DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett/Chavis	5-7-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000374	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Mr. Keck, Kost, Deps, CMS file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 2, 2014

RECEIVED
MAY 07 2014
Department of Health & Human Services
OFFICE OF THE DIRECTOR

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

Dear Mr. Keck:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) quality review of South Carolina's Home and Community Based Statewide Waiver program with control number 0237.R04. This waiver serves individuals of any age with an intellectual disability or delay and who meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care. Thank you for sending comments on the draft report. The state's responses to CMS' recommendations have been incorporated in the appropriate sections of the report.

We found the state to be in compliance three of the six review components. For those areas in which the state in not compliant please be sure they are corrected at the time of renewal. We have also identified recommendations for program improvements in three of the assurance areas.

Finally, we would like to remind you to submit a renewal package on this waiver to CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver (12/31/2014). Your waiver renewal application should address any issues identified in the final report as necessary for renewal and should incorporate the state's commitment in response to the report. Please note the state must provide CMS 90 days to review the submitted application. If we do not receive your renewal request 90 days prior to the waiver expiration date we will contact you to discuss termination plans. Should the state choose to abbreviate the 90 day timeline, 42 CFR 441.307 and 42 CFR 431.210 require the state to notify recipients of services thirty (30) days before the expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter sixty days prior to the expiration of the waiver.

We would again like to extend our sincere appreciation to the Division of Community Long Term Care, who provided information for this review. Additionally, we thank you for your patience in the receipt of this report which was delayed due to CMS staffing changes. If you have any questions, please contact Kenni Howard at 404-562-7413.

Sincerely,

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

Enclosure

cc: Michele MacKenzie, CMS Central Office

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region IV

Final Report

Home and Community-Based Services Waiver Review
South Carolina Mental Retardation and Related Disabilities (MR/RD)Waiver
Control #0237.R04

May 2, 2014

Home and Community-Based Services
Waiver Review Report

Executive Summary

The South Carolina Department of Health and Human Services is authorized under §1915(c) of the Social Security Act to provide home and community based services under the Mental Retardation and Related Disabilities (MR/RD) waiver. The MR/RD waiver serves individuals of any age with mental retardation or related disabilities. All individuals must meet the Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care (LOC). Services offered are designed to provide individuals the choice of remaining in their homes as an alternative to residing in an 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. In its April 11, 2013 submission, the state provided an overview of processes, systems and summary reports for each federal assurance. The state's review addressing each assurance was for the state's fiscal year 2011 (SFY 11), which is July 1, 2010 through June 30, 2011.

The South Carolina Department of Health and Human Services (SCDHHS) has administrative authority for this waiver. The South Carolina Department of Disabilities and Special Needs (SCDDSN) perform waiver operations under a Memorandum of Agreement (MOA) and service contract with SCDHHS.

The SCDDSN ensures South Carolinians who have severe lifelong intellectual disabilities and related disabilities including autism, traumatic brain injuries, spinal cord injuries and similar disabilities receive necessary waiver services. SCDDSN has the operational responsibility for ensuring participants are aware of their options under this waiver. SCDDSN utilizes an organized health care delivery system that includes both county Disability and Special Need (DSN) Boards and private providers as waiver service providers.

The SCDHHS assimilates multiple assurance and/or quality improvement activities into its waiver administration and operation. The SCDHHS and SCDDSN contract with different Quality Improvement Organizations (QIOs) to perform quality tasks. These tasks include conducting participant and provider reviews, interviewing participants and staff and ensuring service are implemented based upon need, as well as follow-up visits when deficiencies have been found during the initial review. When deficiencies are found in the initial review, the QIO conducts a follow-up visit approximately six months later to ensure 100% remediation. However, because the QIO pulls an additional sample of records during the follow-up visit and there are almost always deficiencies in the new sample, the QIO cannot report 100% remediation because it includes the new sample in its review percentages.

Summary of Finding

I. **State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization: The State demonstrates the assurance but CMS recommends improvements or requests additional information.**

CMS recommends the state conduct a full review including SFY 10 and SFY 12. CMS also requests more information regarding remediation, and provide the specific reasons files were "not applicable" for review.

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

CMS requires the state conduct a full review including SFY 10 and SFY 12, and requires more information regarding remediation. The state is also required to provide the specific reasons files were "not applicable" for review.

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

CMS requires the state conduct a full review including SFY 10 and SFY 12, and requires more information regarding remediation. The state is also required to provide the specific reasons files were "not applicable" for review.

IV. **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.**

CMS requires the state explain the lack of compliance for internal reviews being completed within the required timeframe and what happened in the six substantiated cases. CMS also requires the state implement system improvement demonstrating subsequent compliance in this area.

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

CMS recommends the state conduct a full review including SFY 10 and SFY 12.

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

CMS recommends the state conduct a full review including SFY 10 and SFY 12.

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 & 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. This assessment also serves to inform CMS in its review of the state's request to renew the waiver.

State's Waiver Name:	Mental Retardation and Related Disabilities Waiver (MR/RD)
Operating Agency:	South Carolina Department of Disabilities and Special Needs (SCDDSN)
State Waiver Contact:	Kara Lewis
Target Population:	Mentally Retarded and/or with Related Disabilities
Level of Care:	ICF/MR
Number of Waiver Participants:	5,739
Average Annual Per Capita Costs:	$41,488 (Per 372)
Effective Dates of Waiver:	January 1, 2010 – December 31, 2014
Approved Waiver Services:	Adult Day Health Personal Care Residential Habilitation Respite Care Adult Dental Services Adult Vision Audiology Services Incontinence Supplies Prescribed Drugs Adult Attendant Care Services Adult Companion Services Adult Day Health Nursing Adult Day Health Transportation Behavior Support Services Career Preparation Services Community Services

Day Activity
Employment Services
Environmental Modifications
Nursing Services
Personal Emergency Response System
Private Vehicle Modifications
Psychological Services
Specialized Medical Equipment, Supplies and Assistive Technology
Support Center 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 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.)

A package of data containing psychological reports, school history and medical records is submitted to the Consumer Assessment Team (CAT) for each applicant to the waiver. The CAT performs the initial LOC determinations within 30 days prior to enrollment into the waiver. The CAT also performs subsequent determinations for those exceeding the annual renewal date. Service Coordinators complete the annual LOC redeterminations in consultation with their supervisors. The SCDDSN's Consumer Data Support System (CDSS) records the LOC determination date and alerts Service Coordinators when redeterminations are due.

The operating agency, SCDDSN reviewed random sample size of approximately 4.5% of participants in the waiver to determine compliance for the LOC assurance using the three performance measures outlined below. The first performance measure for this assurance is to determine the proportion of new enrollees whose LOC completion date is not 30 days prior to waiver enrollment. For SFY 11, all (214) new waiver participants were enrolled into the waiver within 30 days indicating timely LOC determinations.

The second performance measure for this assurance is to determine the proportion of participants whose LOC re-evaluations does not occur prior to the 365th day of the previous LOC evaluation. The CDSS tracks the LOC re-evaluation due dates and notifies the Service Coordinators and the Service Coordinators supervisors of approaching due dates. For SFY 2011, 99.2% (255 of 257 files) were found to be in compliance.

The third performance measure determined the proportion of LOC determinations that were conducted using the appropriate criteria and instrument. Service Coordinators are responsible for assuring the LOC is supported by assessments and/or documents specified on the LOC determination. The SCDDSN reported Service Coordinators' files were determined to be 98.0% (249 of 257 files) compliant in this area. Five of the files were found to be non-compliant and three files were found to be not-applicable (did not meet the criteria for this performance measure). All participants require LOC determinations; therefore, the state is required to explain the meaning of "not applicable".

Service Coordinators also ensure the current LOC is completed properly. The state reported using SCDDSN's sampling of files that Service Coordinators files were 98.8% (251 of 257 files)

compliant in this area. Of the 6 files which failed to comply, three were found to be non-compliant and three were found to be not-applicable (did not meet the criteria for this performance measure). Again, the state is required to explain the meaning of "not applicable".

While the state reports the QIO worked with the Service Coordinators who had deficiencies in the performance measures until 100% remediation had been accomplished in the deficient files, the evidence lacked metrics to show all deficiencies had been remediated satisfactorily after the QIO's follow up review six months later. The state explained the QIO pulls additional samples during the six month follow-up review, which always results in additional findings. Therefore, 100% compliance cannot be achieved in the QIO's follow-up review.

A QIO report was submitted as additional evidence of adherence to this performance measure. The report showed the QIO reviewed 31 LOC determinations for the MR/RD waiver participants during the month of October 2011. The report revealed the QIO was in agreement with each LOC determination so no remediation was needed. This report is issued by the QIO to the state on both a monthly and quarterly basis.

The state also provided a copy of a monthly report (document #7), "South Carolina Department of Health and Human Services, Utilization Review Contract, ICF/MR Level of Care Validation Review – CAT Completed October 2011", validating adherence to Performance Measure #2. This report documents a sample of LOC determinations by the CAT for all four SCDDSN waivers, Tax Equity Fairness and Responsibility Act (TEFRA) eligibility cases, ICF/MR facilities and all adverse LOC cases.

The Service Coordinators found to have non-compliant files in this assurance were required to submit a Plan of Correction (POC) to the QIO within 30 days that addressed the deficiency both individually and systemically. Remediation examples included late entries or corrections to the record when appropriate, quarterly meetings with peers to review policy, district staff technical assistance and local staff retraining. The QIO schedules a follow-up review approximately six months after the original review to ensure effective remediation and implementation of the POC.

Suggested Recommendations:

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

CMS recommends the state submit aggregate compliance data from SFY 10 and SFY 12 to demonstrate a complete review. CMS also recommends the state provide the specific individual remediation conducted in the POCs for QIO review and the QIO's six month follow-up remediation review. CMS recommends the state identify the specific reasons files were determined to be "not applicable" for review.

State's Response:

The state submitted additional evidence for SFY 2010, 2011 and 2012 for the three performance measures used to evaluate compliance with the level of care determination. The additional evidence indicated that all newly enrolled participants were enrolled into the waiver within the required 30 day time frame for 100% compliance for performance measure #1. For performance

measure #2 (Proportion of participants whose LOC re-evaluation does not occur prior to the 365th day of the previous LOC evaluation) the additional evidence revealed 95.8% compliance for FY 10; 99.2% compliance for FY 11; and 98.2% compliance for FY 12. Performance Measure #3 (Proportion of LOC determinations that were conducted using the appropriate criteria and instrument) reveals 96.6%; 98% and 97.2% compliance for FY 10, 11, and 12 respectively.

Clarification was provided for instances where the state utilized the term not-applicable. It reported that some files did not meet the measurement criteria for LOC re-determinations and were scored N/A for participants that were dis-enrolled from the waiver during the review period. The state also clarified that technical assistance is provided by the operating agency, not by the QIO, to any service coordination providers with deficiencies in the performance measures. The QIO function is to measure the compliance with indicators and review and approve any required plans of corrections. Additionally, a six month follow-up is completed by the QIO for any provider required to submit a plan of correction to ensure successful implementation of same.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13
The State does not 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.)

Service Coordinators have the responsibility of ensuring all participant records include the appropriate documentation including: name and title of their contact person, type of contact, location and purpose of the contact, intervention or services provided, outcome and any follow-up needed. Service Coordinators are responsible for conducting the assessment and monitoring of the service plan, documenting the participant's record with any changes in need and evaluating and updating the service plan. This ensures the service plan's appropriateness and the timely preparation of all service authorizations and terminations. The service coordinators must ensure all waiver services are listed and include the service amounts, frequency, duration and provider type, as well as any other services the waiver participant needs.

The first performance measure for this assurance is to determine the proportion of participants whose plan include services and supports consistent with the needs and personal goals identified in the comprehensive assessment and found the following: SCDDSN reported 99.6% (256 of 257 files) compliance for the participants' needs identified in the service plan being justified by formal or informal assessments documented in the participant's record.

The compliance rate for services/interventions being appropriate to meet the participant's assessed needs was 94.9% (244 of 257 files). The compliance rate for service needs outside the scope of the waiver identified in the service plan and addressed was 98.8% (254 of 257 files).

The second performance measure for this assurance is to determine the proportion of participants whose plans were completed or revised prior to the provision of waiver services and monitored in accordance with state policy. SCDDSN reported the following: The compliance rate for the service plan being amended or updated as needed for SFY 11, was reported by SCDDSN to be 92.6% (214 of 257 files). There were 17 files which were not compliant and 26 files which were not applicable (did not meet the criteria for this performance measure).

The third performance measure for this assurance is to determine the proportion of participants who plans were updated or revisited at least annually and when warranted. SCDDSN reported the following: The compliance rate for the plan being developed by the service coordinator within 365 days for SFY 11 was 99.6% (255 of 256 files). The state is following up on the recoupment for the one file out of compliance. The compliance rate for the plan being amended or updated as needed for SFY 11 was 92.6% (214 of 257 files). Seventeen files were not compliant and 26 files were not applicable.

The fourth performance measure for this assurance is to determine the proportion of participants receiving services and supports in the type, amount, frequency and duration as specified in their service plans. SCDDSN reported the following: The compliance rate for the service plan including MR/RD wavier service names, frequency, amount, duration and valid provider type for SFY 11 was 66.9% (172 of 257 files).

The compliance rate for MR/RD waiver services being provided in accordance with the service definitions found in the waiver document for SFY 11 was 99.6% (256 of 257 files). Remediation included late entries or corrections to the service record if appropriate, staff training, District Staff Technical Assistance, and quarterly meetings to review policy. The QIO schedules a follow-up review approximately six months after the original review to ensure effective remediation and implementation of the POC.

The state self-reported during November and December of 2012, a high volume of participant waiver terminations due to "no services for 30 days". These terminations were the result of service coordinators not monitoring the service plans. The participants were re-enrolled in the waiver and the state required the Service Coordinators to be retrained and supplied CMS with two sign-in sheets to verify the Service Coordinators had attended the training. The QIO schedules a follow-up review approximately six months after the original review to ensure effective remediation and implementation of the POC.

The fifth performance measure for this assurance is to determine the proportion of waiver participant records containing properly completed and signed freedom of choice form demonstrating the choice between waiver services and institutional care to the participant. The freedom of choice form must be verified prior to the CAT approving the initial LOC

for the participant. It is not clear why this performance measure was included in the service plan assurance since it involves approving LOC for the participant.

The compliance rate for the freedom of choice form being properly completed and in the participants' record for SFY 11 was 98.5% files. Sixty-five files were compliant, 1 file was not compliant and 191 files were not applicable (did not meet the criteria for this performance measure).

The sixth performance measure for this assurance is to determine the proportion of waiver participants offered choice of services and providers. SCDDSN reported the following: The compliance rate for documentation verifying a choice of providers was 97.9% (143 of 146 files). There were three files were not compliant and 111 files not applicable (did not meet the criteria for this performance measure). The compliance rate for documentation verifying a choice of services was 98.8% (254 of 257 files). Three files were not compliant and zero files were not applicable.

The providers found to have non-compliant files were required to submit a Plan of Correction (POC) to the QIO within 30 days that addressed the deficiency both individually and systemically. Remediation for the non-compliant files would have included a late entries or correction to the record if appropriate, quarterly meetings with peers to review policy, district staff technical assistance and local staff retraining. The QIO schedules a follow-up review approximately six months after the original review to ensure effective remediation and implementation of the POC.

While the state reports the QIO worked with the providers who had deficiencies in the performance measures until 100% remediation had been accomplished in the deficient files, the evidence lacked metrics to show all deficiencies had been remediated satisfactorily after the QIO's follow up review six month later. The state explained the QIO pulls additional samples during the six month follow-up review, which always results in additional findings. Therefore, 100% compliance cannot be achieved in the QIO's follow-up review.

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 the state submit aggregate compliance data from SFY 10 and SFY 12 to demonstrate a complete review. CMS requires the state provide the specific individual remediation conducted in the POCs for QIO review and the QIO's follow-up review regarding remediation. CMS also requires the state identify the specific reasons files were determined "not applicable" for review.

State's Response:

The state submitted additional evidence to include a full three years of findings (SFYs 10, 11, and 12). For the first performance measure (proportion of participants whose plans include service and supports that are consistent with needs and personal goals identified in the comprehensive assessment), evidence that needs in the service plans are justified by formal or

informal assessment information show compliance at 86.2%; 99.6% and 95.9% for SFY 10, 11, and 12, respectively. The QIO indicator that measures if services or interventions are appropriate to meet assessed needs show no separate review for SFY 2010; 94.9% compliance for SFY 2011 and 95.5% compliance for SFY 2012. Another QIO indicator for this performance measure (service needs outside the scope of waiver services are identified in the service plan and are addressed) shows a 99.2%; 98.8% and 99.5% compliance rate for SFY 10, 11, and 12 respectively.

Additional evidence for performance measure #2 (proportion of participants whose plans were completed/revised prior to the provision of waiver services and monitored in accordance with state policy) indicate 83.4% compliance for SF& 2010 ; 92.6% compliance for SFY 2011; and 95.5% compliance for SFY 2012.

Performance measure #3 (Proportion of participants whose plans were updated/revised at least annually and when warranted) used two indicators: (a) the plan is developed by the service coordinator with 365 days and (b) the plan is amended/updated as needed. For the first indicator, compliance rates were 90%; 99.6% and 98.6% for SFY 10, 11, and 12 respectively. The second indicator revealed 83.4%; 92.6% and 95.5% for SFY 10, 11, and 12 respectively.

Performance measure #4 (Proportion of participants who are receiving service and supports in the type, amount, frequency and duration as specified in their plan) uses two indicators: (G9-02) The plan includes ID/RD waiver services(s) name, frequency, amount, duration and valid provider type for the service(s); and (G9-09), ID/RD waiver services are provided in accordance with the service definitions found in the waiver document. The G9-02 indicator revealed compliance rates of 56.2%; 66.9% and 53.9% for SFY 10, 11, and 12, respectively. The state reported that this indicator was the most frequently cited for all of the ID/RD indicators and continues to be a focused are of the state's technical assistance efforts. Staff was most often cited for omitting one component of the frequency/amount/duration or the authorizations did not match the same unit of measurement indicated on the plan. Remediation consisted of recoupment of funds on those plans found to be out of compliance.

The G9-09 indicator (services provided in accordance with the service definitions) indicated compliance rates of 95.8%; 99.6% and 98.6% for SFY 2010, 2011, and 2012 respectively.

Performance measure #5 (Proportion of waiver participant records which contain an appropriately completed and signed Freedom of Choice Form that specified choice was offered between waiver services and institutional care) found that for SFY 10, there was 98.9% compliance; 98.5% compliance for SFY 11; and 98.7% compliance for SFY 2012.

Performance measure #6 (Proportion of wavier participants who were offered choice among services and providers) revealed compliance rates of 89%; 97.9% and 97.5% for SFY 2010, 2011, and 2012, respectively. The state indicated that remediation would have included late entries to the participant service record, corrections to the participant service record if appropriate, staff training, distract staff technical assistance and quarterly meetings to review policy. As clarification, the state re-affirmed that technical assistance is a function of the operating agency (DDSN) and not the responsibility of the QIO. The QIO is responsible for any

follow-up reviews where corrective actions plans were required.

III. Qualified Providers Serve Waiver Participants

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

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

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

The SCDHHS Division of Community Long Term Care (CLTC) reviews 100% of provider applicants prior to enrollment. New providers contracting with SCDHHS must meet certification and state standards before providing services. The SCDHHS Provider Compliance conducts provider training to potential providers once they have met the state certification and standards requirements. They also provide pre-contractual training including the scope of the waiver services, direct staff training requirements, expectations for business conduct and administrative requirements such as liability insurance, worker's compensation insurance, policy and procedures. The training includes the requirements for staff background checks, tuberculin skin test requirements, first aid certification and documenting waiver services as well. Once a provider is approved, they are included in the SCDDSN's qualified provider list.

Numerous services can only be provided by providers meeting federal, state and SCDDSN requirements for quality and safety. The state law requires licensing of certain programs and residential facilities (all residential and facility-based respite, adult day health care, career preparation, support center, day activity, employment, and community service programs) as well as the creation of standards. This includes the qualifications of staff, staff ratios, fire safety, medication management, facility size and construction, storage of hazardous liquids and health maintenance.

The first performance measure for this assurance is to determine the proportion of providers that meet required licensing, certification and other state standards prior to the provision of waiver services by provider type. The state's evidence reflects every provider applicant is reviewed and not allowed to provide services before they have met the required standards, the state is in 100% compliance for this performance measure. However, the state did not provide the number of providers reviewed during this time period.

The second performance measure for this assurance is to determine the proportion of providers that continue to meet licensing, certification and other state standards. The SCDHHS Provider Compliance conducts on-site reviews of contracted providers to ensure the providers' adherence to the requirements of the provider contract. Reviews by

SCDHHS Provider Compliance are conducted every 12 to 18 months depending on how well the provider performed in their last review. The compliance rate for this performance measure was 92.6% (214 of 257 files). Twenty-six files were not applicable.

The South Carolina Department of Health and Environmental Control (DHEC) conduct licensing inspections. On-site inspections are conducted when all pre-licensing requirements are met, if no deficiencies are noted by the DHEC, licenses are issued. If deficiencies are noted, a provider must submit a POC to the DHEC within 15 days of the licensing inspection report. Once the DHEC finds the provider's POC has been implemented an acceptance letter is issued and a copy of all documentation to submitted SCDDSN. Once a provider is licensed they are added to the qualified provider list.

The SCDDSN conducts behavior support provider reviews, ensuring licensing requirement are met and offers district staff technical assistance and remediation for service coordinators. For any deficiencies found a detailed POC must be provided within 30 days and corrections are required to be in place before the license is issued.

Where there are continuing licensing inspections, the SCDDSN District Office staff provide training and technical assistance to ensure providers continue to meet the standards. For any deficiencies found, remediation is required at an individual level through a POC. As part of the follow-up process, written verification of the correction(s) is required.

The state developed indicators to measure the following at each facility: environment promotes consumer health and safety, each facility will have fire marshal inspections, HVAC, Water Quality and Health and Sanitation inspections, evidence of fire safety training and evacuation, disaster preparedness, first aid supplies and other emergency items, documentation of continuous coordinated health care, appropriate medical follow-up and assistance with medications per the participant's service plan.

The DHEC conducts inspections to ensure providers continue to meet program standards. Providers are re-issued a license on a pre-established schedule after the DHEC determines the provider has continued to meet the program standards. Any provider who fails to meet the standards must submit a POC to DHEC within 15 days of the licensing inspection report. Once the DHEC finds the provider's POC has been implemented, it issues an acceptance letter and forwards a copy of all documentation to SCDDSN.

The exception to the protocol above is when the DHEC finds a provider with a Class 1 deficiency (a deficiency which must be corrected while the inspector is on - site) requiring an immediate POC. There was once Class 1 deficiency for SFY 11. The sheetrock had been damaged in one room and the provider installed plywood over the damage, including the window in that area. The provider was required to have someone remove the plywood from the window opening and repair the sheetrock which had been damaged. The inspector who found the damage remained at the site until the repairs were completed satisfactorily.

The third performance measure for this assurance is to determine the proportion of non-licensed/non-certified providers that meet requirements. Behavior Support or Psychological Service provider applicants are required to complete an application form with a resume and work experience relevant to the service they seek to provide. After SCDDSN reviews the application and conducts an interview with experts in this field, a recommendation is made based upon the results. After enrollment, SCDDSN reviews the provider every two to three years to ascertain the provider continues to meet enrollment requirements.

Registered nurses with CLTC Provider Compliance perform compliance reviews of non-licensed or non-certified waiver providers every 12 to 18 months depending on the findings of the previous reviews. If the CLTC nurse finds the provider out of compliance a POC is required. If the CLTC finds the POC insufficient the CLTC will reject the provider's POC and the provider may be suspended from accepting new participant referrals for 30, 60 or 90 days.

SCDDSN reviewed the day and residential staff at provider agencies to determine the percentage of staff that met the minimum requirements for their positions and found 96.6% (28 of 29) compliance. The one staff person who failed to be in compliance was due to the person's qualifications not being available for the QIO to review.
The SCDDSN reports this finding is generally reported because documentation of provider qualifications was not available for the QIO to review. The provider agencies were required by the state to submit a POC to the QIO within 30 days. The QIO approved the provider agencies POC within 30 days and completed a follow-up review within 6 months and found successful implementation of the POC ensuring remediation.

For the review period, SFY 11, the CLTC conducted 234 reviews finding 161 required no action, 73 resulted in suspensions (all were later reinstated), and 8 resulted in terminations. When a provider is suspended, they are required to submit a successful POC in order to provide services again. The termination of a provider may be due to a provider failing to provide a successful POC or the provider choosing to withdraw after the review.

The fourth performance measure for this assurance is to determine the proportion of providers that meet training requirements in the approved waiver. The SCDHHS Provider Compliance Officer reviews all provider applications in a pre-contractual review. Attendance in in the pre-contractual training is mandatory for all provider applicants.

The pre-contractual trainings are extensive and cover many topics such as scopes of services, direct staff training requirements, business conduct expectations, liability insurance, worker's compensation, policy and procedures, background checks, tuberculin skin tests, first aid certification and service documentation. Any provider applicant to fails to attend the pre-contractual training is not offered a contract with SCDHHS. The

SCDDSN reviewed the percentage of day and residential staff who received training as required and found 75.9% (22 of 29) staff compliant.

The providers found to have non-compliant files were required to submit a Plan of Correction (POC) to the QIO within 30 days that addressed the deficiency both individually and systemically. The QIO completed a follow-up review approximately six months later and found successful implementation of the POC.

While the state reports the QIO worked with the providers who had deficiencies in the performance measures until 100% remediation had been accomplished in the deficient files, the evidence lacked metrics to show all deficiencies had been remediated satisfactorily after the QIO's follow up review six month later. The state explained the QIO pulls additional samples during the six month follow-up review, which always results in additional findings. Therefore, 100% compliance cannot be achieved in the QIO's follow-up review.

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 the state submit aggregate compliance data from SFY 10 and SFY 12 to demonstrate a complete review. CMS requires the state provide the specific individual remediation conducted in the POCs for QIO review and the QIO's follow-up review regarding remediation. CMS also requires the state identify the specific reasons files were determined "not applicable" for review.

State's Response:

The state submitted additional years of evidence as required by CMS. For the first performance measure that reads "the proportion of providers that meet required licensing, certification, and other state standards prior to the provision of waiver services by provider type" the evidence indicates that for SFY 2010, 24 of 28 DDSN Licensing Applications were submitted and approved; 27 of 28 were approved for SFY 2011; and 43 of 45 for SFY 2012. Community Long Term Care (CLTC) Provider contracts requested and approved found that for SFY 2010, 29 of 42 were approved; for SFY 2011, 37 of 43 were approved; and for SFY 2012, 21 of the 31 requested were approved.

For the performance measure that reads "Proportion of waiver providers that continue to meet required licensing, certification and other state standards", the state reiterated that provider compliance reviews are conducted every 12-18 months depending upon the findings of the previous review. Additional information specific to providers that continue to meet licensing/certification or other state standards was submitted to cover SFY 2010, which indicated that 59 provider reviews were conducted with 30 requiring no action; 27 required corrective action plans, and 2 providers required suspensions for 30 days but were later re-instated into the program. No terminations were required for the fiscal year.

For SFY 2011, 65 reviews were completed for contracted, licensed/certified/other state standard providers. 56 of those required no action; 6 required corrective action land and 3 providers were

suspended for either 30, 60, or 90 days with later re-instatement into the program. No providers were terminated from the program.

For SFY 2012; 65 reviews were completed for contracted, licensed/certified/other state standard providers. 59 required no action, 3 required corrective action plans and 3 providers were suspended for 30 days with later re-instatement into the program. Again, no providers were terminated.

The QIO had an indicator that measures "the Board/Provider employee day services and residential staff who meet the minimum requirements for the position." For FY 2010, there was no separate QA review indicator for this year; SFY 11 revealed a 96.6% compliance rate (22 0f 29 provider met requirements); but for SFY 2012, the compliance rate fell to 78% with only 63 of 70 provider meeting all requirements. The state reported that many providers were cited because their efforts to secure personal or prior employment references for new employees were not successful, although they did have the required background checks, abuse registry and CMS Exclusion checks completed. Providers were also cited for not maintaining adequate training records. Remediation included staff training on requirements, district staff technical assistance and quarterly meeting to review policy.

For the QIO indicator that measures that day services and residential staff received training as required, the state indicated no measurement was in place for SFY 2010; 75.9% and 78.6% for SFY 2011 and 2012, respectively. The state indicated that citations for these providers were very similar to those cited above with respect to personal and/or prior employment references.

Performance measure #3 (Proportion of non-licensed/non-certified providers that meet requirements) found in SFY 2010 that a very low percentage of providers met the requirements. Of 140 providers reviewed, only 3 required no action; 91 required corrective action plans; 41 required suspensions and 5 providers were terminated from the program.

For SFY 2011, 169 non-licensed/non-certified providers were reviewed with 69 requiring correction action plans; 70 providers were suspended; 8 providers were terminated and only 22 providers required no action.

SFY 2012 also revealed a very low compliance rate with 187 reviews being conducted. 55 providers required no action; 69 required corrective action plans; 57 required suspensions and 6 were terminated.

Additional evidence submitted included spreadsheets with individual provider entities listed by service type; the original score, final score, outcome and a completion date. The state did not submit additional material indicating types of corrective actions approved; provider actions required for re-instatement following suspensions; or any other remediation strategies. Additionally, there is no mention of strategies to address what appears to be a systemic provider compliance issue.

The state did provide evidence to verify that behavioral support providers met all requirements prior to the provision of services for all three fiscal years.

Additional information presented for performance measure #4 (proportion of providers that meet training requirements in the waiver) shows that this was not a QIO indicator for SFY 2010. There was 75.9% compliance for SFY 2011 and 78.6% compliance for SFY 2012. As previously stated, issues appear to revolve around citations for not securing persona or prior employment references and for not maintaining adequate records for all staff training activities. It is reported that "remediation might have included late entries to the participant record or corrections to the participant service record if appropriate, staff training, District Staff Technical Assistance and quarterly meeting to review policy. The state clarified that the operating agency (DDSN) would be responsible for providing technical assistance to provider with deficiencies, but there is no mention that this remediation actually occurred. There is no mention of an analysis of the systemic issue to find a root cause, nor how the state plans to address for systems improvement.

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.)

SCDDSN employs a full-time Incident Management Coordinator, who uses the state's web-based reporting system using real-time analysis utility to track and trend information. SCDDSN uses this information to respond to reports of abuse, neglect and exploitation, as well as other critical incidents not meeting the criteria for abuse, neglect and exploitation.

The web-based system allows the state to track reporting timeframes and completion of internal reviews, in addition to a review of the provider's action to remediate issues. These issues include staff training, staff suspension or termination, updates to risk management and quality assurance procedures and policies providing safeguards for participants.

The SCDDSN Director of Quality Management also uses this data annually for trending analysis not only at the provider level, but at the statewide level in addition to QIO and licensing data. If a provider's performance differs significantly from the statewide averages, another review will be conducted more often than annually. When this happens, the Incident Management Coordinator goes on-site to conduct training and to offer technical assistance to the providers.

For the providers' convenience, SCDDSN maintains all agency directives online, which providers may use for training or information purposes. Flyers and brochures on how to identify and report suspected abuse, neglect, exploitation, and how to protect against fraud or other types of scams are provided by SCDDSN to provider staff as well as families.

The first performance measure for this assurance is to determine the proportion of incidents of reported abuse, neglect and exploitation. There were 519 reported incidents of abuse, neglect and exploitation for all waivers. Of the 519 reported incidents, SCDDSN found 83.4% (433 of 519) of them were for participants in this waiver.

The SCDDSN found 96.8% (245 of 253) files compliant for the participant or legal guardian receiving information on how to report suspected abuse, neglect or exploitation for the review period. The review also demonstrated 87.7% (151 of 172) files were compliant demonstrating people were trained regarding what constitute abuse, neglect or exploitation and to whom they should report it to.

The second performance measure for this assurance is to determine the number of incidents of abuse, neglect and exploitation that were reported within required timeframes. SCDDSN determined 78.0% (338 of 433) allegations of abuse, neglect or exploitation were reported within 24 hours as required by state policy.

The South Carolina Code of Law for Adult/Child Protective services and the Omnibus Adult Protection Act outlines the procedures for reporting suspected abuse, neglect or exploitation. There are times when a family member or friend of the participant may not report the incident within the required 24 hour period. SCDDSN is considering adding a key indicator to measure reporting timeliness more accurately. When the state reviews this type of raw data, it helps the state determine the types of reports made and the number of cases substantiated.

When the SCDDSN reviewed the compliance rate for providers implementing a risk management and quality assurance program, it found a compliance rate of 90.9% (30 of 33 providers). Non-compliance resulted in the providers having to submit a POC to the QIO within 30 days and the QIO conducting a follow-up review six months later to ensure there had been satisfactory remediation.

SCDDSN determined the providers out of compliance for the review period (SFY 11) were either new providers who failed to establish a Quality Assurance/Risk Management Committee or providers with established committees, but the committees had not tracked or trended information.

A review of providers to determine who followed SCDDSN procedures related to preventing abuse, neglect or exploitation, reporting suspected cases and responding to the report of abuse, neglect or exploitation to see if it was consistent with State Directive 534-02-DD, the agency found 90.9% (30 of 33) providers compliant.

The third performance measure for this assurance is to determine the number of incidents in which the internal review was completed within required timeframes. SCDDSN determined 76.5% (331 of 433) of internal reviews of abuse, neglect and exploitations were completed within the reporting requirements for the review period, SFY 11. The state does not explain the reasons for this substantial lack of compliance for this assurance.

The fourth performance measure determined the number and proportion of substantiated incidents of abuse, neglect and exploitation. The SCDDSN reviewed the number and proportion of substantiated incidents of abuse, neglect and exploitation and found 1.4% (6 of the 433) cases were substantiated. The state does not address what happened in the substantiated cases.

The fifth performance measure for this assurance is to determine the proportion of participants who report concerns by type. Waiver participants and/or family members or legal guardians can voice concerns about the waiver program to SCDDSN. These concerns are entered into a Consumer Complaint Database and investigated after which SCDDSN follows up to ensure the complaint is resolved. SCDDSN reviews the data captured annually to ascertain trends and the best way to eliminate future concerns. SCDDSN determined 16 of the 31 consumer complaints for all waivers for this review period were for participants in this waiver. There was no compliance data for this performance measure. The "types" of complaints were not identified in the evidence submitted by the state, nor the percentage of complaints for this waiver alone.

The sixth performance measure for this assurance is to determine the number and proportion of critical incidents reported (including mortality, injuries, and client to client altercations.) During the review period, SFY 11, the state had a statewide total of 1,318 critical incidents (including mortality, injuries and client to client aggressions) reported. Of the 1,318 cases, 953 (72.2% of the total) critical incidents were reported for participants in this waiver. When broken down into categories, there were: 41 deaths reported statewide, all of which were participants in this waiver; 138 injuries were reported statewide, of those 101 were reported for MR/RD participants; 156 reports statewide for client to client aggressions, 146 of those were reported for participants on this waiver.

The SCDDSN found the compliance rate for providers following SCDDSN procedures regarding preventing, reporting and responding to critical incidents as outlined in State Directive 100-09-DD were 89.7% (26 of 29) provider agencies compliant for the SFY 11 review period. The compliance rate for providers following SCDDSN procedures regarding medication errors or event reporting as outlined in State Directive 100-29-DD was 93.1% (27 of 29) provider agencies. SCDDSN also reviewed the proportion of providers following SCDDSN procedures regarding death or impending death as outlined in State Directive 505-02-DD and found 92.9% (26 of 28) provider agencies compliant.

When providers were cited for not tracking and trending information when reviewing medication errors, they were required to develop a POC to the QIO within 30 days. Approximately six months after the original review, the QIO performs a follow-up review to ensure successful remediation.

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 the state submit aggregate compliance data from SFY 10 and SFY 12 to demonstrate a complete review. CMS requires the state explain the substantial lack of compliance for internal reviews of abuse, neglect and exploitation being completed within the required timeframe and what happened in the six substantiated cases. CMS also requires the

state implement system improvement demonstrating subsequent compliance in this area and identify the different "types" of complaints.

State's Response:

As required by CMS, the state responded with additional information for SFY 2010-2012. For performance measure #1 (number and proportion of incidents of reported abuse, neglect and exploitation), the state reported 73.9%; 83.4% and 39% for SFY 2010, 2011 and 2012, respectively. These percentages reflect the number of allegations for ID/RD waiver participants against the total number of allegations reported across the entire service delivery system including three other waiver populations and all non-waiver consumers.

The QIO indicator that measures if the recipient/legal guardian received information on abuse and neglect annually revealed 89.5%; 96,8% and 98.1% for SFY 2010, 2011, 2012 respectively. A second QIO indicator that measures if people who receive services are trained on what constitutes abuse and now and to whom to report revealed compliance rates of 72.5%; 87.7% and 91,9$ for SFY 2010, 2011, 2012 respectively. A statement indicating that remediation "would have included" late entries to the participant service record, corrections to the participant service record if appropriate, staff training, District Staff Technical Assistance and quarterly meeting to review policy is presented by the state. However, there is no indication that any of these forms of remediation actually occurred.

Performance measure #2 (number of incidents of abuse, neglect and exploitation that reported with the required timeframe) shows 78% for SFY 2011 and 97.3% for SFY 2012. There was not a separate QA review indicator for the measurement in SFY 2010. QIO indicators falling under this performance measure also include: "board/provider implements a risk management and quality assurance program consistent with 100-26-DD and 100-28-DD". This indicator revealed compliance rates of 72.1%; 90.9% and 87.1% for SFY 2010, 2011, 2012, respectively. Additionally, QIO Indicator stating "board/provider follows SCDDSN procedures regarding preventing, reporting and responding to abuse/neglect/exploitation as outlined in 534-02-DD" revealed compliance rates of 85.7%; 90.9% and 92.1% for SFY 2010, 2011, 2012, respectively. The response includes a statement that says "typical remediation would have included letters to the providers regarding the expectations on following the DDSN Directives on Abuse, Neglect and Exploitation, a corrective action plan approved by the QIO, and follow-up reviews conducted by the QIO." There is no indication that these remediation activities actually occurred. The state also indicated the Incident Management Coordinator is available to offer training and power-point training is also available online for providers. The State indicates that they are concerned about the lack of attention by providers to reporting timelines. As a quality improvement strategy, the state has added an indicator for review by the QIO that will measure compliance with reporting timeframes for SFY 2014. Any citations will require a plan of correction and subject the non-compliant provider to a follow-up review.

Performance measure #3 (number of incidents in which the internal review was completed within required timeframes) did not have a separate QA indicate for SFY 2010. SFY 2011 revealed a 76.5% compliance rate and SFY 2012 reveals 87.7% compliance. As previously stated, the additional evidence indicates that "typical remediation would have included…", but

there is no submitted evidence to indicate that any type of remediation actually occurred. The state does mention that while there was considerable improvement in SFY 2012, it remains concerned about the lack of attention by providers to reporting timelines. As above, a quality improvement strategy of an additional QIO indicator to measure compliance with reporting timelines has been added for SFY 2014.

The state provided additional data for performance measure #4 (number and proportion of substantiated incidents of abuse, neglect and exploitation) which indicated in SFY 2010 that 5 of 360 (1.3%) allegations of abuse, neglect and exploitation were substantiated, and 4 0f 245 (1.6%) allegations were substantiated in SFY 2012. There is a QIO indicator that measures if providers have implemented a risk management and quality assurance program consistent with policy. Findings included 72.1% compliance for SFY 2010; 90.9% compliance for SFY 2011; and 87.1% compliance for SFY 2012. The state reported that the Incident Management Coordinator provides on-site training and technical assistance to providers that fall significantly above or below the statewide average for reporting and the types of incidents. Again, the state indicates what would be included as 'typical remediation' but does not verify that actual remediation occurred and/or if remediation was effective.

Performance measure #5 (proportion of participants who report concerns by type) indicated that for SFY 2010 4.3% (2 of 46 complaints) were from ID/RD waiver participants; 55.8% (19 of 34 complaints) were from ID/RD waiver participants for SFY 2011; and 42.1% (8 of 19 complaints) were from ID/RD Waiver participants for SFY 2012. The state did not offer an explanation for the increased number of ID/RD participants who reported concerns. It would be helpful for the state to determine if the increase is a result of additional training provided to waiver participants as to what to report, or if the increase was due to actual issues with service providers, etc.

Performance measure #6 revealed 72.6%, 57.1% and 67.1% for SFY 2010, 2011, 2012, respectively, for the "number and proportion of critical incidents reported (including mortality, injuries, and client to client altercations)." The QIO indicator used for this performance measure states: "board/provider follows SCDDSN procedures regarding preventing, reporting and responding to critical incidents as outlined in 100-09-DD", with the results showing 86.1% compliance (31 of 36 providers) for SFY 2010; 89.7% compliance (26 of 29 providers) for SFY 2011; and 78.1% compliance (25 of 32 providers) for SFY 2012. The state noted that providers were most often cited for not following the tracking/trending/analysis requirements in using their data, although data was available but not utilized effectively.

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

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

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

The first performance measure for this assurance is the presence of an MOA that includes designated functions. The SCDHHS has met this assurance with a current MOA with SCDDSN, the Operating Agency for the provision of HCBS waiver services, effective June, 30, 2010 through June 30, 2015. The purpose of the MOA is to define the operation and administration for four HCBS waivers, including this waiver.

Under the MOA, SCDDSN is to provide participants the opportunity to request a reconsideration or fair hearing if they were not given the choice of services under the waiver, or those whose services were denied, suspended, reduced or terminated, or not given a choice of provider under the state's appeals process.

If a participant (or their family) feels they have received an adverse action, they have the right to request reconsideration. Sometimes participants (or their families) will file a request for reconsideration request to SCDHHS. If the request is filed within the timeliness requirements, a formal hearing is scheduled and the appeal is presented before a Hearing Officer.

SCDHHS and SCDDSN both track the reconsideration and appeal issues filed by the participants (or their families) to trend patterns and the outcomes in the MR/RD waiver appeal log. The state also issued guidelines for SCDDSN staff that outline expectations and general rules of conduct relative to hearings. The state also developed a template for a hearing outline for staff to use in preparation for all testimony.

Under the MOA, SCDHHS uses the QIO to review all adverse LOC determinations made by the CAT for this waiver, as well as three other waivers. A representative sample of all ICF/MR approvals made by SCDDSN is also reviewed by the QIO. SCDHHS has the final determination for any LOC decision based upon the QIO review. While the SCDHHS uses the Medicaid QIO to review all adverse ICF/MR determinations by the SCDDSN CAT, the SCDHHS QIO reviews a representative sample of the SCDDSN's approvals.

The MOA is also used the address the "Appropriation Transfer of State Match" annually for participants who were initially Medicaid eligible prior to enrollment in this waiver. SCDHHS compiles an annual appropriation transfer from SCDHHS to SCDDSN to help with costs related to state plan services.

The second performance measure for this assurance is the presence of a service contract that includes requirements and responsibilities for the provision of services. The state met this requirement as evidenced by the SCDHHS review of the waiver on an ongoing basis and making necessary revisions (amendments) to the waiver. The state has amended this waiver twice since the January 1, 2010, effective date due to budgetary adjustments. However, the state also reviews all areas of the waiver, including provider requirements and responsibilities in providing waiver services in addition to service

definitions and approved service rates.

The third performance measure is the performance of focus reviews, utilization reviews, and/or suspected fraud investigations. The state performs focus reviews, utilization reviews and suspected fraud investigations as part of their administrative oversight. The state reviewed the entire utilization record for one participant and recouped $3,885.77, due to lack of documentation to support Medicaid billing. The state failed to identify metrics for this performance measure.

Under the MOA, the CLTC staff conduct case record reviews focusing on the participant's service plan, including the amount, frequency, duration, provider type, timeliness of the service plan, LOC timeliness standards, freedom of choice, services notes and reviewing other supporting documentation to verify appropriateness and adequacy of services.

The CLTC collects and analyzes data, audit provider payments and review records resulting in the recovery of Medicaid payments when documentation fail to support the amounts billed. When there are indications of possible fraud, the CLTC partners with the SCDHHS Division of Program Integrity and the South Carolina Attorney General's Office to investigate suspected fraud or to initiate criminal investigations.

When the QIO reviews POC actions by providers found non-compliant and conducts follow-up reviews to ensure the remediation is successful, this information/report entered by the QIO on the CDSS. The QIO also pulls an additional sample during its follow-up review of the provider. SCDHHS reviews the QIOs reports, as well as see the additional sample the QIO pulled from the provider's records during the follow-up review. The monthly reviews conducted by SCDHHS allow the state to see any additional findings by the QIO and see recouped funds as a result of the QIO's reviews.

The state's oversight of their Division of Finance and its process of determining erroneous claims resulted in the state identifying unnecessary delays in the process and the state is working to improve responsiveness. The state also found gaps in the reporting of recoupment documents and will require improved transparency.

The state reviewed the York Department of Disabilities and Special Needs (DSN) board record utilization. The review found inappropriate waiver billings for a participant and recoupment of the payment was necessary. After the review was completed, the findings were referred to the SCDHHS Division of Program Integrity to conclude the review.

The fourth performance measure for this assurance require meetings be held to discuss specific waiver issues. The state met this assurance by the SCDHHS, SCDDSN and QA staff holding meetings at least quarterly and sometimes more often, to discuss waiver issues. Evidence of meeting agendas and minutes were submitted to demonstrate this performance measure. The staff are also are in communication daily to resolve waiver concerns. Topics discussed include quality assurance, quality improvement, waiting lists status, and staff training opportunities. Meeting agendas and summaries are kept for the

meetings.

The fifth performance measure for this assurance is policy changes related to the MR/RD waiver are discussed and/or communicated in a timely manner. Under the MOA, SCDHHS disseminates Medicaid information and/or changes in the form of bulletins. These changes are communicated and effected in a timely manner resulting in smoother program operations. The state cited two examples of evidence demonstrating timely communications in 2012, where policy changes had been communicated and implemented within one or two months respectively.

Another example of the state communication and timely changes is the change in the termination, suspension, denial and reduction forms used by SCDDSN last year. The state determined on November 19, 2012, a change was needed regarding a federal code of regulations (CFR) cite on November 19, 2012. The change was made to the notices by January 1, 2013.

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

CMS recommends the state submit aggregate compliance data from SFY 10 and SFY 12 to demonstrate a complete review.

State's Response:

The state did not submit additional aggregate compliance data from SFY 2010 and SFY 2012 as requested above by CMS.

VI. State Provides Financial Accountability for the Waiver

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

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

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

All waiver providers must be enrolled or contracted with SCDHHS. All waiver participants' waiver status is entered into the SCDHHS Medicaid Management Information System (MMIS) with a specific identifier. The participants are also identified by a "Recipient Special Program" (RSP) indicator. Most waiver services are required to be preauthorized by the Service Coordinator. An exception to the preauthorization is extra prescription drugs.

This RSP indicator follows the claim throughout all aspects of processing and controls access to waiver procedure codes. The claim will not be paid unless the participant eligibility file contains the proper RSP for the service dates in question. The RSP indicator is 100% controlled by the State Medicaid Agency. Claims are submitted by the CMS-1500 hard copy claim form or by the agency's electronic web tool. All waiver claims are processed by the MMIS.
The only performance measure for this assurance is the proportion of paid claims that are coded and paid in accordance with policies in the approved waiver. The state pulls detailed claims reports (DCRs) from the MMIS for record reviews quarterly. The state staff looks at multiple items in the paid claims to compare them against participant's record documentation to determine the appropriateness of services billed. These include paid claims against the services listed in the participant's service plan, service rates paid versus service rates approved, service incorrectly billed during inpatient hospitalizations and absences at day programs.

When erroneous claims are identified, the Division of Finance with SCDDSN reviews the findings along with the detailed paid claims history for the participant. Any claims identified as non-allowable is refunded to SCDHHS by SCDDSN, whether SCDDSN or another provider filed the claim and was paid. The state's oversight of this process identified unnecessary delays and it is working to improve responsiveness. The state also found gaps in the reporting of recoupment documents and will require improved transparency.

When complaints or information from various sources regarding inappropriate claims submissions by Medicaid providers are forwarded to the state, the SCDHHS Program Integrity Unit and the CLTC collect and analyze data and audit payments to Medicaid providers. Inappropriate payments made based on the record reviews or other audits result in the recovery of payments if the provider's documentation does not support the amounts billed.

The SCDHHS waiver staff receives financial expenditure reports for all waivers monthly. They use the reports to track waiver expenses month by month and monitor fund codes to make sure they are appropriate.

SCDHHS conduct reviews resulting in discovering billing irregularities requiring the recoupment of the Federal Financial Participant (FFP) from SCDDSN or other providers. If the claim in question is less than one year old, the state will use the "void/replace" web-tool adjustment process to recover the money. If the claim is older than one year, or when SCDDSN has delayed submitting the necessary recoupment to SCDHHS, a debit is placed against the provider's account.

The Service Coordinator Early Interventionist (EI) monitors all waiver services to determine the services are authorized. Providers use prior authorizations when submitting claims to the MMIS for payment. The statewide compliance rate for authorizations for services properly completed as required prior to providing the service

was the review period, SFY 10-11 was 83.3% (214 of 257 records). Any provider out of compliance is required to submit a POC addressing the deficiency within 30 days. Six months after the original review and finding a follow-up review is conducted to ensure remediation and implementation of the POC.

Again, SCDDSN uses the QIO to conduct on-site reviews on provider and participant records to ensure compliance. When recoverable findings are identified by the QIO, SCDDSN returns the money to SCDHHS. The SCDHHS developed a QIO Validation Tool to track reviews and money recovered.

SCDHHS reviews the QIOs reports monthly which allows the state to see any additional findings by the QIO and see recouped funds as a result of the QIO's reviews.

Suggested Recommendations:

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

CMS recommends the state submit compliance data retroactive to the effective date of waiver applications in the future to demonstrate a complete review.

State's Response:

The state did not provide additional information for SFY 2010 or 2012.