remediation activities were needed.

   As previously stated, Delmarva reviews records based on established indicators. The indicators related to the completion of LOC for this waiver are included in the State's original Evidence Report as LOC Document #15. In addition to the compliance reviews conducted by Delmarva, State waiver policy requires that decisions to deny LOC for waiver participants must be confirmed and issued by the CAT. That LOC policy is included as New LOC Document #1.

## II. Service Plans are Responsive to Waiver Participant Needs

*Performance Measures*

1. Proportion of participants whose plans include services and supports that are consistent with needs and personal goals identified in the comprehensive assessment.

   The State's Evidence: As noted in the State's original Evidence Report, DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-02 measures the proportion of participants whose plans include services and supports that are consistent with needs and personal goals identified in the comprehensive assessment. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 98%. When cited by Delmarva, the provider is required to complete a plan of correction and a follow-up review is conducted to assure that needed corrections have been made.

2. Proportion of participants who received assessments in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G11-01 measures the proportion of participants who received assessments in accordance with State policy. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 100%. Therefore, the State determined that remediation activities were not necessary.

3. Proportion of participants whose plans were completed in a timely fashion.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-01 measures the proportion of participants whose plans were completed in a timely fashion. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 95%.

   As an example of remediation conducted by DDSN, we have included Minutes from a Service Coordinator Supervisors Meeting on May 27, 2010. The topic of overdue plans was discussed at this meeting (see New Plan of Care Document #1). Also, SCDHHS is in the process of completing the ongoing CS waiver record review. Once finalized, a decision will be made about a referral to SCDHHS Program Integrity for recoupment of Federal Financial Participation (FFP). CLTC waiver staff will determine at that time if any additional remediation activities or policy changes are necessary.

4. Proportion of participants who received an annual re-assessment in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G11-01 measures the proportion of participants who received annual re-assessments in accordance with State policy. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 100%. Therefore, the State determined that remediation activities were unnecessary.

5. Proportion of participants whose plans were re-written in a timely fashion.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-01 measures the proportion of participants whose plans were re-written in a timely fashion. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 95%.

As an example of remediation conducted by DDSN, we are including Minutes from a Service Coordinator Supervisors Meeting on May 27, 2010. The topic of overdue plans was discussed at this meeting (see New POS Document#1). Also, SCDHHS is in the process of completing the ongoing CS waiver record review. Once finalized, a decision will be made about a referral to SCDHHS Program Integrity for recoupment of FFP. CLTC waiver staff will decide at that time if any additional remediation activities or policy changes are necessary.

6. Proportion of participants whose plans were updated as needs changed.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-04 measures the proportion of participants whose plans were updated as needs changed. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 85%.

   When determined to be out of compliance, the provider was required to submit a Plan of Correction. A follow-up review was conducted to determine if the correction had been made. The data regarding this finding was reviewed by DDSN and submitted to SCDHHS.

   DDSN and DHHS discussed these findings and believe the high error rate is related to new waiver start-up, rather than an on-going concern. Therefore, remediation activities are not warranted at this time.

7. Proportion of participants whose plans were monitored in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. The specific indicators used during SFY10 by Delmarva are included in the State's original Evidence Report as Plan of Care Document #4. Indicator G1-05 measures the proportion of participants whose plans were monitored in accordance with State policy. Based on the Delmarva Annual Report labeled Plan of Care Document #16, the compliance rate for this indicator during SFY10 was 80%. In addition to the Plans of Correction submitted and follow-up reviews conducted by Delmarva, Technical Assistance was provided by DDSN District Office staff to address the issue of plan monitoring. Three examples of Technical Assistance Reports are provided as New Plan of Care Document #2.

8. Proportion of participants who received contact with the case manager in accordance with State policy.

   The State's Evidence: DDSN uses the Quality Contractor Delmarva to review compliance. Indicators G2-01 (contact in excess of the minimum requirements is completed as defined by the Plan) and G2-02 (face-to-face contacts occur as required) are used to measure the proportion of participants who received contact with the case manager in accordance with State policy. The compliance rates for these indicators during SFY10 were 94% and 99% respectively. Based on this, the State determined that remediation activities were not warranted.

To clarify some points made in the Service Plan section of the June 30, 2011 Draft Report of the CS Waiver, the State provides following additional information:

- SCDHHS wishes to address the CMS concerns noted regarding the SCDHHS review of case records (CMS Draft Report, page 5). SCDHHS/CLTC waiver staff perform record reviews per the terms of the MOA as documented in the original CS Evidence Report (page 2, bullet 2, original Plan of Care Document #2). The CS Record Review originally submitted as evidence was in the initial stages at the time of data collection for the CMS Evidence Request. This record review remains ongoing. Soon after the record review was announced to SCDDSN, both SCDHHS/CLTC Waiver Quality Assurance (QA) Staff personnel assigned to coordinate QA for the DDSN waivers left employment with SCDHHS on the same day. One of these positions has been refilled and the other position is pending. This has left gaps in traditional QA activities.

  The State is aware the CS Record Review submitted for evidence included approximately half of the required records needed to complete the confidence level for waiver year one. It was the intent of the State to follow-up with an additional statewide record review to complete the confidence requirement. At this time, we are in the process of completing an intensive training for the recently hired QA staff person assigned to coordinate SCDDSN waiver issues, and we will initiate an additional CS waiver record review by October. Additionally, we are in the process of completing the ongoing CS waiver record review with a target date of October. Once the review is finalized, a decision will be made about the need for referral to SCDHHS Program Integrity for recoupment of FFP. Also, based on the final report, CLTC staff will determine if remediation activities or policy changes are necessary.

  Related to some points raised in this section of the CMS draft report, the State is providing additional documentation: 1) a copy of the cover letter from SCDHHS/CLTC waiver staff to SCDDSN (New Plan of Care Document #3); and 2) a copy of the SCDDSN response to the CS Record Review findings (New Plan of Care Document #4).

- It was noted that no data was associated with Plan of Care documents #5, 6, 7, 8, and 9 in the State's original Evidence Report to show the State or the quality contractor has completed an analysis to determine if the freedom of choice is being adequately and/or properly applied. Indicator G11-03 is used to determine if Freedom of Choice is present and completed appropriately. For SFY10, the compliance rate for G11-03 was 98%.

## III. Qualified Providers Serve Waiver Participants

*Performance Measures*

1. Proportion of providers that meet required licensing, certification, and other state standards prior to the provision of waiver services by provider type.

   The State's Evidence: For Day Activity, Career Preparation, Employment, Support Center, Community Services and Respite, a license is issued only after an application is submitted to DDSN. A completed application must include pre-licensing inspections (State Fire Marshall Inspection, HVAC, and electrical inspection). An on-site inspection is conducted only when

all pre-licensing requirements have been met. These inspections are conducted by the SC Department of Health and Environmental Control (DHEC). Licenses are only issued when no deficiencies are noted at the time of the on-site inspection. If deficiencies are noted, corrections must be made and verified by the licensing agency prior to the issuance of a license. Once the license is issued, the provider's name is added to the Qualified Provider's List.

For Specialized Medical Supplies, Equipment, Assistive Technology and Appliances, Private Vehicle Modifications, and Environmental Modifications, the provider must present to DHHS a valid license number in order to enroll with the Medicaid Agency. This information is explained on the agency website, www.scdhhs.gov, and a copy of the webpage is included as New Qualified Provider Document #1.

The process for contracting to provide Personal Care 1 or Personal Care 2 services is explained in the State's original Evidence Report, Qualified Provider Documents #3. The process for enrollment to provide Adult Day Health Care services is explained in the State's original Evidence Report, Qualified Provider Documents #4 and #5. Additionally, providers of Adult Day Health Care must present to SCDHHS a valid license number in order to contract as a provider.

Therefore, because of the pre-contractual compliance requirements, 100% of providers meet the required licensing, certification or other state standard prior to the provision of waiver services.

2. Proportion of waiver providers that continue to meet required licensing, certification, and other state standards.

The State's Evidence: For Day Activity, Career Preparation, Employment, Support Center, Community Services and Respite, a license is issued on an annual basis. Licensing inspections for all day program and respite facilities occur annually on a schedule determined by the state licensing agency, DHEC. Upon receipt of the licensing inspection report, the provider must submit a Plan of Correction to DHEC, who will then issue an acceptance letter to the POC and forward a copy of all documentation to DDSN. Exceptions may occur when the provider is cited with a Class I deficiency, which requires an immediate Plan of Correction. In the event of a Class I deficiency, DHEC alerts DDSN of the citation and the subsequent resolution. DDSN also notifies SCDHHS whenever there is a Class I deficiency; however, there have been no Class I deficiencies cited during the review period. 100% continue to meet Licensing Standards.

Upon receipt of an application for a license, the DHEC inspects the ADHC. When determined to be in compliance with the requirements, a license is issued. During SFY10, DHEC did not revoke any Adult Day Health Care licenses. All of the providers (100%) continued to meet the standards.

3. Proportion of non-licensed/non-certified providers that meet waiver requirements.

   The State's Evidence: For Behavior Support and Psychological Services, in order to become a provider, applicants must complete the DDSN Application Form (New Qualified Provider Document #2). This application requires submission of a resume and work sample relevant to the type of services for which the applicant is applying. The application is screened by DDSN for compliance with requirements and additional information is requested from the applicant when needed. Once screening is completed, an interview is conducted with experts in the field and based on the applicant's ability to meet the criteria. Based on the results, a recommendation is made to SCDHHS regarding the applicant's enrollment with Medicaid (see New Qualified Provider Document #3). Additionally, providers are reviewed periodically to determine if they continue to meet the specified criteria in the services provided to waiver recipients. This review is conducted by experts in the field using the Quality Assurance Review Form (see New Qualified Provider Document #4). These results are shared with the provider, a plan of correction is requested and a follow-up review is conducted using the same form. If corrections are not made at the time of follow-up review, it is recommended that the provider's Medicaid enrollment be ended. During SFY10, 5 of 11 applicants (45%) were qualified as providers of these services. During SFY10, 8 of 59 providers (13.5%) were removed from the list because they failed to continue to meet qualifications.

   To become a provider for Personal Care 1 or Personal Care 2 services, applications must be submitted for review and approval by SCDHHS in order to receive a contract. This process was described in the State's original CS Evidence report (see page 2, bullets #2 and 3, and Qualified Provider Documents #3, 4, 5 and 6). All applications are reviewed for completeness by the SCDHHS Provider Compliance Officer through a 100% pre-contractual review. Attached for additional evidence is a copy of an entire provider packet submitted by a personal care business seeking to obtain a Medicaid contract to provide: Personal Care 1, Personal Care 2, HASCI Attendant Care, HASCI Respite, Companion and Medicaid Nursing services. This business owner was successful and thus obtained a Medicaid contract as is noted by the email in the packet announcing his addition to the resource directory for choice of providers. Once the provider begins accepting waiver client referrals, he is entered into the SCDHHS Review schedule for compliance reviews. Those reviews are conducted by a SCDHHS Registered Nurse to ensure compliance with the waiver service scopes and contract requirements. The entire enrollment packet is labeled New Qualified Provider Document #5.

   The State does not currently have a licensure process for personal care. However, this past legislative session a licensure bill was passed. Regulations are being developed. Once licensure is in place, SCDHHS will be able to redirect much of its compliance efforts away from these items that will be included in licensure, to other enhancement activities.

4. Portion of providers that meet training requirements in the waiver.

   The State's Evidence: During SFY10, 9 providers of Day Services (Day Activity, Community Services, Career Preparation, Employment and Support Center) received citations related to staff training issues during their annual licensing inspection. The SC Department of Health and Environmental Control completed a licensing inspection for 45

providers, operating a total of 85 day program facilities. DDSN uses this data to determine the need for technical assistance or other support from the DDSN District Office. The procedures require the provider to submit a Plan of Correction for each and every citation.

During SFY10, 3 providers of Respite Services received citations related to staff training issues during their annual licensing inspection. The SC Department of Health and Environmental Control completed a licensing inspection for 11 providers, operating a total of 17 respite facilities. DDSN uses this data to determine the need for technical assistance or other support from the DDSN District Office. The procedures require the providers to submit a Plan of Correction for each and every citation.

For Psychological Services and Behavior Support Services, providers are required to submit to DDSN evidence of the completion of Continuing Education Units (CEUs) every two years. Providers not complying with the requirements are removed from the provider choice list. During SFY10, all providers were compliant with the completion of CEU; therefore the percentage of providers that met was 100%. New Qualified Provider Document #6 includes a memorandum to providers regarding CEU requirements for continued participation, the forms used for reporting CEUs, and an example of the information in the database that is maintained to track submissions.

To become a provider for Personal Care 1, Personal Care 2 or Adult Day Health Care services, applications must be submitted for review and approval by SCDHHS in order to receive a contract. This process was described in the State's original CS Evidence report (see page 2, bullets #2 and 3 and Qualified Provider Documents #3, 4, and 5). All applications are reviewed for completeness by the SCDHHS Provider Compliance Officer through a 100% pre-contractual review. One of the requirements is that potential candidates attend a mandatory pre-contractual training conducted by SCDHHS Staff. Providers who fail to attend the training are not offered a contract with SCDHHS, thus the training requirement for contracted providers is met at 100%. These pre-contractual trainings are extensive, covering many areas such as scopes of services, direct staff training requirements, expectations for business conduct and administrative requirements such as liability insurance, worker's compensation insurance, policy and procedures manual, and requirements for staff background checks, tuberculin skin test requirements, first aid certification, and service documentation. Attached for additional evidence is a copy of the power point presentation used for the April 2011 Training for potential new providers along with the sign-up sheet to document attendance for that training. These items are labeled New Qualified Provider Documents #7 and #8.

To clarify some points made in the Qualified Providers section of the June 30, 2011 Draft Report of the CS Waiver, the State provides the following additional information:

- Regarding the current Request for Proposal used by potential providers to request permission to be placed on the Qualified Provider Listing (Qualified Provider Documents #1 and #2 from the State's Original Evidence Report), each proposal is reviewed by two teams of reviewers to assure that applicants are qualified and meet the terms of the solicitation. Evaluator Reports for Team 1 and Team 2 are included to show the areas that must be evaluated by each team (see New Qualified Provider Document # 9). To qualify, the applicant's proposal must receive from

each reviewer a score no less than 2 in each category. 100% of applicants are reviewed with only those receiving the required number of points in each category being awarded a contract. Once awarded, a contract the name of the provider is added to the list of qualified providers of the specific service. During SFY10, 10 new service providers were approved out of 14 applicants (71.4%). New providers must attend a mandatory training. A training outline and an attendance roster are included as evidence (see New Qualified Provider Document # 10).

- CMS has noted there was no formal approval letter for the Plan of Correction for the Jasper and Orangeburg Day Program Licensing Reports included with the original evidence. The practice of the state licensing agency, DHEC, is to hold the individual Licensing Inspection Reports until the provider has submitted a satisfactory Plan of Correction. The Plans of Correction are due to DHEC within 15 days. An exception to this applies to Class I deficiencies, which require an immediate Plan of Correction with remediation while the licensing inspection team is on-site with the provider. In the case of the Orangeburg report, DHEC received the POC and forwarded the report to DDSN after their review of the POC, although there was no formal letter indicating this approval. Formal approval letters have since been a topic of discussion at management meetings between the two agencies and DHEC now provides formal approval letters for all POCs. As an additional measure of review, DDSN was able to verify that there have been no critical incident reports or consumer complaints related to any issues cited in the Day Program Licensing Reports for Orangeburg.

  Regarding the Jasper Plan of Correction, a formal POC approval letter was provided, noting exceptions to citation corrections for water temperature and occupancy violations. The occupancy violations are addressed below. DDSN staff conducted the 2008 licensing inspection at the JH Hill Center and allowed a variance in the standard of +/- 2.5%. As an overall system's improvement strategy and to enhance objectivity with the inspections, in August of 2009, DDSN began contracting with the state licensing agency, DHEC, to conduct all licensing inspections for all residential habilitation, day services, and respite locations. The water temperature variance that had been previously accepted was then cited at the JH Hill Center in November 2009. The management staff at the JH Hill Center has been monitoring and will continue to monitor the water temperature and testing at least monthly. In addition, an independent contractor has been consulted to make adjustments to the temperature setting. Verification of these measures is included as New Qualified Provider Document #11. As an additional measure of review, DDSN was able to verify that there have been no critical incident reports or consumer complaints related to any issues cited in the Day Program Licensing Reports for the JH Hill Center.

- CMS has noted a concern regarding the Day Program at the J. H. Hill Center, operated by the Jasper County Disabilities and Special Needs Board. In response, DDSN provides the following information:
  On 1/21/09, the annual Licensing Inspection resulted in a report of "No Deficiencies" at JH Hill Center. On 1/23/09, The Ridgeland Fire Department completed an inspection of the JH Hill Center and determined the maximum occupancy was 42. (DDSN did not receive a copy of this report.) It is of note that the Ridgeland Fire Department does not have any jurisdiction regarding day programs: rather the Day Program Licensing Standards, which are based on SC Code of Law, require an annual inspection from the State Fire Marshal, and not a local fire department. On 8/12/09, The State Fire Marshal's Office completed an annual inspection of the JH Hill

Center and did not cite any occupancy issues. There were several other citations which were corrected within appropriate time frames. (DDSN did receive a copy of this report.)

As required by the Day Program Licensing Standards, the state licensing department, DHEC, completed its next annual licensing inspection for JH Hill Center on 11/25/09 and cited the facility for exceeding licensed occupancy and State Fire Marshal occupancy. The State Fire Marshal reference was in error, as this citation was based on the Ridgeland Fire Department's report and on the JH Hill Center's attendance logs. DHEC did not conduct any actual measurements of the facility on the date of the inspection. Attendance on the date of inspection was 42 people, well within their current licensed capacity of 46 (see New Qualified Provider Document # 12). Although 50 were "enrolled", Licensing Standards and SC Code of Law require 50 square feet per person in attendance, not simply enrolled. Based on the square footage of 3193 usable space for day program activities, which excludes office space, restrooms and other areas primarily used by staff, the actual occupancy capacity could be as high as 63.

We also looked at the November 2009 attendance logs for the JH Hill Center. These reflect program "attendance" rates that varied from 42 to 47 adults on any date of service. This does not mean all consumers were on site at the JH Hill Center. On the two dates that "attendance" was over the licensed capacity, as well as other dates of service throughout the month, 25 of the adults were receiving services outside the building in "enclaves" and "mobile work crews." For reporting purposes, the JH Hill Center does not differentiate what type of day service the person is receiving. The attendance logs are used for reporting service delivery, not necessarily the location.

Note: DHEC did not communicate their concerns regarding exceeding the occupancy rates to DDSN during this time period. This communication issue between the two agencies has since been addressed through the management of both agencies. DDSN is also working with DHEC to develop an automated reporting system for Licensing Inspection Reports that will increase efficiency, improve timeliness of receiving reports, and improve data analysis functions.

To ensure that the health and safety of those attending the day program were not in jeopardy, Ann Dalton, DDSN Director of Quality Management, confirmed with Joan Cooper, DDSN Architect and Director of Planning and Design, on 3/22/10 that she had been on-site and was familiar with the building and it posed no obvious safety hazards. Ms. Cooper further stated that the building was far from its capacity level for those in attendance and confirmed that based on the square footage of 3193 for space used for day program activities, the capacity could accommodate 63 people and remain in compliance with the licensing standards and Code of Laws.

On 7/7/10, the State Fire Marshal's office completed their next required annual inspection of JH Hill Center. There were no citations related to occupancy or otherwise. In addition, on 10/21/10, DHEC completed their next annual Licensing Inspection for JH Hill Center. There were no citations related to occupancy issues.

- As a point of clarification, the State would like to address the comment raised by CMS in the draft report (page 8) regarding the Jasper/JH Hill and "poor oversight authority" by the Medicaid Agency. DHHS is aware of the confusing turn of events in this situation. The State is also

aware there were no injuries to waiver participants and no critical incidents filed related to this matter. State staff discussed this matter with DDSN and they agreed to investigate the break-down in receipt of report information from the licensing agency, DHEC, taking steps to improve the communication process.

- As a point of clarification, the State would like to address an issue raised in the CMS draft report regarding the State not conducting follow-up reviews prior to lifting suspensions (page 8). The SCDHHS Compliance Officer and Compliance Registered Nurse review providers to ensure compliance with scopes of services and contact requirements. The Registered Nurse makes on-site visits to review waiver client records. She generates a report of findings if she identifies circumstances where providers do not meet the scope or contract requirements. As outlined in the provider contracts, based on the severity and number of deficiencies as well as the results of prior compliance reviews, one (1) of five (5) sanctions may be applied. These range from requiring a new corrective action plan, to something more serious such as suspending new client referrals for various periods of time, or even contract termination. The first three (3) sanctions do not require a follow-up visit by the Registered Nurse prior to reinstatement; however, they do require approval of an acceptable corrective action plan by the Compliance Officer. The 4th sanction, 90 days suspension and approval of an acceptable corrective action plan, does require a follow-up review visit by the Registered Nurse. The 5th sanction is provider contract termination.

- For additional information, SCDHHS is in the process of adding SCDDSN to its CareCall/Phoenix electronic provider tracking and payment system. Having SCDDSN as a part of this system will greatly enhance reporting and compliance capabilities for providers. Additionally, it will offer tracking and trending options. SCDDSN is expected to be in CareCall by the summer of 2012.

## IV. Health and Welfare of Waiver Participants

*Performance Measures*

1. Number and proportion of incidents of reported ANE.

   The State's Evidence: For SFY10, 5 of 52 reports (9.6%) of ANE were for participants of this waiver.
   **See the bullets below for information about trend analysis and remediation activities.

2. Number of incidents of ANE that are reported within required timeframes.

   The State's Evidence: For SFY10, 2 of 5 incidents (40%) reported were reported within required timeframes. DDSN has consulted with each provider submitting late reports and provided training/technical assistance in order to increase compliance with this indicator. A copy of this training is submitted as New Health and Welfare Document # 1.

3. Number of incidents of ANE in which the internal review was completed within required timeframes.

The State's Evidence: For SFY10, the internal review was completed within required timeframes for 4 of 5 incidents (80%). DDSN has consulted with each provider submitting late reports and provided training/technical assistance in order to increase compliance with this indicator. A copy of this training is submitted as New Health and Welfare Document # 1.

4. Number and proportion of substantiated incidents of ANE.

   The State's Evidence: For SFY10, 0 of 5 incidents (0%) of ANE for participants of this waiver were substantiated. Based on this the State determined that no remediation was necessary.

5. Proportion of people who report they are treated with dignity.

   The State's Evidence: In accordance with DDSN Policy (see original Health and Welfare Document #10), any occurrence of a staff member using disrespectful or profane language toward a consumer is considered a Critical Incident. For SFY10, there were 10 such critical incident reports out of 1161 statewide reports. Therefore, 99.14% consumers appear to be treated with dignity. For any critical incident reported, the provider is required within 10 days to submit a management review outlining any action taken and quality assurance measures to prevent reoccurrence. These reports are included in the DDSN Incident Management system and provider profile reports.

6. Number and proportion of critical incidents reported (included mortality, injuries, and client to client altercations).

   The State's Evidence: For SFY10, 25 of 1,161 critical incidents (2.4%) were reported for participants of this waiver. The incidents included 0 deaths, 11 injuries, and 8 incidents of client-to-client altercations (see New Health and Welfare Document #2). Also, please see the clarification bullets below for information about trend analysis and remediation activities.

7. Proportion who have a primary care physician of their choice.

   The State's Evidence: Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion who have a primary care physician of their choice. 556 out of 563 (98.7%) people had a primary care physician of their choice.

8. Proportion of people who feel safe in their homes and neighborhood.

   The State's Evidence: Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion who feel safe in their homes and neighborhood. 525 out of 563 (93.3%) people feel safe in their homes and neighborhood.

9. Proportion of participants who receive the recommended preventive dental visits.

   The State's Evidence: : Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion who receive the recommended preventive dental visits . 369 out of 563 (65.5%) receive the recommended preventive dental visits.

10. Proportion of participants whom report that they know their rights.

    The State's Evidence: Health and Welfare Document #14 in the State's original Evidence Report (the Needs Assessment) captures data to determine the proportion of participants whom report that they know their rights. 342 out of 563 participants (60.7%) report that they know their rights.

    The Guidelines for Completing the SCDDSN Service Coordination Annual Assessment (see New Health and Welfare Document #3) require a response to each question/item on the assessment (*the Guidelines apply to # 7, 8, 9 and 10 in this section*). Once completed, a decision whether or not to formally address must be made for each need identified by the assessment. To formally address means that the need is included in the Support Plan and services/interventions (Day Activity, Career Preparation, Community Services or In Home Support) in response to the need are authorized. The decision is made by the participant and those chosen by the participant to assist with planning.

    In addition to the services available to formally address identified needs, DDSN offers as a service to its providers, technical assistance from an expert in the area of Quality Management who uses the tenets of the Outcomes Measures © developed by CQL. As part of the technical assistance, providers are assessed on their ability to support people to understand and exercise their rights and assisted to develop a Quality Enhancement Plan to address any shortcomings noted by the assessment in this area.

    DDSN also supports SC IMPACT which is a self-advocacy group whose purpose is to train and support others to learn about their rights and use that information to advocate for themselves.

11. Proportion of participants that report concerns by type.

    The State's Evidence: During SFY10, no concerns were reported for participants of this waiver.

To clarify some points made in the Health and Welfare section of the June 30, 2011 Draft Report of the CS Waiver and provide information about the State's process for trend analysis and remediation, the State provides the following additional information:

- Regarding the absence of findings related to Health and Welfare Documents #2 and #3 in the State's original Evidence Report, DDSN follows the procedures for reporting allegations of ANE according to the SC Code of Laws for Adult/Child Protective services and the Omnibus Adult Protection Act. DDSN has outlined specific reporting procedures in the agency's policy

directive 534-02-DD. By law all allegations of ANE to a vulnerable adult living in a DDSN operated home are reported to the State Law Enforcement Division (SLED). SLED investigates or vets to local law enforcement (LLE) to investigate the allegations. Likewise, all allegations of ANE to a child or to a vulnerable adult not living in a DDSN operated home are reported to the State Department of Social Services (DSS). DDSN receives reports of allegations simultaneous with the reports sent to/called in to SLEDS/DSS and works closely with both investigative entities. We take this a step further by requiring all providers to conduct a management review to determine if any policies, rules, or regulations were violated. When SLED, LLE or DSS finds that abuse occurred, DDSN ensures that appropriate personnel action is taken. DDSN has outlined specific reporting procedures in the agency directive 534-02-DD (Health and Welfare Document#2).

DDSN has a comprehensive system for reporting, collecting & responding to data related to ANE or other critical incidents that do not rise to the threshold of ANE. The agency employs a full-time Incident Management Coordinator who tracks reports throughout the system to ensure compliance with State Law and DDSN policy. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider's management action taken to remediate identified issues such as staff training, staff suspension/termination, updates to risk management and quality assurance procedures and policies and other measures to provide safeguards for the consumers. This data is also reviewed by the SCDDSN Director of Quality Management for trending analysis at both the provider and statewide levels along with corresponding QIO and Licensing data.

Delmarva measures compliance with the established policy and procedures. DDSN developed Administrative Key Indicators to be included with each compliance review conducted by Delmarva. The Administrative Review covers the provider agency to determine if the organization has systems in place, throughout the organization, that identify whether employees are reporting according to state law and DDSN policy and responding appropriately. Three separate indicators address ANE reporting procedures, risk management, and prevention:

> A1-12: Board / Provider follow SCDDSN procedures regarding preventing, reporting and responding to abuse / neglect / exploitation as outlined in 534-02-DD. The compliance rate for this indicator for SFY10 was 85.7%.
>
> A1-13: Board / Provider adhere to procedures regarding initial response to reports of abuse / neglect / exploitation. The compliance rate for this indicator for SFY10 was 97.1%.
>
> A1-14: The Board / Provider follow SCDDSN procedures regarding responding to abuse / neglect / exploitation. The compliance rate for this indicator for SFY10 was 100%.

In addition to the statewide compliance data indicated above (also found in the State's original Evidence Report, Plan of Care Document #16), DDSN has also provided an example of a provider-specific citation regarding ANE reporting. In the attachment, Delmarva has cited the Chester/Lancaster DSN Board for an allegation of abuse on 4/9/09 that was not reported until 4/23/09. The C/L DSNB Plan of Correction is also included to show 100% remediation. The subsequent Delmarva follow-up report includes no repeat citations for this indicator.

- Regarding original Health and Welfare Documents # 4,5,6,7, and the absence of evidence to show that the State analyzed these reports to track or identify trends or patterns and absence of evidence of remediation activities or system improvements identified as a result of State analysis, the State is submitting a detailed report indicating the date of incident, date of initial report, date the final report was due and the date the final report was received (see New Health and Welfare Document #4). This report provides assistance to agency staff in monitoring compliance with timeframes. In addition, DDSN also monitors the compliance indicators reviewed by Delmarva discussed in the previous bullet.

  DDSN continues to track, trend, and analyze all Incident Management data through comprehensive statewide and provider-level profile reports (see New Health and Welfare Document #5 and #6). These reports provide raw data with regard to the number of reports made, cases substantiated and they give a rate per 100 ratio. The rate per/100 information is especially useful in providing a comparative analysis among agencies. This data is often the topic of conversation in statewide Risk Management Meetings and Collaborative DDSN/Quality Assurance Committee Meetings. Copies of these minutes are attached as additional evidence (see New Health and Welfare New Documents #7 and #8).

- Regarding whether appropriate timeframes were met in the reporting of critical incidents, DDSN has mechanisms in place to track, trend, and analyze Critical Incidents. DDSN has the ability to run reports showing the date, time, nature, location, and review outcome, as well as reports to ensure required timeframes are met. An example of this timeline report is included in the State Response (see New Health and Welfare Document #2). In addition, DDSN also monitors the compliance indicators reviewed by Delmarva as previously discussed in the Health and Welfare section. Specifically, indicator A1-15 states that "Board / Provider follows SCDDSN procedures regarding preventing, reporting and responding to critical incidents as outlined in 100-09-DD". The compliance rate for this indicator during SFY10 was 86.1% %, although it should be noted that this rate includes all providers, including multiple Home and Community Based Waiver options and state-only funded services. The POC must address remediation at the individual level.

- As an additional effort towards system improvement, DDSN has also implemented a new, web-based reporting system on its secure provider portal. The automated reporting system went on-line for Critical Incidents July 1, 2009 and on-line for ANE and Death reports on July 1, 2010. The system provides a real-time analysis function and allows the user to pull a variety of reports to assist in tracking and trending information.

- As mentioned above, DDSN has a comprehensive system for collecting data related to ANE or other critical incidents. The agency employs a full-time Incident Management Coordinator that tracks reports throughout the system to ensure compliance with State Law and DDSN policy. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider's management action taken, staff training, risk management and quality assurance activities to provide safeguards for the consumers. This data is also reviewed by the SCDDSN Director of Quality Management, with corresponding QIO and Licensing data. As an additional measure, the Incident Management Coordinator provides on-site training and technical assistance to providers that fall significantly above or below the statewide average for

reporting and the types of incidents. This training is also available to providers upon request (see New Health and Welfare Document #1).

- CMS asked how the State would analyze the database of consumer concerns to identify any trends that might warrant systems improvement if concerns had been reported. Had concerns been reported, DDSN would have reviewed the concerns (annually) to determine if there are identifiable trends. If any trends had been identified, they would be investigated to determine the best course of action to be taken to alleviate future concerns.

## V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

*Performance Measures*

1. Presence of a MOA that includes designated functions.

   The State's Evidence: The State's current Memorandum of Agreement (A50640A) between SCDHHS and SCDDSN is effective for dates July 1, 2010 through June 30, 2015. It was issued to all parties on June 30, 2010. It designates waiver functions and responsibilities for each agency. The presence of a fully executed, current MOA is evidence that the State meets the performance measure for 100% compliance. It was included in the State's original Evidence and labeled Administrative Authority Document #1.

2. Presence of a waiver service contract that includes requirements and responsibilities for the provision of waiver services.

   The State's Evidence: The State's current CS waiver service contract (C14913M) (with amendment) was signed effective July 7, 2010, retroactive to January 1, 2010, and extends thru December 31, 2011. The contract includes requirements and responsibilities for the provision of waiver services, as well as approved service rates. This meets the performance measure for 100% compliance. It was included in the State's Original Evidence and labeled Administrative Authority Document # 17. This amendment is evidence that the State reviews this contract on an ongoing basis and makes the necessary revisions to keep it current.

3. Proportion of ICF/MR LOC validation reviews.

   The State's Evidence: As noted in the State's original Report, the State provided a report submitted by the Quality Improvement Organization (QIO), Qualis, to demonstrate the State's adherence to this performance measure (see Administrative Authority Document # 14). The QIO reviews LOC Determinations issued by the DDSN Consumer Assessment Team (CAT) for all four (4) DDSN waivers, as well as TEFRA eligibility cases, and adverse LOC cases. The QIO then issues a monthly report to SCDHHS summarizing the findings. The example submitted in the State's original Evidence Report (Administrative Authority Document #14) indicates the QIO reviewed 82 ICF/MR LOC Determinations during the month of November 2009. Of these, 23 Determinations were for CS waiver candidates. The report indicates the QIO agreed with each of the LOC Determinations made, therefore, the

State determined no remediation activities were needed since 0% of the LOC Determinations were disputed by Qualis.

With regard to the QIO Quarterly Report for October 2009 – December 2009 for ICF/MR Reviews, also submitted by the State in the original Evidence Report (see Administrative Authority Document #15), this report was produced by the QIO to summarize the monthly reviews conducted by the CAT during the previous 3 months. As noted on the document, it was not intended for public distribution; rather its intent is to serve as an internal quality management tool for staff purposes. However, QA Staff can interpret the information and synthesize the components as needed. For example, pages 4, 5 and 6 of the report, 5th column, indicate the CS waiver ICF/MR LOC Determination reviews that were conducted by the QIO during the 3 months of the summary report. It was also intended to provide specific breakdown information regarding the questions of the LOC instrument. The State uses this report to compare against the information observed in the Plan of Service Documents during CS waiver record reviews. It should be noted that 2 of the 4 LOC findings cited during the CS Record Review (State's original Evidence Report, bullet #7 and Administrative Authority Document # 13) were based on findings from the QIO summary reports compared against waiver participant record documentation. This process has been beneficial to the State in analyzing components of LOC data.

4. Proportion of quality assurance and compliance validation reviews.

The State's Evidence: SCDDSN regularly submits 100% of their final reports to SCDHHS. QA staff review 100% of these final reports. The State has developed a QIO Report Validation Tool to manage and track the receipt and review of these individual provider reviews (see New Administrative Authority Document #1). Additionally, the QIO contract will be amended to provide waiver specific information.

5. Proportion of special focus reviews utilization reviews, and/or suspected fraud investigations.

The State's Evidence: The State included the CS Waiver Record Review in the original Evidence Report (page 3, bullet #7, Administrative Authority Document #13), conducted by SCDHHS/CLTC waiver staff of statewide participants enrolled in the CS Waiver during year 1 of the program. This review focused on LOC, POS and utilization of services/financial accountability. As was stated previously, shortly after the record review was announced to SCDDSN, both SCDHHS/CLTC Waiver Quality Assurance (QA) Staff personnel assigned to coordinate QA for the DDSN waivers left SCDHHS employment on the same day. One of these positions has been refilled and the other position is pending. We are aware that the number of records included in the CS Waiver Record Review was approximately half of those needed to complete the required confidence level for waiver year one. It was the intent of the State to follow-up with an additional state-wide review to complete the confidence requirement. At this time, we are completing an intensive training for the recently hired QA staff person assigned to coordinate SCDDSN waiver issues, and we will initiate an additional CS Waiver Record Review by October of this year. Further, we are in the process of completing the current outstanding CS Waiver Record Review and should have this resolved by October as well. Once finalized, a decision will be made regarding a referral to SCDHHS Program Integrity for recoupment of FFP. At that time, the State will determine if policy

changes or remediation activities are needed. For additional documentation, see the DDSN response to the CS Waiver Record Review, labeled New Administrative Authority Document #2.

Regarding SCDHHS Program Integrity, this unit works cooperatively with waiver staff to investigate complaints, allegations or accept referrals regarding case reviews. They also respond to information from various sources regarding inappropriate billings by Medicaid providers. They collect and analyze data, audit payments to providers and based on record reviews or other audits, recoup payments when provider records do not support the amounts billed for services.

CLTC and Program Integrity also have a relationship with the Medicaid Fraud Control Unit at the South Carolina Attorney General's Office to investigate suspected fraud or initiate criminal investigations.

6. Aggregated discovery and remediation reports submitted by the operating agency, relating to each of the performance measures, for all CMS assurances are reviewed and addressed if applicable.

   The State's Evidence: Information is contained within the QIO reports received to SCDHHS from the operating agency. The State reviews these reports to assure any outstanding irregularities are resolved and follows-up as necessary by requesting corrective action and remediation activities. Waiver specific reports and aggregated reports will be developed during 2012.

7. Meetings are held to discuss specific waiver issues (i.e., review of aggregated reports).

   The State's Evidence: Per the requirements of the MOA, waiver and QA staff from SCDHHS and SCDDSN meet periodically through-out the year to discuss waiver issues. Additionally, frequent, sometimes daily contact is made by phone and email to discuss and resolve concerns. Attached for additional evidence is a copy of the meeting schedule issued by the State for the 2011 meetings. It is labeled New Administrative Authority Document #3.

8. Policy changes are discussed with and/or communicated to the operating agency in a timely manner.

   The State's Evidence: The State frequently issues information and policy changes in the form of Medicaid Bulletins. During CS waiver year one, one such example was the Medicaid Bulletin included in the State's Original Evidence Report (Administrative Authority, page 2, bullet #2). CMS may recall the State submitted amendments to 7 of South Carolina's HCB waivers during the summer of 2010. While awaiting CMS approval, the State issued a Medicaid Bulletin announcing the State's intention regarding Incontinence Supplies. One other note, in the State's original Evidence Report (Administrative Authority, page 2, Document #5) the meeting minutes document the State's instructions to SCDDSN regarding advance preparation for policy manual changes and staff training (see original

Administrative Authority Document #6). We believe this demonstrates 100% compliance with the performance measure.

To clarify some points made in the Administrative Authority section of the June 30, 2011 Draft Report of the CS Waiver, the State provides the following additional information:

- CMS raised issues regarding Administrative Authority Document #12 in the original Evidence Report. The purpose of an appeal log is for the State to quickly and easily determine the number and nature of program appeals. The "outcome" is already identified for 14 of the 15 reconsiderations/appeals that had been submitted at the time of data collection for the original report. These matters were resolved at the DDSN level and did not proceed to DHHS appeal. The State believes this log is an efficient method for tracking any outstanding reconsideration/appeal cases or reviewing the results of current and historical resolved cases. Further, the State is aware that waiver participants/families and attorneys will request reconsideration and/or appeal for almost any issue. Therefore, the State is unsure what value to place on remediation, and to whom the remediation would be offered. However, we can offer the following: in April 2011, the State developed a draft version of a "Hearing Outline Template" and "Hearing Preparation Guidelines" and instructed DDSN staff to use these documents for the next 4-6 months in a test phase. After that time, SCDHHS agreed to take comments for improving the Template document after testing it in actual appeals. Currently, it is scheduled to become a permanent document when it is released by SCDHHS effective October 1, 2011. (See New Administrative Authority Documents #4 and #5). The State hopes these documents will ensure a more consistent process for hearings/appeals across the DDSN waivers, provoking more thorough preparation in advance by DDSN staff.

## VI. State Provides Financial Accountability for the Waiver

*Performance Measure*

1. Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver.

   The State's Evidence: The State's original Evidence Report for Financial Accountability (page 1, bullet #1, and Financial Accountability Document #4) described how the State controls entrance into MMIS by use of "recipient special program" (RSP) codes. These RSP codes further control access to waiver specific procedure codes, which won't pay unless the waiver participant eligibility file contains an appropriate RSP for the dates in question. The RSP entry into participant MMIS files is controlled 100% by the State Medicaid Agency.

   Also noted in the State's original Evidence Report for Financial Accountability (page 2, bullet #5), is information which describes the waiver service authorization process. Service Coordinators authorize waiver services based on need as described in the POS document. Authorizations are forwarded to providers who use the waiver authorization #'s when filing claims for payment in MMIS. SCDDSN uses their QIO, the Delmarva Foundation, to monitor compliance with the authorization indicator during reviews. Indicator G11-14

specifies: "Authorization forms are completed for services as required, prior to service provision." The compliance rate for this indicator for CS waiver year one was 91.4%.

Page 2, bullet #3 of the State's original Evidence Report for Financial Accountability, details the CS Waiver Record Review which has already been referenced in this response. Specific to financial accountability, the State pulled paid claims out of MMIS in accordance with the dates of service for each client in the CS record review. The State looked at multiple items in paid claims and compared them against record documentation, including but not limited to: appropriateness of services billed for payment against services listed in the POS; service rates paid versus service rates approved in the service contract to ensure accuracy of the MMIS system; waiver services incorrectly billed during inpatient hospitalizations; services billed consistent with service authorizations and waiver services billed for noted "absences" at day programs. Included for additional evidence is an example of MMIS Paid Claims from the CS Waiver Record Review for a client identified with findings in the Financial Accountability section of the CS Waiver Record Review. It is labeled New Financial Accountability Document #1. As previously stated, once the CS Waiver Record Review is finalized, a decision will be made regarding a referral to SCDHHS Program Integrity for recoupment of FFP. At that time, the State will determine if policy changes or remediation activities are needed.

The SCDHHS Program Integrity unit works cooperatively with CLTC waiver staff to investigate complaints, allegations or accept referrals regarding case reviews. They also respond to information from various sources regarding inappropriate billings by Medicaid providers. They collect and analyze data, audit payments to providers and based on record reviews or other audits, recoup payments when provider records do not support the amounts billed for services.

Once SCDDSN is added to the SCDHHS's Phoenix/Care Call system, this will provide greater financial accountability for this performance measure. Authorizations will be automated and it will offer enhanced tracking and trending capabilities for service expenditures. SCDDSN is expected to participate in the CareCall Monitoring system by the summer of 2012.

To clarify some points made in the Financial Accountability section of the June 30, 2011 Draft Report of the CS Waiver, the State provides the following information:

- CMS raised the issue that recoupment may be necessary to return FFP based on Delmarva reviews. The State addressed this issue in the original Evidence Report (see original Evidence Report, page 3, bullet 9, Financial Accountability Document #13). For the Chester/Lancaster Delmarva Review submitted, there was no necessary recoupment identified for a CS waiver client. However, there was a necessary recoupment identified for a MR/RD waiver participant within the Chester/Lancaster Delmarva Review so the State submitted that example to demonstrate the process utilized when necessary recoupments are over one (1) year old and unable to use the State's void/replace MMIS system (see original Financial Accountability Document #14).

In addition, the State continues to regularly monitor the void/replace adjustment section of MMIS following Delmarva reviews. To formalize this process we will use the QIO Report Validation Tool for this purpose and will add recoupment tracking data for all necessary Delmarva recoupments to this form. (see New Financial Accountability Document #2).

The State appreciates the opportunity to respond to this CMS Draft Report for the CS Waiver. We are hopeful our many additions of evidence included in this report as well as points of clarification will resolve any outstanding issues. We are grateful for your assistance and any suggestions or recommendations that were included. We will certainly take them under advisement as the State moves toward renewal for the CS waiver. Please contact Kara Lewis, of my staff, at 803-898-2710, with any questions regarding this response.

As we have discussed, I will be glad to provide feedback to CMS on this importance process. I appreciate the opportunity to strengthen the future communication and expectations between CMS and the State.

Sincerely,

Sam Waldrep
Deputy Director

SW/mlh
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Giese | 7-11-11 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 000021 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR _____ | [X] Prepare reply for appropriate signature<br>DATE DUE 7-20-11 |
| | [ ] FOIA<br>DATE DUE _____ |
| | [ ] Necessary Action |

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

Cuspids inc.

3796 Ashley Phosphate Rd.
North Charleston, SC 29418
Phone: (843) 767-3300
Visit us at www.cuspidsinc.com

July 6, 2011



Ms. Melanie "BA" Giese, RN
Deputy Director
SC Department of Health and Human Services
P.O. Box 8206
Cola., SC 29202

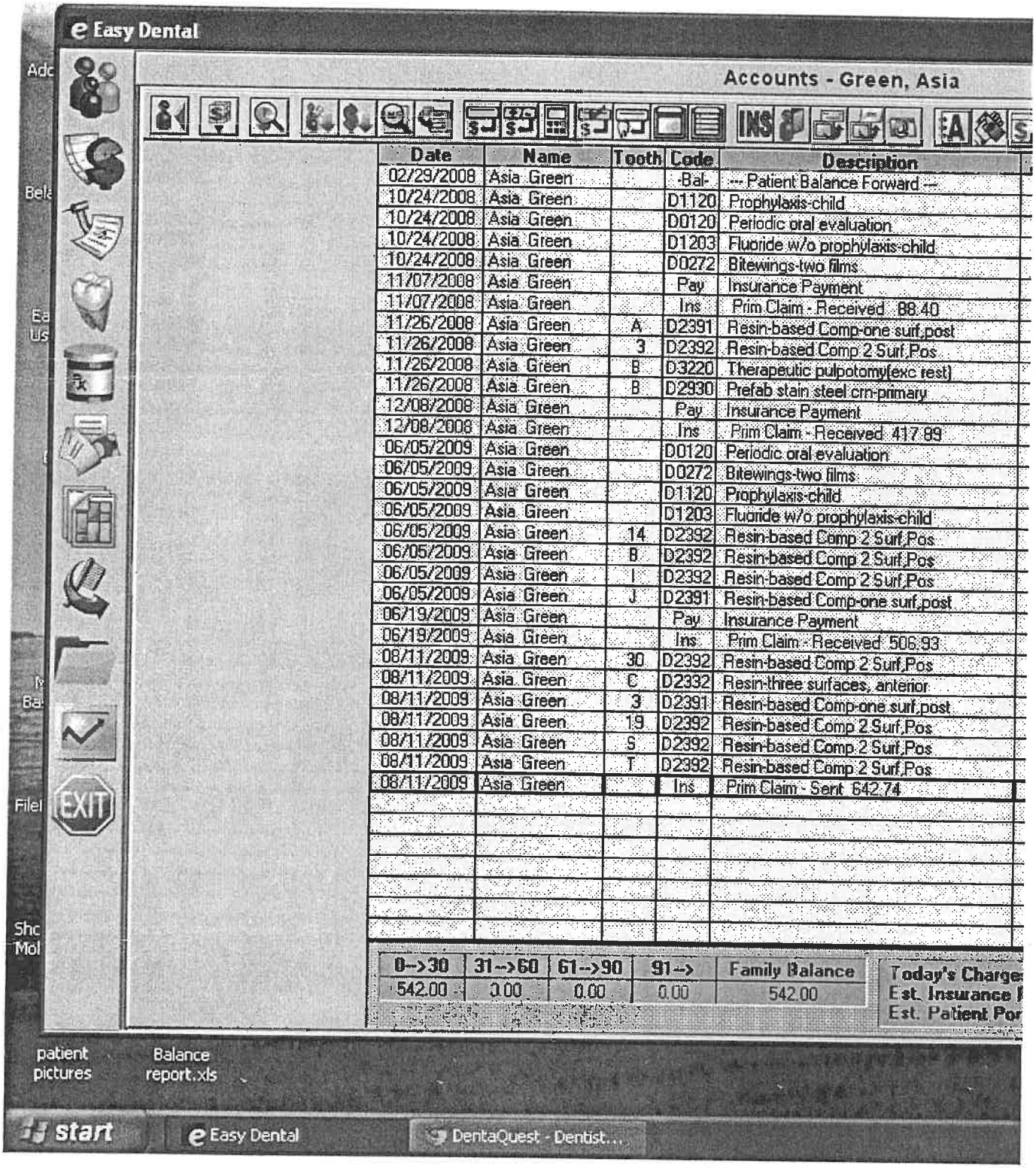
Dear Ms. Giese:

Regarding **Asia Green**, MID#710352820 DOS 08/01/2009, the original claim was created, 08/11/2009, filed, 08/11/2009, traced 02/15/2010 and finally resent again on 10/25/2010. The dates are embedded in the electronic claim which we create prior to printing or entering a claim via the web tool. See attachments (1 & 2)

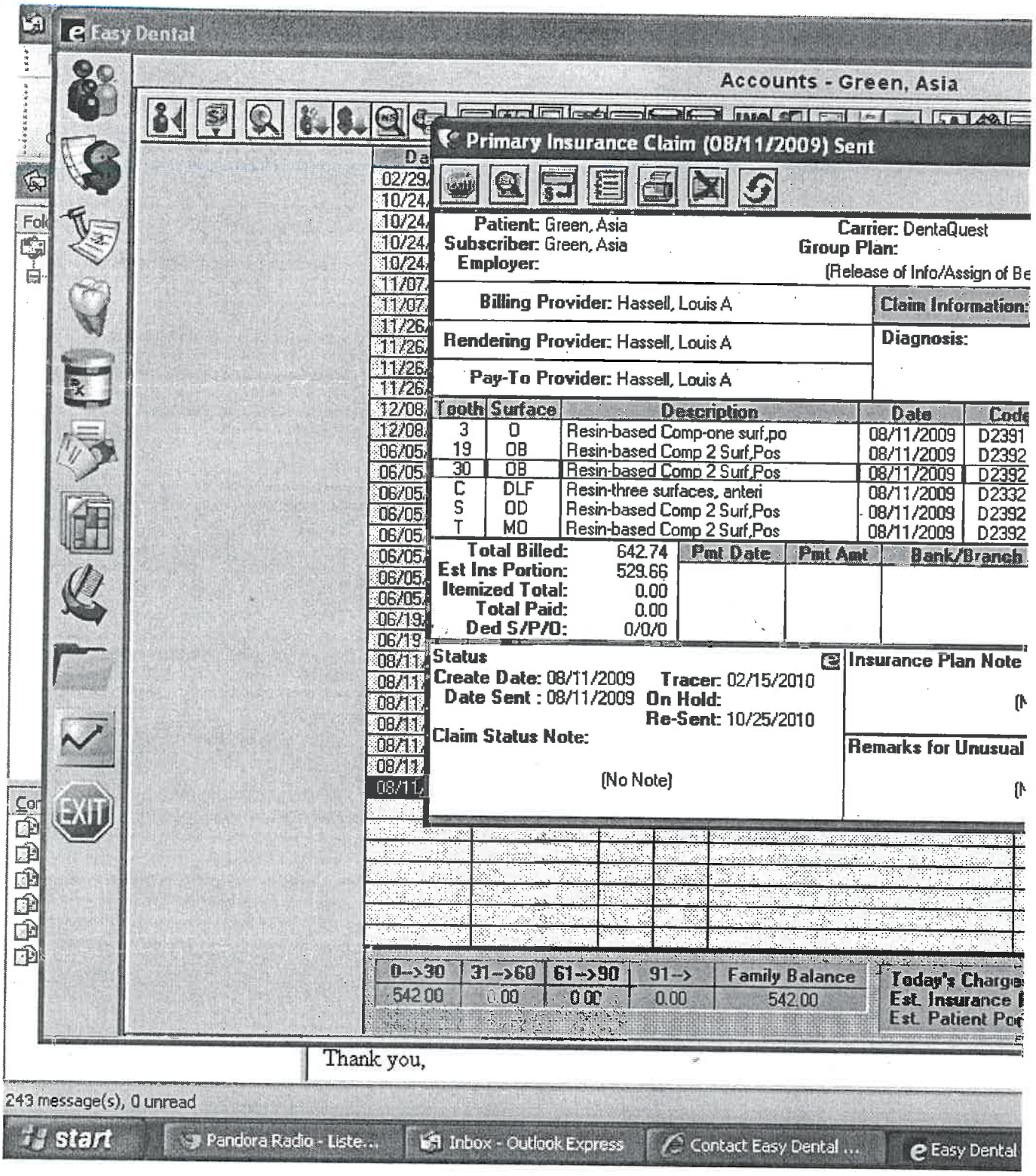
Thank you for your time and consideration of this matter.

V/R,

Marsha L. Hassell,
VP, Cuspids, Inc.




Attachment (1)




attachment (2)

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

Judy David

| TO | DATE |
|---|---|
| Giese/Vaughn | 7-11-11 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 000021 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR _____<br>This is an individual Survey unrelated to [illegible] No further Action Needed. J.S.B. | [X] Prepare reply for appropriate signature<br>DATE DUE 7-20-11 |
| | [ ] FOIA<br>DATE DUE _____ |
| | [ ] Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
|---|---|---|---|
| 1. [signature] | 8/23 | | |
| 2. [signature] | 8/23 cs | | |
| 3. | | | |
| 4. | | | |

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July 6, 2011



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Deputy Director
SC Department of Health and Human Services
P.O. Box 8206
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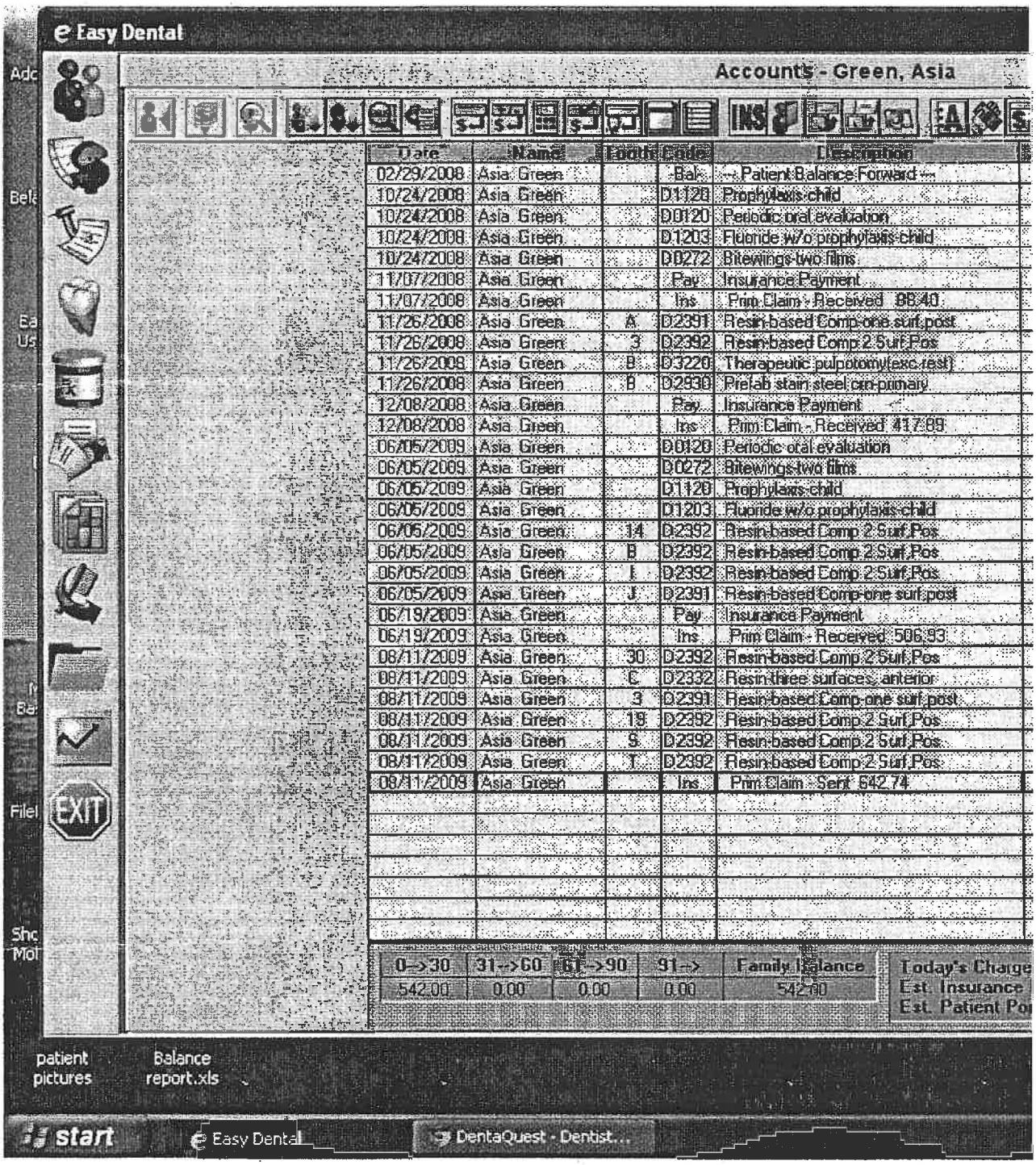
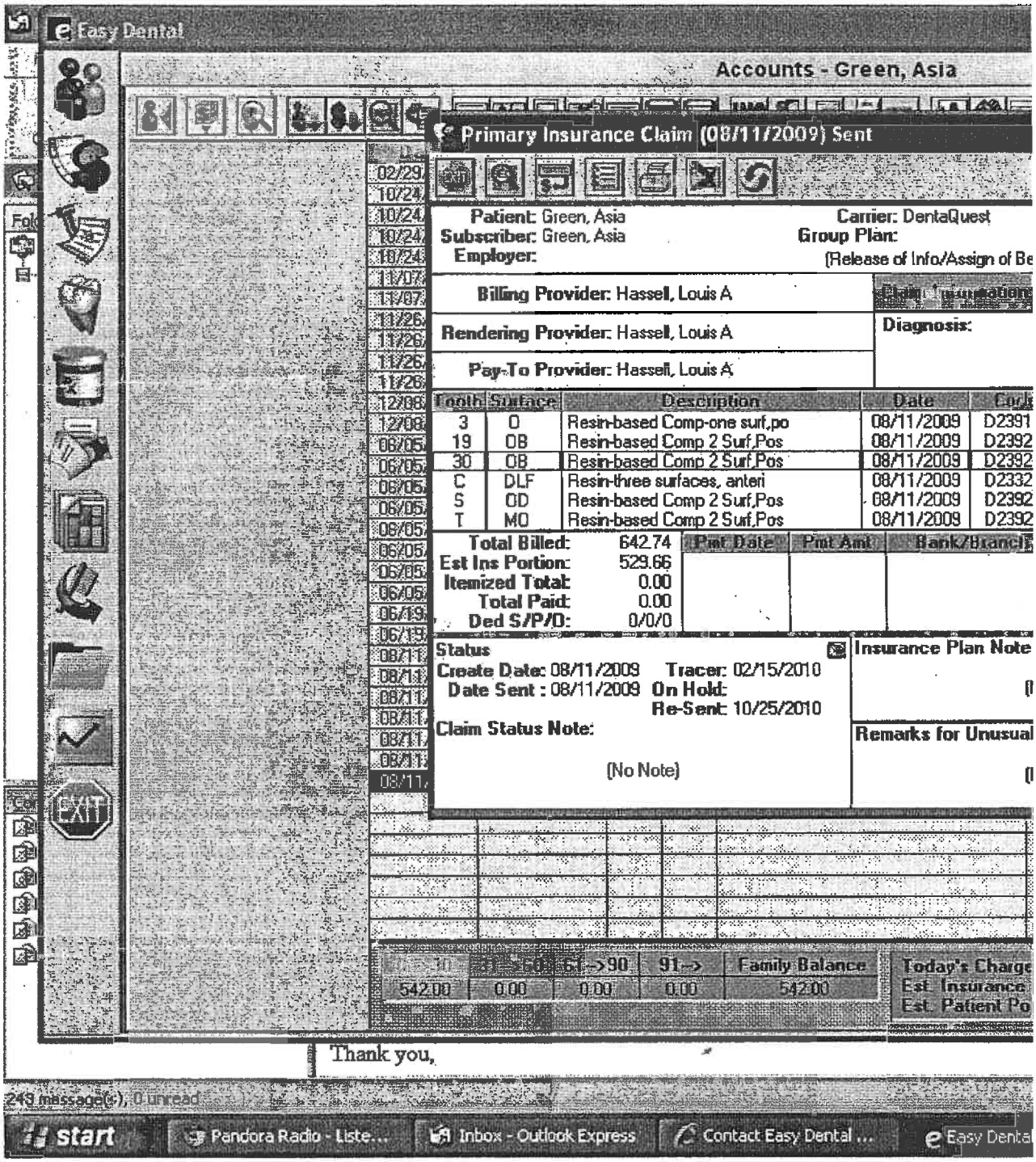
Marsha L. Hassell,
VP, Cuspids, Inc.




Attachment (1)




attachment (2)

DOS 441

South Carolina Department of Health & Human Services

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

May 24, 2011

Ms. Marsha L. Hassell, Vice President
Cuspids, Inc.
3796 Ashley Phosphate Road
North Charleston, South Carolina 29418

Dear Ms. Hassell:

Thank you for your letter dated May 6, 2011 regarding the appeal request for denial of claims by DentaQuest. The basis for your appeal was a to request payment because of a computer crash that resulted in the loss and recovery of claims for three Medicaid recipients. I've had staff to review the information submitted. Research of the claims in question produced the following results:

**Patricia Petteway**, MID#8187211904, DOS 10/22/2009, Procedure code, D0220. This claim paid $ 13.65 to NPI #1275708828 on check date 12/11/2009. A copy of the Remittance Advice is attached.

**Breseis Blanks**, MID#5780538958, DOS 7/23/2009, Procedure codes D0150, D1120 and D1203. Claim paid $85.79 NPI# 1275708828 on check date 11/06/2009. A copy of the Remittance Advice is also attached.

**Asia Green**, MID#710352820, DOS 8/11/2009, Procedure codes: D2391, tooth #3 and D2392, tooth #s 19, 30, C, S and T. This claim was never received by SCDHHS for processing. The appeal to DentaQuest was dated October 26, 2010 which was past the 1 year timely filing guidelines for Medicaid claims submission. We regret that we are unable to process this claim for reimbursement.

We appreciate your continued support of the South Carolina Medicaid program. If you have any further questions regarding this denial, please contact Ms. Shirley W. Carrington in the Division of Dental Services at (803)898-2563.

Sincerely,

Melanie "BZ" Giese, RN
Deputy Director

MG/vcb

Attachments

Medical and Managed Care Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-0178 Fax (803) 255-8235

Dog 538

South Carolina Department of Health & Human Services

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

June 30, 2011

CONFIDENTIAL

Ms. Marsha L. Hassell, Vice President
Cuspids, Incorporated
3796 Ashley Phosphate Road
North Charleston, South Carolina 29418

Dear Ms. Hassell:

Thank you for your letter dated June 2, 2011, asking for additional information to support denial of your request for payment of claims for Asia Green. In my response letter dated May 24, 2011, I wrote:

***Asia Green, MID#710352820, DOS 8/11/2009, Procedure codes: D2391, tooth #3 and D2392, tooth #s 19, 30, C, S and T. This claim was never received by SCDHHS for processing. The appeal to DentaQuest was dated October 26, 2010 which was past the one year timely filing guidelines for Medicaid claims submission. We regret that we are unable to process this claim for reimbursement.***

We took into consideration the loss of your data. We also considered the timeline between the recovery of the data by G&E Enterprises, Incorporated and your request for an appeal. Based on the invoice submitted with your original letter, the recovery disk was installed on 8/1/2009. The appeal to DentaQuest was not made until October 26, 2010. This was past the one year timely filing guidelines. Additionally, claims for Patricia Petteway and Breseis Blanks were also included in the data that was lost yet both of these claims were submitted, processed and paid within the one year timely filing policy. As a result, the request to pay the claim for Ms. Green was denied.

If you are still dissatisfied with the decision, please review the Dental Services Policy Manual located on our website at http://www.scdhhs.gov for your rights as a provider to request an appeal. If you have any further questions regarding the appeal process, please contact Shirley W. Carrington in the Division of Dental Services at (803) 898-2563. We appreciate your continued support of the South Carolina Medicaid program.

Sincerely,

BZ Giese

Melanie "BZ" Giese, RN
Deputy Director

MG/vc

Medical and Managed Care Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-0178 Fax (803) 255-8232

South Carolina Department of
Health & Human Services

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

August 24, 2011

Ms. Marsha L. Hassell, Vice President
Cuspids, Inc.
3796 Ashley Phosphate Road
North Charleston, South Carolina 29418

Dear Ms. Hassell:

We have reviewed the additional information to support reconsideration of the denial for patient Asia Green. My letter dated May 24, 2011 provided an explanation for denying payment for this claim. We received a second letter from you dated June 2, 2011, asking for further explanation of the denial. On June 30, 2011, I provided complete details for how the decision to deny payment was determined. The information you now provide does not alter the outcome of that decision. The only option available to you is through our Appeals and Hearing Division. Please review the Dental Services Policy Manual located on our website at http://www.scdhhs.gov for your rights as a provider to request an appeal.

If you have any further questions regarding the appeal process, please contact Shirley W. Carrington in the Division of Dental Services at (803) 898-2563. We appreciate your continued support of the South Carolina Medicaid program.

Sincerely,

Melanie "Bz" Giese, RN
Deputy Director

MG/vw

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