

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Chyers	7-27-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000050	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Emma Foster Depo & CMS	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE 10-23-09
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Cleared 10/2/09, letter attached.			
2.			
3.			
4.			



July 23, 2009

RECEIVED

JUL 27 2009

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

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Dear Ms. Forkner:

The Centers for Medicare and Medicaid Services (CMS) is conducting a quality review of South Carolina's Home and Community Based Waiver for individuals with HIV or AIDS, CMS control number 0186.90.R03. This review will be used to evaluate the overall performance of this waiver program throughout the currently approved period (October 1, 2006 – September 30, 2011) and to identify the need for any modifications or technical assistance necessary to continue successful operation this waiver program. The results of this review will serve to inform both the State and CMS of the State's compliance with waiver assurances in anticipation of the waiver's renewal. The expiration date of this waiver is September 30, 2011.

The CMS requests States to demonstrate adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis. Enclosed with this letter is a listing of the types of evidence-based information CMS must review in order to determine the State's implementation of its quality management and improvement strategy – that is discovery, remediation and improvement activities with regard to all of the waiver assurances. We request you submit the information identified in the enclosure to this office within ninety days of receipt of this letter. To expedite the review process, we ask that you provide concise, specific information that demonstrates your State's implementation of your quality management and improvement strategy.

While we recognize the value of State policies and procedures with regard to oversight activities, this evaluation focuses on the extent to which the policies and procedures have been implemented, and the results of the State's oversight activities. That is, how does the state identify quality issues, and how do they address them when they are identified? As you will see in the attachment, we are requesting evidence as to the implementation of oversight activities.

After reviewing the requested submissions, I will contact your staff to discuss any necessary follow-up activities. Please feel free to contact me at (404) 562-7413 with any questions related to this request.

Sincerely,

Kenni Howard, RN
Health Insurance Specialist
Division of Medicaid & Children's Health Operations

Attachment: HCBS Quality Review Worksheet

cc: Mark Reed, Central Office Analyst

HCBS Quality Review Work Sheet

I. Level of Care (LOC) Determination

The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating a waiver applicant or participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.

Sub Assurances	CMS Expectations	Types of Evidence
An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	State submits evidence that it has reviewed applicant files to verify that individual levels of care evaluations are conducted.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: ✓ Record Reviews, on-site ✓ Record Reviews, off-site ✓ Training verification records ✓ On-site observations, interview, monitoring ✓ Analyzed collected data (including surveys, focus group, interview, etc.) ✓ Trends, remediation actions proposed / taken
The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.	State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted at least annually or as specified in the approved waiver.	✓ Provider performance monitoring ✓ Operating agency performance monitoring ✓ Staff observation / opinion ✓ Participant / family observation and opinion ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.	State submits that it regularly reviews participant files to verify that the instrument described in the approved waiver is used in all level of care re-determinations, the person(s) who implement level of care determinations are those specified in the approved waiver, and the process/instruments are applied appropriately.	

II. Service Plans

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub Assurances	CMS Expectations	Types of Evidence
Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.	State demonstrates that service plans are reviewed periodically to assure that all of participant needs are addressed and preferences considered.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: <ul style="list-style-type: none"> ✓ Record Reviews, on-site ✓ Record Reviews, off-site ✓ Training verification records ✓ On-site observations, interview, monitoring ✓ Analyzed collected data (including surveys, focus group, interview, etc.) ✓ Trends, remediation actions proposed / taken ✓ Provider performance monitoring ✓ Operating agency performance monitoring ✓ Staff observation / opinion ✓ Participant / family observation and opinion ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The state monitors service plan development in accordance with its policies and procedures	State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.	
Service plans are update/revised at least annually or when warranted by changes in the waiver participant's needs.	State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures.	

II. Service Plans (Continued)

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.		
Sub Assurances	CMS Expectations	Types of Evidence
Services are delivered in accordance with the service plan, including the type, scope, amount, and frequency specified in the service plan.	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> ✓ Record Reviews, on-site ✓ Record Reviews, off-site ✓ Training verification records ✓ On-site observations, interview, monitoring ✓ Analyzed collected data (including surveys, focus group, interview, etc.) ✓ Trends, remediation actions proposed / taken ✓ Provider performance monitoring ✓ Operating agency performance monitoring ✓ Staff observation / opinion ✓ Participant / family observation and opinion ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
<p>Participants are afforded choice:</p> <ol style="list-style-type: none"> 1) Between waiver services and institutional care; and 2) Between/among waiver services and providers 	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	

III. Qualified Providers

The State demonstrates it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub Assurances	CMS Expectations	Types of Evidence
The State verifies that providers initially and continually met required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.	State provides documentation of periodic review by licensing/certification entity.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: <ul style="list-style-type: none"> ✓ Record Reviews, on-site ✓ Record Reviews, off-site ✓ Training verification records ✓ On-site observations, interview, monitoring ✓ Analyzed collected data (including surveys, focus group, interview, etc.) ✓ Trends, remediation actions proposed / taken ✓ Provider performance monitoring ✓ Operating agency performance monitoring ✓ Staff observation / opinion ✓ Participant / family observation and opinion ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements	State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants.	
The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	State provides documentation of monitoring and training and actions it has taken when providers have not met requirements (e.g., technical assistance, training).	

IV. Health and Welfare

The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub Assurances	CMS Expectations	Types of Evidence
The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	State demonstrates that, on an ongoing basis, abuse, neglect and exploitation are identified, appropriated actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect and exploitation trends and strategies it has implemented for prevention.	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> ✓ Record Reviews, on-site ✓ Record Reviews, off-site ✓ Training verification records ✓ On-site observations, interview, monitoring ✓ Analyzed collected data (including surveys, focus group, interview, etc.) ✓ Trends, remediation actions proposed / taken ✓ Provider performance monitoring ✓ Operating agency performance monitoring ✓ Staff observation / opinion ✓ Participant / family observation and opinion ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

V. Administrative Authority

The State demonstrates it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.

Sub Assurances	CMS Expectations	Types of Evidence
The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.	State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program.	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> ✓ Record Reviews, on-site ✓ Record Reviews, off-site ✓ Training verification records ✓ On-site observations, interview, monitoring ✓ Analyzed collected data (including surveys, focus group, interview, etc.) ✓ Trends, remediation actions proposed / taken ✓ Provider performance monitoring ✓ Operating agency performance monitoring ✓ Staff observation / opinion ✓ Participant / family observation and opinion ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

VI. Financial Accountability

The State demonstrated that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Sub Assurances	CMS Expectations	Types of Evidence
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver.	Summary reports based on a significant sample of any single or combined method or source of evidence as follows: <ul style="list-style-type: none"> ✓ Record Reviews, on-site ✓ Record Reviews, off-site ✓ Training verification records ✓ On-site observations, interview, monitoring ✓ Analyzed collected data (including surveys, focus group, interview, etc.) ✓ Trends, remediation actions proposed / taken ✓ Provider performance monitoring ✓ Operating agency performance monitoring ✓ Staff observation / opinion ✓ Participant / family observation and opinion ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentations of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other

October 2, 2009

Kenni Howard, RN
Health Insurance Specialist
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

Ms. Howard:

Enclosed is South Carolina's Submission of Evidentiary-Based Information with regard to oversight activities of the South Carolina HIV/AIDS Waiver. We look forward to your evaluation of South Carolina's performance.

Please contact Sam Waldrep, (803) 898-2725 should you need additional information regarding this waiver assessment.

Sincerely,



Emma Forkner
Director

Enclosures

CC: Sam Waldrep, Bureau Chief
Vanessa Busbee, Department Head

Evidentiary-Based Information
South Carolina HIV/AIDS Waiver
Home and Community Based Waiver Program (#0186.90.R03)

Introduction

The HIV/AIDS program offers a variety of services to address participants' needs. The program is designed to help participants stay at home and avoid extended hospitalization. The number of participants enrolled in this waiver is approximately 1,200.

Program operations are based on policies and procedures that address Federal assurances and State policies and procedures. Although some of these policies are specific to the HIV/AIDS Waiver, the program operates in tandem with the Community Choices program policies and procedures. Regional office internal quality assurance reviews are conducted by senior case management staff, and Central Office staff conducts statewide annual quality assurance reviews. However, due to evidentiary based requirements the chart review data collection process changed during the waiver review period. In 2006 an interim quality assurance tool for regional offices internal chart reviews was used to collect data. Though an interim tool, Federal assurances were addressed. In 2007 the interim quality assurance tool was replaced with the permanent tool, and a new Central Office quality assurance tool was implemented.

The regional office and central office quality assurance review tool is an Excel spread sheet that allows collection of data on one form and based on coding (1 for CC and 2 for HIV/AIDS) the data is separated by program. Prior to the 2007 permanent quality assurance tool, the standard requirement for compliance was 85%. However, the requirement changed to a 94% - 100% range (except one indicator has an 85% - 95% range) when the 2007 permanent tool was developed.

As case management functions are performed by more contract agencies, the following practices ensure the maintenance and improvement of our QA efforts. 1. All new case managers are required to attend a one day orientation with SCDHHS Central Office staff. 2. Five Regional Trainers provide 40 hours of training to all new case managers and other case managers in need of retraining in specific areas. This training begins the day following orientation, and retraining for other case managers begins upon request. 3. Contract and Case Management Scopes of Practice revisions are revised effective July 1, 2009.

In March 2008 an on-site visit, under the National Quality Contractor, was held with Medstat staff. This training resulted in further changes to our chart review collection process. Compliance rates were increased to reflect a requirement of 94% or 100% compliance on all, except one (89%), indicators. (Each tool indicator was assigned a compliance rate of either 94% or 100%.) These changes are reflected in 2008 chart review data collected in 2009.

Lastly, as a result of Medstat staff training in 2005, a Quality Assurances Task Force of pertinent SCDHHS Central Office staff was developed in February 2006. The Task Force meets every other month to discuss the following information: quality assurance chart review results (regional office and central office); case management agencies; service providers' (i.e. personal care, companion, home delivered meals, etc) growth and/or concerns; care call system reports; Adult Protective Services reports; appeals; and other QA activities. This information is used to make program enhancements, policy changes and to identify training needs and pertinent information is shared

with appropriate regional office staff.

This Evidentiary-based report enclosed will identify the years and programs covered through the reporting and data collection processes. All data through the automated Case Management System (CMS) and Care Call are waiver specific.

I. Level of Care (LOC) Determination:

Sub Assurances:

- A. An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

State's Evidence: All waiver referrals go through an intake process. Intake criteria are applied by a Nurse Consultant and the case is assigned to a Nurse Consultant for assessment. Assessments are keyed in to the SCDHHS's Case Management System (CMS). Individuals that met the eligibility requirements may enroll in the HIV/AIDS program. A Nurse Consultant verifies that the participant is Medicaid eligible, meets Level of Care (LOC) and wants to participate. Justification for LOC determination is documented in the narrative and/or narrative checklist and on the assessment form.

CMS generated reports for the time period of October 1, 2006 forward indicate that 100% of HIV/AIDS applicants had an assessment and LOC on file. Of the 357 enrollees reviewed, forty three (43) did not have level of care determinations conducted within thirty (30) calendar days of waiver enrollment. However, approximately one half (20) of these can be explained through updated assessments completed prior to program entry but NC did not enter updated LOC in assessment LOC grid (7); program entry date is date of transfer from one regional office to another instead of date applicant entered the HIV/AIDS program (10); and incorrect assessment/LOC code or other information inadvertently noted on assessment (3). One regional office has already addressed, with NC staff, the first explanation noted above.

The following documents are provided as evidence to support that an evaluation of LOC is provided to all applicants are as follows:

- ☐ **Attachments #1A and 1B:** Instructions and Sample nurse consultant quality assurance review tools (interim and permanent) that address Team Staffing, Checklists and Assessments/Levels of Care completed timely. All of these elements cover the initial assessment process as defined in State policies and procedures manual.
- ☐ **Attachment #2:** Samples of Nurse Consultant completed checklists and assessments to support level of care determination and Medicaid eligibility.
- ☐ **Attachment #3:** CMS generated report showing that of 357 applicants that entered (October 1, 2006 – September 14, 2009) the HIV/AIDS Program all had assessments within 180 days of enrollment and a LOC on file. Pages 1 - 27 attached
- ☐ **Attachment #4:** Sample documentation to support team staffing and LOC determinations thirty calendar days prior to enrollment, though updated LOC not entered on assessment (1718)
- ☐ **Attachment #5:** Copy of regional office correspondence with NC staff to address

improvement on attachment #4 above

- ☐ **Attachment #6:** Documentation to support case transfer date used as waiver enrollment date
- ☐ **Attachment #7:** Copies of policy and procedure that addresses transfer of cases from one regional office to another and use of transfer date
- ☐ **Attachment #8:** Documentation to support inadvertent use of incorrect code on assessment or other incorrect documentation

B. The level of care of enrolled participants is re-evaluated at least annually or as specified in its approved waiver.

State's Evidence: Enrolled participants are re-evaluated at least annually or more frequently if warranted. The assigned contracted case manager completes the assessment within 365 days of the last completed assessment. The same assessment tool used for initial assessments LOC determination is used for re-evaluations.

CMS generated reports indicate that 850 participants had approximately 2700 re-evaluations completed between October 1, 2006 – September 14, 2009. Of the 850 participants 276 had a total of 432 timeliness errors. There are explanations for sixty percent (60%) of the errors, leaving a true 6.4% error rate. The majority were due to late LOC determinations. A physician input is required prior to LOC determination. And, Central Office approval is also required for any physician's input that includes a CD4 count of 500 or greater. Therefore, LOC determinations could not be documented until all required information was provided. Other errors were due to inadvertent incorrect data entry or re-evaluation completion during the anniversary month instead of on or before anniversary date. In May 2007 SCDHHS made a significant policy change. Policy no longer allowed re-evaluations to be conducted during the anniversary month; re-evaluations were required to be completed prior to or on the anniversary date.

The following changes were made to ensure compliance with this requirement: Community Choices policies and procedures (which applies to HIV/AIDS re-evaluations) were revised to more clearly address this mandate; Team staffing for LOC determination must be conducted with a State case manager, nurse consultant or Area Administrator; and Regional Trainers discuss assessment and LOC determination during training of all new contract cases managers and provide retraining to other case managers in need of retraining. Chart reviews are also conducted to assess requirement compliance. And, case manager concerns (i.e. inappropriate LOC determinations) are shared during Quality Assurance Task Force Meetings. The following documents are provided as evidence to support that the LOC of all applicants is re-evaluated at least annually or more frequently are as follows:

- ☐ **Attachment #9:** CMS generated report that shows participants who had re-evaluations completed between October 1, 2006 – September 14, 2009 (date report was run). Pages 1-88
- ☐ **Attachment #10:** Assessment Form 1718A
- ☐ **Attachment #11:** HIV/AIDS Waiver Level of Care Exception Request Form

- **Attachment #12:** Copies of CLTC Community Choices (which applies to HIV/AIDS waiver) policies and procedures revisions (2007, 2008 and 2009) to address timeliness of participant re-evaluations and team staffing with State employee for LOC determination.
 - **Attachment #13:** Copy of "SC Department of Health and Human Services CLTC Regional Trainers/Teachers Guide". Assessment and Level of Care Training (Day 3 #4A and Day 4, #3 and Day 5, #3)
 - **Attachment #14:** Copy of "CLTC Orientation" (Assessment and LOC Training)
 - **Attachment #15:** Copy of "CLTC Case Management Training" (Quality Assurance topic includes an overview of assessment and level of care) including roster of attendees.
 - **Attachment #16:** Copy of "CLTC Case Management Orientation - Quality Assurance" Handout (Topic # 1 Initial Assessments)
 - **Attachment #17A:** Copy of Statewide Summary for Central Office 2007 - 2008 Quality Assurance Review. Indicators 2D, 3D, 5D, 10 and 11 address re-evaluation requirements. Compliance requirements for indicators 2D and 3D are 90%-94%; and 5D, 10 and 11 is 95% - 100%.
 - **Attachment #17B:** Copies of Central Office (CO) QA Reviews
 - **Attachment #18:** Sample SCDHHS Annual 2007 – 2008 Quality Assurance Reports and Regional Office Corrective Action Plans
 - **Attachments #19 and 20:** Instructions and copies of regional office monthly internal quality assurance reviews (interim and permanent). These quality assurance tools have indicators that address timely re-evaluations for participants. The interim (indicator 7) and permanent tools (indicator 19) address this need.
 - **Attachments #21A and 21B:** "Quality Assurance Task Force Meeting Agendas and Notes" (March 11, 2009 and May 13, 2009) regarding LOC concerns and follow up.
 - **Attachments #22A and 22B:** "Quality Assurance Task Force Meeting Agenda and Notes (September 9, 2009) regarding LOC concerns follow up; and Copy of CO e-mail regarding LOC follow up
- C. The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

State's Evidence: The approved assessment instrument is part of the CMS program. CMS ensures that the approved assessment form is used for 100% of applicants. A 3% sample of HIV/AIDS and Community Choices participants is involved in Central Office chart reviews covering 2007 and 2008. As data is entered into an Excel spread

sheet HIV/AIDS and Community Choices data is separated and scored by program. The state has a 95% statewide average for using the appropriate process for LOC determination and 82% statewide average for level of care determinations. The sixteen (16%) percentage level of care determination error is due to LOC determinations prior to receipt of all required information (physicians input and/or CO LOC exception form). The physician's input can be obtained verbally or by form (1718A). Central Office HIV/AIDS Waiver exception may be obtained verbally; however, a copy of the form must be sent and filed in participant's chart. Though all required information must be obtained (verbally and/or written) prior to LOC determination, once information is received LOC determination must be made within five (5) calendar days. The required compliance score is 95%-100%. We are currently in the data collection process for the 2008 – 2009 quality assurance review period and have changed the compliance score to 100%. The following documents are provided as evidence that individual service plans are reviewed to assure that all participant needs and personal goals are addressed

- ☐ **Attachment #17A:** Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Reviews (indicators #10 and #11)
- ☐ **Attachment #17B:** Copies of CO review tool (indicators 10 and 11)
- ☐ **Attachment #18:** Regional Office Corrective Action Plans for three regional offices (Rock Hill, Sumter and Florence) with scores below the 95%-100% compliance rate for indicators #10 and/or #11 (referenced in attachment #17A). The compliance scores for these two indicators (on the Central Office and Regional Office internal quality assurance tool) have been changed to 100%. As stated previously, new rate reflected in 2008-2009 reviews.
- ☐ **Attachment #20:** Instructions and Copies of regional office monthly internal QA review permanent tool (indicators 8 & 9)
- ☐ **Attachment #23:** Copies of regional office case management narratives, assessment (1718), physicians input form (1718A), and/or CO HIV/AIDS Waiver Exception Form

II. Service Plans:

Sub Assurances:

A. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

State's Evidence: SCDHHS is responsible for developing participant service plans based on the comprehensive assessment of the participant's medical needs, activities of daily living, psychobehavioral information, instrumental activities of daily living, and strengths. Each problem addressed on the service plan includes a goal, objective and interventions. The State CMS program has a component (referred to as the "Wizard") that links problems identified in the assessment to the service plan. Case Managers use this component to identify all problems in the assessment and gives them the option of addressing them in the service plan. Service plan development and updates are discussed during new case managers orientation and training with regional trainers. Central Office annual reviews and regional office monthly internal reviews of service plans ensure participant needs are met. The following documents are provided as

evidence that individual service plans are reviewed to assure that all participant needs and personal goals are addressed:

- **Attachment #24:** Copy of assessments, service plans and service plan wizard requirements
- **Attachment #16:** Copy of “CLTC Case Management Orientation” – Quality Assurance” – Handout (Topic: #2 Service Plan)
- **Attachment #13:** Copy of “SC Department of Health and Human Services, CLTC Regional Trainers Teaching/Training Guide” (Day 4 – Review of Chapter 6)
- **Attachment #17A:** Copy of Statewide Summary for Central Office 2007 – 2008 Quality Assurance Reviews (indicators 8A-E)
- **Attachment #20:** Instructions and Copies of regional office monthly internal QA review permanent tool (indicators 6A-E)

B. The state monitors service plan development in accordance with its policies and procedures.

State's Evidence: On a monthly basis, SCDHHS Regional Office senior case management staff review one to four charts, of each case manager, to ensure accurate service plan development. Any problems found are recorded on the internal QA tool and discussed with appropriate case manager. As of January 2009, case managers' monthly QA scores are accumulated on a quarterly basis. Accumulated data is shared with case managers and case management agencies. Additionally, Central Office conducts yearly QA reviews in each regional office. The results of the review are shared with the Area Administrator. Any QA tool indicators that fall below the compliance rate must be addressed in a corrective action plan. The compliance score for this indicator was 90 – 94% in 2007 – 2008 but has been changed to 94%. This change is reflected in 2008-2009 reviews. The following documents are provided as evidence that the State monitors service plan development in accordance with its policies and procedures:

- **Attachment #20:** Instructions and Copies of regional office monthly internal QA review permanent tool (indicators 6A-E)
- **Attachments #25 and 26:** Instructions for distribution of quarterly case managers accumulated internal QA scores and Sample quarterly case managers accumulated regional office internal QA scores (indicators 6A-E)
- **Attachment #27:** Copy of August 20, 2009 Agenda for regional office management and supervisory staff training (which included reminder of quality assurance review instructions and process for sharing information with case management agencies and/or independents)
- **Attachment #28:** Copy of September 1, 2009 Agenda for Case Management Provider Meeting (which included reminder of quality assurance review process for receiving information)

- **Attachment #17A:** Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Reviews (indicators 8A-E)
- **Attachment #18:** SCDHHS Annual 2007 - 2008 Quality Assurance Report and Regional Office Corrective Action Plan

C. Service plans are updated/ revised at least annually or when warranted by changes in the waiver participant's needs

State's Evidence: Regional office monthly internal QA reviews; quarterly accumulated internal QA review data and CO yearly reviews are used to monitor the updating of service plans annually or when warranted by changes in participant's needs. The compliance rate for indicator(s) that address this requirement was 90% - 94%. The compliance score for this indicator has been changed to 94% and is reflected in 2008 - 2009 reviews. The following documents are provided as evidence to support the monitoring of service plan updates/revisions:

- **Attachment #20:** Instructions and Copies of regional office monthly internal QA review permanent tool (indicator 7)
- **Attachments #25 and 26:** Instructions for distribution of quarterly case managers accumulated internal QA scores and Sample quarterly case manager accumulated internal scores (indicator 7).
- **Attachment #17A:** Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Reviews (indicator 9). The indicator score of 71% is below the compliance rate of 90-94%. August 2009 training for regional office management and supervisory staff was scheduled to include review this and all QA tool indicators (CO and regional office QA tools). Also, the sample regional office corrective actions plans address this below compliance rate.
- **Attachment #29:** Regional Trainers meeting minutes that address scheduling of August 2009 training
- **Attachment #27:** Copy of August 20, 2009 Agenda for regional office management and supervisory staff training

D. Services are delivered in accordance with the service plan, including the type, scope, amount, and frequency specified in the service plan.

State's Evidence: The CMS program will not allow service authorizations that do not contain amount, duration, scope, and frequency criteria. Care Call reports monitor service delivery. Regional office management staff monitors care call activities and note results on the internal monthly QA tool (indicators 4,4A and 5). Also, the CO annual QA reviews monitor care call (indicators 6,6A and 7). The required compliance score for indicators 4 and 6 is 95% - 100%; and 4A, 5, 6A and 7 is 90% - 94%. The following evidence supports the monitoring of service plan delivery:

- **Attachment #30:** Sample Care Call Reports

- **Attachment #20:** Instructions and Copies of regional office monthly internal QA review permanent tool (indicators 4, 4A, 5)
- **Attachment #17A:** Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Reviews (indicator 6, 6A and 7)

E. Participants are afforded choice: (1) between waiver services and institutional care; and (2) between/among waiver services and providers.

State's Evidence: 1. Each participant or responsible party signs and dates a LOCUS form prior to program entry. The LOCUS form indicates participant's choice of community care or institutional care. Signature and Date on LOCUS forms are monitored during regional office internal monthly quality assurance reviews and CO annual quality assurance reviews. This indicator compliance score was 95% - 100%. But, it has been changed to 100% and is reflected in 2008 – 2009 reviews (Central Office and Regional Office). The following documents serve as evidence that each participant is afforded choice between waiver services and institutional care:

- **Attachment #20:** Instructions and Copies of regional office monthly internal QA review permanent tool (indicator 2B)
- **Attachment #17A:** Copy of Statewide Summary for Central Office 2007- 2008 Quality Assurance Review (indicator 5B). The statewide average was 99%.

State's Evidence: 2. A State case manager (lead team or CMI) presents contracted case manager choices to each participant for verbal case manager selection. Other service provider selections may be made with state or contracted case manager. At case manager's and participant's initial visit, the participant signs and dates a choice form confirming verbal provider selections. Subsequent selections for additional or changes in provider services are narrated in the participants chart. Proper documentation of provider choice is monitored during regional office internal QA and Central Office annual QA reviews. Participant and/or responsible party dissatisfaction with provider or services reported through CLTC complaint system is addressed by CLTC staff and with the appropriate CM for resolution. Also, a sample of participants is surveyed yearly for participant satisfaction with services. The following documents serve as evidence that each participant is afforded choice between waiver services and providers:

- **Attachment #20:** Instructions and Copies of regional office monthly internal QA review permanent tool (indicator 2A with required compliance score of 90% - 94%).
- **Attachment #17A:** Copy of Statewide Summary for Central Office 2007 -2008 Quality Assurance Review (indicator 5A with required compliance score of 90% - 94%).
- **Attachment #31:** Copies of CLTC Complaints
- **Attachment #32:** Copy of "2008 Annual Survey of Community Long Term Care (CLTC) Consumer Experience and Satisfaction" report (pages 1-3 of 34 and 25 - 34 cover HIV/AIDS waiver participants)

III. Qualified Providers:

Sub Assurances:

- A. **The State verifies that providers initially and continually met required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.**

State's Evidence: The state requires potential providers to complete an application and attend a pre-contractual training. Providers must meet requirements as outlined in the application and attending pre-contractual training. The state monitors providers to assure adherence to waiver requirements. The State employs a licensed Registered Nurse to conduct on-site reviews periodically of providers. The following document serves as evidence that the State verifies providers initially and continually meet required standards and adhere to other state standards prior to their furnishing waiver services:

- ☐ **Attachment #33:** Copy of a provider's Personal Care II application with required attachments

The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet tuberculin skin test requirements, first aide certification requirement and any other requirements as outlined in the contract. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, policy and procedure manuals, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met. The following documents serve as evidence that the State verifies providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services:

- ☐ **Attachment #34:** Copy of a provider compliance review
- ☐ **Attachment #35:** Copy of follow-up letters relative to provider compliance review

- B. **The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

State Evidence: The CLTC Compliance Review Officer monitors contracted providers, licensed and non-licensed, to ensure compliance with waiver requirements. The reviewer identifies and rectifies situations where providers do not meet requirements.

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

sanctions may be applied. The sanctions can range from requiring a corrective action plan to recoupment to suspending new referrals for a period to termination of the contract. Following is a chart that outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1 = secondary, 2 = serious, 3 = major

Client Service Questions	Possible Answers	Severity level
Was supervisory visit made within 30 days after PC II services initiated?	Y,N,NA	3
Was the initial supervisory visit documented in Care Call?	Y,N,NA	3
Does provider maintain individual client records?	Y,N	2
Did provider give participant written information regarding advanced directives?	Y,N,NA	1

There are five types of sanctions:

- **Corrective Action Plan** – This is the least severe sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a corrective action plan for correcting deficiencies and avoiding recurrence.
- **30-day suspension** – This sanction level is moderate. At this level, new referrals are suspended for 30 days. The provider is required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 30-day period.
- **60-day suspension** – This sanction level is substantial. At this level, new referrals are suspended for 60 days. The provider is required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 60-day period.
- **90-day suspension** – Indicates major and/or widespread deficiencies. The 90-day suspension of new referrals will only be lifted after an accepted corrective action plan. In addition, an acceptable follow-up review visit will be conducted, if warranted, prior to reinstatement.

- **Termination** – Indicates major and substantial deficiencies, generally coupled with a history of reviews with repeated moderate to major deficiencies. Termination is a last resort.

The compliance review system scores reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews are scored:

Calculating process

- The level of sanction is decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.
- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.
- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted basic points x 3 + level 2 = unweighted basic points x 2 + level 1 = unweighted basic points x 1

Example:

<u>Level</u>	<u>Deficiency percentage</u>	<u>Basic points</u>	<u>Final points</u>
<u>Level 1 (secondary)</u>	<u>28%</u>	<u>5</u>	<u>5x1=5</u>
<u>Level 2 (serious)</u>	<u>20%</u>	<u>4</u>	<u>4x2=8</u>
<u>Level3 (major)</u>	<u>35%</u>	<u>7</u>	<u>7x3=21</u>
<u>Final score</u>			<u>34</u>

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the review score:

Determine sanction

Score scale & Sanction Level

<u>Sanction Type</u>	<u>Final score - Standard</u>	<u>Final Score – Positive History</u>
<u>Correction Plans</u>	<u>1-99</u>	<u>0-149</u>
<u>30 Days Suspension</u>	<u>100-199</u>	<u>150-249</u>
<u>60 Days Suspension</u>	<u>200-299</u>	<u>250-349</u>
<u>90 Days Suspension</u>	<u>300-399</u>	<u>350-449</u>
<u>Termination</u>	<u>400 +</u>	<u>450 +</u>

Positive History is determined based on previous review scores. For example, if a provider's previous year review had a score that did not include a suspension, but required them to submit a corrective action plan and the current review score warrants a 30-day suspension, the current review will be scored using the Positive History scoring scale and the provider will be required to only submit a corrective action plan rather than be subject to a 30-day suspension based on the previous review.

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

☐ **Attachment #36:** Copy of Memorandum of Agreement between the State Office on Aging and SCDHHS

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

For environmental modification services, identified deficiencies could result in suspension of new referrals for a period of time or recoupment of funds depending on the severity of the deficiency. Environmental modification providers will be given the opportunity to correct the deficiencies when warranted. If corrections are not done timely, this may result in recoupment of funds and/or termination.

☐ **Attachment #37:** Copy of sanctions for Environmental Modification providers

Attendant care services are provided by individuals directly employed by participants. SCDHHS has a contract with the University of South Carolina to ensure that these attendants meet all requirements to provide services. The University employs registered nurses to assess attendants and determine that they are capable of providing all needed care. In addition, the case manager consults with the participant at least monthly to ensure that services are being provided appropriately. Attendants are required to submit copies of their task sheets to case managers monthly.

Individual companion services are provided to participants capable of self-directing their care, who can terminate companions for any reason. In addition, case managers check monthly with participants regarding companion as well as all other services.

For attendants and individual companion services, participants may terminate services for any reason at any time. Any allegations of inappropriate actions would be investigated and could result in termination from the Medicaid program and/or recoupment of payments.

☐ **Attachment #38:** Copy of Attendant termination and recoupment letters

C. The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

and provides technical assistance to all providers of the HIV/AIDS waiver. The state conducts training with providers prior to the initiation of a contract and more often on an individual as needed basis. The state also conducts provider training bi-annually at contract renewal.

IV. CMS Assurance: Health and Welfare

Sub Assurance:

A. The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation.

State Evidence: New staff orientation was provided on a 4 to 6 month basis until July 2007. After July 2007, due to frequent hiring of new contract case managers and fewer state case managers, orientation is conducted every other month to all new contract case managers. Part of the orientation agenda includes training on Adult Protective Services (APS). Also, an APS Powerpoint has been developed and placed on the internal website for training purposes. The State Law, mandatory reporting, importance of referrals and narration are stressed. There is also a "Memorandum of Agreement Between South Carolina Department of Health and Human Services and South Carolina Department of Social Services". The agreement is currently in the Department of Social Services legal department for signatures. The CLTC complaint system is used to notify Central Office of reported allegations of abuse, neglect and/or exploitation. Reported allegations that are not resolved at the regional office level are discussed for resolution at Quality Assurance Task Force Meetings. The following evidence supports that the State identifies, addresses and seeks to prevent occurrences of abuse, neglect, and exploitation on an ongoing basis:

- ☐ **Attachments #14 and 15:** "CLTC Orientation" Agendas and "CLTC Case Management Training" topics (including rosters of attendance)
- ☐ **Attachment #39:** "CLTC Orientation" APS information and State Law
- ☐ **Attachment #40:** Copy of APS internal website power point
- ☐ **Attachment #41:** "Memorandum Of Agreement Between South Carolina Department Of Health and Human Services And South Carolina Department Of Social Services"
- ☐ **Attachment #22A:** Copy of Quality Assurance Task Force Meeting Notes (September 9, 2009) item "G" – follow up on MOA with DSS
- ☐ **Attachment #42:** Copy of CLTC Complaint and Resolution

V. CMS Assurance: Administrative Authority

Sub Assurance:

A. The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.

State Evidence: SCDHHS retains administrative authority and responsibility for

operation of the HIV/AIDS waiver program. Waiver functions are performed by eleven area SCDHHS offices and two satellite offices. Each area and satellite office has state employees (Area Administrators, Lead team case managers and Lead team nurse consultants and other nurse consultants) that manage and supervise the daily operations of the waiver. Initial assessments and level of care determinations are performed by state nurse consultant staff. Initial service plan development is performed by state senior case managers. On-going waiver services are performed by contracted case managers and a limited number of state case managers. Services provided by contracted case managers are monitored by area office supervisory staff and central office staff. Area office state employees are monitored by supervisors and during Central Office quality assurance reviews.

- ☐ **Attachment #17A: Copy of Statewide Summary for Central Office 2007 -2008 Quality Assurance Review**

- ☐ **Attachment #20: Instructions and Copies of regional office monthly internal QA review permanent tool**

VI. CMS Assurance: Financial Accountability

Sub Assurance:

- A. State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.**

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

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

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

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

At this time, Personal Care II, Personal Care I, Agency Companion, Private Duty Nursing, Attendant, Home Delivered Meals, Case Management and all home modifications are billed through the Care Call system. In all cases, no claim can be submitted that is not supported by a service authorization.

It is planned that at some point all waiver claims will come through the Care Call system. Currently, for services not part of the system, South Carolina has developed a system which checks to ensure that the participant was enrolled in the waiver and Medicaid eligible at the time of the service. Case managers review service delivery with participants on a monthly basis to ensure that claims are appropriate and that authorized services are being delivered.

In addition to the financial accountability offered by the Care Call system, the State also employs a licensed Registered Nurse who conducts on-site reviews with personal care, companion, and nursing providers. The reviews consist of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculosis test requirements, ongoing training requirements and any other requirements contractually specified (e.g., background checks). The administrative review determines that all agency administrative requirements (liability insurance, list of officers, emergency back-up plans, etc.) have been met. The participant review pulls a sample of participants and verifies that all requirements relating to the actual conduct of service have been met. As an example, personal care service reviews would identify documentation of nurse supervision (including appropriate on-site visits), nurse sign-off on aide task sheets, case manager notification of any problems/changes in condition and other required elements.

These reviews have been automated for a number of years. Since April, 2008, personal care reviews have been scored based upon number of and seriousness of deficiencies. Provider sanctions are based upon these scores. Since then, approximately 10% of providers have received sanctions which included suspension of new referrals. Many more providers have had to submit written corrective action plans. Review schedule is based upon results of prior reviews. Every provider receives an on-site review at least every 18 months.

Also, the Division of Program Integrity at DHHS monitors services (e.g. incontinence supplies and prescription drugs) not billed through care call; responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers; and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to CLTC service providers. Recoupments are made when provider records do not support billings of services.

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

Evidentiary-Based information
South Carolina HIV/AIDS
Home and Community Based Waiver Program (#0186.90.R03)

- Attachment 1A - Instructions and Sample NC Interim QA Tools**
- Attachment 1B - Instructions and Sample NC Permanent QA Tools**
- Attachment 2 - Sample NC Assessments, Narratives, Checklists, 1718 and/or LOC Exceptions**
- Attachment 3 - CMS LOC Report for HIV/AIDS Waiver**
- Attachment 4 - Sample Signature Sheets Documentation for LOC Team Staffing**
- Attachment 5 - Copy of Regional Office E-Mail Regarding LOC Team Staffing**
- Attachment 6 - Documentation Supporting Case Transfer Date as Waiver Enrollment Date**
- Attachment 7 - Copies of CLTC Transfer Policies & Procedures**
- Attachment 8 - Documentation Supporting Inadvertent Incorrect Coding or Other Information**
- Attachment 9 - CMS Re-Evaluation Report for HIV/AIDS Waiver**
- Attachment 10 - Assessment Form 1718**
- Attachment 11 - HIV/AIDS Waiver LOC Exception Request Form**
- Attachment 12 - Copies of CLTC Re-Evaluation Policies & Procedures Revisions**
- Attachment 13 - "SC Department of Health and Human Services CLTC Regional Trainers/Teachers Guide" Assessment and LOC Training**
- Attachment 14 - "CLTC Orientation" Assessment and LOC Training**
- Attachment 15 - "CLTC Case Management Training" QA Topics on Assessment and LOC; and Attendee Roster**
- Attachment 16 - "CLTC Case Management Orientation" QA Topic on Initial Assessments**
- Attachment 17A - Statewide Summary of CO 2007-2008 QA Reviews**
- Attachment 17B - Copies of Central Office QA Reviews**
- Attachment 18 - Sample SCDHHS Annual 2007-2008 QA Reports and Regional Office Corrective Action Plans**
- Attachment 19 - Instructions and Copies of Interim Regional Office Internal QA Reviews**
- Attachment 20 - Instructions and Copies of Permanent Regional Office Internal QA Reviews**

Evidentiary-Based information
South Carolina HIV/AIDS
Home and Community Based Waiver Program (#0186.90.R03)

- Attachment 21A – “Quality Assurance Task Force Meeting Agenda and Notes” (March 11, 2009)**
- Attachment 21B – “Quality Assurance Task Force Meeting Agenda and Notes” (May 13, 2009) Follow-up**
- Attachment 22A - “Quality Assurance Task Force Meeting Agenda and Notes” (September 9, 2009)**
- Attachment 22B - Central Office E-Mail Regarding LOC Follow-up**
- Attachment 23 - Copies of Regional Office CM Narratives, Assessments (1718), 1718A, and/or CO HIV/AIDS Waiver Exception Form**
- Attachment 24 - Copies of Assessments, Service Plans, Service Plan Wizard**
- Attachment 25 - Instructions for Distribution of CM Quarterly Accumulated QA Scores**
- Attachment 26 - Sample CM Quarterly Accumulated QA Scores**
- Attachment 27 - Copy of August 20, 2009 Agenda for Regional Office QA Training**
- Attachment 28 - Copy of September 1, 2009 Agenda for CM Provider Meeting (QA Topic)**
- Attachment 29 - Regional Trainers Meeting Minutes (August 2009 Meeting)**
- Attachment 30 - Sample QA Care Call Report**
- Attachment 31 - Copies of CLTC Complaints**
- Attachment 32 - Copy of 2008 Annual Survey of CLTC Consumer “Experience and Satisfaction”**
- Attachment 33 - Copy of Provider’s PC II Application with Required Attachments**
- Attachment 34 - Copy of Provider Compliance Review**
- Attachment 35 - Copy of Follow-up Letters Relative to Provider Compliance Review**
- Attachment 36 - Copy of MOA between State Office on Aging and SC DHHS**
- Attachment 37 - Copy of Sanctions for Environmental Modification Providers**
- Attachment 38 - Copy of Attendant Termination and Recoupment Letters**
- Attachment 39 - “CLTC Orientation” APS Information and State Law**
- Attachment 40 - Copy of APS Internal Website Power Point**

**Evidentiary-Based Information
South Carolina HIV/AIDS
Home and Community Based Waiver Program (#0186.90.R03)**

Attachment 41 - Copy of MOA between SCDHHS and SCDS

Attachment 42 - Copy of CLTC Complaint and Resolution