

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>1-25-10</i>
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DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>3011315</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>4-9-10</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action		
<i>cc: Ms. Forkner, Dep't, CMS file Clean &amp; 3/9/10, letter attached.</i>			

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

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
61 Forsyth St., Suite 4120  
Atlanta, Georgia 30303-8909



January 15, 2010

**RECEIVED**

JAN 22 2010

Emma Forkner, Director  
South Carolina Department of Health and Human Services  
1801 Main Street  
Columbia, South Carolina 29201

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Dear Ms. Forkner:

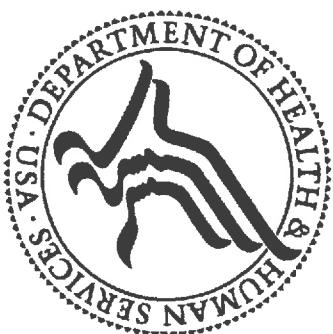
Enclosed is the draft compliance report for South Carolina's Home and Community Based Waiver for individuals with HIV/AIDS (control # 0186.90.R03). This review was conducted based upon evidentiary-based information submitted by your office on October 2, 2009. Please review this report and provide any comments to this office no later than April 15, 2010. The State's comments will be incorporated into the final report.

We wish you continued success in your Home and Community Based Waiver (HCBW) program and look forward to working with you in the future. If you have any questions or need assistance, please contact Kenni Howard at 404-562-7413.

Sincerely,

Mary K. Justus, RN, MBA  
Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Mark Reed, Central Office



**U.S. Department of Health and Human Services**  
**Centers for Medicare & Medicaid Services**  
**Region IV**

**Draft Report**

**Assessment of South Carolina's Home & Community-  
Based Waiver for Individuals with HIV/AIDS**  
**Control # 0186.90.R03**



# **South Carolina HIV/AIDS Waiver Assessment**

## **Control # 0186.90.R03**

### **Introduction:**

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

This review was conducted in accordance with the Interim Procedural Guidance for Assessing HCBS Waivers. Therefore, Regional Office staff did not conduct an on-site visit; review actual case records or conduct interviews with clients, caregivers or providers. Conclusions in this report are based on information submitted by the State to the Regional Office.

**Operating Agency:** State Medicaid Agency, the Division of Community Long Term Care Waiver Management

**State Waiver Contact:** Roy Smith, Director, Division of Community Long Term Care Waiver Management

**Target Population:** Individuals diagnosed with HIV and/or AIDS

**Level of Care:** Hospital

**# of Participants Approved for Year 4 of the Waiver:** 1,151

**# of Participants reported on the most recent 372 Report (dated):** 1,700 (10/1/07 - 09/30/08)

**Effective Dates of Waiver:** 10/01/06 – 09/30/11

**Approved Waiver Services:**

(1)	Case Management
(2)	Personal Care
(3)	Attendant Care
(4)	Home Delivered Meals
(5)	Companion Care
(6)	Home Accessibility Adaptations
(7)	Nursing

- (8) Specialized Medical Equipment & Supplies
- (9) Prescriptions

**CMS RO Contact:** Kenni Howard, RN

**Date Report Issued:** January 15, 2010

## **Background and Description of the Waiver:**

South Carolina was granted a waiver of Section 1902(a)(10)(B), "amount, duration, and scope of services," requirements of the Social Security Act in order to provide home and community based services to individuals diagnosed with HIV and / or AIDS who meet hospital level of care. The eligibility groups covered are those individuals with Medicaid coverage through SSI; low income families with children as provided in §1931 of the Act; those aged or disabled individuals who have income at 100% of the Federal poverty level; working individuals with disabilities who buy into Medicaid as provided in §1902(a)(10)(A)(ii)(XIII) of the Act; disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group); and, those individuals eligible under 42 CFR §435.217. South Carolina operates this waiver statewide.

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

**The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating / reevaluating an applicant's/waiver participant's level of care (LOC) need 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; SMM 4442.6*

All waiver referrals go through an intake process. Intake criteria are applied by a Nurse Consultant (NC) and the case is assigned to a second Nurse Consultant for an assessment. Assessments are keyed in to the South Carolina's Division of Health and Human Services (SCDHHS) Case Management System (CMS). Individuals who meet the eligibility requirements may enroll in the HIV/AIDS program. The Nurse Consultant verifies that the applicant is Medicaid eligible, meets Level of Care (LOC) and desires to participate in the waiver program. Justification for LOC determination is documented in the narrative and/or on the narrative checklist and on the assessment form.

Enrolled participants are re-evaluated at least annually or more frequently if warranted. The assigned contracted case manager completes the assessment within 365 days from the last completed assessment. The same assessment tool used for initial assessments and LOC determination is used for re-evaluations. The approved waiver assessment instrument is part of the Case Management System.

**The State demonstrates this assurance but CMS recommends improvements or request additional information.**

*(The State's system to assure appropriate level of care determinations is adequate and effective, and the State demonstrates ongoing, systemic oversight of the level of care determination process.)*

The Case Management System reports for the time period of October 1, 2006 forward indicate 100% of applicants have a Level of Care on file. Of the 357 enrollees reviewed, 43 did not have Level of Care determinations conducted within 30 days of waiver enrollment. However, approximately one half (20) of these can be explained through updated assessments completed prior to program entry but the Nurse Consultant did not enter updated LOC in the assessment LOC grid; program entry date is the date of transfer from one regional office to another instead of the date the applicant entered the program (10); and incorrect assessment/LOC code or other information inadvertently noted on the assessment (3).

The CMS generated reports indicated 850 participants had approximately 2700 re-evaluations completed between October 1, 2006 – September 14, 2009. Of the 850 participants, 276 had a total of 432 timeliness errors. There are explanations for sixty percent (60%) of the errors, leaving a true 6.4% error rate. The majority were due to late LOC determinations. Other errors were due to inadvertent incorrect data entry or re-evaluation completion during the anniversary month instead of on or before the anniversary date. The State reports that in May 2007, a significant policy change was implemented that no longer allows re-evaluations to be conducted during the anniversary month; all re-evaluations are now required to be completed prior to or on the anniversary date.

The approved waiver assessment instrument is part of the CMS program. The CMS program ensures that the approved assessment is used for 100% of applicants. A 3% sample of HIV/AIDS participants is involved in Central Office chart review covering 2007 and 2008. The data is entered into an Excel spread sheet and HIV/AIDS data is scored. The state has a 95% statewide average for using the appropriate process for level of care determination and 82% statewide average for level of care determinations. The 16% LOC determination error is due to LOC determinations submitted prior to receipt of all required information. A Central Office HIV/AIDS Waiver exception may be obtained verbally; however, a copy of the form must be sent and filed in the participant's chart.

**Evidence Supporting Conclusions:**

*(Evidence that supports the finding that the State substantially meets this assurance.)*

- Attachments 1A and 1B: Instructions and sample Nurse Consultant quality assurance review tools
- Attachment 2: Samples of NC completed checklists and assessment to support level of care determination and Medicaid eligibility
- Attachment 3: Report indicating that 357 applicants were assessed within 180 days of enrollment and had a LOC on file
- Attachment 4: Sample documentation to support team staffing and LOC determinations 30 days prior to enrollment
- Attachment 5: Copy of Regional Office correspondence with NC staff
- Attachment 6: Documentation to support case transfer date used as waiver enrollment date

- Attachment 7: Copies of policy & procedures that address transfer of cases from one regional office to another
- Attachment 8: Documentation to support inadvertent use of incorrect codes on assessments
- Attachment 9: CMS report that shows re-evaluations
- Attachment 10: Copy of assessment form
- Attachment 11: HIV/AIDS Waiver Level of Care Exception Request Form
- Attachment 12: Copies of Policy & Procedure revisions to address timeliness of participant re-evaluations and team staffing with State employee for LOC determination
- Attachment 13: Copy of SCDHHS LOC training
- Attachment 14: Copy of Community Long Term Care (CLTC) Orientation – Assessment & LOC Training
- Attachment 15: Copy of CLTC Case Management Training
- Attachment 16: Copy of CLTC Case Management Orientation
- Attachment 17A: Copies of Statewide Summary of Central Office Quality Assurance Review
- Attachment 17B: Copies of Central Office QA Reviews
- Attachment 18: Sample of SCDHHS Annual QA Reports and Regional Office Corrective Action Plans
- Attachments 19 & 20: Instructions & copies of RO monthly internal QA reviews.
- Attachments 21A & 21B: Quality Assurance Task Force Meeting Agendas and notes (March 11, 2009 and May 13, 2009)
- Attachments 22A & 22B: Quality Assurance Task Force Meeting Agency agenda and notes (September 9, 2009) and follow-up emails on LOC concerns
- Attachment 23: Copies of RN case management narratives, assessments, physicians input forms and/or CO HIV/AIDS exception form

### **CMS Recommendations:**

The Centers for Medicare & Medicaid Services requires that LOC determinations be completed prior to enrollment into the waiver, and recommends the State set the compliance rate for this assurance at 100%. For those recipients who did not have LOC determination completed at enrollment (23 identified by the State to lack LOC determinations within 30 days of enrollment), federal financial participation (FFP) should be returned to CMS for any services provided to those recipients. FFP for services provided to waiver recipients should also be returned for those identified whose LOC were past due or were outside the 365 day required time-frame for re-evaluation.

It is recommended that the State implement a systems edit (if not already available) to ensure that services are not paid until a LOC determination is on file or if a re-determination of that LOC is outside the 365 days required time-frame.



## **II. Plans of Care Responsive to Waiver Participant Needs**

**The State must demonstrate that it has designed and implemented a system to assure that plans of care for waiver participants are adequate and services are delivered and are meeting their needs.**

*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*

SCDHHS is responsible for developing participant service plans based on the comprehensive assessment of the participant's medical needs, activities of daily living, psycho-behavioral information, instrumental activities of daily living, and the individual's strengths. Each problem addressed on the service plan includes goals, objectives and interventions. The State CMS program has a component (the "Wizard") that links problems identified in the assessment to the service plan. Case Managers use this component to identify all problems in the assessment and review options for addressing them in the service plan. Service plan development and updates are discussed during new case managers orientation and training with regional trainers.

Regional office monthly internal QA reviews, quarterly accumulated and internal QA review data and CO yearly reviews are used to monitor the updating of service plans annually or when warranted by changes in participants' needs.

On a monthly basis, SCDHHS regional office senior case management staff review files from each case manager to ensure accurate service plan development. Any problems found are recorded on an internal QA tool and discussed with the appropriate case manager. Case Managers' monthly QA scores are accumulated on a quarterly basis and shared with case managers and case management agencies. Any QA tool that falls below the compliance threshold must be addressed with a corrective action plan.

### **The State substantially meets this assurance**

*(The State has an adequate and effective system to assure that all aspects of Plan of Care requirements are addressed; has an adequate and effective system for monitoring Plans of Care; has a system for assuring that participants are afforded choice between/among waiver services and providers; and demonstrates ongoing, systemic oversight of POCs.)*

The State's Case Management System (CMS) program provides a means to ensure that service needs are addressed through the "Wizard" component. This links problems identified in the assessment to the service plan and Case Managers use this component to identify all problems in the assessment and address them in the service plan development.

Central Office annual reviews and regional office monthly internal reviews of service plans ensure participant needs are addressed. Regional Office monthly internal QA reviews; quarterly accumulated internal QA review data and CO yearly reviews are used to monitor the updating of service plans annually, or when warranted by changes in participant's needs.

The CMS program will not allow service authorizations that do not contain amount, duration, scope and frequency criteria. Care Call reports monitor service delivery. Regional office management staff monitors care call activities and note results on the internal monthly QA tool.

The State ensures that participants are offered a choice between waiver services and institutional care; and, between/among services and providers by having the participant and/or responsible party sign and date a LOCUS form prior to program entry. The LOCUS form indicates the participant's choice of community care or institutional care. Also, a State case manager presents contracted case manager choices to each participant for verbal case management selection. Other service providers are selected at the initial visit made by the chosen case manager. Proper documentation of provider choice is monitored as part of the internal QA process.

Participant and/or responsible party dissatisfaction with provider or services reported through the FLTC complaint system is addressed by CLTC staff and with the appropriate Case Manager for resolution. Also, a sample of participants is surveyed yearly for participant satisfaction with service.

**Evidence Supporting Conclusions:**

*(Evidence that supports the finding that the State substantially meets this assurance.)*

- Attachment 13: Copy of SCDHHS Regional Trainers Teaching/Training Guide.
- Attachment 16: Copy of CLTC Case Management Orientation – Quality Assurance handout.
- Attachment 17A & 18: Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Reviews.
- Attachment 20: Copy of regional office monthly internal QA reviews.
- Attachment 24: Copy of assessments, service plans and service plan wizard requirements.
- Attachment 25 and 26: Instructions for distribution of quarterly case managers' accumulated internal QA scores and sample of quarterly case managers' accumulated regional office internal QA scores.
- Attachment 27: Copy of 8/20/09 agenda for regional office management and supervisory staff training (which included reminder of quality assurance review instructions and process for sharing information with case management agencies and/or independents)
- Attachment 28: Copy of 9/1/09 agenda for case management provider meeting
- Attachment 29: Regional Trainers meeting minutes
- Attachment 30: Sample Care Call Reports
- Attachment 31: Copies of CLTC Complaints
- Attachment 32: Copy of 2008 Annual Survey of CLTC Consumer Experience & Satisfaction report

### 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 requires that potential providers complete an application, meet requirements as outlined in the approved waiver document, and attend a pre-contractual training. The state monitors providers to assure adherence to waiver requirements. The CLTC Compliance Review Officer monitors contracted providers, licensed and non-licensed, to ensure compliance with waiver requirements. The State implements its policies and procedures for verifying that training is provided in accordance with state requirements in the approved waiver.

#### **The State substantially meets this assurance**

*(The State has an adequate and effective system for qualifying and monitoring providers, and demonstrates ongoing, systemic oversight of providers.)*

The State employs a Registered Nurse (RN) reviewer to conduct on-site periodic reviews of providers. These reviews consist of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other training requirements as outlined in the contract. The administrative review determines whether all agency administrative requirements (liability insurance, list of officers, emergency backup plans, policy and procedure manuals, etc.) have been met. The participant review verifies whether all requirements relating to the actual conduct of service have been met.

For services monitored by the compliance registered nurse, a report is generated listing all identified deficiencies. The report will also score the review based on a sanctioning scale; the scores will determine if the provider will receive a sanction and if so, the level of the sanction. The scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed. Currently only Personal Care II and Adult Day Care reviews are being scored. Based upon the severity and number of deficiencies, along with results of prior reviews, sanctions may take place.

There are five types of sanctions:

- (1) Corrective Action Plans – This is the least severe sanction and indicates the provider is in substantial compliance with contractual requirements. The provider is required to submit a corrective action plan for correcting deficiencies and avoiding recurrence.
- (2) 30-day suspension – This sanction level is moderate and at this level, new referrals are suspended for 30 days. The provider is required to submit a corrective action plan and if approved, the suspension is lifted at the end of the 30 day period.

- (3) 60-day suspension – This sanction level is substantial and new referrals are suspended for 60 days. The provider is required to submit a corrective action plan and if approved, the suspension is lifted at the end of the 60-day period.
- (4) 90-day suspension – Indicates major and/or wide spread deficiencies. The 90 day suspension of new referrals will only be lifted after an acceptable corrective plan and an acceptable follow-up review is conducted.
- (5) Termination – Indicates major and substantial deficiencies, generally coupled with a history of reviews with repeated moderate to major deficiencies. The provider is terminated from the Medicaid program.

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

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

Attendant care services are provided by individuals directly employed by participants. SCDHHS has a contract with the University of South Carolina to ensure that attendants meet all requirements to provide services. Individual companion services are provided to participants who are capable of self-directing their care. Participants may discharge companions for any reason.

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

#### **Evidence Supporting Conclusions:**

*(Evidence that supports the finding that the State substantially meets this assurance.)*

- Attachment 33: Copy of provider's Personal Care Application with required attachments
- Attachment 34: Copy of a provider compliance review
- Attachment 35: Copy of follow-up letters relative to provider compliance review
- Attachment 36: Copy of MOU between State Office on Aging and SCDHHS
- Attachment 37: Copy of sanctions for Environmental Modification providers
- Attachment 38: Copy of Attendant termination and recoupment letters

#### **IV. Health and Welfare of Waiver Participants**

**The State must demonstrate that it assures the health and welfare of waiver participants including identification, remediation and prevention of abuse, neglect and exploitation.**

*Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 447.200; SMM 4442.4; SMM 4442.9*

New staff orientation was provided on a four to six month basis until July of 2007. After July 2007, due to frequent hiring of new contract case managers and fewer state case managers, orientation is now conducted every other month to all new contract case managers. Part of the orientation includes training on Adult Protective Services (APS). Also, an APS power point has been developed and is placed on the internal website for training purposes. The State Law, mandatory reporting, importance of referrals and narration are stressed. There is also a Memorandum of Agreement between SCDHHS and South Carolina Department of Social Services (SCDSS) for providing a system for receiving and investigating reports of alleged abuse, neglect and exploitation occurrence to vulnerable adults receiving services.

**The State substantially meets this assurance** *(The State's system to assure health and welfare is adequate and effective, and the State demonstrates ongoing, systemic oversight of health and welfare.)*

The CLTC complaint system is used to notify Central Office of reported allegations of abuse, neglect and/or exploitation. Reported allegations that are not resolved at the regional office level are discussed for resolution at Quality Assurance Task Force Meetings.

**Evidence Supporting Conclusions:**  
*(Evidence that supports the finding that the State substantially meets this assurance.)*

- Attachments 14 & 15: CLTC Orientation agendas and CLTC Case Management Training topics.
- Attachments 22A: Copies of QA Task Force Meeting Agendas and notes regarding allegations of abuse, neglect and/or exploitation.
- Attachment 39: CLTC Orientation APS information.
- Attachment 40: Copy of APS internal website power point presentation.
- Attachment 41: MOU between SCDHHS and SCDSS
- Attachment 42: Copy of CLTC Complaint and Resolution Report

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

**The State must demonstrate that it retains 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*

SCDHHS retains administrative authority and responsibility for operation of the HIV/AIDS waiver program. Waiver functions are performed by eleven (11) area SCDHHS offices and two satellite offices. Each area and satellite office has state employees (Area Administrators, lead team case managers and lead team nurse consultants and other nurse consultants) that manage and supervise the daily operations of the waiver.

**The State substantially meets this assurance**

*(The State Medicaid agency has an adequate and effective system for administrative oversight of the waiver, and the administration of the waiver program is consistent with the approved waiver.)*

Initial assessments and level of care determinations are performed by state nurse consultant staff. Initial service plan development is performed by state senior case managers. On-going waiver services are performed by contracted case managers and a limited number of state case managers. Services provided by contracted case managers are monitored by area office supervisory staff and central office staff. Area office state employees are monitored by supervisors and during Central Office quality assurance reviews.

**Evidence Supporting Conclusions:**

*(Evidence that supports the finding that the State substantially meets this assurance.)*

- Attachment 17A: Copy of Statewide Summary for Central Office 2007-2009 QA Review.
- Attachment 20: Copies of regional office monthly internal QA reviews.

**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; 42 CFR 447.200; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10*

As noted, the State Medicaid Agency serves as both the Administrative and Operating Authority for the HIV/AIDS waiver program. The agency has direct responsibility for ensuring financial accountability. This is done in a number of ways.

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

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

**The State substantially meets this assurance**  
*(The State's system for assuring financial accountability is adequate and the State demonstrates ongoing, systemic oversight of waiver finances.)*

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

At this time, Personal Care, Agency Companion, Nursing, Attendant, Individual Companion, Adult Day Care, Adult Day Care Nursing, Adult Day Care Transportation, Home Delivered Meals, Case Management and Home Modifications are billed through the Care Call system. In all cases, no claim can be submitted that is not supported by a service authorization. It is planned that at some point all waiver claims will process through the Care Call system. Currently, for services not part of the Care Call system, South Carolina has developed a system which checks to ensure that the participant is enrolled in the waiver and is Medicaid eligible at the time of the service. Case Managers review service delivery with participants on a monthly basis to ensure that claims are appropriate and that authorized services are being delivered.

In addition to the financial accountability offered by the Care Call system, the State also employs a licensed Registered Nurse who conducts on-site reviews with personal care, companion, and nursing providers. The reviews consist of three components: staffing review, administrative review and participant review. These reviews have been automated for a number of years. Since April 2008, personal care reviews have been scored based upon number and seriousness of deficiencies. Provider sanctions are based upon these scores. The review schedule is based upon results of prior reviews and every provider receives an on-site review at least every 18 months.

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

**Evidence Supporting Conclusions:**

*(Evidence that supports the finding that the State substantially meets this assurance.)*

- State's written explanation and documentation submitted
- Most recent 372 report



To Cheryl,  
HOBW,  
HNV  
3/5

State of South Carolina  
Department of Health and Human Services

Mark Santord  
Governor

Emma Forkner  
Director

March 9, 2010

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

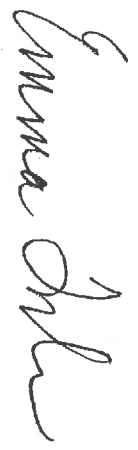
Dear Ms. Glaze:

Enclosed is South Carolina's response to the draft compliance report for South Carolina's Home and Community Based Waiver for individuals with HIV/AIDS (control # 0186.90.R03). This response is based upon comments and recommendations submitted by your office on January 15, 2010.

We appreciate your feedback and thank you for the opportunity to comment on recommendations noted in the draft report.

We look forward to your final report on South Carolina's performance. If you have any questions please contact Sam Walidrepp at (803) 898-2725.

Sincerely,

  
Emma Forkner  
Director

EF:jip

Enclosures

in response to 1. State Conduct Level of Care Determinations Consistent with the Need for institutionalization:

South Carolina has been working on improving the initial and redetermination level of care processes for the HIV/AIDS waiver. The State has redesigned its automated case management system for all waivers. This web-based system, Phoenix, is scheduled for implementation April 1, 2010. The software has been designed to address many of the issues identified in the CMS draft report.

Our original assessment reported 23 level of care determinations not updated within 30 days of enrollment. Upon further investigation, we found 5 that should not have been reported in our October 2, 2009 original assessment. As you know, South Carolina relies heavily on computerized reporting. Our investigation led us to extensive chart reviews. We found one chart that had a level of care with a typographical error which caused the computerized report to be incorrect; we discovered an eligibility error but not a break in service, and therefore there should not have been a loss in level of care; there was one mistake on our reviewer's part; and we found 2 computer glitches which created misreporting. Due to the above situations, we are asking to reduce our error rate from 23 cases to 18 cases where initial level of care was not documented within 30 days of entry into the waiver program.

Our original assessment reported there were past due level of care determinations outside of the 365 day required period for re-evaluations. We have identified 27 participants with 35 late level of care determinations.

We are implementing a retraining initiative with all nurses and case managers that will cover all aspects of level of care determination and timeliness. This training will be conducted statewide by our 5 regional trainers. They will utilize the Community Long Term Care Level of Care Manual and the CMS HCBS Waiver Assurance online Training through the Muskie School of Public Service. All training will be conducted in the month of June.

Phoenix will not allow entry into any of the waiver programs without a level of care within 30 days of enrollment. The software also has what is known as a dashboard. This dashboard is personalized for each worker and will show them when participants have re-evaluations due and flag them ahead of time.

CLIC Central Office has already been working, on a one-on-one basis, with regional offices that were identified during chart reviews as needing intervention. This intervention has led to inter-office training for clarification of current policies and procedures. Central Office is sending out statewide directives to clarify policy. Central Office also met with Regional Area Administrators and Lead Team supervisory staffs to discuss the HIV/AIDS draft report and the importance of appropriate and timely level of care determinations for all waiver applicants and participants.

Lastly, actions are being taken to assess federal financial participation repayment for services provided to recipients who did not have LOC determination completed at enrollment and waiver participants

whose LDC determinations were past due or outside the 365 day required time-frame for re-evaluations. In addition, as stated in our original assessment, effective January 2009 the compliance rate for initial and re-evaluation level of care determinations changed to 100%.

South Carolina has no other comments on the draft report and appreciates the opportunity to review and comment.