DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Waldrop	12-7-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10218	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Deps, CMS file No response needed, see attached.	[X] Prepare reply for appropriate signature DATE DUE 2/3/12
	[ ] 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

December 1, 2011

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

Dear Mr. Keck:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of South Carolina's Mechanical Ventilator Dependent waiver program with control number 40181.R03.02, that services the frail elderly and persons with physical disabilities requiring mechanical ventilation who otherwise would require placement in a Nursing Facility (NF). Thank you for your assistance throughout this process and for sending comments on the draft report. The State's responses to CMS' recommendations have been incorporated in the appropriate sections of the report.

Once again we would like to recognize exceptional aspects of your waiver program. Specifically, your Case Management System and its most recent version of software, the Phoenix System. These software systems stand out as promising practices and we encourage you to continue their development.

We found the State to be out of compliance with one of the review components. For the area in which the State is not compliant, please be sure it is corrected at the time of renewal. We have also identified recommendations for program improvements in five of the assurance areas.

Finally, we would like to remind you to submit a renewal package on this waiver to CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver, November 30, 2012. Your waiver renewal application should address any issues identified in the final report as necessary for renewal and should incorporate the State's commitments in response to the report. Please note the State must provide CMS with 90 days to review the submitted application. If we do not receive your renewal request ninety days prior to the waiver expiration date we will contact you to discuss termination plans. Should the State choose to abbreviate the 90 day timeline, 42 CFR 441.307 and 42 CFR 431.210 require the State to notify recipients of service thirty days before expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter sixty days prior to the expiration of the waiver.

If you have any questions, please contact Connie Martin at 404-562-7412. We would like to express our appreciation to the South Carolina Department of Health and Human Services, who provided information for this review.

Sincerely,

Jackie Glaze

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

Enclosure
cc: Ellen Blackwell, CO

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region IV

FINAL REPORT

Home and Community-Based Services Waiver Review
South Carolina Mechanical Ventilator Dependent Waiver
Control #40181.R03.02
December 1, 2011

Home and Community-Based Services
Waiver Review Report

Executive Summary

The South Carolina Department of Health and Human Services (SCDHHS) is authorized under §1915(c) of the Social Security Act to provide home and community based services under the Mechanical Ventilator Dependant Waiver to serve frail elderly and persons with physical disabilities that require mechanical ventilation and meet nursing facility level of care (LOC) criteria. Services offered are designed to provide participants choice of remaining in their homes instead of being placed in a nursing home. As of January 21, 2011, there were 34 recipients enrolled in the waiver.

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 submission of April 29, 2011, the State provided an overview of processes, instrument(s), systems and summary reports for each Federal assurance.

The State has been working to create comprehensive Quality Management Framework over the last several years based upon State initiatives and ongoing consultation and technical assistance from the National Quality Enterprise contracted by CMS. In 2009, a compliance score of 100% was required for most QA indicators and all indicators directly related to Federal Assurances.

South Carolina's Case Management System (CMS) was featured by the CMS in Promising Practices in Long Term Care. The Service Plan Wizard was also featured in a separate Promising Practices Paper. In 2010, the State implemented its most recent version of this software, the Phoenix system. The Phoenix system is designed to be used with tablets so case managers and nurses can work toward a paperless system.

Additional features of Phoenix include home assessment, caregiver supports and being able to measure quality indicators and reporting by individual case workers and Community Long Term Care (CLTC) office to ensure the service plan reflects all identified needs and goals. The Phoenix system also allows the State to identify waiver participants most at risk for missed in-home visits and those most at risk in the event of natural disasters.

The Phoenix system also generates electronic billing on a weekly basis for services provided (as captured by the Phoenix system when initiated by the State's Care Call system). This billing ensures only authorized services and the total units provided are submitted to MMIS for payment.

While the Medicaid agency serves as both Administrative and Operating Authority, the direct administration of this waiver comes through twelve of the thirteen regional South Carolina Department of Health and Human Service (SCDHHS) offices in the State, each of which covers designated counties of South Carolina. Nurses working in these regional offices areas are responsible for ensuring that participants are aware of their options within the waiver and can make informed choices as to which service(s) they prefer.

The waiver operates statewide. The minimum age for individuals in this program is 18.

SCDHHS' Care Call system tracks the delivery of services. This is a system in which providers make a call to a toll-free number to document service delivery.

Every component of the State's quality assurance activities requires corrective action to address negative findings through its Quality Assurance (QA) Task Force. The QA Task force consists of approximately 12 CLTC Central Office staff. The CLTC division has a Central Office QA Task Force to review all data accumulated through supervisory reviews, timeliness reports, case reviews, participant satisfaction surveys, administrative reviews, care call system reports, provider compliance reviews, participant complaint log reports, Adult Protective Services reports, program CMS reports, and other QA activities.

Summary of Findings

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

Suggested Recommendations:

CMS suggests the State develop a methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid. The State should also provide documentation to establish remediation efforts were successful.

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

Suggested Recommendations:

CMS recommends the State monitor the State's Regional Offices more frequently to ensure monitoring.

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

Required Recommendations:

The evidence submitted by the State lacked specific outcomes of monitoring and oversight activities to support compliance with this assurance.

4. Health and Welfare of Waiver Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information

Suggested Recommendations:

CMS suggests monitoring activities to ensure performance measures are ensuring compliance with this assurance.

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

Suggested Recommendations:

The State should also be providing metrics to demonstrate sampling size and outcomes with reviews.

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

Suggested Recommendations:

CMS recommends the State submit documentation to support financial monitoring activities.

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:	Home and Community-Based Waiver for Mechanical Ventilator Dependent
Operating Agency:	South Carolina Department of Health and Human Services/Division of Community Long Term Care Waiver Management
State Waiver Contact:	Roy Smith
Target Population:	Frail elderly and persons with physical disabilities requiring mechanical ventilation
Level of Care:	Nursing Facility
Number of Waiver Participants:	34 (as of January 21, 2011)
Average Annual per capita costs:	$27,173
Effective Dates of the Waiver:	December 1, 2007 – November 30, 2012
Approved Waiver Services:	Personal Care 1 and Personal Care 2, Respite Care, Prescription Drugs (except drugs furnished to participants who are eligible for Medicare part D benefits,) Attendant Care, Home Accessibility Adaptations, Personal Emergency Response Service, Private Duty Nursing, Specialized Medical Equipment and Supplies.
CMS Contact:	Connie Martin

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 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.)

The Mechanical Ventilation Dependent Waiver is designed to provide participants choice of remaining in their homes rather than being placed in a nursing facility (NF). The South Carolina Medicaid Agency has direct responsibility for performing level of care (LOC) evaluations and re-evaluations for this waiver. Responsible individuals for LOC evaluations are registered nurses licensed by the State or Licensed Practical Nurses working under the supervision of a registered nurse.

Narrative included with the evidence stated, "A manual review of all files for the review period of December 1, 2007, forward indicate that 94% of Mechanical Ventilator Dependent applicants had a LOC on file within thirty (30) days of waiver enrollment." The State goes on to write, "Of the 15 enrollees reviewed, only one (1) did not have a level of care determination within thirty (30) days of waiver enrollment." The State reports as of January 2011, there are 34 individuals being served in the waiver. Therefore, there should have been 34 files reviewed instead of 15. These statements also failed to address whether the LOC was on file prior to enrollment instead electing to use the term "within 30 days of waiver enrollment," which technically could also include 30 days after enrollment.

During the December 1, 2007 through January 31, 2011 review period, the State found that 92% of re-evaluations were completed within required timeframes (annually). The Medicaid Agency states, "The errors were not redundant in any particular regional office and occurred over a three year period (2008-2010); therefore, instances were viewed as isolated situations." However, the evidence submitted to CMS, reflect there were twelve of the thirteen Regional Offices conducting evaluations and at least two Regional Offices were found to have completed only 67% percent of their re-evaluations within 365 days of the previous evaluations. There were five out of the twelve offices below 100%. To remediate, all Nurse Consultants were required to attend Case Management and HCBS Waiver Training written by CMS and the University of Southern Maine, Muskie School of Public Health, to ensure future compliance.

There was no evidence presented indicating the effectiveness of the training, nor did the State identify how they remediated the individual re-evaluations found outside the 365 day required time frame.

The approved assessment instrument was the State's Case Management System until April 2010; then the Phoenix System from April 2010 forward. The Phoenix system includes a dashboard showing all assigned cases, activities due, activities performed and notifications. Both of these programs ensure the approved assessment form is used for 100% of the waiver applicants. All assessments must be selected from the State's computerized system. The State's Central Office reviews determined the State has a 100% statewide average for using the appropriate process and 100% statewide average for appropriate level of care determinations.

Evidence submitted to support a LOC assessment and determination are as follows:

- Samples of assessments completed to support LOC determination,
- Attendance sheets for nurse consultants attending mandatory Case Management and HCBS Waiver training written by CMS and University of Southern Main, Muskie School of Public Health, and
- Phoenix Feature capturing waiver enrollment denial due to LOC determination beyond 30 days.

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

CMS suggests the State develop a methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid. Documentation that describes the State's efforts for remediation should be made available to CMS as well.

State Response:

In response to the CMS' concerns regarding only fifteen enrollees being reviewed instead of 34 individuals and the State's failure to address whether the LOC was on file prior to enrollment, the State clarified the fifteen assessments were conducted on new enrollees. The State clarified the LOC determinations were made *no more than 30 days prior* to the waiver enrollment rather than their previous statement of *within 30 days* of waiver enrollment.

The State has also implemented the following performance measures:

- The number and percent of all LOC determinations completed using the appropriate forms/instruments as required by SMA

- The number and percent of applicants who had a LOC determination that indicated a need for institutional LOC prior to waiver enrollment and receipt of services and LOC criteria was accurately applied.

To the CMS' finding of 67% of re-evaluations were within 365 days of the previous evaluation, the State clarified of the 65 re-evaluations conducted, 58 were conducted on time, which represents a 90% compliance with the assurance. Of the 7 reviews conducted untimely, the re-evaluations were conducted no more than two weeks late and it was determined the enrollees met eligibility requirements for the waiver.

The State is now evaluating training on an ongoing basis and has implemented a policy that a RN employed by the Medicaid agency will review all cases at least monthly. Any problems identified from that review will be discussed with the case worker and an annual performance evaluation will include the results of any findings.

The Phoenix System was designed to not allow enrollment if a LOC is more than thirty days old and the enrollee demonstrated he/she has met the LOC. Phoenix will also flag errors made on a real time basis, such as when a re-evaluation visit wasn't conducted within one year.

The State is also determining the number and percentage of participants who received a re-evaluation within 365 days of their last LOC evaluation and LOC criteria was accurately applied as a performance measure.

CMS Response:

The State's response clarified this issue satisfactorily.

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 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 State utilizes nursing consultants, who are employees of the State and are responsible for developing service plans based on a comprehensive assessment of each participant's medical needs, activities of daily living, psychological behavioral information and instrumental activities of daily living. The State's earlier case management/nurse web-based data collection system (CMS) linked problems identified in the assessment to the service plan. The current system (Phoenix) also has a component that links assessment deficits to the service plan and does not allow identified deficits to be removed.

The Phoenix system also lists all appropriate interventions for specific problems, as well as goals noted on the participant's service plan. To evaluate the effectiveness of the Phoenix components and ensure future compliance, the State will conduct ongoing Quality Assurance (QA) reviews of service plan development.

For the review period (December 2007 through January 2011), the State accumulated data to indicate service plan development is conducted in accordance with its policy and procedure guidelines 97% of the time. The State's Central Office conducts yearly reviews to monitor whether service plans are updated and revised at least annually, or when warranted by a change in the participant's needs. A 100% review (65 records) showed a statewide compliance rate of 98%.

To remediate deficiencies, all nurse consultants were required to attend Case Management and HCBS Waiver Training. In addition, the Phoenix System has a QA feature that accumulates annual service plan development data. The ongoing QA reviews to be conducted in 2011 will include evaluations of service plan updates and revisions to ensure all issues found in previous reviews have been resolved.

Both systems (CMS and Phoenix) prohibit service authorizations that do not contain amount, duration, scope and frequency criteria. The State utilizes Care Call reports to monitor service delivery. Each Regional Office management staff monitors Care Call activities and document any concerns identified in the participant's file.

Four Regional Offices show a need for improvement in documenting Care Call activity date reviews. Evidence submitted by the State indicates that one Regional Office conducted no reviews of client services and another Regional Office only reviewed 50%. When aggregated over the 12 Regional Offices, evidence found that only 66% Care Call reviews of client services were documented.

The State indicates QA reviews will be conducted in 2011 to monitor improvement of Care Call activity reviews and documentation of review dates. A narrative checklist feature in the Phoenix system has been modified to require documentation of dates of Care Call activities reviewed.

To ensure participants are afforded choice between waiver services and institutional care each participant (or responsible party) signs and dates a LOCUS form (freedom of choice form) prior to program entry. While these forms were previously maintained in hard copy, since implementation of the Phoenix System in April 2010, these forms are generated and signed in Phoenix. These forms are monitored during Quality Assurance reviews.

All participants except one had the required LOCUS form signed. However, upon discovery of this error, a LOCUS form was signed by the participant, and the State is 100% compliant. The Phoenix System Quality Assurance component is being developed to monitor the compliance of this sub-assurance.

The participants are also afforded a choice among waiver services and providers. Nurse consultants discuss service provider options with the each participant on their first visit. Initial service provider selections are noted on the provider choice forms by the nurse consultant. The participant and/or responsible party signs and dates the choice form confirming verbal provider selection. Subsequent selections for additional services or changes in providers are noted in the participants chart.

If a participant is dissatisfied with a provider or service it is reported through the CLTC complaint system and is addressed by CLTC Central Office staff and resolved by a nurse consultant. Telephone interviews with all participants are conducted yearly to assess satisfaction with services. Evidence submitted by the State indicated 50% of the waiver recipients participating in a 2008 satisfaction survey resulted in a 90% satisfaction rate. There was no survey results submitted for subsequent years.

The State assures monitoring will continue to ensure adherence with requirements specified in the approved waiver. The State's Central Office is continuing to meet with all Regional Offices to identify work flow and performance issues. While the State also indicates additional plans are being developed to monitor and ensure improvement, the State did not provide specific details.

Evidence submitted to support adequate review of Plans of Care is as follows:

- Copy of service plans and service plan wizard requirements;
- Copy of Phoenix assessment and Service Plan;
- Copy of Statewide Summary for Central Office 2007–2011 Quality Assurance Reviews (indicators 4A and 4B);
- Attendance sheets for Nurse Consultants that attended mandatory case management and HCBS Waiver Assurances Training written by CMS and University of Southern Maine, Muskie School of Public Health;
- Sample QA feature reflecting percentage of annual service plan updates/revisions;
- Sample Care Call Reports;
- Copy of Statewide Summary for Central Office 2007-2011 Quality Assurance Reviews (indicators 3 and 3A);
- Copies of Phoenix-generated checklist that includes Care Call review dates;
- Statewide Summary Central Office 2007-2011 QA Review (indicator 2B);
- Copy of Phoenix LOCUS Quality Assurance feature;
- Statewide Summary Central Office 2007-2011 Q Review (indicator 2A); and
- Copy of 2008 and 2009 Annual Survey of Community Long Term Care (CLTC) Consumer Experience and Satisfaction Report

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 monitor the State's Regional Offices more frequently to ensure monitoring. If a Regional Office only has one or two recipients, it is recommended the State review those recipients' client services.

State Response:

The State uses the Phoenix System to capture data from the assessment, home evaluation and caregiver supports and place identified issues into the service plan. While the review can add other issues as identified from the assessment, they cannot remove any identified issues. This will assure service plans address all enrollees' needs in every service plan. The State DHHS staff and an area State employee will review all the service plans at the time of development.

The Phoenix System is identifying all cases where a service plan is not done timely. The Regional Office Supervisors review this information at least monthly. Findings are discussed with the case worker and corrective action plans are implemented for the case worker. This element is also contained in the nurses' performance evaluations. Care Call is used as a review tool to ensure waiver services are provided in accordance with the service plans. The State is also developing enhanced review procedures to assure monthly monitoring.

The State is also using the Phoenix System to generate a random list of providers for each participant's serviced needs which is shared with the participant. The nurse uses a signed copy of the participants choice of providers (or narrates the participants choices within the Phoenix System) once received to enter into the Phoenix System.

In response to the CMS finding that one Regional Office (Greenville) conducted no reviews of client services, the State clarified the office with no review had only one participant on the waiver and because the State did not conduct a review of the one client, it resulted in reporting zero reviews for that Regional Office. Additionally, the State clarified the CMS's finding that another Regional Office (Spartanburg) only reviewed 50%, the Regional Office had only two participants on the waiver and a 50% review is based upon reviewing only one of the two participant files.

In the response to the CMS finding that two Regional Offices failed to report any signatures or dates on provider choice forms, the State responded a lack of percentage rate for the two Regional Offices was due to no data to report for the review period in the evidentiary package submitted to CMS.

The State clarified that 2009 participant surveys were included in the evidentiary report indicating 80% were satisfied with services and the 2010 survey results were not available at the time of the evidentiary package submitted. Since the Draft Report was issued, the 2010 results have been prepared and resulted in a 90% satisfaction rating by enrollees.

The State provided specific details of the additional plans developed to monitor and ensure improvement with waiver requirements. Details include, requirement for

Regional Office supervisory staff to conduct monthly QA reviews on waiver specific indicators for each nurse consultant caseload which was implemented June of 2011. Failure to improve work performance is brought to the attention of the Regional Office Administrator to address the nurse consultant's performance.

The State will also conduct on-going QA reviews on all Mechanical Ventilator Dependent waiver participants' files, which began August 2011. Area Office Administrators will be notified of the results and remediation will be conducted to improve quality. This process will be conducted annually. The State will also conduct additional reviews when warranted.

The State is using the following performance measures:

- Number and percent of participants' reviewed whose needs and personal goals identified in the assessment were addressed in the service plan
- The number and percent of participants' reviewed whose needs were identified regarding caregiver support was addressed in the service plan
- The number and percent of participant's reviewed whose home environmental needs were addressed in the service plan
- The number and percent of participants who received services based on type, amount, frequency and duration as delineated in his/her services plan.
- Number and percent of participants who received all services identified in his/her service plan
- Number and percent of service plans completed in Phoenix and team staffed within required time frames.
- The number and percent of service plans updated as needed
- The number and percent of service plans revised on or before the annual review date.

CMS Response:

To explain why the State had only 66% of Care Call reviews, the State explained there was no review completed on the one recipient in the Greenville Regional Office and only one of the two recipients in the Spartanburg Regional Office had been reviewed. The CMS expectation is all Regional Offices review and document calls.

The State provided a more thorough explanation as to why two Regional Offices failed to report any signatures or dates on provider choice forms. While the two offices may have not have had any data to report for the review period in the evidentiary report, the State did not address how it would remediate and demonstrate improvement in the performance of the Regional Office which reported 67% compliance.

Instead of generating a random list of providers for the participant to choose from, the State should provide participants with a complete listing of providers to afford all participants freedom of choice.

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 State utilizes Nurse Consultants to verify on a periodic basis that providers meet required licensing and/or certification standards and adhere to other State standards. However, the State fails to define "periodic," (i.e., monthly, annually etc.). The Nurse Consultants also monitor non-licensed/non-certified providers to assure their adherence to waiver requirements "periodically." Again, the evidence fails to define "periodic." The reviews conducted by the Nurse Consultants are on past-performance of the following services:

- Personal Care I,
- Personal Care II, and
- Medicaid Nursing

The three components of the review are:

(1) staffing review,
(2) administrative review, and
(3) participant review

The staffing review entails sampling staff members at different levels to ensure they meet all training and certification requirements, tuberculin skin test requirements, ongoing training requirements and other requirements as outlined in the contract. However, the State did not include in the evidence of the results of those reviews.

The State conducts a review of providers to determine that all agency administrative requirements (liability insurance, list of officers, emergency backup plans, policy and procedure manuals, etc.) have been met. The State did not submit evidence to show the results of those reviews.

The State Unit on Aging monitors home delivered meals since all but three providers are part of the aging network. The State has a formal memorandum of agreement (MOA) with the State Unit on Aging to perform this function. The State Medicaid Agency fails to demonstrate what oversight is conducted to ensure adequate monitoring by the Unit on Aging. There was no MOA submitted with the evidence package.

The State employs a reviewer who conducts onsite reviews of a sample of environmental or home modifications by home modification providers to ensure the modifications met applicable State codes and were completed by a licensed provider. Those reviews are available to the State upon request. The State doesn't identify the qualifications of the reviewer or how large a sample the reviewer examined.

Attendant care services are provided by individuals who have been hired directly by the participants. The State has a contract with the University of South Carolina to ensure these attendants meet all requirements to provide the services. The University of South Carolina employs registered nurses to determine if the attendants are capable of providing all the participants' needed care. At least monthly a case manager consults with the participant to ensure services are being provided appropriately. The evidence doesn't demonstrate the State is conducting oversight of the University's monitoring of the registered nurses performance in monitoring the attendants.

The CLTC Compliance Review Officer monitors contracted providers to ensure they are in compliance with the contractual requirements. If it is determined a provider does not meet requirements, the Review Officer rectifies the situation. The State did not include evidence of monitoring to establish compliance in this area, nor did the State identify how the Review Officer "rectifies" the situation.

A compliance registered nurse (in CLTC) monitors services generating a report listing all identified deficiencies. The report also scores the review based on a sanctioning scale. Currently, only Personal Care II reviews are being scored. The scores determine if the provider will receive a sanction and if so, the level of sanction. No explanation was offered as to why only one service is currently being scored.

In addition, CMS found no explanation as to why Personal Care I and Medicaid Nursing aren't being scored in the more than 3 years the current waiver has been in effect. Based on the severity and number of deficiencies, along with results or prior reviews, sanctions may range from requiring a corrective action, recoupment of funds, suspending new referrals to termination of the contract.

The State uses "Good History" as a factor in the scoring process of providers. If the State determines a provider's previous year review had a score that required submission of a correction action plan (CAP) and the current year score warrants a 30-day suspension, the previous year's "Good History" reduces the consequences to another CAP as was imposed the previous year. In this scoring method, a provider could be in violation of moderate to major compliance issues and continue to be placed on a CAP even if the provider is in violation of more serious issues in a subsequent year. Also, the evidence did not show monitoring by the State to establish 100% compliance in this area.

Required Recommendations:

(CMS recommendations include the 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 State is required to identify remediation actions if providers were found out of compliance with licensing and or certification standards for both licensed and non-licensed providers.

The State contracts with the University of South Carolina to ensure attendant care providers meet requirements specified in the waiver. CMS requires the State to identify the types of monitoring activities used by the University of South Carolina to ensure compliance in this area.

The State is required to specify the qualifications of the home modifications reviewer and how often the State audits a sample of modifications reviewed. Also, please identify the performance measures used to assure compliance and remediation if a modification failed to meet requirements either through licensing, or State or county code, etc.

Examples of how the State may accomplish these tasks include capturing the:

- Number and percentage of new waiver provider applications, by provider type, for which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision;
- Number and percentage of new provider applications for which appropriate background and registry checks, as required by the State/waiver, were conducted;
- Number and percentage of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment;
- Number of non-licensed/non-certified provider applicants, by provider type, who met waiver provider qualifications;
- Number of non-licensed/non-certified provider, by provider type, who continue to meet waiver provider qualifications; and
- Number and percentage of providers, by provider type, meeting provider training requirements.

The State has a five-tiered sanctioning system currently in place. This system uses the reports generated by the compliance nurse to identify deficiencies and based upon the severity of deficiencies establishes which sanctions may take place. Only Personal Care II reviews are currently being scored even though the waiver has been approved since December 2007. While the State has a good scoring system in place, it doesn't appear utilized to its best ability. The State is required to identify monitoring activities for Personal Care I and Medicaid Nursing to ensure compliance.

Since provider "scores" are assessed on a yearly basis and the State uses previous "Good History" as a factor in determining consequences for the current year, CMS recommends the State ensure the practice doesn't mitigate the consequences of an egregious action on the part of the provider if the previous year the same provider had no sanctions or only a minor sanction resulting in a Correction Action Plan. CMS recommends that each yearly review stand alone.

State Response:

The State forwarded to CMS a matrix indicating a review of non-licensed/non-certified providers it has monitored. This matrix has identified and the number of nursing, personal care and attendant providers trained during the evidentiary review period (December of 2007 through December 2010).

The matrix submitted by the State in their response reflects 21 out of 23 (91%) nursing provider types applied and were ultimately enrolled after training. There were 143 personal care providers who applied and 106 (76%) were enrolled after training.

The State clarifies through its response Nurses employed by the University of South Carolina verifies the qualifications of personal attendants, including acceptable criminal background checks. The nurses also observe the personal care attendants through a visit with the participants to ensure the attendant knows proper care procedures. If the personal care attendant needs help in this area, the nurses instruct the attendant in proper care.

The State submitted evidence to support compliance reviews for a March 2009 through December 2010 review period in which 378 reviews were completed on 271 providers. Of those 271 providers reviewed, 117 providers were required to submit an acceptable corrective action plan, 29 resulted in 30 day suspension, 25 resulted in 60 day suspension, 16 providers received a 90 day suspension and 11 providers were terminated. At the end of the review, 260 out of 271 personal care and/or nursing providers (96%) continued to meet provider qualifications.

In response to the CMS concern that good history of reviews should not mitigate an egregious action by a provider, the State reports all provider contracts include a breach of contract clause if the State doesn't feel leniency is not warranted.

The State has added the additional information that their Division of Program Integrity conducts post payment reviews of waiver providers. The reviews are conducted by random sample, by complaint and/or at the request of waiver program staff. During the review period in the evidentiary package, Program Integrity reviewed 29 waiver providers.

The State also clarified in its original submitted information compiled for the Draft Report, it erroneously submitted information regarding Meals providers. The State does not offer meals in its Mechanical Ventilation Dependent waiver.

The State is using the following performance measures:

- For all applicable providers, the number and percent of potential providers who meet the initial application criteria.

- For all applicable providers, the number and percent of potential provider applicants that meet initial contractual requirements (e.g., liability, workers compensation insurance, documentation of financial stability, nursing licenses).
- The number and percent of providers monitored on an ongoing basis through unannounced on-site reviews by waiver staff.
- The number and percent of Program Integrity post-payment reviews done on a random basis, by compliant, and/or at the request of waiver program staff.
- For all applicable waiver participants, the number and percent of times case managers monitor provider serviced delivery through the use of Care Call in their monthly participant contacts.

CMS Response:

In the State's response to the Draft Report (attachments 3 through 6) demonstrating compliance reviews, the State did not address how the provider in attachment 3, who had repeated deficiencies and whose response was not cohesively written, was resolved.

The State provided additional information that their Division of Program Integrity conducts post payment reviews of waiver providers. However, CMS notes there were no results of those reviews submitted in the State's response.

Although the State responded to the CMS Draft Report that 100% of Mechanical Ventilation waiver attendants maintained an annual tuberculin skin test during the evidentiary review period, the provider in the State's attachment #3 alone, indicate 29% (5 staff personnel) did not have a current tuberculin skin test.

The State submitted their procedure of using a licensed general contractor to inspect home modifications and the training given to home modification providers for the review period of 2010. While there were providers who were in compliance and others were out of compliance resulting in suspension or termination, the State does not identify the sample size reviewed.

The State provided a matrix showing non-licensed/non-certified providers applying to provide services under the waiver, but failed to show monitoring of all providers (licensed/certified and non-licensed/non-certified). Also, the matrix lists "Nursing" as one of the provider types reviewed, which is licensed professional.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.
Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

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

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

Evidence submitted from the State on this assurance was:

- The South Carolina Code regarding "Adult Protection" and the "Duties and Procedures of Investigative Entities" (Chapter 35, Article 1)
- Adult Protection Act (APA) PowerPoint; which was developed and placed on the State's internal website for staff to review for training purposes;
- A copy of the Memorandum of Agreement (MOA) between the South Carolina Department of Health and Human Services (SCDHHS) and the Department of Social Services (DSS); and
- Copies of the CLTC Complaint Forms generated in Phoenix

The State's evidence package does not address procedures in place to ensure the sharing of information and data and does not address how the CLTC complaint system contained in Phoenix is being used to notify the State's Central Office of reported allegations of abuse, neglect and/or exploitation.

The approved waiver (Appendix G-1.d) states, "SCDHHS currently conducts face-to-face meetings or communicates with appropriate DSS staff via e-mail about every 3-4 months to discuss critical incident reporting. The State DSS is working on programming and data changes that will allow for monthly data exchange on referrals." However, there is no evidence to support these meetings are occurring.

The MOA between SCDHHS and DSS submitted in the evidence package that expired March 14, 2011, requires, "the provision of a system for generating reports of alleged abuse, neglect and exploitation occurring with vulnerable adults receiving services from CLTC." However, CMS found no evidence of monitoring activities focused on these reports in the State's submission.

According to the State's evidence, there were no complaints regarding abuse, neglect and/or exploitation from December 1, 2007 through January 31, 2011, nor was there any knowledge of unreported allegations of abuse, neglect and/or exploitation.

The State reported it "did not receive complaints regarding abuse, neglect and/or exploitation during the December 1, 2007 – January 31, 2011 review period." This statement is inconsistent with submitted evidence which shows four reports (between October 2010 and February 2011) that appear to come from a "complaint tracker." One complaint indicates an instance of neglect and abuse; the second complaint indicates self neglect and abuse; the third complaint indicates abuse by a relative; and the last is a monitoring note indicating it took more than a month to obtain confirmation the complaint was investigated.

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 requires the State to provide documentation to support monitoring activities completed to identify and address incidents, as well as efforts to prevent instances of abuse, neglect and exploitation. Such documentation could include a system-generated report to verify existence of complaints. In addition, the State could provide documentation of staff observations/opinions and/or obtain completed surveys to substantiate communication with participants (and family) to assess potential problems.

State response:

The State would like to show the following as evidence it ensures the sharing of information, data and how the CLTC complaint system is used to notify its Central Office of reported allegations of abuse, neglect, and/or exploitation using the State's MOA:

- SCDSS investigates reports of alleged abuse, neglect or exploitation made by CLTC, or a family member or relative of a Medicaid beneficiary
- SCDSS notifies the CLTC Director of the Division of Field Management of substantiated abuse, neglect or exploitation cases involving CLTC clients.
- SCDSS will receive access and provide a copy of the data to the CLTC Director of the Division of Field Management and the appropriate CLTC Area Administrator on substantiated cases involving CLTC clients.
- SCDSS investigates reports of alleged abuse, neglect or exploitation in settings other than facilities when the allegations are made by the participant's family member. If the alleged abuse, neglect or exploitation occurred in a facility, SCDSS will forward the report to the appropriate investigative entity.

Once a nurse consultant with the State becomes aware that a report has been filed with SCDSS, they complete a complaint in Phoenix. Completed reports are automatically sent by Phoenix and emailed to all designated Central Office staff. Once reviewed by designated staff on a monthly basis and appropriate follow-up is completed, all complaints of abuse, neglect and/or exploitation are assigned to a QA Reviewer.

QA Reviewers monitor substantiated cases and track them on a monthly basis using the Phoenix system. QA Reviewers close referrals that were not accepted or found as unsubstantiated. Reasons for closure are noted in the Phoenix System. The open cases continue to be monitored by the QA reviewers on a monthly basis until the case is stabilized by DSS staff. These cases are also discussed by nurse consultants, the Regional Office Administrator and/or Central Office staff to assess the need for additional waiver or community services.

The State submitted evidence that SCDSS conducts face-to-face meetings or communicates with appropriate SCDSS staff every three to four months intervals to

discuss critical incident reporting. The State clarified the complaints submitted as evidence in their prior submission for the Draft Report actually was not for Mechanical Ventilator Dependent participants. Those were only submitted to show how the "Complaint Tracker" would be used if anyone had submitted a complaint.

The State submitted a current MOA between the State and DSS to replace the expired MOA submitted in the original evidence package.

The State is using the following performance measures:

- The number of abuse, neglect and/or exploitation complaints reported in the complaint system and the percentage of those complaints resulting in referrals to Adult Protective Services (APS).
- The number and percentage of referred APS complaints substantiated by APS.
- The number and percentage of unsubstantiated APS referrals resolved effectively.
- The number and percentage of complaints not investigated by DSS that are resolved by State DHHS.

CMS Response:

The State provided evidence that SCDHHS meets face-to-face with DSS staff or communicates via email with DSS staff every 3-4 months to discuss critical incident reporting, but doesn't address remediation efforts when issues are identified.

The State clarified the complaint tracker used as an example to track complaints of abuse, neglect and/or exploitation was from another waiver to establish how complaints would be handled under this waiver if there were any.

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 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 State submitted a Statewide Summary for its Central Office 2007 – 2010 Quality Assurance Review and detailed the hierarchy of how waiver functions are performed in twelve of the thirteen Regional SCDHHS offices. While each of the Regional offices has State employees which manage and supervise the daily operations of the waiver, the evidence did not fully demonstrate the State Medicaid Agency retained administrative authority over the waiver.
In the approved waiver the State assures, "The administering agency engages in routine, ongoing oversight of the waiver program. However, our review of the Quality Assurance Review findings included in the evidence submitted found the State failed to document it effectively monitors performance and compliance.

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

The State is required to show it is operating in accordance with the approved wavier meeting statutory and regulatory requirements and demonstrating oversight. CMS requires the State to show evidence of administrative authority, i.e., record reviews, surveys, staff observations, financial records, meeting minutes, etc., to demonstrate monitoring of all delegated functions. If a delegated function shows less than 100% compliance, remediation efforts should be identified.

State Response:

Since June 2011, Regional Office supervisors are required to conduct monthly quality assurance reviews on each nurse consultant's caseload. Non-compliance by the assigned nurse consultant is addressed by the lead team nurse. Failure of the nurse consultant to improve will result in the Office Administrator addressing the nurse consultant's performance.

On-going QA reviews on all Mechanical Ventilator Dependent participant files began in August 2011. These reviews are now conducted annually. If warranted, additional reviews will be conducted. Analyzing and trending results will be used to make necessary changes.

The State conducts on-going administrative reviews of all offices to include a review of: service authorization levels, training for upcoming initiatives and discussions with supervisory staff regarding any non-compliance with policy and procedures. The State provided the 2008 schedule of the reviews.

The State also submitted evidence of monthly management meetings with Area Administrators and quarterly meetings with lead team supervisors to address policy updates and to discuss process improvement.

Also, the State provided a copy of the State's Employee Performance Management System (EPMS) used to remediate problems with nursing staff to address any problems with nursing staff.

The State reports it maintains full operational and administrative authority of the waiver. There are no other contracted entities performing operational or administrative functions.

CMS Response:

The State provided the 2008 schedule of on-going administrative reviews of all offices to include a review of service authorization levels, training for upcoming initiatives and discussions with supervisory staff regarding any non-compliance with policy and procedures. However, there were no metrics to demonstrate the sample size or the outcome of those reviews.

The State also submitted evidence of monthly management meetings with Area Administrators and quarterly meetings with lead team supervisors to address policy updates and to discuss process improvement. While there were monthly highlights and agendas provided, there were no minutes to demonstrate the actions taken by the State when problems were identified.

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.)

Personal Care I, Personal Care II, Nursing, Attendant Care Nursing, Home Delivered Meals and all Home Modifications are billed via the South Carolina's Care Call System. No claim can be submitted that is not supported by a service authorization. The Care Call System ensures provider billings do not exceed authorized amounts, as well as checks to see if the phone call was made from the authorized location.

For services which are not part of the Care Call System, South Carolina has developed a system to ensure the participant was enrolled in the waiver and Medicaid eligible at the time of the service. The State's Nurse Consultants review service delivery with participants on a monthly basis to ensure authorized services are being delivered.

The State employs a licensed registered nurse who conducts on-site reviews with personal care, respite and nursing providers. The Nurse conducts a staffing review, administrative review and a participant review.

The State's Program Integrity Division responds to complaints and allegations of inappropriate billings by Medicaid providers. The Program Integrity Division collects and analyzes provider data, audits payments to CLTC service providers and recoups payments when provider records do not support the amounts billed for services.

The CLTC and Program Integrity Division work closely with the Medicaid Fraud Control Unit at the South Carolina Attorney General's Office to investigate suspected fraud and initiate criminal investigations.

Suggested Recommendations:

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

The State submitted evidence of its monitoring process and some monitoring results. However, the State did not submit documentation to support monitoring activities. When the submitted information reflected State-identified deficiencies, e.g., when 10% of all personal care providers received sanctions, including suspension of new referrals, the State failed to demonstrate remediation efforts.

CMS recommends the State review to ensure providers maintain financial records according to provider agreements/contracts.

CMS recommends the State submit documentation to support the financial monitoring conducted by the State. Examples of evidence that may be used to support monitoring include: record reviews, training verification records, data collected / analyzed, trends, remediation actions taken, and financial records. CMS also recommends the State develop or describe sampling methodologies.

State Response:

The State has submitted the following performance measures to ensure and assess compliance it provides financial accountability for the waiver:

- The number and percentage of claims for waiver services submitted with the correct service code. There must be a valid authorization in Phoenix for Care Call to submit a claim over to the State's Medicaid Management Information System (MMIS). This ensures that 100% of claims are submitted only for the service authorized.

- The number and percentage of waiver claims submitted with the correct rate as specified in the waiver application. Rates are established on the authorization that is sent via Phoenix. These rates for most services are not editable and submit

automatically to Care Call. In 100% of cases during the review period, the correct rate was submitted to the State's MMIS.

- The number and percentage of wavier claims submitted for participants enrolled in the waiver program. In 100% of the cases reviewed, claims were submitted for participants in the waiver program. In order for claims to submit and pay appropriately, the participant needs to be enrolled into the waiver program in Phoenix. A claim must be submitted via Care Call and the participant must be enrolled in the appropriate waiver program that matches the information in Phoenix and Care Call within the State's MMIS.

CMS Response:

While the State developed performance measures to show financial accountability for the waiver, it should recognize the language justifying the metrics, e.g., "There must be a valid authorization in Phoenix for Care Call to submit a claim over to the State's Medicaid Management Information System (MMIS). This ensures that 100% of claims are submitted only for the service authorized." should not be included in the performance measure itself. The same applies to the two subsequence performance measures included in the State's response to the Draft Report.

Brenda James - Fwd: Log 218

From: Teeshla Curtis
To: Brenda James
Date: 01/13/2012 1:21 PM
Subject: Fwd: Log 218

>>> Teeshla Curtis 12/19/2011 2:34 PM >>>
Brenda,

This log is related to a final report for CMS regarding a waiver. We will include all the recommendations from CMS in our waiver renewal. There is no direct response needed for this log.

Teeshla