DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Waldrop	10-6-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-156	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Peck, Depp, CMS file Response attached.	[X] Prepare reply for appropriate signature DATE DUE 2/1/12 [ ] FOIA DATE DUE _____ [ ] Necessary Action

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

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

September 28, 2011

RECEIVED
OCT 06 2011
Department of Health & Human Services
OFFICE OF THE DIRECTOR

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

Dear Mr. Keck:

Enclosed is the final 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/MR). Thank you for your assistance throughout this process.

The draft report, issued June 30, 2011 found the State to be out of compliance with all assurances. On August 19, 2011, you submitted a substantial amount of additional information that further clarified your original submission that addressed issues CMS cited in the draft report. After reviewing the additional information submitted, we now find the State is in compliance with all six of the review components. However, we have identified recommendations for program improvements in five of the assurance areas.

Finally, we would like to remind you to submit a renewal package on this waiver to CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver 06/30/12. Your waiver renewal should address any issues identified in the final report as necessary for renewal and should incorporate the State's commitments in response to the report. Please note the State must provide CMS with 90 days to review the submitted application. If we do not receive your renewal request ninety days prior to the waiver expiration date we will contact you to discuss termination plans. Should the State choose to abbreviate the 90 day timeline, 42 CFR 441.307 and 42 CFR 431.210 require the State to notify recipients of service thirty days before expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter sixty days prior to the expiration of the waiver.

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

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

FINAL REPORT

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

September 28, 2011

Home and Community-Based Services
Waiver Review Report

Executive Summary:

The South Carolina Department of Community Health and Human Services (SCDHHS) 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 1,987 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. **The State conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State substantially meets this assurance.**

   Suggested Recommendations

   CMS has no recommendations at this time.

2. **Service Plans are Responsive to Waiver Participant Needs – The State demonstrates this assurance but CMS recommends improvements or request additional information.**

   Suggested Recommendations

   CMS suggests that SCDHHS utilize independent look-behind reviews to verify that reports submitted by contracted entities and the operating agency are reliable and accurate. In addition, the State should develop performance measures that capture statistical data reflective of the independent reviews.

3. **Qualified Providers Serve Waiver Participants – The State demonstrates the assurance but CMS recommend improvements or request additional information.**

   Suggested Recommendations

   CMS suggests that the Medicaid Agency, DDSN and DHEC work together to facilitate the automation of licensure and inspection reporting as well as improve upon existing, or implement new methods of communication between all three State agencies.

4. **Health and Welfare – The State demonstrates this assurance but CMS recommends improvement or requests additional information.**

Suggested Recommendations

CMS recommends that in addition to tracking incidents of ANE, the State should also develop performance measures that will collect evidence to provide data on health and welfare as it relates to the home environment and safety, that needs of the participants are being addressed and met, and that any emergency plans are effective when put into action.

5. **State Medicaid Agency Retains Administrative Authority Over the Waiver Program – The State demonstrates the assurance but CMS recommends improvements or requests additional information.**

Suggested Recommendations

CMS suggests that the Medicaid Agency validate the accuracy and reliability of reports submitted by DDSN, Delmarva and Qualis by conducting independent look-behind reviews. We suggest that the State develop performance measures with metrics so that statistical data can be utilized to indicate that the Medicaid Agency maintain ultimate administrative authority.

6. **State Provides Financial Accountability for the Waiver – The State demonstrates the assurance but CMS recommends improvements or requests additional information.**

Suggested Recommendations

CMS suggest that the State develop additional performance measures to demonstrate that financial oversight exists. In addition, CMS agrees with and highly encourages the State to proceed with adding DDSN to the Phoenix/Care Call System.

In addition, the application for renewal will require a description of the methodology used for determining statistically valid sample size for monitoring processes.

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:	1,987
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 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 substantially meets this assurance.

Evidence Supporting This Conclusion:
(Evidence is included that supports the finding that the State substantially meets this assurance.)

The evidence submitted by the State indicates they have a determination process in place that assures waiver applicants meet the ICF/MR level of care (LOC) requirement. The responsibility for LOC determination has been delegated to the operating agency which uses a Consumer Assessment Team (CAT) consisting of clinical licensed psychologists. By the tenth of each month, the CAT submits a list of initial LOC determinations completed during the previous month to the SCDHHS 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 SCDHHS uses a Quality Improvement contractor (Qualis) to review all adverse ICF/MR LOC decisions to assure the decisions are appropriate and submitted in the correct format using waiver approved documents.

Suggested Recommendations:
(Although the State substantially meets this assurance, CMS may recommend improvements, through the improvements are suggestions and not requirements for renewal.)

In response to the draft report, the State submitted additional evidence that further explained the process of Level of Care determinations, as well as additional statistical data to substantiate compliance with this assurance.

The Medicaid Agency reports that the operating agency (DDSN) utilizes a Quality Improvement Contractor (Delmarva) to determine if LOC determinations are completed within 30 days prior to enrollment in the waiver; that re-evaluations are completed within 364 days of the previous LOC determination; that LOC determinations are conducted using the appropriate criteria and waiver approved instruments; and, that LOC outcomes are appropriately determined. However, it remains unclear what look-behind reviews, if any, are conducted by DDSN or SCDHHS to determine if Delmarva's reports are accurate. We encourage the State to analyze data submitted by the Quality Improvement Contractor to identify trends and develop systems for improvement. CMS recommends the State Medicaid Agency conduct an independent review of the operating agency to determine if they maintain adequate oversight of Delmarva.

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 demonstrates the assurance but CMS recommends improvements or requests additional information.

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 original evidence submitted by the State was primarily composed of processes and copies of pages from the Memorandum of Agreement (MOA) between the SCDHHS and DDSN. The description of the processes indicated service plans were developed as outlined in the approved waiver. The State submitted a copy of the MOA page that indicates SCDHHS 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. The August 19, 2011 response to the draft report further explained original evidence and addressed most of CMS' concerns.

The operating agency utilizes the Quality Contractor Delmarva to review compliance with the Service Plan assurance. Indicators used by Delmarva appear to monitor 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.

For the indicator that measures the proportion of participants whose plans include services and supports that are consistent with needs and personal goals identified in the comprehensive assessment, the compliance rate reported by Delmarva in 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 required corrections have been made. However, the State did not clearly specify the timeline for plans of corrections, to whom they are submitted and how long providers are given to make necessary corrections.

The State reports a compliance rate of 85% for the Delmarva indicator that measures the proportion of participants whose plans were updated as needed. To remediate, the provider was required to submit a plan of correction with a follow-up review to determine if corrections were made. The State also reported that following discussions with the operating agency, it is believed that this high error rate was related to waiver start-up rather than an on-going concern and therefore, no remediation was required. However, the State did not indicate if additional measures were put into place to determine if their assessment was accurate, or whether the high error rate continues to exist. CMS remains concerned that there is a potential for participant needs being unmet if service plans are not adequately updated when warranted by changes in the participant's health or other situations.

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 suggest that SCDHHS conduct their own reviews to substantiate the reports submitted by contracted entities and the operating agency is both reliable and accurate. In addition, the State should develop performance measures that capture statistical data reflective of their independent reviews.

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 demonstrates the assurance but CMS recommends improvements or requests additional information.

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

The State currently uses four performance measures identified in the approved waiver to measure compliance with the Qualified Provider assurance. However, the majority of the original evidence submitted was policy and copies of reviews by DSSN.

In the State's additional evidence submitted in response to the draft report, the State thoroughly outlined provider qualifications and explained where additional information could be found on their web-site. The State further explained that each provider proposal is evaluated by two teams of reviewers to assure that applicants are qualified and meet the terms of the solicitation. To qualify, the applicant's proposal must receive a score of no less than two in each category by each reviewer. In SFY 10, 10 new service providers were approved out of 14 applicant's (71.4%). The CMS accepts the State's explanation that, due to the process of enrollment, only licensed, qualified providers can be enrolled as waiver providers.

For Day Activity, Career Preparation, Employment, Support Center, Community Services and Respite facilities, a license is issued only after an application is submitted to DDSN. A completed application must include pre-licensing inspections (State Fire Marshall, Heating and Air, and an 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 an on-site inspection is conducted and determined no deficiencies exist.

In the draft report, CMS noted that there was no evidence present to indicate who approved plans of corrections when deficiencies were found. The State explained in its response that 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, which are due within 15 days. The only exception would be a Class I deficiency which would require an immediate plan of correction with remediation while the licensing inspection team is on site with the provider. The State further indicated that formal approval letters for plans of correction have been a topic

at management meetings between the two agencies for some time and DHEC now provides formal letters of approval for all plans of corrections.

In response to the draft report, the State provided a detailed explanation of the day program at the JH Hill Center, operated by the Jasper County Disabilities and Special Needs Board. It is noted that DHEC did not communicate their concerns regarding the center exceeding the occupancy rates to DDSN. This lack of communication 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 timelines of receiving reports, and improve data analysis functions.

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.)

CMS suggests that the State Medicaid Agency, DDSN and DHEC work together to facilitate the automation of licensure and inspection reporting as well as improve upon existing, or implement new methods of communication between all three State agencies.

The State may wish to consider DDSN develop a Memorandum of Understanding (MOU) with DHEC with clear deliverables to help further monitor provider licensing and inspection issues. Additional performance measures could be utilized to help monitor this process.

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 demonstrates the assurance but CMS recommends improvements or requests additional information.

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

Original evidence from the State indicated eleven (11) performance measures are utilized to assess the health and welfare assurance. The August 19, 2011 submission of additional evidence by the State clarified and explained reports submitted in the original evidence package. The State reports that in SFY10, 5 of 52 reports of abuse, neglect or exploitation (9.6%) were for participants of this waiver. Two of the five incidents (40%) were reported within the required timelines. Four of the five incidents (80%) had internal reviews completed within the required timeframes. To remediate, DDSN consulted with the provider submitting late reports and provided training and technical assistance. However, there is no mention to determine if the remedial training has been effective.

Additional evidence also explained that DDSN has outlined specific abuse, neglect or exploitation (ANE) 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 to investigate all allegations. All allegations of ANE to a child or 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 the SLEDS and DSS and works closely with both investigative entities. DSSN also requires that all providers conduct a management review to determine if any policies, rules or regulations were violated. When SLED, DSS or local law enforcement determines that abuse has occurred, DDSN ensures appropriate personnel action occurred if required (i.e.; additional training, official reprimands, suspension, termination, etc.).

DDSN also has a comprehensive system for reporting, collecting and 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 involves 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 DDSN Director of Quality Management for trending analysis at both the provider and statewide levels along with data from the Quality Improvement Organization and Licensing Agency. This data is often the topic of conversation in statewide Risk Management meetings and collaborative DDSN/Quality Assurance Committee meetings.

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.)

CMS recommends that in addition to tracking incidents of ANE, the State should collect evidence of health and welfare as it relates to the home environment and safety, that needs of the participant are being addressed and met, and that any emergency plans are effective when put into action.

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 demonstrates the assurance but CMS recommends improvements or requests additional information.

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

Several performance measures currently in the State's approved waiver unfortunately are not measurable and therefore not able to substantiate that the Medicaid Agency maintains full administrative authority for this waiver program. Original evidence submitted included a copy of the Memorandum of Agreement (MOA), which identifies specific functions of the operating agency (DDSN) and the Medicaid agency.

The State's response to the draft report indicates that DDSN regularly submits 100% of all final quality assurance and compliance validation reviews to SCDHHS. They further report that SCDHHS QA staff review 100% of these final reports to assure any outstanding irregularities are resolved and follows-up as necessary by requesting corrective action and remediation activities. A Delmarva report validation tool manages and tracks the receipt and review of individual provider reviews.

The State also additionally reported that waiver and QA staff from both SCDHHS and DDSN meets periodically during the year to discuss waiver specific issues. Additionally, frequent contact is made via phone or email to discuss and resolve concerns.

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.)

CMS recommends the Medicaid Agency confirm the accuracy and validity of reports submitted by DDSN, Delmarva and Qualis by conducting look behind reviews. The submitted evidence tends to suggest that SCDHHS relies heavily on the operating agency and contracted entities to provide oversight for this program.

With the renewal application for this waiver, CMS suggests that the State develop performance measures with metrics so that statistical data can be utilized to indicate the Medicaid Agency retains ultimate administrative authority over this waiver. Additional performance measures could 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 demonstrates the assurance but CMS recommends improvements or requests additional information.

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

The State's original evidence included 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. The RSP entry into participant MMIS files is controlled 100% by the Medicaid Agency. Each month SCDHHS 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.

Additional information submitted in response to the draft report further clarified that service coordinators authorize services based on needs as described in service plan. Authorizations are forwarded to providers who must use the waiver authorization numbers when filing claims for payment in MMIS. DDSN also utilizes Delmarva to monitor compliance with the authorization indicators during reviews.

The State pulled paid claims from MMIS in accordance with dates of service for each client in the record review. The State looked at multiple items and compared them against record documentation including appropriateness of service billed against services listed on the service plan; service rates paid versus service rates approved; waiver services incorrectly billed during inpatient hospitalizations; services billed consistent with services authorizations and services billed for noted absences at day programs.

The State also provided further evidence that indicates the Community Long Term Care staff works collaboratively with the Program Integrity Unit to investigate complaints, allegations or accept referrals regarding case reviews. They collect and analyze data, audit payments to providers based on record reviews or other audits, recoup payments when provider records do not support the amounts billed for services.

SCDHHS reported that the operating agency will be added to the Phoenix/Care Call System. Authorizations will be automated and it will offer enhanced tracking and trending capabilities for service expenditures and will provide greater financial accountability. This is expected to be in place by the summer of 2012.

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.)

CMS is in agreement that adding DDSN to SCDHHS's Phoenix/Care Call System will provide greater financial accountability for this assurance.

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 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.

Brenda James - Fwd: Reg Log 156

From: Teeshla Curtis
To: Brenda James
Date: 02/28/2012 12:00 PM
Subject: Fwd: Reg Log 156
Attachments: Ref Log 000156 2.1.11.PDF

Explanation of Log 156. I told Sam that the Director may ask him about this in his one-on-one time. Please let me know if you need more information.

Thanks,
Teeshla

>>> George Maky 2/27/2012 8:11 PM >>>
as I understand it there should be no response due for this letter. it indicates the cs evidentiary report is accepted and cms is indicating the cs 5 year renewal request should include what the state indicated it would do in the RAI.

Kara has been working on the cs renewal document and has just rec'd the ddsn 5 year fiscal projections. we presume their delay in submitting it to us was due to the adding case mgt as a waiver service and unsure what rate to use. as we have in the past, we again found questionable assumptions in the ddsn proposal.

Kara's target submission date has been 2/29, but that appears to be backing up related to the TCM rate issue, which may not be ready until 3/15. the drop dead submission date for cms is 3/29.

>>> Teeshla Curtis 2/27/2012 5:35 PM >>>
George,

I need an update on the status of Log 156. I know we put this off for a while because it relates to the Community Supports Waiver renewal. Now the Director wants an update. See the attached.

Thanks,
Teeshla