DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Waldrop	6-5-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-457	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Deps, CLS file Cleared 8/30/12, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 8-1-12 [ ] FOIA DATE DUE _____ [ ] Necessary Action

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

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

June 1, 2012

Log: Waldrep
C: Director, COS

Mr. Anthony E. Keck, Director
Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29201

RECEIVED
JUN 04 2012
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Dear Mr. Keck:

Enclosed is the draft report of the Centers for Medicare & Medicaid Services' (CMS) review of South Carolina's Head and Spinal Cord Injury (HASCI) Waiver, control number 0284.R03. This waiver serves individuals with traumatic brain injury, spinal cord injury or both, or a similar disability, who meet Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care.

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 two of the review components. For the non-compliant assurance, the State must show compliance at the time of renewal in order for CMS to approve the waiver renewal. As such, we included necessary recommendations for program improvements in the assurance area. We suggest you address these prior to renewal of the waiver in order to meet the assurance and maximize the quality of the waiver program. Please include a detailed plan, with target dates, to show compliance and/or improvements in required waiver performance issues identified in the report. Beginning September 1, 2012, CMS requires the State to submit quarterly reports on the areas of non-compliance so that we can monitor your improvement as you work toward the renewal application of this waiver program.

Please review the draft report and submit your comments within 60 days of receiving this letter. Your response will be incorporated into the final report, which will then become a public document. Should we receive no response from you by 60th day, July 31, 2012, this draft report becomes a final document. We are available to discuss the report and to provide technical assistance. Please do not hesitate to let us know how we may be of assistance.

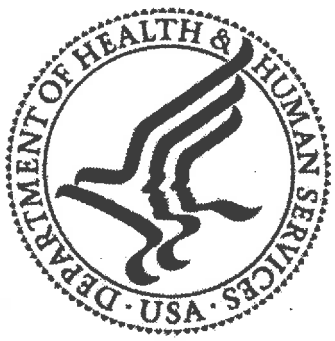
We would again like to extend our sincere appreciate to the South Carolina Department of Health and Human Services, which provided information for this review. If you have any questions, please contact Kenni Howard at 404-562-7413.

Sincerely,

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

Enclosure
cc: Alexandra Smilow, CO

CMS
CENTERS for MEDICARE & MEDICAID SERVICES



U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region IV

DRAFT REPORT

Home and Community-Based Services Waiver Review
South Carolina Head and Spinal Cord Injury Waiver
Control #0284.R03

June 1, 2012

Home and Community-Based Services
Waiver Review Report

Executive Summary

The South Carolina Department of Health and Human Services (DHHS) is authorized by §1915(c) of the Social Security Act to provide home and community based services through the Head and Spinal Cord Injury (HASCI) Waiver. This waiver serves individuals up to age 65 with traumatic brain injury, spinal cord injury or both, or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to aging. All individuals must meet either nursing facility (NF) level of care (LOC) or Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care. Services offered are designed to provide participants the choice of remaining in their homes as an alternative to residing in a NF or ICF/MR.

As requested per the CMS Interim Procedural Guidance, South Carolina submitted evidence to document adherence with program assurances as required per §42 CFR 441.302. In the September 30, 2011 submission, the State provided an overview of processes, systems and summary reports for each federal assurance.

The HASCI waiver is operated by the South Carolina Department of Disabilities and Special Needs (DDSN). A Memorandum of Agreement (MOA) and service contract establishes the role of DDSN as the operating agency and the oversight role of DHHS. The HASCI waiver services are provided to participants in their homes and other community settings while promoting maximum independence through person centered services which focus on individual needs. This waiver offers participant direction allowing individuals to direct attendant care services if they so choose. The DDSN service coordination staff arranges and authorizes waiver services.

The DHHS has administrative oversight and monitors health, safety and welfare of waiver participants through its Bureau of Community Long Term Care (CLTC). The CLTC is responsible for both institutional and community based long term care programs for the elderly and other special needs populations. DHHS ensures a formal system is in place to periodically review participant services and to ensure that services provided are consistent with the needs of the HASCI waiver participants. DHHS also assures financial accountability for funds expended and appropriate documentation of services for participants enrolled in the HASCI waiver.

The DDSN contracts with Delmarva, a Quality Improvement Organization (QIO) to review compliance with state and federal regulatory standards.

Summary of Findings

1. **State Conducts Level of Care Determinations Consistent with the Need for Institutionalization: The State substantially meets the assurance.**

   Suggested Recommendations:

   Evidence submitted substantiates the State has an effective system for LOC determinations and redeterminations. The CMS recommends that the State utilize the National Quality Enterprise (NQE) for technical assistance in developing performance measures, identifying data sources, creating remediation actions and strategies for systems improvements.

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

   Required Recommendations:

   The CMS requires the State to reevaluate the current processes utilized for service plan development. The review period of July 1, 2008 through June 30, 2009 revealed that 69% of service plans required corrective action. Further, the April 2010 review revealed that only 89% of service plans were in compliance, indicating failed remediation strategies. CMS reminds the State that the quality standards require demonstrating compliance through 100% discovery or less than 100% discovery plus 100% remediation. The State should work to ensure that remediation is documented and tracked. Please provide CMS with quarterly updates on remediation actions, strategies and system improvements beginning July 1, 2012.

   While the State has some performance measures in please, the CMS requires the State to develop additional ones with metrics that will identify specific outcomes; remediation strategies (both individual and systemic); and, to develop follow-up actions to ensure remediation activities are effective. Examples of acceptable performance measures include: The percent of service plans that address risk (as identified by the participant assessment) adequately and appropriately; and/or. The percent of service plans that are updated at least annually or as specified in the approved waiver."

   The State is required to ensure Freedom of Choice between institutional care and HCBS as well as between waiver services and providers. This could be accomplished through a simple performance measure that reads, "The number of waiver participants whose file contains a completed, signed freedom of choice form".

   The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

3. Qualified Providers Serve Waiver Participants: The State does not demonstrate the assurance.

Required Recommendations:

The CMS requires the State strengthen performance measures, demonstrate its ability to collect data, identify remediation strategies, systems improvements and follow-up actions taken to assure 100% compliance rate for providers. Providers that do not meet the necessary re-licensure, re-certification, and/or training requirements should be disqualified from providing services and sanctioned per DHHS policies. A suitable performance measure for provider trainings should evaluate not only the provision of trainings, but also the number of providers, by provider type meeting the training requirements. Beginning September 1, 2012, please provide CMS with quarterly updates on the progress of remediation actions/strategies utilized for providers who do not meet 100% compliance.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

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

Required Recommendations:

The State has performance measures in place to address abuse, neglect and exploitation. However, little to no evidence was submitted on remediation actions or improvement strategies; therefore, the State should develop and implement remediation actions/strategies for each performance measure and develop a mechanism to track remediation to ensure it was completed and successful.

CMS requires that the State develop performance measures to ensure the health and welfare of the waiver participant is being monitored beyond abuse, neglect and exploitation. Performance measures that address sufficient back up plans for the absence of attendant care/personal care providers; emergency evacuation plans in the event of hurricanes and/or other acts of nature; and, participant satisfaction surveys should be considered for use by the State. Please provide the CMS with quarterly reports indicating the State's progress on development of performance measures, beginning September 1, 2012.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

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.

Required Recommendations:

The CMS requires DHHS to assess functions delineated to DDSN in the MOA to ensure full compliance with this assurance. The Medicaid Agency should specify its expectations for the performance of these functions by including the standards to which it will hold the delegated entity. These standards should be measurable and the DHHS should be able to develop performance measures from the standards. DHHS should use the performance measures to monitor the achievement of standards by the delegated entity, as well as to demonstrate to CMS that it is exercises and maintains administrative authority.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

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

Suggested Recommendations:

Currently, the State uses one performance measure (Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver) for this assurance. CMS recommends the State develop additional performance measures to ensure financial accountability. The State should consider developing and implementing procedures to consolidate data from ongoing audits to analyze the overall financial performance of the waiver. The CMS suggest the State utilize the NQE for technical assistance in developing performance measures.

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 assurances are met. The assessment also serves to inform CMS in its review of the State's request to renew the waiver.

State's Waiver Name	South Carolina Head and Spinal Cord Injury Waiver
Operating Agency:	South Carolina Department of Disabilities and Special Needs
State Waiver Contact:	Anita Atwood
Target Population:	Individuals ages 0 to 65yrs with traumatic brain injury, spinal cord injury or both, or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to aging
Level of Care:	Nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR)

Number of Waiver Participants: 625 (as of September 1, 2011)

Average Annual per capita costs: $28,063 (as of June 30, 2011)

Effective Dates of the Waiver: July 1, 2008 – June 30, 2013

Approved Waiver Services: Attendant Care/Personal Assistance, Day Habilitation, Residential Habilitation, Prevocational, Respite Care, Supported Employment, Occupational Therapy, Physical Therapy, Prescribed Drugs, Speech/ Hearing/Language Services, Behavioral Support, Environmental Modifications, Health Education for Consumer-Directed Care, Medicaid Waiver Nursing, Medical Supplies/Equip. & Assistive Technology, Peer Guidance for Consumer-Directed Care, Personal Emergency Response System, Vehicle Modifications, and Psychological Services.

CMS Contact: Kenni Howard

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 consistent with care provided in a hospital, nursing facility or ICF/MR.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State substantially meets the assurance
(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.)

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

Initial determinations for NF LOC are made by nurses employed by or contracted with DHHS through its' Bureau of CLTC. The licensed nurse determines if the individual applying for enrollment into the HASCI waiver meets NF LOC by using recent medical and functional documentation, information provided by the participant or their representative, and direct observation of the participant. Following the assessment, CLTC notifies a HASCI service coordinator if the individual meets NF LOC. If the individual is not enrolled within 30 calendar days after the date of the initial LOC determination, the HASCI service coordinator requires an updated LOC assessment.

When an individual does not meet NF LOC criteria, the HASCI service coordinator will notify the HASCI Division, who is required to provide the individual with the DHHS Medicaid appeal notification. Upon appeal, if the DHHS finds the individual meets the NF LOC, a new or corrected "DDSN/CLTC Transmittal Form for Nursing Facility Level of Care" form and a new or corrected "South Carolina Long Term Care Assessment Form" is sent to the HASCI service coordinator and the individual is enrolled into the HASCI waiver

The State reported completing 51 NF initial LOC determinations between July 2010 and August 2011, although the evidence submitted by the State indicated 7 initial determinations were outside of the review period and one determination was a duplicate reducing the number of completed initial determinations to 43. The State reported 100% of new enrollees during the reporting period had an initial LOC determination within 30 days prior to waiver enrollment.

Once participants are determined to meet NF LOC, they must be formally reevaluated at least every 365 days. DDSN uses the automated Consumer Data Support System (CDSS) to track the due date for the LOC reevaluations. If the participant demonstrates marked improvement in function when visited by the service coordinator, the individual is reevaluated immediately rather than waiting until the next scheduled reevaluation.

The NF LOC reevaluations are conducted by the HASCI service coordinator using recent medical and functional information provided by the participant or the participant's representative. A direct observation of the participant is conducted to determine if there is a change or improvement in the functioning that could affect participant's NF LOC determination.

In May 2009, a quality assurance review of 480 NF LOC reevaluations was conducted by DHHS for the review period of November 2008 – April 2009. The review identified 103 NC LOC reevaluations were overdue with an additional 380 errors on the assessment forms completed by the service coordinators. To remediate, DHHS and DDSN collaborated to develop a strategy by which all service coordinator supervisors are now required to review all information contained on the assessment form before they provide their signature approving the assessment. Also, all HASCI service coordinators are required to attend training on the assessment process.

A follow-up quality assurance review was conducted by DHHS in November of 2009. The review consisted of 200 LOC reevaluations and DHHS found 100% were completed within 365 days of the previous LOC determination.

Initial determinations for ICF/MR LOC are conducted by the DDSN's Consumer Assessment Team (CAT). The individual's medical and/or school records, psychological or adaptive testing reports and functional information supporting a formal diagnosis of intellectual or related disability are considered in making the determination.

When the CAT finds an individual meets ICF/MR LOC, the HASCI service coordinator is notified. If the individual is not enrolled within 30 days after the date of the initial ICF/MR LOC certification, the HASCI service coordinator is required to request the CAT re-certify the determination.

When an individual does not meet the ICF/MR LOC, the HASCI service coordinator will notify the HASCI Division, who is required to provide the individual with the DHHS Medicaid appeal notification. If DHHS reverses the adverse LOC determination, the CAT will complete a new LOC for ICF/MR and notify the HASCI service coordinator of the LOC determination date and the individual will be enrolled into the HASCI waiver.

The State reported it completed 14 ICF/MR initial determinations between July 2010 and August 2011. Evidence submitted indicated 100% of new enrollees met ICF/MR LOC and had an initial LOC determination within 30 days prior to waiver enrollment; however, five ICF/MR determinations were outside the review period.

Participants who are determined to meet ICF/MR LOC must be formally reevaluated at least every 365 days. If the participant demonstrates marked improvement in function when seen by the Service Coordinator, he/she is reevaluated immediately rather than waiting until the next scheduled reevaluation.

The State reviewed a sample of 34 participants for the July 2010 and August 2011 review period to establish 97.2% compliance for re-certifications within 365 days of the last re-certification. Remediation was to issue a directive to the provider to submit a plan of correction addressing the action taken to bring compliance up to 100%.

Suggested Recommendations:

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

Evidence submitted substantiates the State has an effective system for LOC determinations and redeterminations. The CMS recommends that the State utilize the National Quality Enterprise (NQE) for technical assistance in developing performance measures, identifying data sources, creating remediation actions and strategies for systems improvements.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that is 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 Number13

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

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

DHHS utilizes the State Plan Targeted Case Management option for service coordination for HASCI waiver participants. The DDSN uses service coordination standards, which include core functions of assessment and care planning, in addition to requirements for a comprehensive assessment of the participant's needs. The DDSN assist participants in minimizing the severity of their disabilities by identifying individual needs and coordinating services. Service plans must be completed and approved prior to waiver participants receiving HCBS services. The DDSN also follows-up to ensure the service plan is implemented and the status of the participant is reviewed quarterly.

The DDSN uses the Consumer Data Support System (CDSS) to obtain the participant's annual assessment, service plan and service notes to facilitate effective service coordination. Service notes should reflect monitoring within two weeks of the start date of an ongoing service or provider change and include the usefulness, effectiveness, frequency, duration, as well as the participant's (or participant's legal guardian's) satisfaction with the service.

For the sub assurance that indicates if service plans address all participants' assessed needs and personal goals, the State reported for the review period of 7/1/08 – 6/30/09, 69% of the reviewed cases required corrective action by the service coordinators and follow-up review by a supervisor before the participants' support plan could be finalized. For the review period of 7/1/09 – 6/30/10, only 79.1% met the requirements. In an effort to remediate this, five percent or more HASCI waiver participants are reviewed by the DDSN District Office staff within 90 days prior to the annual assessment and service plan due dates. Findings of the review are sent to the Service Coordinators and their supervisors through a transmittal called the "Service Coordination Plan Review Disposition Form" which identifies areas that require corrective actions. DDSN also tracks this activity and utilizes the findings to determine training and technical assistance needs of the Service Coordination providers.

For the sub assurance that measures if service plans were developed in accordance with State policy and procedures, the State utilizes an electronic system known as the Consumer Data Support System (CDSS). This system allows for retrieval of the participant's annual assessment, service plan and service notes. Service notes should reflect monitoring within two weeks of service implementation and/or provider changes and should include the usefulness, effectiveness, frequency, duration and the participant's satisfaction with the service. The system also alerts service coordinators and supervisors within 60 days of the date the annual service plan update is due. During the review period of 7/1/09 – 6/30/10, the QIO found that only 87.5% of service notes reflected documentation identified above. Also, during the same review period, the QIO reports only 84.4% of the service notes reflected monitoring as often as necessary but as least quarterly and a statement of usefulness and effectiveness of all ongoing waiver services with justification of continued need.

The State reports for the period of 7/1/08-6/30/09, a review was conducted to determine if participants' service plans were updated and/or revised at least annually and when warranted by changing needs of the participant. The results of the review indicated 89.8% compliance for annual updates and 83.3% compliance for service plans being updated when warranted by documented changes. Providers who did not meet key indicators were required to address them with a Plan of Correction (POC) submitted to the QIO. The POC indicated that the provider issued "refresher training" to service coordinators. A follow-up review by the QIO revealed 92% compliance but also that one indicator continued as "not met" (service coordination staff receive training as required.)

To determine if the sub-assurance for services being delivered in accordance with the service plan (type, scope, amount, duration, and frequency), the State submitted results of the review conducted during the time period of 7/1/09 – 6/30/10. Findings showed only 62.2% compliance with this sub-assurance. The State's remediation strategy of training staff how to "lock" print jobs to avoid staff retrieving information not pertinent does not explain how this ensures each waiver service plan has the appropriate documentation to support the amount, frequency and duration of services.

A copy of a signed Freedom of Choice form documenting the participant's choice is submitted by the Service Coordinator to the HASCI Division to provide evidence that participants are offered choice between waiver services and institutional care. The QIO conducts reviews to ensure these forms are maintained. The State reported 96.4% compliance when reviewing participant records to assure there was a signed Freedom of Choice form. The evidence to support that statement, SP Document # 12, was directed at patient management of their personal funds. There was no evidence to support reviews to ensure participant Freedom of Choice had been conducted.

Required Recommendations:

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

The CMS requires the State to reevaluate the current processes utilized for service plan development. The review period of July 1, 2008 through June 30, 2009 revealed that 69% of service plans required corrective action. Further, the April 2010 review revealed that only 89%

of service plans were in compliance, indicating failed remediation strategies. CMS reminds the State that the quality standards require demonstrating compliance through 100% discovery or less than 100% discovery plus 100% remediation. The State should work to ensure that remediation is documented and tracked. Please provide CMS with quarterly updates on remediation actions, strategies and system improvements beginning July 1, 2012.

While the State has some performance measures in place, the CMS requires the State to develop additional performance measures with metrics that will identify specific outcomes; remediation strategies (both individual and systemic); and, to develop follow-up actions to ensure remediation activities are effective. Examples of acceptable performance measures include: The percent of service plans that address risk (as identified by the participant assessment) adequately and appropriately; the percent of service plans that are updated at least annually or as specified in the approved waiver

The State is required to ensure Freedom of Choice between institutional care and HCBS as well as between waiver services and providers. This could be accomplished through a simple performance measure that reads, "The number of waiver participants whose file contains a completed, signed freedom of choice form".

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

III. Qualified Providers Serve Waiver Participants

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

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

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

For the sub-assurance requiring the State verify that providers initially and continually meet licensure and/or certification standards, the DHHS requires licensed provider applicants submit proof of licensure and attend pre-contractual training before being allowed to enroll as provider. The South Carolina Department of Labor (DOL), Licensing and Regulation, licenses and monitors all HASCI wavier providers who administer nursing, prescribed drugs, medical supplies, equipment and assistive technology, personal emergency response systems, environmental modifications, private language services, psychological services and health education for consumer directed care. The DOL informs DHHS of any negative actions taken against a licensed provider. The DHHS will then take appropriate actions to sanction and/or terminate provider enrollment if required.

The DHHS employs a registered nurse to periodically conduct on-site reviews of the licensed providers. The nurse reviews three components: staffing, administrative and participant reviews, during an on-site visit. During this time the State ensures staff members have met tuberculin

skin test requirements, first aid certification and any other requirements as outlined in the contract between the provider and the State.

All home modification providers must be licensed general and/or residential contractors and must have a State employed licensed general contractor with seven years of experience inspect their work to ensure the project is completed to the specifications of local and Americans with Disability Act (ADA) codes. During the evidentiary review period (SFY 09-10), 100% (30) of the home modification providers met the training and policy and procedure requirements.

Attendant care providers are non-licensed/non-certified individuals directly employed by the participants who are capable of self-directing their care. The DDSN contracts with the University of South Carolina (USC) to ensure attendants meet all requirements to provide services. A registered nurse employed by USC assesses attendants through direct observation, and determines if they are capable of providing personal care according to the participant's service plan. The nurse also ensures the provider has had an acceptable criminal background check, tuberculin test, is able to read, write and speak English, has no known convictions for abuse or neglect and is capable of following the participant's service plan and completing task sheets. A case manager also meets with the participant on an ongoing basis to ensure services are properly provided. During the evidentiary review period (7/1/09-6/39/10), 21 out of 23 (91%) applicants of attendant care providers were accepted.

If providers are found to be out of compliance, there are five types of provider sanctions utilized by the State: 1) corrective action plan – the least severe sanction; 2) 30-day suspension where there are no new participant referrals for 30 days and the provider is required to submit a corrective action plan; 3) 60-day suspension, which is substantial and the provider receives no new participant referrals for 60 days and the provider is required to submit a corrective action plan; 4) 90-day suspension indicating major deficiencies where the provider does not get new participant referrals for 90 days and is required to submit a corrective action plan and follow-up review by a registered nurse prior to reinstatement; and 5) termination, which indicates major and substantial deficiencies often with a history of repeated moderate to major deficiencies.

During the review period of March of 2009 to December 2010, 378 reviews were conducted on 271 attendant care and nursing providers to determine if they continued to meet licensure and/or certification and other State standards. Of the 378 reviews: 117 reviews led to the provider being required to submit a correction action plan; 29 reviews resulted in a 30-day suspension; 25 reviews resulted in a 60-day suspension and 16 reviews resulted in a 90-day suspension. Eleven out of 271 providers of attendant care and/or nursing were terminated for compliance issues. At the end of this review period, 260 out of 271 (96%) attendant care and /or nursing providers continued to meet waiver provider qualifications.

For the performance measure that states providers must meet required licensing, certification and other State standards prior to the provision of services, the State's evidence for review year July 2009 through June 2010 revealed a review of five (25%) service coordination staff hired prior to the review period resulted in 77.8% compliance for staff receiving training as required. Another review of five (25%) of service coordination staff hired prior to the review period resulted in a

97.3% compliance. Remediation strategies were not identified, nor did the State submit evidence of additional follow-up.

For the performance measure that determines if providers meet training requirements, one provider of HASCI wavier residential services received a citation related to training issues and/or criminal background checks during annual licensing inspection. A follow-up review of that provider and twelve others demonstrated 100% compliance. While the agency identified it reviewed 20 providers, it did not identify the total number of providers establishing the provider universe to determine if this was a valid sample size.

Required Recommendations:

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

The CMS requires the State strengthen performance measures, demonstrate its ability to collect data, identify remediation strategies, systems improvements and follow-up actions taken to assure 100% compliance rate for providers. Providers that do not meet the necessary re-licensure, re-certification, and/or training requirements should be disqualified from providing services and sanctioned per DHHS policies. A suitable performance measure for provider trainings should evaluate not only the provision of trainings, but also the number of providers, by provider type meeting the training requirements. Beginning September 1, 2012, please provide CMS with quarterly updates on the progress of remediation actions/strategies utilized for providers who do not meet 100% compliance.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

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.)

South Carolina State law requires any suspected abuse, neglect, or exploitation be reported. If the suspected abuse involves a child (age 17 and under) the laws governing reporting abuse are specified in "The Child Protection Reform Act." Allegations of abuse, neglect or exploitation of a child are reported to the State Department of Social Services (DSS).

The laws governing reports of suspected abuse of adults (age 18 or above) are specified in "The Omnibus Adult Protection Act." Abuse, neglect or exploitation of an adult living in a DDSN

operated home is reported to the State Law Enforcement Division (SLED). The SLED works with local law enforcement to investigate the allegations. Allegations of abuse, neglect or exploitation of a vulnerable adult not living in a DDSN operated home are also reported to the DSS. A Memorandum of Agreement (MOA) between SLED and DSSN allows for DDSN to receive reports of allegations simultaneously with the reports submitted to SLED or DSS and also allows for collaborative efforts for investigations. This MOA allows for DDSN to be immediately involved when allegations are reported which helps ensure that policies are followed.

The DDSN also requires all providers conduct a management review to establish if policies, rules, or regulations have been violated. The QIO reviews the provider agencies to ensure the organization has systems in place that identify whether employees are following the state law and the DDSN policy of reporting alleged incidents and responding appropriately. When it is determined by SLED, local law enforcement or the DSS there has been abuse, the DDSN ensures appropriate personnel action is taken.

In SFY 2010, four percent (19 out of 471) of all reports of abuse, neglect, or exploitation involved participants in the HASCI waiver. All 19 incidents were reported within the required timeframes. In a quality assurance review conducted by the QIO for SFY 2010, the QIO identified a 85.7% provider compliance rate with following DDSN procedures regarding preventing, reporting and responding to abuse/neglect/exploitation as outlined in procedures. There was a 97.1% provider compliance rate regarding initial response to reports of abuse, neglect, or exploitation.

The QIO report shows that 86.1% of providers demonstrated usage of current critical incident county profile data to evaluate provider specific trends, determine is specific providers have above or below critical incident rates over the statewide average, or demonstrate systemic actions to prevent future incidents. Findings also indicate 77.8% of providers demonstrated consumers were provided with follow-up support and assistance as required. Evidence substantiates that the QIO requested and received corrective action plans from the providers failing to meet all health and welfare requirements.

An Incident Management Coordinator, employed by the State tracks compliance with state law and the DDSN policy regarding health and welfare. The components reviewed by the Coordinator are: reporting within appropriate timeframes, completion of internal reviews and a review of the provider's remediation actions. The DDSN also reviews the data gathered by the Incident Management Coordinator.

Effective July 1, 2009, the DDSN implemented a new web-based reporting system on its secure portal to allow providers to report critical incidents. This system allows reporting of abuse, neglect, and exploitation, as well as death reports. This system allows the user to pull a variety of reports to track and trend information and provides "real time" analysis. This assists in completing internal reviews of incidents within the required timeframes.

Required Recommendations:

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

The State has performance measures in place to address abuse, neglect and exploitation. However, little to no evidence was submitted on remediation actions or improvement strategies; therefore, the State should develop and implement remediation actions/strategies for each performance measure and develop a mechanism to track remediation to ensure it was completed and successful.

CMS requires that the State develop performance measures to ensure the health and welfare of the waiver participant is being monitored beyond abuse, neglect and exploitation. Performance measures that address sufficient back up plans for the absence of attendant care/personal care providers; emergency evacuation plans in the event of hurricanes and/or other acts of nature; and, participant satisfaction surveys should be considered for use by the State. Please provide the CMS with quarterly reports indicating the State's progress on development of performance measures, beginning September 1, 2012.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the wavier 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.)

The South Carolina DHHS is the single State Medicaid agency with administrative oversight to renew and amend the HASCI waiver. The DHHS and the DDSN have a current Memorandum of Agreement (MOA) in place to ensure the operation and the administration of the HASCI waiver operates smoothly. The DDSN is responsible for the day to day operation of the program, including intake/referral, obtaining freedom of choice selection for institutional or waiver services, and provider choice. DDSN is also responsible for service plan development, service authorizations, monitoring of services and the LOC and service plan reevaluations annually. Additionally, DDSN has responsibility for the first step in any reconsideration or hearings and the appeals process. The MOA is in effect through June 30, 2015.

Evidence submitted indicate the DHHS and the DDSN hold quarterly meetings to discuss HASCI waiver operations, including upcoming amendment proposals, budget, provider rates, enrollments, terminations and any other relevant actions or events pertaining to the HASCI waiver and its participants. HASCI waiver staff also meets weekly, or daily if warranted to

discuss specific waiver issues as well as policy changes in preparation for the distribution of Medicaid bulletins to the waiver participants.

As the administrative authority of the waiver, the DHHS developed a Hearing Outline Template and Hearing Preparation Guide for the DDSN staff. On October 1, 2011, the DDSN began using this template to ensure staff becomes familiar with the State's hearing and appeals policies and procedures.

The DHHS quality assurance staff conducts utilization reviews to determine frequency and duration of services, claims data and service authorizations are commensurate with the service plan. The State had 93% compliance in focused desk and utilization reviews. Remediation was accomplished through the State developing a QIO Report Validation Tool, which is now used to manage, track and evaluate the reviews.

The DHHS maintains a current HASCI wavier service contract identifying requirements and responsibilities for the provision of HASCI services. Compliance is assured through: MMIS claim edits to ensure proper coding and reimbursement; the DHHS provider reviews to verify appropriate authorization and billing; and the QIO reviews of service plans to ensure participant needs are met through appropriate services.

Although evidence confirmed ongoing communication between agencies, no clear documentation was produced that demonstrates the State Medicaid Agency retains ultimate authority over the waiver. The evidence submitted covered various fiscal years; therefore, it is not clear how often the DHHS monitors the operating agency. The majority of evidence submitted included copies of reports, forms, appeals, hearings, staff meeting agendas and minutes but no clear data elements, analysis, trending or remediation of any findings.

Required Recommendations:

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

The CMS requires DHHS to assess functions delineated to DDSN in the MOA to ensure full compliance with this assurance. The Medicaid Agency should specify its expectations for the performance of these functions by including the standards to which it will hold the delegated entity. These standards should be measurable and the DHHS should be able to develop performance measures from the standards. DHHS should use the performance measures to monitor the achievement of standards by the delegated entity, as well as to demonstrate to CMS that it is exercises and maintains administrative authority.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

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 wavier program.
Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74 ~ SMM 2500; SMM 4442.8; SMM 4442.10

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

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

When claims are submitted through the Medicaid Management Information System (MMIS), they must meet all applicable criteria, i.e., proper procedure codes, recipient special program (RSP) codes, authorization numbers, etc. for claims to be paid. (RSP codes are 100% controlled by the State Medicaid Agency.)

Service coordinators authorize waiver services based on service needs identified in a participant's service plan. Authorizations are forwarded to providers and are required when claims are submitted to MMIS for payment. The QIO monitors for compliance with the authorization requirement. The compliance rate for authorizations for services prior to the service being provided was 100% for SFY10.

The DDSN reviews reported findings along with paid claims history and dates of service to identify any claims determined to be non-allowable for payment. The DDSN compares the paid claim history against record documentation. This is to determine appropriateness of services billed against services listed in the service plans; service rates paid versus service rates approved; service incorrectly billed during hospitalizations or absences at day program to ensure accuracy of the claims. The State reports the proportion of paid claims coded and paid in accordance with approved waiver policies met 100% compliance.

Entities that receive Medicaid financial assistance via program contracts, grants, sub-grants etc., are required to obtain an annual financial audit by the DDSN. Any entity expending $500,000 or more in federal awards, must obtain a DDSN provider audit as well. The State reported 100% compliance for claims paid in accordance with the approved waiver policies.

The State's fiscal, audit and program integrity staff monitor cost reports, paid claims data and participant utilization reports, as well as collect, analyze and audit payments to providers. When providers' supporting documentation does not support the amount billed for services, the State recoups the amount overpaid to the providers.

The DDSN is being added by the DHHS to its' Care Call/Phoenix System in the near future in order to provide greater financial accountability. Care Call is an automated system used to document and monitor services. It also allows web-based reporting and billing to MMIS. To use the Care Call System, workers call a toll free number to document personal care services

provided in the participant's home. For services not provided in the participant's home, providers also call a toll free number for documentation purposed. All services documented are compared with the prior authorization to determine if the service was provided appropriately.

For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services. On a weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment.

Suggested Recommendations:

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

Currently, the State uses one performance measure (Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver) for this assurance. CMS recommends the State develop additional performance measures to ensure financial accountability. The State should consider developing and implementing procedures to consolidate data from ongoing audits to analyze the overall financial performance of the waiver. The CMS suggest the State utilize the NQE for technical assistance in developing performance measures.

Log #457

Brenda James

From: Teeshla Curtis
Sent: Thursday, August 30, 2012 2:57 PM
To: Brenda James
Cc: GEORGE MAKY; Anita Atwood
Subject: Response Log 457 & 24
Attachments: SCDHHS Response to CMS HASCI Compliance Report.pdf

Attached is the response for Logs 457 & 24.

Teeshla Curtis

Administrative Coordinator
Office of Information Management
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29202
(803) 898-2502

South Carolina Department of
Health & Human Services

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

August 30, 2012

Ms. Jackie Glaze
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Kenni Howard, RN

Dear Ms. Glaze:

Enclosed is South Carolina's response to the Centers for Medicare and Medicaid Services (CMS) draft compliance report for the Head and Spinal Cord Injury (HASCI) Waiver, control number 0284.R03. We appreciate the opportunity to work with CMS staff on completing the report.

As indicated, upon CMS acceptance of the State's planned actions for program improvements, we will begin implementation of the recommendations and submit quarterly reports of our progress. We expect to complete all the recommendations prior to the submission of the waiver renewal.

We look forward to receiving the CMS final report. Should you need additional information, please contact Anita Atwood at (803) 898-4641.

Sincerely,

Anthony Keck
Director

Enclosure
cc: Alexandra Smilow, CO

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

State Response to the Draft CMS Evidentiary Report
HASCI Waiver #0284.R03

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 consistent with care provided in a hospital, nursing facility or ICF/MR.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State substantially meets the assurance.
(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.)

State Response:

No further action required by the State.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that is 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 Number13

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

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

DHHS utilizes the State Plan Targeted Case Management option for service coordination for HASCI waiver participants. The DDSN uses service coordination standards, which include core functions of assessment and care planning, in addition to requirements for a comprehensive assessment of the participant's needs. The DDSN assist participants in minimizing the severity of their disabilities by identifying individual needs and coordinating services. Service plans must be completed and approved prior to waiver participants receiving HCBS services. The DDSN also follows-up to ensure the service plan is implemented and the status of the participant is reviewed quarterly.

The DDSN uses the Consumer Data Support System (CDSS) to obtain the participant's annual assessment, service plan and service notes to facilitate effective service coordination. Service notes should reflect monitoring within two weeks of the start date of an ongoing service or provider change and include the usefulness, effectiveness, frequency, duration, as well as the participant's (or participant's legal guardian's) satisfaction with the service.

For the sub assurance that indicates if service plans address all participants' assessed needs and personal goals, the State reported for the review period of 7/1/08 – 6/30/09, 69% of the reviewed cases required corrective action by the service coordinators and follow-up review by a supervisor before the participants' support plan could be finalized. For the review period of 7/1/09 – 6/30/10, only 79.1% met the requirements. In an effort to remediate this, five percent or more HASCI waiver participants are reviewed by the DDSN District Office staff within 90 days prior to the annual assessment and service plan due dates. Findings of the review are sent to the Service Coordinators and their supervisors through a transmittal called the "Service Coordination Plan Review Disposition Form" which identifies areas that require corrective actions. DDSN also tracks this activity and utilizes the findings to determine training and technical assistance needs of the Service Coordination providers.

For the sub assurance that measures if service plans were developed in accordance with State policy and procedures, the State utilizes an electronic system known as the Consumer Data Support System (CDSS). This system allows for retrieval of the participant's annual assessment, service plan and service notes. Service notes should reflect monitoring within two weeks of service implementation and/or provider changes and should include the usefulness, effectiveness, frequency, duration and the participant's satisfaction with the service. The system also alerts service coordinators and supervisors within 60 days of the date the annual service plan update is due. During the review period of 7/1/09 – 6/30/10, the QIO found that only 87.5% of service notes reflected documentation identified above. Also, during the same review period, the QIO reports only 84.4% of the service notes reflected monitoring as often as necessary but as least quarterly and a statement of usefulness and effectiveness of all ongoing waiver services with justification of continued need.

The State reports for the period of 7/1/08-6/30/09, a review was conducted to determine if participants' service plans were updated and/or revised at least annually and when warranted by changing needs of the participant. The results of the review indicated 89.8%compliance for annual updates and 83.3% compliance for service plans being updated when warranted by documented changes. Providers who did not meet key indicators were required to address them with a Plan of Correction (POC) submitted to the QIO. The POC indicated that the provider issued "refresher training" to service coordinators. A follow-up review by the QIO revealed 92% compliance but also that one indicator continued as "not met" (service coordination staff receive training as required.)

To determine if the sub-assurance for services being delivered in accordance with the service plan (type, scope, amount, duration, and frequency), the State submitted results of the review conducted during the time period of 7/1/09 – 6/30/10. Findings showed only 62.2% compliance with this sub-assurance. The State's remediation strategy of training staff how to "lock" print jobs to avoid staff retrieving information not pertinent does not explain how this ensures each waiver service plan has the appropriate documentation to support the amount, frequency and duration of services.

A copy of a signed Freedom of Choice form documenting the participant's choice is submitted by the Service Coordinator to the HASCI Division to provide evidence that participants are offered choice between waiver services and institutional care. The QIO conducts reviews to

ensure these forms are maintained. The State reported 96.4% compliance when reviewing participant records to assure there was a signed Freedom of Choice form. The evidence to support that statement, SP Document # 12, was directed at patient management of their personal funds. There was no evidence to support reviews to ensure participant Freedom of Choice had been conducted.

CMS Required Recommendation:

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

The CMS requires the State to reevaluate the current processes utilized for service plan development. The review period of July 1, 2008 through June 30, 2009 revealed that 69% of service plans required corrective action. Further, the April 2010 review revealed that only 89% of service plans were in compliance, indicating failed remediation strategies. CMS reminds the State that the quality standards require demonstrating compliance through 100% discovery or less than 100% discovery plus 100% remediation. The State should work to ensure that remediation is documented and tracked. Please provide CMS with quarterly updates on remediation actions, strategies and system improvements beginning July 1, 2012.

While the State has some performance measures in place, the CMS requires the State to develop additional performance measures with metrics that will identify specific outcomes; remediation strategies (both individual and systemic); and, to develop follow-up actions to ensure remediation activities are effective. Examples of acceptable performance measure include: The percent of service plans that address risk (as identified by the participant assessment) adequately and appropriately; the percent of service plans that are updated at least annually or as specified in the approved waiver.

The State is required to ensure Freedom of Choice between institutional care and HCBS as well as between waiver services and providers. This could be accomplished through a simple performance measure that reads, "The number of waiver participants whose file contains a completed, signed freedom of choice form".

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

State Response

As requested by CMS the State will:

- Reevaluate the current processes utilized for service plan development;
- Work to ensure that remediation is documented and tracked;
- Provide CMS with quarterly updates on remediation actions, strategies and system improvements upon CMS approval of the Evidentiary Report;
- Develop additional performance measures with metrics that will identify specific outcomes; remediation strategies (both individual and systemic); and
- Develop follow-up actions to ensure remediation activities are effective;
- Develop additional performance measures that include the percent of service plans that address risk (as identified by the participant assessment) adequately and appropriately; the percent of service plans that are updated at least annually; and

- Develop a performance measure that identifies the number of waiver participants whose file contains a completed and signed freedom of choice form, in the HASCI Waiver renewal.

The State and DDSN has consulted with the National Quality Enterprise (NQE) for technical assistance (10/19/2011) to review recommendations for a design of a Quality Improvement System (QIS) to identify appropriate data sources, validation, collection and reporting.

III. Qualified Providers Serve Waiver Participants

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

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

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

For the sub-assurance requiring the State verify that providers initially and continually meet licensure and/or certification standards, the DHHS requires licensed provider applicants submit proof of licensure and attend pre-contractual training before being allowed to enroll as provider. The South Carolina Department of Labor (DOL), Licensing and Regulation, licenses and monitors all HASCI wavier providers who administer nursing, prescribed drugs, medical supplies, equipment and assistive technology, personal emergency response systems, environmental modifications, private language services, psychological services and health education for consumer directed care. The DOL informs DHHS of any negative actions taken against a licensed provider. The DHHS will then take appropriate actions to sanction and/or terminate provider enrollment if required.

The DHHS employs a registered nurse to periodically conduct on-site reviews of the licensed providers. The nurse reviews three components: staffing, administrative and participant reviews, during an on-site visit. During this time the State ensures staff members have met tuberculin skin test requirements, first aid certification and any other requirements as outlined in the contract between the provider and the State.

All home modification providers must be licensed general and/or residential contractors and must have a State employed licensed general contractor with seven years of experience inspect their work to ensure the project is completed to the specifications of local and Americans with Disability Act (ADA) codes. During the evidentiary review period (SFY 09-10), 100% (30) of the home modification providers met the training and policy and procedure requirements.

Attendant care providers are non-licensed/non-certified individuals directly employed by the participants who are capable of self-directing their care. The DDSN contracts with the University of South Carolina (USC) to ensure attendants meet all requirements to provide services. A registered nurse employed by USC assesses attendants through direct observation,

and determines if they are capable of providing personal care according to the participant's service plan. The nurse also ensures the provider has had an acceptable criminal background check, tuberculin test, is able to read, write and speak English, has no known convictions for abuse or neglect and is capable of following the participant's service plan and completing task sheets. A case manager also meets with the participant on an ongoing basis to ensure services are properly provided. During the evidentiary review period (7/1/09-6/39/10), 21 out of 23 (91%) applicants of attendant care providers were accepted.

If providers are found to be out of compliance, there are five types of provider sanctions utilized by the State: 1) corrective action plan – the least severe sanction; 2) 30-day suspension where there are no new participant referrals for 30 days and the provider is required to submit a corrective action plan; 3) 60-day suspension, which is substantial and the provider receives no new participant referrals for 60 days and the provider is required to submit a corrective action plan; 4) 90-day suspension indicating major deficiencies where the provider does not get new participant referrals for 90 days and is required to submit a corrective action plan and follow-up review by a registered nurse prior to reinstatement; and 5) termination, which indicates major and substantial deficiencies often with a history of repeated moderate to major deficiencies.

During the review period of March of 2009 to December 2010, 378 reviews were conducted on 271 attendant care and nursing providers to determine if they continued to meet licensure and/or certification and other State standards. Of the 378 reviews: 117 reviews led to the provider being required to submit a correction action plan; 29 reviews resulted in a 30-day suspension; 25 reviews resulted in a 60-day suspension and 16 reviews resulted in a 90-day suspension. Eleven out of 271 providers of attendant care and/or nursing were terminated for compliance issues. At the end of this review period, 260 out of 271 (96%) attendant care and /or nursing providers continued to meet waiver provider qualifications.

For the performance measure that states providers must meet required licensing, certification and other State standards prior to the provision of services, the State's evidence for review year July 2009 through June 2010 revealed a review of five (25%) service coordination staff hired prior to the review period resulted in 77.8% compliance for staff receiving training as required. Another review of five (25%) of service coordination staff hired prior to the review period resulted in a 97.3% compliance. Remediation strategies were not identified, nor did the State submit evidence of additional follow-up.

For the performance measure that determines if providers meet training requirements, one provider of HASCI wavier residential services received a citation related to training issues and/or criminal background checks during annual licensing inspection. A follow-up review of that provider and twelve others demonstrated 100% compliance. While the agency identified it reviewed 20 providers, it did not identify the total number of providers establishing the provider universe to determine if this was a valid sample size.

Required Recommendations:

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

The CMS requires the State strengthen performance measures, demonstrate its ability to collect data, identify remediation strategies, systems improvements and follow-up actions taken to assure 100% compliance rate for providers. Providers that do not meet the necessary re-licensure, re-certification, and/or training requirements should be disqualified from providing services and sanctioned per DHHS policies. A suitable performance measure for provider trainings should evaluate not only the provision of trainings, but also the number of providers, by provider type meeting the training requirements. Beginning September 1, 2012, please provide CMS with quarterly updates on the progress of remediation actions/strategies utilized for providers who do not meet 100% compliance.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

State Response:

As requested by CMS the State will:

- Strengthen performance measures to demonstrate its ability to collect data, identify remediation strategies, systems improvements and follow-up actions taken to assure 100% compliance rate for providers following remediation actions;
- Ensure that providers that do not meet the necessary re-licensure, re-certification, and/or training requirements will be disqualified from providing services and sanctioned per DHHS policies;
- Develop a performance measure to evaluate the number and percent of enrolled providers, by provider type, who continue to meet training requirements as specified in the approved waiver in the inclusion of the renewal of the HASCI Waiver; and
- Provide CMS with quarterly updates on remediation actions, strategies and system improvements upon CMS approval of the Evidentiary Report.

The State and DDSN has consulted with the National Quality Enterprise (NQE) for technical assistance (10/19/2011) to review recommendations for a design of a Quality Improvement System (QIS) to identify appropriate data sources, validation, collection and reporting.

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.**)*

South Carolina State law requires any suspected abuse, neglect, or exploitation be reported. If the suspected abuse involves a child (age 17 and under) the laws governing reporting abuse are

specified in "The Child Protection Reform Act." Allegations of abuse, neglect or exploitation of a child are reported to the State Department of Social Services (DSS).

The laws governing reports of suspected abuse of adults (age 18 or above) are specified in "The Omnibus Adult Protection Act." Abuse, neglect or exploitation of an adult living in a DDSN operated home is reported to the State Law Enforcement Division (SLED). The SLED works with local law enforcement to investigate the allegations. Allegations of abuse, neglect or exploitation of a vulnerable adult not living in a DDSN operated home are also reported to the DSS. A Memorandum of Agreement (MOA) between SLED and DSSN allows for DDSN to receive reports of allegations simultaneously with the reports submitted to SLED or DSS and also allows for collaborative efforts for investigations. This MOA allows for DDSN to be immediately involved when allegations are reported which helps ensure that policies are followed.

The DDSN also requires all providers conduct a management review to establish if policies, rules, or regulations have been violated. The QIO reviews the provider agencies to ensure the organization has systems in place that identify whether employees are following the state law and the DDSN policy of reporting alleged incidents and responding appropriately. When it is determined by SLED, local law enforcement or the DSS there has been abuse, the DDSN ensures appropriate personnel action is taken.

In SFY 2010, four percent (19 out of 471) of all reports of abuse, neglect, or exploitation involved participants in the HASCI waiver. All 19 incidents were reported within the required timeframes. In a quality assurance review conducted by the QIO for SFY 2010, the QIO identified a 85.7% provider compliance rate with following DDSN procedures regarding preventing, reporting and responding to abuse/neglect/exploitation as outlined in procedures. There was a 97.1% provider compliance rate regarding initial response to reports of abuse, neglect, or exploitation.

The QIO report shows that 86.1% of providers demonstrated usage of current critical incident county profile data to evaluate provider specific trends, determine is specific providers have above or below critical incident rates over the statewide average, or demonstrate systemic actions to prevent future incidents. Findings also indicate77.8% of providers demonstrated consumers were provided with follow-up support and assistance as required. Evidence substantiates that the QIO requested and received corrective action plans from the providers failing to meet all health and welfare requirements.

An Incident Management Coordinator, employed by the State tracks compliance with state law and the DDSN policy regarding health and welfare. The components reviewed by the Coordinator are: reporting within appropriate timeframes, completion of internal reviews and a review of the provider's remediation actions. The DDSN also reviews the data gathered by the Incident Management Coordinator.

Effective July 1, 2009, the DDSN implemented a new web-based reporting system on its secure portal to allow providers to report critical incidents. This system allows reporting of abuse, neglect, and exploitation, as well as death reports. This system allows the user to pull a variety

of reports to track and trend information and provides "real time" analysis. This assists in completing internal reviews of incidents within the required timeframes.

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.)

CMS requires that the State develop performance measures to ensure the health and welfare of the waiver participant is being monitored beyond abuse, neglect and exploitation. Performance measures that address sufficient back up plans for the absence of attendant care/personal care providers; emergency evacuation plans in the event of hurricanes and/or other acts of nature; and, participant satisfaction surveys should be considered for use by the State. Please provide the CMS with quarterly reports indicating the State's progress on development of performance measures, beginning September 1, 2012.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

State Response

As requested by CMS the State will:

- Implement remediation actions and strategies for each performance measure and develop a mechanism to track remediation to ensure completion and success;
- Develop performance measures to monitor the health and welfare of the waiver participant beyond abuse, neglect and exploitation;
- Develop performance measures to address sufficient back up plans for the absence of attendant care/personal care providers; emergency evacuations in the event of a hurricane or other acts of nature;
- DHHS will evaluate implementing a participant satisfaction survey for HASCI waiver participants utilizing an independent entity; and
- Provide CMS with quarterly updates indicating the State's progress on development of performance measures upon CMS approval of the Evidentiary Report.

The State and DDSN has consulted with the National Quality Enterprise (NQE) for technical assistance (10/19/2011) to review recommendations for a design of a Quality Improvement System (QIS) to identify appropriate data sources, validation, collection and reporting.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the wavier 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.)

The South Carolina DHHS is the single State Medicaid agency with administrative oversight to renew and amend the HASCI waiver. The DHHS and the DDSN have a current Memorandum of Agreement (MOA) in place to ensure the operation and the administration of the HASCI waiver operates smoothly. The DDSN is responsible for the day to day operation of the program, including intake/referral, obtaining freedom of choice selection for institutional or waiver services, and provider choice. DDSN is also responsible for service plan development, service authorizations, monitoring of services and the LOC and service plan reevaluations annually. Additionally, DDSN has responsibility for the first step in any reconsideration or hearings and the appeals process. The MOA is in effect through June 30, 2015.

Evidence submitted indicate the DHHS and the DDSN hold quarterly meetings to discuss HASCI waiver operations, including upcoming amendment proposals, budget, provider rates, enrollments, terminations and any other relevant actions or events pertaining to the HASCI waiver and its participants. HASCI waiver staff also meets weekly, or daily if warranted to discuss specific waiver issues as well as policy changes in preparation for the distribution of Medicaid bulletins to the waiver participants.

As the administrative authority of the waiver, the DHHS developed a Hearing Outline Template and Hearing Preparation Guide for the DDSN staff. On October 1, 2011, the DDSN began using this template to ensure staff becomes familiar with the State's hearing and appeals policies and procedures.

The DHHS quality assurance staff conducts utilization reviews to determine frequency and duration of services, claims data and service authorizations are commensurate with the service plan. The State had 93% compliance in focused desk and utilization reviews. Remediation was accomplished through the State developing a QIO Report Validation Tool, which is now used to manage, track and evaluate the reviews.

The DHHS maintains a current HASCI wavier service contract identifying requirements and responsibilities for the provision of HASCI services. Compliance is assured through: MMIS claim edits to ensure proper coding and reimbursement; the DHHS provider reviews to verify appropriate authorization and billing; and the QIO reviews of service plans to ensure participant needs are met through appropriate services.

Although evidence confirmed ongoing communication between agencies, no clear documentation was produced that demonstrates the State Medicaid Agency retains ultimate authority over the waiver. The evidence submitted covered various fiscal years; therefore, it is not clear how often the DHHS monitors the operating agency. The majority of evidence submitted included copies of reports, forms, appeals, hearings, staff meeting agendas and minutes but no clear data elements, analysis, trending or remediation of any findings.

Required Recommendations:

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

The CMS requires DHHS to assess functions delineated to DDSN in the MOA to ensure full compliance with this assurance. The Medicaid Agency should specify its expectations for the performance of these functions by including the standards to which it will hold the delegated entity. These standards should be measurable and the DHHS should be able to develop performance measures from the standards. DHHS should use the performance measures to monitor the achievement of standards by the delegated entity, as well as to demonstrate to CMS that it is exercises and maintains administrative authority.

The CMS recommends the State contact the NQE for assistance with development of an overall QIS and to identify appropriate data sources, validation, collection and reporting.

State Response

As requested by CMS the State will:

- Assess functions delineated in the MOA, and develop standards to which it will hold DDSN; and
- Develop performance measures of the MOA standards to delineate functions and to monitor the achievement of standards in order to demonstrate the administrative authority.

The State and DDSN has consulted with the National Quality Enterprise (NQE) for technical assistance (10/19/2011) to review recommendations for a design of a Quality Improvement System (QIS) to identify appropriate data sources, validation, collection and reporting.

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 wavier program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74 ~ SMM 2500; SMM 4442.8; SMM 4442.10

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

Evidence Supporting This Conclusion:

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

When claims are submitted through the Medicaid Management Information System (MMIS), they must meet all applicable criteria, i.e., proper procedure codes, recipient special program (RSP) codes, authorization numbers, etc. for claims to be paid. (RSP codes are 100% controlled by the State Medicaid Agency.)

Service coordinators authorize waiver services based on service needs identified in a participant's service plan. Authorizations are forwarded to providers and are required when claims are submitted to MMIS for payment. The QIO monitors for compliance with the

authorization requirement. The compliance rate for authorizations for services prior to the service being provided was 100% for SFY10.

The DDSN reviews reported findings along with paid claims history and dates of service to identify any claims determined to be non-allowable for payment. The DDSN compares the paid claim history against record documentation. This is to determine appropriateness of services billed against services listed in the service plans; service rates paid versus service rates approved; service incorrectly billed during hospitalizations or absences at day program to ensure accuracy of the claims. The State reports the proportion of paid claims coded and paid in accordance with approved waiver policies met 100% compliance.

Entities that receive Medicaid financial assistance via program contracts, grants, sub-grants etc., are required to obtain an annual financial audit by the DDSN. Any entity expending $500,000 or more in federal awards, must obtain a DDSN provider audit as well. The State reported 100% compliance for claims paid in accordance with the approved waiver policies.

The State's fiscal, audit and program integrity staff monitor cost reports, paid claims data and participant utilization reports, as well as collect, analyze and audit payments to providers. When providers' supporting documentation does not support the amount billed for services, the State recoups the amount overpaid to the providers.

The DDSN is being added by the DHHS to its' Care Call/Phoenix System in the near future in order to provide greater financial accountability. Care Call is an automated system used to document and monitor services. It also allows web-based reporting and billing to MMIS. To use the Care Call System, workers call a toll free number to document personal care services provided in the participant's home. For services not provided in the participant's home, providers also call a toll free number for documentation purposed. All services documented are compared with the prior authorization to determine if the service was provided appropriately.

For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services. On a weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment.

Suggested Recommendations:

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

Currently, the State uses one performance measure (Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver) for this assurance. CMS recommends the State develop additional performance measures to ensure financial accountability. The State should consider developing and implementing procedures to consolidate data from ongoing audits to analyze the overall financial performance of the waiver. The CMS suggest the State utilize the NQE for technical assistance in developing performance measures.

State Response

As requested by CMS the State will:

- Develop additional performance measures to ensure financial accountability; and
- Consider development and implementation of procedures to consolidate data from ongoing audits to analyze the overall financial performance of the waiver.

The State and DDSN has consulted with the National Quality Enterprise (NQE) for technical assistance (10/19/2011) to review recommendations for a design of a Quality Improvement System (QIS) to identify appropriate data sources, validation, collection and reporting.