DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett/Chavis	5-13-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000379	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Mr. Keck, Kost, Deps, CMS file Per Annie, change to N/A on 5/16/14	Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

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

If you have any questions, please contact Kenni Howard and 404-562-7413 or kenni.howard@cms.hhs.gov. We would again like to extend our sincere appreciation to the South Carolina Community Long Term Care Division, who provided information for this review.

Sincerely,

Irina Roberts for

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

Enclosure

PC: Michele MacKenzie, Central Office

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 Pervasive Developmental Disorder Waiver
#0456.R01

May 8, 2014

Home and Community-Based Services
Waiver Review Report

Executive Summary:

The South Carolina Department of Health and Human Services (SCDHHS) is authorized under §1915(c) of the Social Security Act to provide home and community-based services under the Pervasive Developmental Disorder (PDD) waiver. PDD is characterized by delays in the development of socialization and communication skills. The PDD waiver serves Medicaid eligible children ages three through ten who meet Intermediate Care Facility for the Intellectually Disabled (ICF/IID) level of care (LOC). Services offered are designed to provide individuals the choice of remaining in their family homes as an alternative to residing in an ICF/IID.

The SCDHHS maintains administrative authority over this waiver and day to day operations are provided by the South Carolina Department of Disabilities and Special Needs (SCDDSN). There is a Memorandum of Agreement and a service contract in place that identifies requirements for each agency.

Services offered in this waiver include Case Management and Early Intensive Behavioral Intervention (EIBI). EIBI services are habilitative in nature and are not available to children through the Medicaid State Plan. EIBI services consist of assessment and behaviorally oriented treatment of children diagnosed with a neurological disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV) category of Pervasive Developmental Disorder. Applied Behavior Analysis is used to develop a child's cognition, behavior, communication and social interaction skills, which are essential to Autism and Asperger's Syndrome.

EIBI providers must not render PDD waiver services in any setting where educational services are being provided. Additionally, EIBI service providers may not bill any entity (SCDHHS, SCDDSN, or parents) for EIBI services provided in a public school, private school, home school or other setting where educational services are being simultaneously provided to the child during identified school hours.

SCDHHS and SCDDSN contracts with a Quality Improvement Organization (QIO) to review and determine the overall performance of this waiver program. In addition, staff from both the Administrative Agency and the Operating Agency participates with QIO staff to ensure compliance.

As requested per the CMS Interim Procedural Guide, South Carolina submitted evidence to document adherence with program assurances as required per §42 CFR 441.303. In its April 11, 2013 submission of evidence, the state provided an overview of processes, systems and summary reports for each federal assurance. The review period for evidence submitted was for state fiscal year 2011 (July 1, 1010 through June 30, 2011). Because quality improvement is constant and evolving, the state is expected to gather, trend and analyze data on an ongoing basis at a minimum of annually. Therefore, in future waiver evidentiary submissions, a full three years of evidence is required.

The most recent 372 report, submitted on December 19, 2013, indicates that the waiver served 767 children with an average expenditure of $18,130 per recipient.

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

Because the state presented only one year of evidence, CMS is unable to determine that the state fully or substantially meets this assurance. However, it appears the SCDDSN has established LOC determinations consistent with the need for ICF/ID placement in accordance with the approved waiver application. The state is required to submit a full three years of data that will indicate baseline findings, improvements, and/or decline. If a decline is found, the state should submit remediation strategies for system improvements, as quality improvement is continuous and ongoing. Current performance measures are written so that outcomes appear negative. With the renewal application, the state is required to revise current performance measures so that positive outcomes are identified.

2. Service Plans are Responsive to Waiver Participant Needs – The State does not demonstrate the assurance

CMS requires the state to submit three years of data which captures and reports on all performance measures as listed in the approved waiver. In addition, the performance measure data is required to be statistically appropriate and valid.

3. Qualified Providers Serve Waiver Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

For those entities which require licensure/certification, the state appears to have an adequate process for allowing only qualified applicants to become PDD providers. However, for provider applicants who do not require licensure/certifications, the state failed to meet the assurance and to identify remediation strategies for improvement. Also, with only one year of evidence submitted, CMS is unable to determine that the state meets the overall assurance. It is also unclear when the state reports 100% compliance with a qualified provider performance measure, if the data is reflective against all enrolled providers or only those providers included in the particular review.

Additionally, providers appear to consistently lack the state's required documentation to show compliance. The state is required to collect, analyze and trend data on provider improvement by providing a full three years of data to determine if providers have improved with documentation requirements. CMS recommends the state consider implementing other actions in addition to corrective action plans for those providers found out of compliance. Financial sanctions based on the number and severity of citations discovered may prove helpful to ensure that providers are meeting the documentation requirements.

4. Health and Welfare of Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

During the renewal process, CMS requires the state to include performance measures that look beyond the scope of abuse, neglect and exploitation. In addition, a full three years of evidence is required for future evidentiary information as quality improvement is constant and on-going. The state should consider including the additional information now captured from the case manager's annual assessment as performance measures.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program - The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

Evidence submitted indicates that SCDHHS and SCDDSN have an adequate working relationship for the operation of this waiver. The MOA and service contract identify specific measures the operating agency must meet in a timely fashion. However, the fact that the MOA and service contract exist does not ensure 100% assurance for full administrative authority. CMS requires the state to report a full three years of data in subsequent evidentiary reports that will show the intent of CMS's recommended quality assurance strategy – discovery, remediation and quality improvement. With only one year of data, it is not possible to determine if SCDHHS maintains full administrative authority of this waiver program. CMS also requires the state to develop additional performance measures in the waiver renewal process.

6. State Provides Financial Accountability for the Waiver – The State does not demonstrate the assurance

The state's process for financial accountability appears to identify erroneously paid claims through a post payment audit process. At the time of waiver renewal, CMS requires the state strengthen its financial accountability oversight by adding performance measures.

Additionally, federal regulations require annual 372 reports be submitted 18 months after the end of the waiver year to ensure cost neutrality for waiver programs. To date, no 372 reports for the current waiver (effective date of 01/01/10) have been submitted. The 372 reports for waiver years one and two are past due. These reports were due on 6/30/12 and 6/30/13 respectively. CMS requires the state to submit these reports no later than 30 days after receipt of this report

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 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:	Pervasive Developmental Disorder Waiver
Operating Agency:	South Carolina Department of Disabilities and Special Needs
State Waiver Contact:	Anita Atwood
Target Population:	Individuals diagnosed with Pervasive Developmental Disorders
Level of Care:	ICF/IDD
Number of Waiver Participants:	767 (per 2012 372 report)
Average Annual per capita costs:	$18,130 (per 2012 372 report)
Effective Dates of Waiver:	January 1, 2010 through December 31, 2014
Approved Waiver Services:	Case Management and Early Intensive Behavioral Intervention
CMS RO Contact:	Kenni Howard, RN

I. State Conducts Level of Care 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.)

Levels of care (LOC) determinations are completed by a Consumer Assessment Team (CAT) which consists of the Director of Consumer Assessments and a Psychologist. The CAT reviews a package of data containing psychological reports, school history and medical records of the waiver applicant. This review must be completed no more than 30 days prior to enrollment into the waiver, as the initial LOC determination is valid for one month. If the individual's enrollment is not received by SCDHHS within one month from the initial LOC determination, an update or new review must be completed before the individual may enroll into the waiver.

As stated in the approved waiver, the state conducts a 100% review to determine the percentage of new enrollees whose LOC completion date was not more than 30 days old. The state submitted one year of evidence (SFY 2011) on a performance measure that reads "Proportion of new enrollees whose level of care completion date is not 30 days prior to waiver enrollment." The state reported that 39 files were reviewed with zero participants being enrolled with a LOC determination more than 30 days old. While the state reports this as 100% compliance, the performance measure is actually written to produce negative results. The state has used the numerator as the number of LOCs more than 30 days old (zero in this case) and the denominator as the number of files reviewed (39). Zero divided by 39 yields 0%. The performance measure should be re-evaluated and written to produce positive results. Furthermore, only one year of evidence was submitted, therefore CMS is unable to determine if the state has improved, declined or remains constant with this performance measure throughout the waiver cycle.

The evidence submitted states that if a significant change has occurred in the participant's condition and more than 180 days have passed since the previous evaluation, a new LOC determination is required. The updated LOC then becomes the new effective date for requiring a re-evaluation within 365 days. In any instance where the state determines there is a need to re-evaluate the participant earlier than 365 days, (i.e., based on case management monitoring, provider reports or parent's concerns), contact is made with the participant's family to schedule such.

Subsequent re-evaluations are due within 365 days of the initial or previous LOC determination. The CAT also performs re-evaluation LOC determinations. This process is monitored through an internal database within SCDDSN's Consumer Data Support System (CDSS). The system

notifies case managers and supervisors 60 days in advance of an upcoming re-evaluation due date. The system also produces monthly reports indicating re-evaluations due in the month, as well as any that are past due. Case managers complete the annual LOC determination in consultation with their supervisors prior to submission to the CAT.

For re-evaluations of LOC, the sampling methodology in the approved waiver is also a 100% review. The performance measure looks for re-evaluations that do not occur prior to the 365th day of the previous LOC evaluation. The compliance rate for this performance measure for SFY 2011 was 92.1% (35 of 38 files) due to LOC information not being submitted timely for the re-evaluation to occur within the 365 day required timeframe. Three files were cited by Delmarva Foundation, the QIO, and plans of correction were required. During a six-month follow-up, 100% compliance was discovered. It is unclear to CMS why the state is measuring re-evaluations that do not occur prior to the 365th day versus re-evaluations that exceed 365 days. There is no issue in re-evaluations being completed earlier than due; however, those that exceed the due date would require discharge until a new LOC evaluation was completed. Based on the Consumer Data Support System described, it appears this performance measure would also produce negative results.

As a systems improvement strategy, the state reported that SCDDSN has a system to assist in tracking LOC evaluation dates. However, the state also reported that the CDS system was already in place. The state did not identify how the system would be enhanced or revised to improve and/or ensure LOC evaluations are completed timely.

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.)

Because the state presented only one year of evidence, CMS is unable to determine that the state fully or substantially meets this assurance. However, it appears the SCDDSN has established LOC determinations consistent with the need for ICF/ID placement in accordance with the approved waiver application. The state is required to submit a full three years of data that will indicate baseline findings, improvements, and/or decline. If a decline is found, the state should submit remediation strategies for system improvements, as quality improvement is continuous and ongoing. Current performance measures are written so that outcomes appear negative. With the renewal application, the state is required to revise current performance measures so that positive outcomes are identified.

State's Response:

The state submitted additional evidence for performance measure #1 (Proportion of new enrollees whose level of care completion date is not 30 days prior to waiver enrollment) for SFY 10 and SFY 12 indicating that 100% of waiver participants had a LOC determination less than 30 days old at the time of enrollment. For the performance measure that reads "Proportion of participants whose LOC re-evaluation does not occur prior to the 365th day of the previous LOC re-evaluation," the state submitted additional evidence. For SFY 10, compliance was at 94% and for SFY 12, compliance was 91.7%. Remediation was in the form of late entries or corrections

where appropriate, staff training, direct staff technical assistance, quarterly meetings to review policy, and in some cases recoupment of Medicaid payments from DDSN.

CMS Response:

The CMS appreciates the state submitting additional information and accepts remediation activities undertaken by the state. As stated previously, CMS encourages the state to revise performance measures that will provide positive outcomes.

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 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 demonstrate the assurance
(The State demonstrated 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 service plan is based on the comprehensive assessment of the participants' strengths, needs, and personal priorities (goals) and preferences. All needs identified during the assessment process must be addressed in the service plan. During the planning process, the participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The case manager uses the information obtained to determine how the participant's goals and needs will be met.

After development, case managers are responsible for ongoing monitoring of the support plan, fully documenting waiver services, monitoring the participant's waiver record, ongoing evaluation and updating of the support plan to ensure its appropriateness, and preparation of all service authorizations and terminations in a timely manner. Support plans must include the appropriate documentation including: name and title of their contact person, type of contact, location and purpose of the contact, intervention or services provided, outcome and any follow-up needed.

Case managers must also ensure all waiver services are listed and include the amounts, frequency, duration and provider type, as well as any other services the waiver participant needs. The case record must also reflect that each child's parent(s) or legal guardian has been fully informed how to file a complaint and/or an appeal any time a waiver service is reduced, terminated, suspended or denied. This information is required to be provided at least annually and again when any service is negatively affected. Any complaint must be fully documented in the child's record and describe all actions taken by the state to resolve.

At a minimum, case managers are required to document a monthly case note with input from the EIBI service provider and/or family. On a quarterly basis, a complete review of the service plan

is required which includes the most recent EIBI service provider quarterly progress report and contact with a completed response with the participant's family. If progress does not meet expectations, a consultation with SCDDSN will occur. There is a required annual face-to-face contact with the family.

The assessment and support plans are maintained on the CDSS and are reviewed through a random sampling methodology using a representative sample with a confidence interval of +/- 15%.

For SFY 2011, the evidence revealed a 76.3% compliance rate for plans that clearly included and justified the need for all waiver services received. The state reported that citations for the performance measure were related to the case managers using wrong or inconsistent terminology (i.e. noting "service coordination" instead of case management or "line therapy" instead of EIBI services). In other instances, the service frequency was not specified consistently. Providers were required to submit a plan of correction to the QIO for approval, and received a follow-up review. However, the evidence submitted did not contain the follow-up results.

In August 2011, the state implemented a quality improvement measure. A system was developed to ensure service plans and annual assessments were reviewed through a random review process. SCDDSN selected a random sample and those waiver participants were tracked via a database. Using this sample, SCDDSN staff reviewed the selected plans and provided feedback to the provider. The case manager's supervisor is responsible to ensure records are corrected. The Case Management Plan Review Disposition Form was revised in September 2012 to ensure clarity of the review and verify remediation occurred when necessary.

Data submitted for the performance measure that reads "proportion of participants whose plans include services/supports to address personal goals in accordance with waiver policy" was identical to data submitted for "plans that clearly included and justified the need for all waiver services received." Therefore, it is not possible for CMS to determine if this performance measure was met, or if remediation was conducted.

Additionally, there was no data submitted for the third performance measure which states "proportion of newly enrolled participants whose plans were updated to include the need for any waiver services prior to authorization, in accordance with waiver policy." The state included a statement indicating a specific key indicator for the QIO reviews to address this performance measure will be added in SFY 2014.

Submitted data indicated that 100% of plans of care were developed every 365 days or more often if needed. However, only SFY 2011 was reviewed and a small sampling size of 39 files was utilized for the review. Therefore, the validity of the 100% overall compliance for this performance measure is questionable.

For the performance measure that assesses whether participants are receiving services and supports in the type, amount, frequency and duration as specified in their plan of care, the compliance rate for SFY 2011 was 88.9%. Thirty-six files were reviewed, and in four files documentation of monthly monitoring was not available. The QIO required providers to submit a plan of correction and receive a follow-up review. Data of the follow-up review was not

submitted in the evidence package received. The state indicated that in September 2012, the Case Management Plan Review Disposition Form was revised so that the amount, frequency and duration on the plan are reviewed for accuracy and appropriateness. SCDDSN uses the findings from this quality assurance activity to determine technical assistance and training needs for case management providers.

The proportion of newly enrolled waiver participant records that contain an appropriately completed and signed freedom of choice form specifying choice between waiver services or institutional care was 100%. The freedom of choice form documenting the person's choice of community service is required before enrollment into the waiver can occur. This requirement is verified by the CAT prior to approving the initial level of care.

Data submitted revealed a 96.8% compliance rate for participants who were offered choice of qualified providers. Case record documentation must reveal that the child's parents were given a choice from all qualified EIBI providers in the state. For SFY 2011, a 90% compliance rate was accomplished. Three files contained no documentation to verify participants had been given a statewide list of all qualified providers. Plans of correction were required by the QIO and providers received a follow-up review.

Required Recommendations:

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

CMS requires the state to submit three years of data which captures and reports on all performance measures as listed in the approved waiver. In addition, the performance measure data must be statistically appropriate and valid.

Additional performance measures the state may wish to consider include:

- Percent of service plans that contain functional outcomes
- Percent of service plans that contain action steps applicable to functional outcomes specified
- Percent of service plans that contain action steps written in measurable terms
- Percent of service plans that included a risk factor assessment

State's Response:

The state submitted additional information for SFY 10 and SFY 12. Based on the information submitted, for SFY 2010, 61.1% of participants had plans that include services and supports that are consistent with needs identified in the assessment and the proportion of participant who are receiving services and supports in the type, scope, amount, duration and frequency specified in the service plan, and only 43.6% compliance for SFY 2012. The state reports that the low compliance rate is related to lack of documentation and is not reflective of inadequate quality of service. The state reports that DDSN is considering revising the indicators used to capture data for this performance measure and collaboration between the two agencies will continue during the renewal process.

Additionally, the state reported the same low compliance rates (61.1% and 43.6% for SFY 2010 and 2012, respectively) for the performance measure that shows the proportion of participants whose plans include services/supports to address personal goals. As indicated in the draft report, citations for the performance measure were related to the case managers using wrong or inconsistent terminology (i.e. noting "service coordination" instead of case management or "line therapy" instead of EIBI services). In other instances, the service frequency was not specified consistently. Remediation included plans of corrections from providers that are required to address both individual and systemic remediation. Follow-up reviews by the QIO are conducted to ensure successful implementation of the plan of correction. Additional remediation included late entries or corrections where appropriate, staff training, direct staff technical assistance, and quarterly meetings to review policy.

For the performance measure that measures the proportion of newly enrolled participants whose plans were updated to include the need for any waiver services prior to authorization, the state provided additional information for SFY 2010 and SFY 2012 with results being 80% and 94.9% respectively. Citations included errors such as the case manager not including the name of the service provider, nullifying previously completed authorization by not including all services on a new authorization to the same provide, or not having the case management supervisor authorizing case management. In a few cases, the authorization form was not present in the file at the time of review. Remediation strategies were as previously stated.

Results of the performance measure that indicate the proportion of participants whose new support plans were updated/revised at least annually and when warranted were found to be at 91.7% and 100% for SFY 2010 and 2012, respectively. Plans that were monitored at least quarterly revealed 79.4% and 100% for SFY 2010 and 2012, respectively. Remediation for this performance measure is identified above.

Additional evidence for SFY 2010 and 2012 both indicated that 100% of participant had an appropriately completed and signed Freedom of Choice form that specified choice was offered between waiver services and institutional care. Evidence presented for the proportion of participants who were offered choice of qualified providers was 90.6% and 100% for SFY 2010 and 2012, respectively. Remediation again included late entries or corrections where appropriate; staff training; distract staff technical assistance; and quarterly meetings to review policy.

CMS Response:

The CMS again appreciates the state for additional evidence. However, the additional information does not change the finding that the state does not meet this assurance. CMS accepts the state's plan to collaborate with the operating agency to develop additional performance measures and quality indicators for the upcoming renewal. CMS is available for technical assistance if necessary.

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 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.)

Case management and EIBI provider qualifications are identified in the approved waiver. Case management objectives include counseling, supporting and assisting participants/families with all activities and/or services within the PDD waiver. They must coordinate community-based services, refer to other agencies and participate in interagency meetings as needed to discuss the waiver participant and to ensure there is no duplication of services. In addition, case managers are required to attend at least one training/in-service related to autism and the provision of case management for individuals enrolled in the PDD waiver. These trainings must be facilitated by the SCDDSN Autism division and documentation of participation must be maintained in the case manager's personnel files.

SCDDSN uses its QIO to conduct assessments of service providers by making on-site visits. Participant records are reviewed, staff and consumers are interviewed, and direct observation is used to evaluate if services are being implemented as planned and based on the consumer's needs. In addition, service provider's files and administrative qualifications are reviewed to ensure compliance with SCDDSN standards, policies and procedures, and contracts.

SCDDSN reviews the QIO reports to monitor overall compliance with quality assurance measures and to ensure that appropriate and adequate remediation occurs. Providers are required to submit plans of correction for deficiencies cited and follow-up reviews take place approximately six months later to ensure successful implementation of the plan of correction and remediation.

The QIO reports are also used by SCDDSN to identify larger system-wide trends that require additional training or technical assistance, and to analyze trends that require remediation through policy or standard changes. Issues found are addressed at quarterly meetings between SCDDSN staff and representatives of the SC Human Services Provider Association.

For the performance measure, "proportion of new providers that meet required licensing, certification, and other state standards prior to the provision of waiver services by provider type," the state reports 100% compliance for SFY 2011 for 26 EIBI provider agencies reviewed. For Case Management provider agencies, the compliance rate was 97.4% (25 of 26) for the review period. The state reports a 100% compliance rate for case managers who are free from tuberculosis based on required documentation in the personnel files.

There was a 90.8% compliance finding for providers that employ individuals who meet the requirements for the position in which they serve. Sixty files were reviewed and six files that were not compliant were limited to one EIBI service provider who reported that the qualifications of staff were not available during the review.

For providers to be included on the qualified provider list for EIBI services, documentation must be included to show they have completed the initial approval process. SFY 2011 revealed a 56% compliance rate with 36 of 64 files lacking the required documentation of qualifications. Evidence submitted did not identify any required plans of correction, remediation requirements, follow-up visits or improvement strategies.

In efforts to create systems improvement, SCDDSN contracted with a professional recruiting company to recruit, screen and conduct background checks on Line Therapists applying as providers. The recruiting company (Ambassador) is responsible for ensuring the applicant meets all requirements for the position including: state/federal criminal checks, drug screenings, first aid, cardiopulmonary resuscitation, tuberculin skin testing, and checking references. Individuals will not be referred to the hiring provider unless all the requirements have been met.

For providers that continue to meet required licensing, certification and other state standards, the state reported 100% compliance for service coordination staff, 97.4% for case managers who meet the minimum requirements, 100% compliance for case managers free of tuberculosis, 90.8% compliance for employees who meet the requirements for the position in which they serve, 56.3% compliance for documentation was present for those individuals/entities who are on the qualified provider list for EIBI services, and a 53.2% compliance rate for approved providers of EIBI services who submitted the required data to the child's case manager and the Autism Division within the required timeframes. All areas of non-compliance were due to the records or required documentation not being available for the QIO to review. The state did not identify if remediation occurred or if follow-up activities took place.

Non-licensed/non-certified providers that meet waiver requirements prior to the provision of waiver services revealed 100% compliance based on the pre-contractual hiring requirements. There was a 90.8% compliance rate for the indicator that states providers must ensure that each employee meets the requirements for the position in which they serve. Six files out of compliance were limited to one EIBI service provider that did not have proper documentation available for the QIO to review. The state did not identify if this was an agency or an individual provider. It was not identified if the provider was required to submit a plan of correction or if any other remediation and follow-up was required.

The compliance rate for individuals/entities that become approved providers of EIBI services and submit required data to the child's case manager and the Autism Division within the specified timeframes is reported as 53.2%. Thirty-three of 62 files were deficient due to the lack of the required documentation. Again, there was no mention of required plans of correction, required remediation or strategies for overall improvement.

The state also measures the proportion of providers that meet training requirements in the waiver. Findings for this measure indicate 100% compliance for case managers who attended at

least one PDD specific training annually. It is uncertain if this means that 100% of all case managers attended the required training or if 100% of those case managers who did attend training were compliant with PDD specific training annually.

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.)

For those entities which require licensure/certification, the state appears to have an adequate process for allowing only qualified applicants to become PDD providers. However, for provider applicants who do not require licensure/certifications, the state failed to meet the assurance and to identify remediation strategies for improvement. Also, with only one year of evidence submitted, CMS is unable to determine that the state meets the overall assurance. It is also unclear when the state reports 100% compliance with a qualified provider performance measure, if the data is reflective against all enrolled providers or only those providers included in the particular review.

Additionally, providers appear to consistently lack the state's required documentation to show compliance. The state is required to collect, analyze and trend data on provider improvement by providing a full three years of data to determine if providers have improved with documentation requirements. CMS recommends the state consider implementing other actions in addition to corrective action plans for those providers found out of compliance. Financial sanctions based on the number and severity of citations discovered may prove helpful to ensure that providers are meeting the documentation requirements.

State's Response:

The state provided additional outcome evidence for SFY 2010 and 2012 that showed 97.3% and 93%, respectively for providers that meet required licensing, certification, and other state standards prior to the provision of waiver services. There is also a statement that indicates that PDD providers, as a subgroup, were 100% compliant for SFY 2012. However, for the QI indicator that determines that all individuals who serve as Line Therapist must meet requirements, only 48% of provider's employee records were compliant. Therefore, it is unclear if the previous statement that 100% of PDD providers actually met licensing, certification and other standards prior to the provision of waiver services.

CMS Response:

Because all QI indicators revealed less than 50% of all individuals who serve as Line Therapist meet the requirements, CMS recommends that the state look at the indicators closely to determine if they are measuring for appropriate outcomes. As stated in the draft report, the state should consider implementing financial sanctions for those providers who continue to show low compliance results.

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 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 state reported that SCDDSN has a comprehensive system for reporting, collecting and responding to data related to abuse, neglect, or exploitation, as well as critical incidents that do not rise to that threshold. SCDDSN employs a full time Incident Management Coordinator who tracks reports within the system to ensure compliance with state law and agency policy. The reporting system provides a real-time analysis function and allows users to create a variety of reports that help track and trend information.

The state tracks reporting timeframes, completion of internal reviews and a review of the providers' management action taken to remediate identified concerns. Concerns may include staff training, staff suspension or termination, updates to risk management, and quality assurance policies and procedures designed to help safeguard the participant's health and welfare.

The SCDDSN Director of Quality Management also reviews the data for trending analysis at both the individual provider and statewide levels with corresponding QIO and licensing data. These reviews are completed on an annual basis unless there is an indication a provider's performance differs significantly from statewide averages. The state did not define what criterion is used that would indicate a provider's performance falling "significantly" from statewide averages, nor did it define how the statewide average is determined. In cases of this nature, the state reported a review of all systems is conducted. It is unclear to CMS what a "review of all systems" means or how the information is used. The Incident Management Coordinator also provides on-site training and technical assistance to providers who fall significantly higher or lower than the statewide average for reporting and types of incidents.

South Carolina's Code of Laws for Adult/Child Protection services and the Omnibus Adult Protection Act outline procedures for reporting allegations of Abuse, Neglect, and Exploitation (ANE). Allegations of ANE for a child are reported to the State Department of Social Services (DSS) and SCDDSN simultaneously (through an MOU between the agencies) which allows both agencies to work closely with investigative entities. SCDDSN also requires that providers conduct a management review for all reported allegations to determine if policies, rules or regulations violations occurred. If DSS finds the allegation is valid, SCDDSN ensures appropriate action is taken. Upon initial enrollment in the PDD Waiver and as part of the annual review process, parents/guardians are informed on how to report ANE. During the SFY 2011, no reports of ANE were received. It is unclear to CMS if this was due to the fact that no incidents of ANE occurred, or were merely not reported correctly to be captured within the system.

The QIO performs a quality review of all providers, using established policy and procedures, to ensure the organization has systems in place, throughout the organization, that identify whether employees are reporting incidents according to state law and DDSN policy, and are responding appropriately. The QIO also developed indicators by which they measure the compliance of this assurance. SCDDSN monitors the indicators reviewed by the QIO. In the event of a citation, the provider is required to submit a plan of correction and the QIO conducts a follow-up review in approximately six months to ensure successful implementation of the corrective action plan.

Quality Indicators measure the provider implement a risk management and quality assurance program consistent with established policies. For SFY 2011, the compliance rate was 91.2%, with 21 of 34 files being compliant. Again, the sampling methodology used is unclear. Data submitted does not establish whether 100% of providers were reviewed or if 34 files were reviewed for one provider. Citations included new providers who had not yet established a QA/risk management committee and providers with committees that were not tracking/trending information as required by policy. Additionally, the QIO reviews assess that providers follow SCDDSN procedures regarding preventing, reporting and responding to ANE. The findings were 89.7% with 26 of 29 providers reviewed determined compliant. All provider agencies are required to review statewide information to establish how their organization compares with other providers regarding reporting and responding to ANE. Due to the fact there were no reports of ANE for waiver participants three providers did not review statewide information.

The state also measures the number of incidents of ANE in which an internal review was completed within required timeframes. Because there were no reports of ANE during SFY 2011, no internal reviews were required. The data submitted did not address if there were any reports of ANE during SFY 2010 or 2012.

Measuring the number of substantiated incidents of ANE is accomplished via the Incident Management system through comprehensive statewide and provider level profile reports which track, trend and analyze data. The reports provide raw data concerning the number of reports made, cases substantiated and they are rated in a ratio format of number per 100 (i.e., 7:100). This ratio information is useful in providing a comparative analysis among agencies and is discussed in the statewide Risk Management Meetings and collaborative DDSN/Quality Assurance Committee Meetings. Additionally, DDSN established another key indicator for QIO use when conducting reviews of provider agencies that determines the provider's compliance with SCDDSN Quality Management and Risk Management policies and whether the provider is utilizing their own data to track, trend and analyze incident management data.

In an effort to further ensure participant health and welfare, SCDDSN also submitted evidence of the state's monitoring of assurances not specifically captured in the PDD waiver performance measures. Information is captured from the case manager's annual assessment of each waiver participant. Required information is captured annually and used to develop service plans. Questions that must be answered in the assessment include: does the person have a primary care physician with regular visits; does the person have a dentist with regular visits; does the person have a diet prescribed by a professional; have there been any injuries in the past year due to mobility; have there been any mobility issues related to exit during a fire or other emergency; does the person have basic transportation; does the person seem to feel safe in the setting; does

the setting have any obvious hazards that may jeopardize health/safety; does the person appear to be satisfied in the setting; is there a plan for the person to live elsewhere if current living arrangement cannot continue; is there a plan of how care will be provided if the primary caregiver is unexpectedly unable to provide care; and is there a plan for what to do in the event of specific types of emergencies/natural disasters that would require displacement from this home. After completion of the assessment, a decision is made whether to formally address each need identified (the decision is made by the parents and/or legal guardians to assist with planning and include on the service plan). If included on the service plan, services/interventions in response to the needs are authorized. Guidelines for completing the SCDDSN service coordination annual assessment require a response to each question and will not allow completion of the assessment until a response has been provided for each item.

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.)

During the renewal process, CMS requires the state to include performance measures that look beyond the scope of abuse, neglect and exploitation. In addition, a full three years of evidence is required for future evidentiary information as quality improvement is constant and on-going. The state should consider including the additional information now captured from the case manager's annual assessment as performance measures. Some examples the state may wish to consider include:

- # and % of participant records that indicate parents are provided information as to how and when to report instances of suspected abuse, neglect, exploitation, or other areas of concern
- # and % of participants (parents) who report being treated well and with respect by direct support staff and service providers
- # and % of participants (parents) who report they receive regular physician visits and immunizations are up to date
- # and % of complains, by type, filed with SCDDSN (examples include behavior issues, health issues, staffing issues, case management or other provider issues, service plan issues)

State's Response:

The state provided additional information for SFY 2012 and 2013 that revealed 85.7% and 82.1% compliance, respectfully, for the number and proportion of incidents of reported abuse, neglect and exploitation. The state reported for all years of evidence submitted there were no reports of abuse, neglect or exploitation among PDD waiver participants. Providers were, however cited for not following the tracking/trending/analysis requirements in using their data.

CMS Response:

As recommended in the draft report, CMS recommends the state add performance measures that go beyond the scope of abuse, neglect and exploitation.

V. The 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 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.)

SCDHHS is the single state Medicaid agency with administrative oversight for this waiver program. This oversight includes the authority to request renewal and/or to amend the current CMS approved waiver, review and approve SCDDSN policy and procedures, improve and clarify policies and procedures, perform quality assurance reviews, and provide necessary training to providers on specific Medicaid policy issues. Additionally, SCDHHS issues Medicaid information and policy changes in the form of provider bulletins.

SCDDSN is the agency responsible for the day-to-day operations of this waiver, including intake/referral, obtaining freedom of choice selection for waiver or institutional services as well as provider choice, service plan development, service authorizations, monitoring of services, and annual level of care and service plan evaluations. They are the first line in reconsiderations or the hearing and appeals process. Participants are notified in writing by SCDDSN of their right to request a fair hearing in response to any adverse action. If the operating agency upholds the adverse determination, the participant may appeal to SCDHHS. There have been five SCDDSN reconsiderations since 2010, SCDHHS had heard three PDD appeals, one appeal was dismissed and one was pending a hearing at the time of evidence submission.

CMS is unable to determine if the state fully or substantially meets this assurance, as only one year of evidence was submitted. The evidence package submitted included outcomes of performance measures in the approved waiver. The state measures administrative authority by two performance measures which include the proportion of desk/focus reviews, utilization reviews, and/or suspected fraud investigations whose results are specific to delegated operational waiver functions as outlined in the MOA and service contract, and quarterly meetings held between SCDHHS and SCDDSN waiver administrative staff to discuss significant waiver issues.

Findings submitted indicated that SCDHHS Quality Assurance waiver staff examined specific waiver records on PDD providers for quality assurance reviews. The QA reviews indicate primary issues related to CMS waiver assurances. Deficiencies found included: amount, frequency, or duration of services were not specified on the service plan; case management providers not meeting minimum qualifications; and case management providers not meeting service activity requirements. SCDHHS QA staff required SCDDSN to develop a thorough remediation plan to address each issue within 30 days. SCDHHS reviews the corrective action

plan for improvements to ensure cited deficiencies were appropriately completed according to Medicaid laws, regulations, waiver requirements, waiver policy, and the MOA. If required, SCDHHS QA staff makes referrals to the Program Integrity Division for post payment review of records. It is unclear to CMS if SCDHHS and SCDDSN are utilizing the same QIO or different entities. Additionally, it is unclear if these entities are working independently of each other, together, or with the administrative and/or the operating agency.

Utilization reports are conducted by SCDHHS QA waiver staff as needed and sampling is determined by evidence warranting a special review and/or investigation. SCDHHS QA waiver staff work with Program Integrity staff to investigate complaints, allegations, or accept referrals regarding case reviews. If excess or inappropriate payments are made to Medicaid providers, Program Integrity will analyze data and recoup any payments. For suspected fraud, the Program Integrity Unit along with SCDHHS QA waiver staff collaborates with the Medicaid Fraud Control Unit of the SC Attorney General's Office to investigate any criminal intent.

The state reported 100% compliance for focus desk and utilization reviews. Remedial actions were completed and corrective actions verified. No suspected fraud investigations were required. However, it is unclear to CMS what the state is actually reporting as 100%. Is the state reporting that the required numbers of focus desk reviews were conducted, or that the findings of the focus desk reviews revealed 100% compliance?

The state also reported 100% compliance for conducting quarterly meetings to discuss specific waiver issues. Copies of the MOA and examples of meeting minutes, meeting agendas, reports, the 2011 meeting schedule, and specific PDD policy input/outcome were submitted as evidence.

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 indicates that SCDHHS and SCDDSN have an adequate working relationship for the operation of this waiver. The MOA and service contract identify specific measures the operating agency must meet in a timely fashion. However, the fact that the MOA and service contract exist does not ensure 100% assurance for full administrative authority. CMS requires the state to report a full three years of data in subsequent evidentiary reports that will show the intent of CMS's recommended quality assurance strategy – discovery, remediation and quality improvement. With only one year of data, it is not possible to determine if SCDHHS maintains full administrative authority of this waiver program. CMS also requires the state to develop additional performance measures in the waiver renewal process. Some examples include:

- # and % of individual findings regarding level of care reevaluations that were appropriately and timely remediated by SCDDSN
- # and % of service plans that did not include outcomes, measurable action steps that were appropriately remediated by SCDDSN
- # and % of substantiated cases of abuse, neglect and exploitation that were appropriately and timely remediated by SCDDSN

State's Response:

The state reports that SCDHHS exercises administrative authority through the enrollment and termination process of waiver participants. SCDHHS maintains sole change rights of the Medicaid Management Information System (MMIS) with regard to the "Recipient special Program", the process by which applicants are technically "entered" and ":removed" from the Medicaid waiver programs. DDSN enrollment staff must submit documents to DHHS that verify Medicaid eligibility and LOC determinations before DHHS will enter change records into MMIS.

The State additionally reports that DHHS wavier staff conducts case record reviews focusing on participant plans of care, level of care timeliness, freedom of choice, service notes and other supporting documentation to verify appropriateness and adequacy of series. They also make referrals to the Division of Program Integrity whenever recoupment of FFP may be indicated. Quarterly meeting between the agencies occur and are held and documented on a variety of issues, including policy updates/changes, enrollment, waiting lists, and training.

CMS Response:

The state appears to have adequate activities outlined in its Memorandum of Agreement (MOA) and service contract to indicate that the Single State Medicaid Agency maintains administrative authority of this waiver program. However, the existence of these documents alone does not ensure 100% compliance. The state should use the activities indicated in the MOA and service contract to develop additional performance measures that will produce statically valid data that can be tracked/trended/analyzed so the state can assure CMS they retain full authority over this waiver program.

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 demonstrate the assurance
(The State demonstrated 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 utilizes only one performance measure to ensure financial accountability for the waiver program: "The proportion of paid claims that are coded and paid in accordance with policies in the approved waiver." SCDHHS Fiscal, Audits, and Program Integrity (PI) staff conduct ongoing monitoring of finances. The QA process is used to monitor paid claims and participant utilization. The PI unit receives information from various sources regarding potentially inappropriate billings by Medicaid providers, they collect and analyze data, audit

payments to the provider in question based on record reviews or other audits, and recoup payments when provider records do not support the amount of services billed.

The Division of Finance within the SCDDSN also receives information regarding potentially erroneous claims from the QA efforts of both SCDHHS and SCDDSN. The Medicaid Management Information System (MMIS) is utilized to ensure waiver participants were eligible for services on the dates provided. If SCDDSN finds issues with claims in question and determines they are non-allowable, the Medicaid program is reimbursed by SCDDSN. The SCDDSN Finance Division also adheres to state audit policy that requires SCDDSN to void/replace incorrect claims using the web-based system.

SCDHHS invoices SCDDSN for the Federal Medicaid Assistance Percentage (FMAP) associated with any claims in question and SCDDSN pays the invoice via an Interdepartmental Transfer (IDT) within the State of SC Enterprise-Wide accounting system. During SFY 2011, four citations were made for indicators that were deemed as "recoupable."

Required Recommendations:

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

The state's process for financial accountability appears to identify erroneously paid claims through a post payment audit process. At the time of waiver renewal, CMS requires the state strengthen its financial accountability oversight by adding performance measures. Some examples the state should consider include:

- # and % of claims that were denied or suspended for incorrect billing codes and service rates
- # and % of claims that contain a prior authorization number, when required
- # and % of paid claims for services delivered to persons enrolled in the waiver in accordance with the approved service plan and with documentation to support the amount, frequency and duration of services billed

Additionally, federal regulations require annual 372 reports be submitted 18 months after the end of the waiver year to ensure cost neutrality for waiver programs. To date, no 372 reports for the current waiver (effective date of 01/01/10) have been submitted. The 372 reports for waiver years one and two are past due. These reports were due on 6/30/12 and 6/30/13 respectively. CMS requires the state to submit these reports no later than 30 days after receipt of this report.

State's Response:

The state submitted and CMS approved the 2010, 2011, and 2012 372 reports as required. The state also submitted evidence for SFY 2010 and 2012 as requested. Findings that a proportion of claims are coded and paid in accordance with policies in the approved waiver were 94.4% and 91.7%, respectively. Certain QI indicators are recoupable and when non-compliance occurs, DHHS will initiate the recoupment process. The state reports that at the time of renewal, it will review the financial accountability performance measures and revise or add as appropriate to strengthen financial oversight.

CMS response:

The CMS appreciates the state's submission of the 372 reports and accepts the state's review of the financial accountability performance measures for the upcoming renewal. The CMS is available for technical assistance if necessary.

RECEIVED
MAY 14 2014
Bureau of Long Term Care Services
SC Department of Health and Human Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett/Chavis/Maley	5-13-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000379	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR	[ ] Prepare reply for appropriate signature DATE DUE _____
CC: Mr. Keck, Kost, Deps, CMS file	[ ] FOIA DATE DUE _____
Colbi Pro Chg	[X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.	to NHA Just like #3+		*3/16/14 - change to Necessary Action
2.			
3.			
4.			

Hey Bren -
Can we change this to Necessary Action - this is a final report.
Thanks,
Anne
5/16/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett/Chavis/Maley	5-13-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000379	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Mr. Keck, Kost, Deps, CMS file	[X] Prepare reply for appropriate signature DATE DUE 7/31/14 [ ] 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
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 8, 2014

Anthony E. Keck, Director
Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

Dear Mr. Keck:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) quality review of South Carolina's Home and Community Based Waiver (control number 0456.R01) for individuals with Pervasive Developmental Disorder. This waiver serves children ages three through ten who have been diagnosed with a pervasive developmental disorder and who would otherwise require placement in an Intermediate Care Facility for the Intellectually Disabled (ICF/IID). Thank you for your assistance throughout this process and for sending comments on the draft report. The state's responses to CMS' recommendations have been incorporated in the appropriate sections of the report.

Once again, 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 six of the six assurances. For those areas in which the state is not in compliance, please be sure they are corrected at the time of renewal. We have identified recommendations for program improvements in all six 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 date of the waiver, December 31, 2014. Your waiver renewal application 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 90 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 30 days before the expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter 60 days prior to the expiration of the waiver.

If you have any questions, please contact Kenni Howard and 404-562-7413 or kenni.howard@cms.hhs.gov. We would again like to extend our sincere appreciation to the South Carolina Community Long Term Care Division, who provided information for this review.

Sincerely,

Irina Roberts for

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

Enclosure

PC: Michele MacKenzie, Central Office

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 Pervasive Developmental Disorder Waiver
#0456.R01

May 8, 2014

Home and Community-Based Services
Waiver Review Report

Executive Summary:

The South Carolina Department of Health and Human Services (SCDHHS) is authorized under §1915(c) of the Social Security Act to provide home and community-based services under the Pervasive Developmental Disorder (PDD) waiver. PDD is characterized by delays in the development of socialization and communication skills. The PDD waiver serves Medicaid eligible children ages three through ten who meet Intermediate Care Facility for the Intellectually Disabled (ICF/IID) level of care (LOC). Services offered are designed to provide individuals the choice of remaining in their family homes as an alternative to residing in an ICF/IID.

The SCDHHS maintains administrative authority over this waiver and day to day operations are provided by the South Carolina Department of Disabilities and Special Needs (SCDDSN). There is a Memorandum of Agreement and a service contract in place that identifies requirements for each agency.

Services offered in this waiver include Case Management and Early Intensive Behavioral Intervention (EIBI). EIBI services are habilitative in nature and are not available to children through the Medicaid State Plan. EIBI services consist of assessment and behaviorally oriented treatment of children diagnosed with a neurological disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV) category of Pervasive Developmental Disorder. Applied Behavior Analysis is used to develop a child's cognition, behavior, communication and social interaction skills, which are essential to Autism and Asperger's Syndrome.

EIBI providers must not render PDD waiver services in any setting where educational services are being provided. Additionally, EIBI service providers may not bill any entity (SCDHHS, SCDDSN, or parents) for EIBI services provided in a public school, private school, home school or other setting where educational services are being simultaneously provided to the child during identified school hours.

SCDHHS and SCDDSN contracts with a Quality Improvement Organization (QIO) to review and determine the overall performance of this waiver program. In addition, staff from both the Administrative Agency and the Operating Agency participates with QIO staff to ensure compliance.

As requested per the CMS Interim Procedural Guide, South Carolina submitted evidence to document adherence with program assurances as required per §42 CFR 441.303. In its April 11, 2013 submission of evidence, the state provided an overview of processes, systems and summary reports for each federal assurance. The review period for evidence submitted was for state fiscal year 2011 (July 1, 1010 through June 30, 2011). Because quality improvement is constant and evolving, the state is expected to gather, trend and analyze data on an ongoing basis at a minimum of annually. Therefore, in future waiver evidentiary submissions, a full three years of evidence is required.

The most recent 372 report, submitted on December 19, 2013, indicates that the waiver served 767 children with an average expenditure of $18,130 per recipient.

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

Because the state presented only one year of evidence, CMS is unable to determine that the state fully or substantially meets this assurance. However, it appears the SCDDSN has established LOC determinations consistent with the need for ICF/ID placement in accordance with the approved waiver application. The state is required to submit a full three years of data that will indicate baseline findings, improvements, and/or decline. If a decline is found, the state should submit remediation strategies for system improvements, as quality improvement is continuous and ongoing. Current performance measures are written so that outcomes appear negative. With the renewal application, the state is required to revise current performance measures so that positive outcomes are identified.

2. Service Plans are Responsive to Waiver Participant Needs – The State does not demonstrate the assurance

CMS requires the state to submit three years of data which captures and reports on all performance measures as listed in the approved waiver. In addition, the performance measure data is required to be statistically appropriate and valid.

3. Qualified Providers Serve Waiver Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

For those entities which require licensure/certification, the state appears to have an adequate process for allowing only qualified applicants to become PDD providers. However, for provider applicants who do not require licensure/certifications, the state failed to meet the assurance and to identify remediation strategies for improvement. Also, with only one year of evidence submitted, CMS is unable to determine that the state meets the overall assurance. It is also unclear when the state reports 100% compliance with a qualified provider performance measure, if the data is reflective against all enrolled providers or only those providers included in the particular review.

Additionally, providers appear to consistently lack the state's required documentation to show compliance. The state is required to collect, analyze and trend data on provider improvement by providing a full three years of data to determine if providers have improved with documentation requirements. CMS recommends the state consider implementing other actions in addition to corrective action plans for those providers found out of compliance. Financial sanctions based on the number and severity of citations discovered may prove helpful to ensure that providers are meeting the documentation requirements.

4. Health and Welfare of Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

During the renewal process, CMS requires the state to include performance measures that look beyond the scope of abuse, neglect and exploitation. In addition, a full three years of evidence is required for future evidentiary information as quality improvement is constant and on-going. The state should consider including the additional information now captured from the case manager's annual assessment as performance measures.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program - The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

Evidence submitted indicates that SCDHHS and SCDDSN have an adequate working relationship for the operation of this waiver. The MOA and service contract identify specific measures the operating agency must meet in a timely fashion. However, the fact that the MOA and service contract exist does not ensure 100% assurance for full administrative authority. CMS requires the state to report a full three years of data in subsequent evidentiary reports that will show the intent of CMS's recommended quality assurance strategy – discovery, remediation and quality improvement. With only one year of data, it is not possible to determine if SCDHHS maintains full administrative authority of this waiver program. CMS also requires the state to develop additional performance measures in the waiver renewal process.

6. State Provides Financial Accountability for the Waiver – The State does not demonstrate the assurance

The state's process for financial accountability appears to identify erroneously paid claims through a post payment audit process. At the time of waiver renewal, CMS requires the state strengthen its financial accountability oversight by adding performance measures.

Additionally, federal regulations require annual 372 reports be submitted 18 months after the end of the waiver year to ensure cost neutrality for waiver programs. To date, no 372 reports for the current waiver (effective date of 01/01/10) have been submitted. The 372 reports for waiver years one and two are past due. These reports were due on 6/30/12 and 6/30/13 respectively. CMS requires the state to submit these reports no later than 30 days after receipt of this report

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 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:	Pervasive Developmental Disorder Waiver
Operating Agency:	South Carolina Department of Disabilities and Special Needs
State Waiver Contact:	Anita Atwood
Target Population:	Individuals diagnosed with Pervasive Developmental Disorders
Level of Care:	ICF/IDD
Number of Waiver Participants:	767 (per 2012 372 report)
Average Annual per capita costs:	$18,130 (per 2012 372 report)
Effective Dates of Waiver:	January 1, 2010 through December 31, 2014
Approved Waiver Services:	Case Management and Early Intensive Behavioral Intervention
CMS RO Contact:	Kenni Howard, RN

I. State Conducts Level of Care 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.)

Levels of care (LOC) determinations are completed by a Consumer Assessment Team (CAT) which consists of the Director of Consumer Assessments and a Psychologist. The CAT reviews a package of data containing psychological reports, school history and medical records of the waiver applicant. This review must be completed no more than 30 days prior to enrollment into the waiver, as the initial LOC determination is valid for one month. If the individual's enrollment is not received by SCDHHS within one month from the initial LOC determination, an update or new review must be completed before the individual may enroll into the waiver.

As stated in the approved waiver, the state conducts a 100% review to determine the percentage of new enrollees whose LOC completion date was not more than 30 days old. The state submitted one year of evidence (SFY 2011) on a performance measure that reads "Proportion of new enrollees whose level of care completion date is not 30 days prior to waiver enrollment." The state reported that 39 files were reviewed with zero participants being enrolled with a LOC determination more than 30 days old. While the state reports this as 100% compliance, the performance measure is actually written to produce negative results. The state has used the numerator as the number of LOCs more than 30 days old (zero in this case) and the denominator as the number of files reviewed (39). Zero divided by 39 yields 0%. The performance measure should be re-evaluated and written to produce positive results. Furthermore, only one year of evidence was submitted, therefore CMS is unable to determine if the state has improved, declined or remains constant with this performance measure throughout the waiver cycle.

The evidence submitted states that if a significant change has occurred in the participant's condition and more than 180 days have passed since the previous evaluation, a new LOC determination is required. The updated LOC then becomes the new effective date for requiring a re-evaluation within 365 days. In any instance where the state determines there is a need to re-evaluate the participant earlier than 365 days, (i.e., based on case management monitoring, provider reports or parent's concerns), contact is made with the participant's family to schedule such.

Subsequent re-evaluations are due within 365 days of the initial or previous LOC determination. The CAT also performs re-evaluation LOC determinations. This process is monitored through an internal database within SCDDSN's Consumer Data Support System (CDSS). The system

notifies case managers and supervisors 60 days in advance of an upcoming re-evaluation due date. The system also produces monthly reports indicating re-evaluations due in the month, as well as any that are past due. Case managers complete the annual LOC determination in consultation with their supervisors prior to submission to the CAT.

For re-evaluations of LOC, the sampling methodology in the approved waiver is also a 100% review. The performance measure looks for re-evaluations that do not occur prior to the 365th day of the previous LOC evaluation. The compliance rate for this performance measure for SFY 2011 was 92.1% (35 of 38 files) due to LOC information not being submitted timely for the re-evaluation to occur within the 365 day required timeframe. Three files were cited by Delmarva Foundation, the QIO, and plans of correction were required. During a six-month follow-up, 100% compliance was discovered. It is unclear to CMS why the state is measuring re-evaluations that do not occur prior to the 365th day versus re-evaluations that exceed 365 days. There is no issue in re-evaluations being completed earlier than due; however, those that exceed the due date would require discharge until a new LOC evaluation was completed. Based on the Consumer Data Support System described, it appears this performance measure would also produce negative results.

As a systems improvement strategy, the state reported that SCDDSN has a system to assist in tracking LOC evaluation dates. However, the state also reported that the CDS system was already in place. The state did not identify how the system would be enhanced or revised to improve and/or ensure LOC evaluations are completed timely.

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.)

Because the state presented only one year of evidence, CMS is unable to determine that the state fully or substantially meets this assurance. However, it appears the SCDDSN has established LOC determinations consistent with the need for ICF/ID placement in accordance with the approved waiver application. The state is required to submit a full three years of data that will indicate baseline findings, improvements, and/or decline. If a decline is found, the state should submit remediation strategies for system improvements, as quality improvement is continuous and ongoing. Current performance measures are written so that outcomes appear negative. With the renewal application, the state is required to revise current performance measures so that positive outcomes are identified.

State's Response:

The state submitted additional evidence for performance measure #1 (Proportion of new enrollees whose level of care completion date is not 30 days prior to waiver enrollment) for SFY 10 and SFY 12 indicating that 100% of waiver participants had a LOC determination less than 30 days old at the time of enrollment. For the performance measure that reads "Proportion of participants whose LOC re-evaluation does not occur prior to the 365th day of the previous LOC re-evaluation," the state submitted additional evidence. For SFY 10, compliance was at 94% and for SFY 12, compliance was 91.7%. Remediation was in the form of late entries or corrections

where appropriate, staff training, direct staff technical assistance, quarterly meetings to review policy, and in some cases recoupment of Medicaid payments from DDSN.

CMS Response:

The CMS appreciates the state submitting additional information and accepts remediation activities undertaken by the state. As stated previously, CMS encourages the state to revise performance measures that will provide positive outcomes.

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 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 demonstrate the assurance
(The State demonstrated 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 service plan is based on the comprehensive assessment of the participants' strengths, needs, and personal priorities (goals) and preferences. All needs identified during the assessment process must be addressed in the service plan. During the planning process, the participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The case manager uses the information obtained to determine how the participant's goals and needs will be met.

After development, case managers are responsible for ongoing monitoring of the support plan, fully documenting waiver services, monitoring the participant's waiver record, ongoing evaluation and updating of the support plan to ensure its appropriateness, and preparation of all service authorizations and terminations in a timely manner. Support plans must include the appropriate documentation including: name and title of their contact person, type of contact, location and purpose of the contact, intervention or services provided, outcome and any follow-up needed.

Case managers must also ensure all waiver services are listed and include the amounts, frequency, duration and provider type, as well as any other services the waiver participant needs. The case record must also reflect that each child's parent(s) or legal guardian has been fully informed how to file a complaint and/or an appeal any time a waiver service is reduced, terminated, suspended or denied. This information is required to be provided at least annually and again when any service is negatively affected. Any complaint must be fully documented in the child's record and describe all actions taken by the state to resolve.

At a minimum, case managers are required to document a monthly case note with input from the EIBI service provider and/or family. On a quarterly basis, a complete review of the service plan

is required which includes the most recent EIBI service provider quarterly progress report and contact with a completed response with the participant's family. If progress does not meet expectations, a consultation with SCDDSN will occur. There is a required annual face-to-face contact with the family.

The assessment and support plans are maintained on the CDSS and are reviewed through a random sampling methodology using a representative sample with a confidence interval of +/- 15%.

For SFY 2011, the evidence revealed a 76.3% compliance rate for plans that clearly included and justified the need for all waiver services received. The state reported that citations for the performance measure were related to the case managers using wrong or inconsistent terminology (i.e. noting "service coordination" instead of case management or "line therapy" instead of EIBI services). In other instances, the service frequency was not specified consistently. Providers were required to submit a plan of correction to the QIO for approval, and received a follow-up review. However, the evidence submitted did not contain the follow-up results.

In August 2011, the state implemented a quality improvement measure. A system was developed to ensure service plans and annual assessments were reviewed through a random review process. SCDDSN selected a random sample and those waiver participants were tracked via a database. Using this sample, SCDDSN staff reviewed the selected plans and provided feedback to the provider. The case manager's supervisor is responsible to ensure records are corrected. The Case Management Plan Review Disposition Form was revised in September 2012 to ensure clarity of the review and verify remediation occurred when necessary.

Data submitted for the performance measure that reads "proportion of participants whose plans include services/supports to address personal goals in accordance with waiver policy" was identical to data submitted for "plans that clearly included and justified the need for all waiver services received." Therefore, it is not possible for CMS to determine if this performance measure was met, or if remediation was conducted.

Additionally, there was no data submitted for the third performance measure which states "proportion of newly enrolled participants whose plans were updated to include the need for any waiver services prior to authorization, in accordance with waiver policy." The state included a statement indicating a specific key indicator for the QIO reviews to address this performance measure will be added in SFY 2014.

Submitted data indicated that 100% of plans of care were developed every 365 days or more often if needed. However, only SFY 2011 was reviewed and a small sampling size of 39 files was utilized for the review. Therefore, the validity of the 100% overall compliance for this performance measure is questionable.

For the performance measure that assesses whether participants are receiving services and supports in the type, amount, frequency and duration as specified in their plan of care, the compliance rate for SFY 2011 was 88.9%. Thirty-six files were reviewed, and in four files documentation of monthly monitoring was not available. The QIO required providers to submit a plan of correction and receive a follow-up review. Data of the follow-up review was not

submitted in the evidence package received. The state indicated that in September 2012, the Case Management Plan Review Disposition Form was revised so that the amount, frequency and duration on the plan are reviewed for accuracy and appropriateness. SCDDSN uses the findings from this quality assurance activity to determine technical assistance and training needs for case management providers.

The proportion of newly enrolled waiver participant records that contain an appropriately completed and signed freedom of choice form specifying choice between waiver services or institutional care was 100%. The freedom of choice form documenting the person's choice of community service is required before enrollment into the waiver can occur. This requirement is verified by the CAT prior to approving the initial level of care.

Data submitted revealed a 96.8% compliance rate for participants who were offered choice of qualified providers. Case record documentation must reveal that the child's parents were given a choice from all qualified EIBI providers in the state. For SFY 2011, a 90% compliance rate was accomplished. Three files contained no documentation to verify participants had been given a statewide list of all qualified providers. Plans of correction were required by the QIO and providers received a follow-up review.

Required Recommendations:

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

CMS requires the state to submit three years of data which captures and reports on all performance measures as listed in the approved waiver. In addition, the performance measure data must be statistically appropriate and valid.

Additional performance measures the state may wish to consider include:

- Percent of service plans that contain functional outcomes
- Percent of service plans that contain action steps applicable to functional outcomes specified
- Percent of service plans that contain action steps written in measurable terms
- Percent of service plans that included a risk factor assessment

State's Response:

The state submitted additional information for SFY 10 and SFY 12. Based on the information submitted, for SFY 2010, 61.1% of participants had plans that include services and supports that are consistent with needs identified in the assessment and the proportion of participant who are receiving services and supports in the type, scope, amount, duration and frequency specified in the service plan, and only 43.6% compliance for SFY 2012. The state reports that the low compliance rate is related to lack of documentation and is not reflective of inadequate quality of service. The state reports that DDSN is considering revising the indicators used to capture data for this performance measure and collaboration between the two agencies will continue during the renewal process.

Additionally, the state reported the same low compliance rates (61.1% and 43.6% for SFY 2010 and 2012, respectively) for the performance measure that shows the proportion of participants whose plans include services/supports to address personal goals. As indicated in the draft report, citations for the performance measure were related to the case managers using wrong or inconsistent terminology (i.e. noting "service coordination" instead of case management or "line therapy" instead of EIBI services). In other instances, the service frequency was not specified consistently. Remediation included plans of corrections from providers that are required to address both individual and systemic remediation. Follow-up reviews by the QIO are conducted to ensure successful implementation of the plan of correction. Additional remediation included late entries or corrections where appropriate, staff training, direct staff technical assistance, and quarterly meetings to review policy.

For the performance measure that measures the proportion of newly enrolled participants whose plans were updated to include the need for any waiver services prior to authorization, the state provided additional information for SFY 2010 and SFY 2012 with results being 80% and 94.9% respectively. Citations included errors such as the case manager not including the name of the service provider, nullifying previously completed authorization by not including all services on a new authorization to the same provide, or not having the case management supervisor authorizing case management. In a few cases, the authorization form was not present in the file at the time of review. Remediation strategies were as previously stated.

Results of the performance measure that indicate the proportion of participants whose new support plans were updated/revised at least annually and when warranted were found to be at 91.7% and 100% for SFY 2010 and 2012, respectively. Plans that were monitored at least quarterly revealed 79.4% and 100% for SFY 2010 and 2012, respectively. Remediation for this performance measure is identified above.

Additional evidence for SFY 2010 and 2012 both indicated that 100% of participant had an appropriately completed and signed Freedom of Choice form that specified choice was offered between waiver services and institutional care. Evidence presented for the proportion of participants who were offered choice of qualified providers was 90.6% and 100% for SFY 2010 and 2012, respectively. Remediation again included late entries or corrections where appropriate; staff training; distract staff technical assistance; and quarterly meetings to review policy.

CMS Response:

The CMS again appreciates the state for additional evidence. However, the additional information does not change the finding that the state does not meet this assurance. CMS accepts the state's plan to collaborate with the operating agency to develop additional performance measures and quality indicators for the upcoming renewal. CMS is available for technical assistance if necessary.

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 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.)

Case management and EIBI provider qualifications are identified in the approved waiver. Case management objectives include counseling, supporting and assisting participants/families with all activities and/or services within the PDD waiver. They must coordinate community-based services, refer to other agencies and participate in interagency meetings as needed to discuss the waiver participant and to ensure there is no duplication of services. In addition, case managers are required to attend at least one training/in-service related to autism and the provision of case management for individuals enrolled in the PDD waiver. These trainings must be facilitated by the SCDDSN Autism division and documentation of participation must be maintained in the case manager's personnel files.

SCDDSN uses its QIO to conduct assessments of service providers by making on-site visits. Participant records are reviewed, staff and consumers are interviewed, and direct observation is used to evaluate if services are being implemented as planned and based on the consumer's needs. In addition, service provider's files and administrative qualifications are reviewed to ensure compliance with SCDDSN standards, policies and procedures, and contracts.

SCDDSN reviews the QIO reports to monitor overall compliance with quality assurance measures and to ensure that appropriate and adequate remediation occurs. Providers are required to submit plans of correction for deficiencies cited and follow-up reviews take place approximately six months later to ensure successful implementation of the plan of correction and remediation.

The QIO reports are also used by SCDDSN to identify larger system-wide trends that require additional training or technical assistance, and to analyze trends that require remediation through policy or standard changes. Issues found are addressed at quarterly meetings between SCDDSN staff and representatives of the SC Human Services Provider Association.

For the performance measure, "proportion of new providers that meet required licensing, certification, and other state standards prior to the provision of waiver services by provider type," the state reports 100% compliance for SFY 2011 for 26 EIBI provider agencies reviewed. For Case Management provider agencies, the compliance rate was 97.4% (25 of 26) for the review period. The state reports a 100% compliance rate for case managers who are free from tuberculosis based on required documentation in the personnel files.

There was a 90.8% compliance finding for providers that employ individuals who meet the requirements for the position in which they serve. Sixty files were reviewed and six files that were not compliant were limited to one EIBI service provider who reported that the qualifications of staff were not available during the review.

For providers to be included on the qualified provider list for EIBI services, documentation must be included to show they have completed the initial approval process. SFY 2011 revealed a 56% compliance rate with 36 of 64 files lacking the required documentation of qualifications. Evidence submitted did not identify any required plans of correction, remediation requirements, follow-up visits or improvement strategies.

In efforts to create systems improvement, SCDDSN contracted with a professional recruiting company to recruit, screen and conduct background checks on Line Therapists applying as providers. The recruiting company (Ambassador) is responsible for ensuring the applicant meets all requirements for the position including: state/federal criminal checks, drug screenings, first aid, cardiopulmonary resuscitation, tuberculin skin testing, and checking references. Individuals will not be referred to the hiring provider unless all the requirements have been met.

For providers that continue to meet required licensing, certification and other state standards, the state reported 100% compliance for service coordination staff, 97.4% for case managers who meet the minimum requirements, 100% compliance for case managers free of tuberculosis, 90.8% compliance for employees who meet the requirements for the position in which they serve, 56.3% compliance for documentation was present for those individuals/entities who are on the qualified provider list for EIBI services, and a 53.2% compliance rate for approved providers of EIBI services who submitted the required data to the child's case manager and the Autism Division within the required timeframes. All areas of non-compliance were due to the records or required documentation not being available for the QIO to review. The state did not identify if remediation occurred or if follow-up activities took place.

Non-licensed/non-certified providers that meet waiver requirements prior to the provision of waiver services revealed 100% compliance based on the pre-contractual hiring requirements. There was a 90.8% compliance rate for the indicator that states providers must ensure that each employee meets the requirements for the position in which they serve. Six files out of compliance were limited to one EIBI service provider that did not have proper documentation available for the QIO to review. The state did not identify if this was an agency or an individual provider. It was not identified if the provider was required to submit a plan of correction or if any other remediation and follow-up was required.

The compliance rate for individuals/entities that become approved providers of EIBI services and submit required data to the child's case manager and the Autism Division within the specified timeframes is reported as 53.2%. Thirty-three of 62 files were deficient due to the lack of the required documentation. Again, there was no mention of required plans of correction, required remediation or strategies for overall improvement.

The state also measures the proportion of providers that meet training requirements in the waiver. Findings for this measure indicate 100% compliance for case managers who attended at

least one PDD specific training annually. It is uncertain if this means that 100% of all case managers attended the required training or if 100% of those case managers who did attend training were compliant with PDD specific training annually.

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.)

For those entities which require licensure/certification, the state appears to have an adequate process for allowing only qualified applicants to become PDD providers. However, for provider applicants who do not require licensure/certifications, the state failed to meet the assurance and to identify remediation strategies for improvement. Also, with only one year of evidence submitted, CMS is unable to determine that the state meets the overall assurance. It is also unclear when the state reports 100% compliance with a qualified provider performance measure, if the data is reflective against all enrolled providers or only those providers included in the particular review.

Additionally, providers appear to consistently lack the state's required documentation to show compliance. The state is required to collect, analyze and trend data on provider improvement by providing a full three years of data to determine if providers have improved with documentation requirements. CMS recommends the state consider implementing other actions in addition to corrective action plans for those providers found out of compliance. Financial sanctions based on the number and severity of citations discovered may prove helpful to ensure that providers are meeting the documentation requirements.

State's Response:

The state provided additional outcome evidence for SFY 2010 and 2012 that showed 97.3% and 93%, respectively for providers that meet required licensing, certification, and other state standards prior to the provision of waiver services. There is also a statement that indicates that PDD providers, as a subgroup, were 100% compliant for SFY 2012. However, for the QI indicator that determines that all individuals who serve as Line Therapist must meet requirements, only 48% of provider's employee records were compliant. Therefore, it is unclear if the previous statement that 100% of PDD providers actually met licensing, certification and other standards prior to the provision of waiver services.

CMS Response:

Because all QI indicators revealed less than 50% of all individuals who serve as Line Therapist meet the requirements, CMS recommends that the state look at the indicators closely to determine if they are measuring for appropriate outcomes. As stated in the draft report, the state should consider implementing financial sanctions for those providers who continue to show low compliance results.

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 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 state reported that SCDDSN has a comprehensive system for reporting, collecting and responding to data related to abuse, neglect, or exploitation, as well as critical incidents that do not rise to that threshold. SCDDSN employs a full time Incident Management Coordinator who tracks reports within the system to ensure compliance with state law and agency policy. The reporting system provides a real-time analysis function and allows users to create a variety of reports that help track and trend information.

The state tracks reporting timeframes, completion of internal reviews and a review of the providers' management action taken to remediate identified concerns. Concerns may include staff training, staff suspension or termination, updates to risk management, and quality assurance policies and procedures designed to help safeguard the participant's health and welfare.

The SCDDSN Director of Quality Management also reviews the data for trending analysis at both the individual provider and statewide levels with corresponding QIO and licensing data. These reviews are completed on an annual basis unless there is an indication a provider's performance differs significantly from statewide averages. The state did not define what criterion is used that would indicate a provider's performance falling "significantly" from statewide averages, nor did it define how the statewide average is determined. In cases of this nature, the state reported a review of all systems is conducted. It is unclear to CMS what a "review of all systems" means or how the information is used. The Incident Management Coordinator also provides on-site training and technical assistance to providers who fall significantly higher or lower than the statewide average for reporting and types of incidents.

South Carolina's Code of Laws for Adult/Child Protection services and the Omnibus Adult Protection Act outline procedures for reporting allegations of Abuse, Neglect, and Exploitation (ANE). Allegations of ANE for a child are reported to the State Department of Social Services (DSS) and SCDDSN simultaneously (through an MOU between the agencies) which allows both agencies to work closely with investigative entities. SCDDSN also requires that providers conduct a management review for all reported allegations to determine if policies, rules or regulations violations occurred. If DSS finds the allegation is valid, SCDDSN ensures appropriate action is taken. Upon initial enrollment in the PDD Waiver and as part of the annual review process, parents/guardians are informed on how to report ANE. During the SFY 2011, no reports of ANE were received. It is unclear to CMS if this was due to the fact that no incidents of ANE occurred, or were merely not reported correctly to be captured within the system.

The QIO performs a quality review of all providers, using established policy and procedures, to ensure the organization has systems in place, throughout the organization, that identify whether employees are reporting incidents according to state law and DDSN policy, and are responding appropriately. The QIO also developed indicators by which they measure the compliance of this assurance. SCDDSN monitors the indicators reviewed by the QIO. In the event of a citation, the provider is required to submit a plan of correction and the QIO conducts a follow-up review in approximately six months to ensure successful implementation of the corrective action plan.

Quality Indicators measure the provider implement a risk management and quality assurance program consistent with established policies. For SFY 2011, the compliance rate was 91.2%, with 21 of 34 files being compliant. Again, the sampling methodology used is unclear. Data submitted does not establish whether 100% of providers were reviewed or if 34 files were reviewed for one provider. Citations included new providers who had not yet established a QA/risk management committee and providers with committees that were not tracking/trending information as required by policy. Additionally, the QIO reviews assess that providers follow SCDDSN procedures regarding preventing, reporting and responding to ANE. The findings were 89.7% with 26 of 29 providers reviewed determined compliant. All provider agencies are required to review statewide information to establish how their organization compares with other providers regarding reporting and responding to ANE. Due to the fact there were no reports of ANE for waiver participants three providers did not review statewide information.

The state also measures the number of incidents of ANE in which an internal review was completed within required timeframes. Because there were no reports of ANE during SFY 2011, no internal reviews were required. The data submitted did not address if there were any reports of ANE during SFY 2010 or 2012.

Measuring the number of substantiated incidents of ANE is accomplished via the Incident Management system through comprehensive statewide and provider level profile reports which track, trend and analyze data. The reports provide raw data concerning the number of reports made, cases substantiated and they are rated in a ratio format of number per 100 (i.e., 7:100). This ratio information is useful in providing a comparative analysis among agencies and is discussed in the statewide Risk Management Meetings and collaborative DDSN/Quality Assurance Committee Meetings. Additionally, DDSN established another key indicator for QIO use when conducting reviews of provider agencies that determines the provider's compliance with SCDDSN Quality Management and Risk Management policies and whether the provider is utilizing their own data to track, trend and analyze incident management data.

In an effort to further ensure participant health and welfare, SCDDSN also submitted evidence of the state's monitoring of assurances not specifically captured in the PDD waiver performance measures. Information is captured from the case manager's annual assessment of each waiver participant. Required information is captured annually and used to develop service plans. Questions that must be answered in the assessment include: does the person have a primary care physician with regular visits; does the person have a dentist with regular visits; does the person have a diet prescribed by a professional; have there been any injuries in the past year due to mobility; have there been any mobility issues related to exit during a fire or other emergency; does the person have basic transportation; does the person seem to feel safe in the setting; does

the setting have any obvious hazards that may jeopardize health/safety; does the person appear to be satisfied in the setting; is there a plan for the person to live elsewhere if current living arrangement cannot continue; is there a plan of how care will be provided if the primary caregiver is unexpectedly unable to provide care; and is there a plan for what to do in the event of specific types of emergencies/natural disasters that would require displacement from this home. After completion of the assessment, a decision is made whether to formally address each need identified (the decision is made by the parents and/or legal guardians to assist with planning and include on the service plan). If included on the service plan, services/interventions in response to the needs are authorized. Guidelines for completing the SCDDSN service coordination annual assessment require a response to each question and will not allow completion of the assessment until a response has been provided for each item.

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.)

During the renewal process, CMS requires the state to include performance measures that look beyond the scope of abuse, neglect and exploitation. In addition, a full three years of evidence is required for future evidentiary information as quality improvement is constant and on-going. The state should consider including the additional information now captured from the case manager's annual assessment as performance measures. Some examples the state may wish to consider include:

- # and % of participant records that indicate parents are provided information as to how and when to report instances of suspected abuse, neglect, exploitation, or other areas of concern
- # and % of participants (parents) who report being treated well and with respect by direct support staff and service providers
- # and % of participants (parents) who report they receive regular physician visits and immunizations are up to date
- # and % of complains, by type, filed with SCDDSN (examples include behavior issues, health issues, staffing issues, case management or other provider issues, service plan issues)

State's Response:

The state provided additional information for SFY 2012 and 2013 that revealed 85.7% and 82.1% compliance, respectfully, for the number and proportion of incidents of reported abuse, neglect and exploitation. The state reported for all years of evidence submitted there were no reports of abuse, neglect or exploitation among PDD waiver participants. Providers were, however cited for not following the tracking/trending/analysis requirements in using their data.

CMS Response:

As recommended in the draft report, CMS recommends the state add performance measures that go beyond the scope of abuse, neglect and exploitation.

V. The 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 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.)

SCDHHS is the single state Medicaid agency with administrative oversight for this waiver program. This oversight includes the authority to request renewal and/or to amend the current CMS approved waiver, review and approve SCDDSN policy and procedures, improve and clarify policies and procedures, perform quality assurance reviews, and provide necessary training to providers on specific Medicaid policy issues. Additionally, SCDHHS issues Medicaid information and policy changes in the form of provider bulletins.

SCDDSN is the agency responsible for the day-to-day operations of this waiver, including intake/referral, obtaining freedom of choice selection for waiver or institutional services as well as provider choice, service plan development, service authorizations, monitoring of services, and annual level of care and service plan evaluations. They are the first line in reconsiderations or the hearing and appeals process. Participants are notified in writing by SCDDSN of their right to request a fair hearing in response to any adverse action. If the operating agency upholds the adverse determination, the participant may appeal to SCDHHS. There have been five SCDDSN reconsiderations since 2010, SCDHHS had heard three PDD appeals, one appeal was dismissed and one was pending a hearing at the time of evidence submission.

CMS is unable to determine if the state fully or substantially meets this assurance, as only one year of evidence was submitted. The evidence package submitted included outcomes of performance measures in the approved waiver. The state measures administrative authority by two performance measures which include the proportion of desk/focus reviews, utilization reviews, and/or suspected fraud investigations whose results are specific to delegated operational waiver functions as outlined in the MOA and service contract, and quarterly meetings held between SCDHHS and SCDDSN waiver administrative staff to discuss significant waiver issues.

Findings submitted indicated that SCDHHS Quality Assurance waiver staff examined specific waiver records on PDD providers for quality assurance reviews. The QA reviews indicate primary issues related to CMS waiver assurances. Deficiencies found included: amount, frequency, or duration of services were not specified on the service plan; case management providers not meeting minimum qualifications; and case management providers not meeting service activity requirements. SCDHHS QA staff required SCDDSN to develop a thorough remediation plan to address each issue within 30 days. SCDHHS reviews the corrective action

plan for improvements to ensure cited deficiencies were appropriately completed according to Medicaid laws, regulations, waiver requirements, waiver policy, and the MOA. If required, SCDHHS QA staff makes referrals to the Program Integrity Division for post payment review of records. It is unclear to CMS if SCDHHS and SCDDSN are utilizing the same QIO or different entities. Additionally, it is unclear if these entities are working independently of each other, together, or with the administrative and/or the operating agency.

Utilization reports are conducted by SCDHHS QA waiver staff as needed and sampling is determined by evidence warranting a special review and/or investigation. SCDHHS QA waiver staff work with Program Integrity staff to investigate complaints, allegations, or accept referrals regarding case reviews. If excess or inappropriate payments are made to Medicaid providers, Program Integrity will analyze data and recoup any payments. For suspected fraud, the Program Integrity Unit along with SCDHHS QA waiver staff collaborates with the Medicaid Fraud Control Unit of the SC Attorney General's Office to investigate any criminal intent.

The state reported 100% compliance for focus desk and utilization reviews. Remedial actions were completed and corrective actions verified. No suspected fraud investigations were required. However, it is unclear to CMS what the state is actually reporting as 100%. Is the state reporting that the required numbers of focus desk reviews were conducted, or that the findings of the focus desk reviews revealed 100% compliance?

The state also reported 100% compliance for conducting quarterly meetings to discuss specific waiver issues. Copies of the MOA and examples of meeting minutes, meeting agendas, reports, the 2011 meeting schedule, and specific PDD policy input/outcome were submitted as evidence.

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 indicates that SCDHHS and SCDDSN have an adequate working relationship for the operation of this waiver. The MOA and service contract identify specific measures the operating agency must meet in a timely fashion. However, the fact that the MOA and service contract exist does not ensure 100% assurance for full administrative authority. CMS requires the state to report a full three years of data in subsequent evidentiary reports that will show the intent of CMS's recommended quality assurance strategy – discovery, remediation and quality improvement. With only one year of data, it is not possible to determine if SCDHHS maintains full administrative authority of this waiver program. CMS also requires the state to develop additional performance measures in the waiver renewal process. Some examples include:

- # and % of individual findings regarding level of care reevaluations that were appropriately and timely remediated by SCDDSN
- # and % of service plans that did not include outcomes, measurable action steps that were appropriately remediated by SCDDSN
- # and % of substantiated cases of abuse, neglect and exploitation that were appropriately and timely remediated by SCDDSN

State's Response:

The state reports that SCDHHS exercises administrative authority through the enrollment and termination process of waiver participants. SCDHHS maintains sole change rights of the Medicaid Management Information System (MMIS) with regard to the "Recipient special Program", the process by which applicants are technically "entered" and ":removed" from the Medicaid waiver programs. DDSN enrollment staff must submit documents to DHHS that verify Medicaid eligibility and LOC determinations before DHHS will enter change records into MMIS.

The State additionally reports that DHHS wavier staff conducts case record reviews focusing on participant plans of care, level of care timeliness, freedom of choice, service notes and other supporting documentation to verify appropriateness and adequacy of series. They also make referrals to the Division of Program Integrity whenever recoupment of FFP may be indicated. Quarterly meeting between the agencies occur and are held and documented on a variety of issues, including policy updates/changes, enrollment, waiting lists, and training.

CMS Response:

The state appears to have adequate activities outlined in its Memorandum of Agreement (MOA) and service contract to indicate that the Single State Medicaid Agency maintains administrative authority of this waiver program. However, the existence of these documents alone does not ensure 100% compliance. The state should use the activities indicated in the MOA and service contract to develop additional performance measures that will produce statically valid data that can be tracked/trended/analyzed so the state can assure CMS they retain full authority over this waiver program.

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 demonstrate the assurance
(The State demonstrated 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 utilizes only one performance measure to ensure financial accountability for the waiver program: "The proportion of paid claims that are coded and paid in accordance with policies in the approved waiver." SCDHHS Fiscal, Audits, and Program Integrity (PI) staff conduct ongoing monitoring of finances. The QA process is used to monitor paid claims and participant utilization. The PI unit receives information from various sources regarding potentially inappropriate billings by Medicaid providers, they collect and analyze data, audit

payments to the provider in question based on record reviews or other audits, and recoup payments when provider records do not support the amount of services billed.

The Division of Finance within the SCDDSN also receives information regarding potentially erroneous claims from the QA efforts of both SCDHHS and SCDDSN. The Medicaid Management Information System (MMIS) is utilized to ensure waiver participants were eligible for services on the dates provided. If SCDDSN finds issues with claims in question and determines they are non-allowable, the Medicaid program is reimbursed by SCDDSN. The SCDDSN Finance Division also adheres to state audit policy that requires SCDDSN to void/replace incorrect claims using the web-based system.

SCDHHS invoices SCDDSN for the Federal Medicaid Assistance Percentage (FMAP) associated with any claims in question and SCDDSN pays the invoice via an Interdepartmental Transfer (IDT) within the State of SC Enterprise-Wide accounting system. During SFY 2011, four citations were made for indicators that were deemed as "recoupable."

Required Recommendations:

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

The state's process for financial accountability appears to identify erroneously paid claims through a post payment audit process. At the time of waiver renewal, CMS requires the state strengthen its financial accountability oversight by adding performance measures. Some examples the state should consider include:

- # and % of claims that were denied or suspended for incorrect billing codes and service rates
- # and % of claims that contain a prior authorization number, when required
- # and % of paid claims for services delivered to persons enrolled in the waiver in accordance with the approved service plan and with documentation to support the amount, frequency and duration of services billed

Additionally, federal regulations require annual 372 reports be submitted 18 months after the end of the waiver year to ensure cost neutrality for waiver programs. To date, no 372 reports for the current waiver (effective date of 01/01/10) have been submitted. The 372 reports for waiver years one and two are past due. These reports were due on 6/30/12 and 6/30/13 respectively. CMS requires the state to submit these reports no later than 30 days after receipt of this report.

State's Response:

The state submitted and CMS approved the 2010, 2011, and 2012 372 reports as required. The state also submitted evidence for SFY 2010 and 2012 as requested. Findings that a proportion of claims are coded and paid in accordance with policies in the approved waiver were 94.4% and 91.7%, respectively. Certain QI indicators are recoupable and when non-compliance occurs, DHHS will initiate the recoupment process. The state reports that at the time of renewal, it will review the financial accountability performance measures and revise or add as appropriate to strengthen financial oversight.

CMS response:

The CMS appreciates the state's submission of the 372 reports and accepts the state's review of the financial accountability performance measures for the upcoming renewal. The CMS is available for technical assistance if necessary.