DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett	2-10-15

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000181	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Kost, Dep's, Chavis, CMS file	[X] Prepare reply for appropriate signature DATE DUE 3-23-15 [ ] 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.			

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region IV

Draft Report

Home and Community-Based Services Waiver Review
South Carolina HIV/AIDS Waiver
Control # 0186.R05

January 30, 2015

Home and Community-Based Services
Waiver Review Report

Summary of Finding

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

Suggested Recommendations:

The CMS has no recommendations at this time and applauds the state for its current Phoenix system. We encourage the state to consider system enhancements or edits to accommodate any new and/or revised federal guidelines or regulations that will assist the state in meeting all LOC sub-assurances in the future.

II. **Service Plans are Responsive to Waiver Participant Needs: The state demonstrates the assurance but CMS recommends improvements or requests additional information**

Suggested Recommendations:

The state appears to have an adequate system to monitor all aspects of service plans. However, the compliance rates in this area are lower than other assurance areas where evidence was submitted. The CMS recommends the state utilize additional training modules and/or opportunities with providers to stress the importance of waiver requirements to comply with federal regulations. Additionally, the state should ensure it is consistent with using the scoring algorithm utilized for provider reviews and impose sanctions against providers as specified by the state's existing policy.

III. **Qualified Providers Serve Waiver Participants: The state substantially meets this assurance**

Suggested Recommendations:

The state utilizes multiple performance measures to ensure that only qualified individuals and/or agencies are allowed to provide services to waiver participants. The state's scoring algorithm and sanction policies are commendable and appear to be appropriate based on the severity of findings. The CMS suggest that the state considers amending performance measures #2, #3, #4 and #5 in the qualified provider section as they measure a number of actions the state conducts but do not provide actual data on the performance of providers.

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

Suggested Recommendations:

The state has recognized that adequate data is not being collected to determine the outcomes of APS referrals. The CMS recommends the state revise the current

Please note that for all waivers renewed or amended after June 1, 2014, CMS requires the state to update performance measures to reflect the modifications to quality measures and reporting. The sub-assurances for discovery purposes have been revised. States are still required to monitor all the waiver assurances and report on compliance and must continue to remediate identified issues; however, states are no longer required to submit reporting on individual remediation except in cases of substantiated abuse, neglect, or exploitation. In addition, if the threshold of compliance for any measure is 85% or below, CMS will require quality improvement projects and/or remediation.

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

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, nursing facility or ICF/MR.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

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

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

Applicants must utilize the intake process for the HIV/AIDS Waiver. A Nurse Consultant applies established intake criteria to determine if an assessment is warranted. If so, applicants are assigned to Registered Nurse Consultants who then completes an assessment and keys the results into the Phoenix system, an automated case management system designed by the state. Individuals who meet eligibility requirements may enroll in the HIV/AIDS waiver. The Nurse Consultant verifies the applicant is Medicaid eligible, meets hospital Level of Care (LOC) and wants to participate in the waiver. Justification of LOC is documented in a narrative report and/or checklist as well as on an assessment form.

The state utilizes two performance measures for the sub-assurance that a LOC determination is provided to all applicants for whom there is reasonable indication that services may be needed in the future: (1) 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 (2) the number and percent of all applicants who received a LOC determination.

Reports generated from the Phoenix system for the review period of July 1, 2011 through June 30, 2014 indicated there were 493 individuals who applied for the program. Of those, 271 (55%) received a LOC evaluation. For the 222 (45%) who did not receive a LOC, closures were found to be justified. The largest indicators for closures included 51 applicants who declined participation; 7 applicants died; and 27 applicants did not complete the financial application. The remaining 137 applicants were spread across 17 other indicators of various reasons. One hundred percent of applicants enrolled received LOC determinations before enrollment and before services were initiated.

The state uses one performance measure for the sub-assurance that states the LOC of enrolled participants is re-evaluated at least annually or as specified in the approved waiver (the number and percent of participants who received a re-evaluation within 365 days of their last LOC determination). For re-evaluations, the Phoenix reports generated found that 2,402 (96.5%) participants had re-evaluations during the review period. 2,515 re-evaluations should have been done during the multi-year timeframe. A special review of the remaining 113 was conducted and found that 87 of the re-evaluations had acceptable reasons for being late. Situations such as the participant was hospitalized, out of town or could not be located contributed to the finding. The remaining 1% of the cases (26) was not justified for being late and recoupment of funds was

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)

SCDHHS is responsible for developing participant service plans based on the comprehensive assessment conducted through the Phoenix system. The assessment includes aspects of the participant's medical needs, activities of daily living, psycho-behavioral information, instrumental activities of daily living, strengths, caregiver needs/supports, home environmental needs and personal goals. The automated Phoenix system links needs identified in the assessment, caregiver supports section and the home assessment to the service plan. Case managers cannot move forward for service plan approval if all identified needs are not addressed. Each need identified also includes a goal and objective which allows case managers to connect interventions with each problem. Interventions can include waiver services, actions by informal caregivers or other resources. Personal goals have also been developed and included in the Phoenix system. The case managers work with the participant and any involved family members to determine if there are personal goals, and if so, will help them identify steps to assist them in achieving those goals.

Ensuring the effectiveness and accuracy of service plans is an on-going process. Service plan development and updates are a topic covered in new case manager orientation and any training with regional trainers. Using the Phoenix system, SCDHHS staff in the central office conducts annual reviews and regional office staff conduct monthly internal reviews of service plans to ensure participants' needs are met and the accuracy of service plan development. The Phoenix system will not allow services to be authorized without a completed service plan.

The state uses three performance measures to determine that service plans address all participants' assessed needs and personal goals, either by waiver services or through other means: (1) number and percent of participants reviewed whose needs and personal goals identified in the assessment were addressed in the service plan, (2) number and percent of participants reviewed whose identified needs regarding caregiver support was addressed in the service plan, and (3) number and percent of participants reviewed whose home environmental needs were addressed in the service plan.

Service plans for all waiver participants during the review period of July 1, 2011 through June 30, 2014 were reviewed. One hundred percent (100%) of all participants had needs addressed in their service plans that related to information in the overall assessment, including medical needs, activities of daily living, instrumental activities of daily living and psycho-behavioral information. Personal goals were not included into the Phoenix system until 2012. A 100% review of individual service plans reviewed for a period of July 20, 2012 – June 30, 2014 revealed that 88% had documentation present to show that personal goals were discussed and addressed. A sample of the remaining 12% revealed that in 2% of the cases, the case managers failed to properly interpret questions on the narrative check-list. The adjusted compliance rate following the sample review indicates that 90% of the records reviewed were in compliance with the personal goal requirement.

Remediation included technical assistance from Truven Health who made recommendations as to how the state could assure personal goals were discussed with participants. The state added

Remediation included reporting Phoenix system errors via a "Report a problem" feature. Additionally, the case manager scope of service has been updated to include training, remediation strategies and sanction guidelines for non-compliance with policy, procedure and waiver requirements.

For the sub-assurance that determines if service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs, the state uses two performance measures: (1) number and percent of service plans updated as needed and (2) number and percent of service plans revised on or before the annual review due date. The Phoenix system generates checklists that include three questions: (1) did the participant's need change, (2) did the change warrant a service plan update, and (3) was the service plan updated? These are used to generate reports from the Phoenix system to monitor case managers' compliance with service plan updates. Phoenix automatically calculates the number of days between the previous service plan development and the current service plan. Any plans greater than 365 days are reviewed. Again, this data is used to generate reports within the Phoenix system to show case manager compliance with the development or revisions of annual service plans.

Phoenix revealed that of 711 service plans reviewed, 93% (658) had service plans updated based on need during the review timeframe. The remaining 7% were reviewed more closely to see if there were extenuating circumstances that caused plans to be late or not updated timely. Findings revealed that 33% of those cases had care plan updates, but the case managers were confused on how to answer one of the questions on the checklist, which caused the service plan to show as not updated, when it fact, it had been updated. The revised compliance rate based on the extended review was determined to be 95%.

Remediation again included posting a statewide banner in the Phoenix system reminding case managers to carefully review the three questions before answering; on-going policy and procedure review with providers and case managers; and addressing non-compliance issues at the training held in September 2014.

Further findings also indicate that 87% of HIV/AIDS participants' service plans were updated on or before the annual due date. The remaining 13% were mostly found to be completed, but not signed, resulting in a revised compliance rate of 88%. Remediation was consistent with previously stated remediation actions and also included recoupment of payment where service plans were late.

For the sub-assurance that addresses if services are delivered in accordance with the service plan, including the type, scope, amount and frequency specified in the service plan, the state uses two performance measures: (1) number and percent of participants who received service based on type, amount, frequency and duration as delineated in his/her service plan, and (2) number and percent of participants who receive all services identified in his/her service plan.

Providers of waiver services are required to utilize the Phoenix and Care Call system to document service delivery. The Phoenix system compares service documentation in both systems and only allows for billing up to the authorized amounts and during the required time frame. The Care Call system documents delivery of services by providers and compares the claims to authorizations to ensure appropriate provision of services.

Participants and/or caregivers are required to sign a Phoenix generated copy of the service plan which indicates that they participated in its development and that they were provided a choice of services and service providers. The form also states that the participant may choose to change service providers at any time. These forms are required to be signed at the initial visit after service plan development and at the first quarterly visit after the annual service plan development.

Of 2,557 service plans reviewed during the multi-year time frame, 2,040 (80%) had an appropriately completed service plan agreement indicating the participant was given a choice of all qualified waiver service providers. The remaining 20% of service plans were reviewed in depth and 28% of them were justified in that the participant's case was closed prior to a quarterly visit to obtain service plan agreement sheet signature. Accordingly, the adjusted compliance rate is 85%.

Remediation included reporting a few Phoenix system errors by creating a "Report a Problem" features in Phoenix so that developers could address concerns, and on-going policy and procedure reviews with providers and case managers.

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 appears to have an adequate system to monitor all aspects of service plans. However, the compliance rates in this area are lower than other assurance areas where evidence was submitted. The CMS recommends the state utilize additional training modules and/or opportunities with providers to stress the importance of waiver requirements to comply with federal regulations. Additionally, the state should ensure it is consistent with using the scoring algorithm utilized for provider reviews and impose sanctions against providers as specified by the state's existing policy.

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

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

Potential providers are required to submit a completed enrollment application online which is screened by a contracted entity within the Provider Enrollment area. Provider Enrollment is tasked with verifying the applicant has no state or federal exclusions and also conducts site visits (if necessary) to ensure providers meet all other agency and program criteria. After completion of the screening process and site visits, provider applications are sent to the state for processing. Approved applicants are required to attend a mandatory pre-contractual meeting prior to being

delivery monthly and include documentation on checklists via the Phoenix reporting system. Documentation revealed that 100% of all licensed/certified providers were monitored.

There were 18 complaints on providers that triggered ad hoc reviews (performance measure #7). Approximately 1% of the complaints warranted the ad hoc review. The remaining 99% are closed or were still being investigated at the time of evidence submission.

Eighteen complaints were logged into the Phoenix system (performance measure #8). 61% of the complaints were closed and the remaining 39% remained in the review process at the time evidence was submitted.

Remediation on issues with licensed/certified provider reviews and/or complaints which indicated the need for corrective action plans or recoupment of funds have been resolved or are in the process of being resolved by the state. Remediation strategies include the submission of corrective action plans and/or provider terminations. A new set of protocols is being developed in 2014 to ensure more cohesive work flows for complaint systems reviews. Reports will be run on a routine basis to ensure timely processing of complaints and a quicker identification of any issues.

In the state's submission of evidence, it also included information concerning the review process and sanctions that could be imposed on providers. For services monitored by the Compliance Registered Nurse, a report is generated listing all identified deficiencies. This report also scores the review based on a sanctioning algorithm and that score determines if the provider will receive a sanction, and the level of the sanction. This method was developed to ensure that reviews are equitable across providers and so providers would know what to expect. Currently, Personal Care II, Adult Day Care and Nursing are the only service reviews being scored. Reports for other services are generated which list all deficiencies identified. The severity and number of deficiencies, along with outcomes of prior reviews, determine if sanctions are applied. Sanctions can include anything from corrective action plans, recoupment of payments, suspension of new referrals for 30, 60 or 90 days depending on the severity of deficiencies, and/or termination of the provider's contract. Additionally, providers who have two consecutive reviews that result in suspensions of new referrals will be terminated if the third consecutive review would also result in suspensions of new referrals.

Other services are reviewed by different means. Home Delivered Meals are monitored by the State Office of Aging, since all but three providers are part of the aging network. There is a formal Memorandum of Agreement (MOA) between SCDHHS and the State Unit on Aging. In addition, case managers consult with participants monthly to ensure that meals are being delivered as authorized and that they are satisfied with the service.

Environmental modification services require the provider to be a licensed contractor. In addition to the contractor being required to meet the initial provider requirements, the state employs a review Registered Nurse who conducts on-site reviews of environmental modifications to ensure all state building codes and regulations are followed. If deficiencies are found, suspensions of new referrals or recoupment of payment is initiated, depending upon the severity of the deficiency. The contractor is provided the opportunity to correct any deficiency prior any sanctions and they must be completed within a certain timeframe.

There were 824 complaints logged into Phoenix's complaint system regarding unlicensed providers (performance measure #9). 85% or 700 of those complaints have been investigated and closed. The remaining 15% (124) were still being reviewed at the time of the evidence submission.

Remediation for unlicensed/uncertified provider reviews and/or complaints that indicated need for corrective actions, recoupment of payment or sanctions have been resolved or are in the process of being resolved by the state. As with the licensed/certified providers, the state has created a new set of protocols this year to ensure more cohesive work flows for the complaint system reviews.

For the sub-assurance that ensures the state implements its policies and procedures for verifying provider training is conducted, the state uses six performance measures: (1) number and percent of potential providers who meet the additional application criteria and attend mandatory training prior to being issued a provider contract; (2) number of provider meetings held to review state and waiver policies and procedures; (3) number of bulletins, memos and other correspondences both electronically and in writing educating providers on waiver and state policies and procedures; (4) number of meetings held with providers requesting education or training, including trainings when major policy changes are enacted; (5) number of trainings conducted by various state and contracted entities encompassing Medicaid waiver and state policies and procedures; (6) and, for all applicable providers, the number of providers conducting in-service training for staff and the percentages not completing training.

Training requirements are monitored as part of the reviews conducted by the Compliance Registered Nurse. The reviews include all pre-service requirements, competency evaluations for personal care aides and all ongoing in-service annual requirements. During the review period, there were 139 providers who met the initial application criteria and attended mandatory pre-contract training for a compliance rate of 100% (performance measure #1).

Twenty five (25) provider meetings were held to review state waiver policies/procedures (performance measure #2). Forty one (41) bulletins, memos or other correspondences were sent to providers (both electronically and in written form) to educate them on waiver and state policies and procedures (performance measure #3). For performance measure # 4, 15 meetings were held with providers who requested additional education and/or training when policy changes were enacted. For performance measure #5, eight trainings/meetings were conducted by other contracted entities encompassing Medicaid waiver and state policies/procedures.

Performance measure #6 revealed that 255 providers were required to do in-service training for staff during the review period. 207 (81%) providers were compliant with training requirements. 48 (19%) did not complete training as required and appropriate corrective action plans and/or sanctions were imposed according to the state's scoring algorithm.

Suggested Recommendations:

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

The state utilizes multiple performance measures to ensure that only qualified individuals and/or agencies are allowed to provide services to waiver participants. The state's scoring algorithm

not denote open substantiated cases from one report to the next. Further, participant identifying information cannot be disclosed in the report submitted to SCDHHS due to the Omnibus Act. Therefore to remediate this issue, SCDHHS and SCDSS met in early June 2014 and again in September to discuss ways to improve the quality of information shared. Other remediation strategies included requesting SCDSS supervisor contact information to assist case managers in contacting SCDSS social workers for monthly monitoring of open APS cases; sending e-mails to case managers and case management provider supervisors when case managers fail to document monthly monitoring activities on open APS cases; conducting statewide training on APS reporting and monitoring; and training on APS referrals and follow-up.

Required Recommendations:

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

The state has recognized that adequate data is not being collected to determine the outcomes of APS referrals. The CMS recommends the state revise the current performance measures which are written to only collect numbers of referrals and numbers of substantiated or unsubstantiated complaints with no real data of outcomes. Additionally, CMS recommends the state develop additional performance measures that focus more broadly on health and welfare. Some suggested performance measures include:

- Number and percent of individuals who report knowing how to report ANE (either through case management questioning or via participant satisfaction surveys)
- Number and percent of critical incidents investigated by type (e.g., unknown or suspicious injury; exploitation; neglect; abuse; serious injury of unknown cause)
- Number and percent of waiver participants for whom a critical incident was reported and investigated, by type of incident
- Average number of critical incidents per waiver participant
- Number and percent of investigations completed within required timeframes
- Number and percent of substantiated investigations, by type, for which appropriate corrective actions were verified within required timeframes
- Number and percent of complains received from each type of referral source (e.g., State Medicaid Agency, concerned citizen, waiver participant, family member, advocate, provider, etc.)
- Number and percent of complaints by type (e.g., environmental issues, service issues, staffing issues, case management issues, etc.)

Additionally, waiver participants should have the ability and/or process where they can file complaints concerning case management issues without going through the case managers.

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

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

authorized (e.g., if services are authorized for Tuesday/Thursday, the system will not pay for services delivered on other days).

Claims are generated based upon service delivery documented in the Care Call and Phoenix systems. Claims based on authorized services are always the lesser of the delivered and authorized times (e.g., 2 hours authorized and 1.5 hours delivered would generate a claim for 1.5 hours, whereas 2 hours authorized and 3 hours delivered would generate a claim for 2 hours). This method ensures that providers do not exceed authorized amounts. Case Managers also review service delivery with the participants on a monthly basis to ensure that authorized services are being delivered.

Additionally, the state employs a licensed Registered Nurse who conducts on-site reviews with personal care, companion, adult day health and nursing providers. The reviews consist of three parts: staffing; administrative; and participant. The participant component looks at a sampling of participant records and the reviewer verifies that all requirements related to the conduct of service provision have been met. This includes verifying that services were provided as authorized, documented appropriately and paid correctly.

These reviews are automated and are scored based on the number of and seriousness of any deficiencies. Since 2008, approximately 10% of providers have received sanctions which included suspension of new referrals. Multiple providers have been required to submit corrective action plans. The provider review schedule is based upon results of previous reviews, but every provider receives an on-site review at least every 18 months.

The SCDHHS Program Integrity Unit monitors services; responds to complaints and allegations of inappropriate or excessive billing by Medicaid providers; and collects and analyzes provider data to identify any billing exceptions and deviations. If trends indicate the need, the Program Integrity Unit may audit payments to service providers. Recoupments of payments are made if any provider records or documentation does not support billing of the service.

The SCDHHS and the Program Integrity Unit work with the Medicaid Fraud Control Unit of the state's Attorney General's Office. Suspected fraud is referred for investigation. This office has been able to use information provided by the Medicaid agency to initiate successful criminal investigations against many providers.

To help ensure this assurance is met, the state uses four performance measures: (1) number and percent of claims for waiver services submitted with the correct service code; (2) number and percent of waiver claims submitted with the correct rate as specified in the waiver document; (3) number and percent of waiver claims submitted for participants enrolled in the waiver; and, (4) number and percent of claims submitted timely with accurate payment information.

Because the Phoenix system generates and submits claims directly to the MMIS, service codes and billing rates are automatically entered for each claim. This ensures 100% compliance for all performance measures. For the review period reported, 307,607