South Carolina Department of Disabilities and Special Needs

House Legislative Oversight Committee

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Health Care and Regulatory Sub-Committee September 18, 2017

SCDDSN OVERVIEW

South Carolina Department of Disabilities and Special Needs

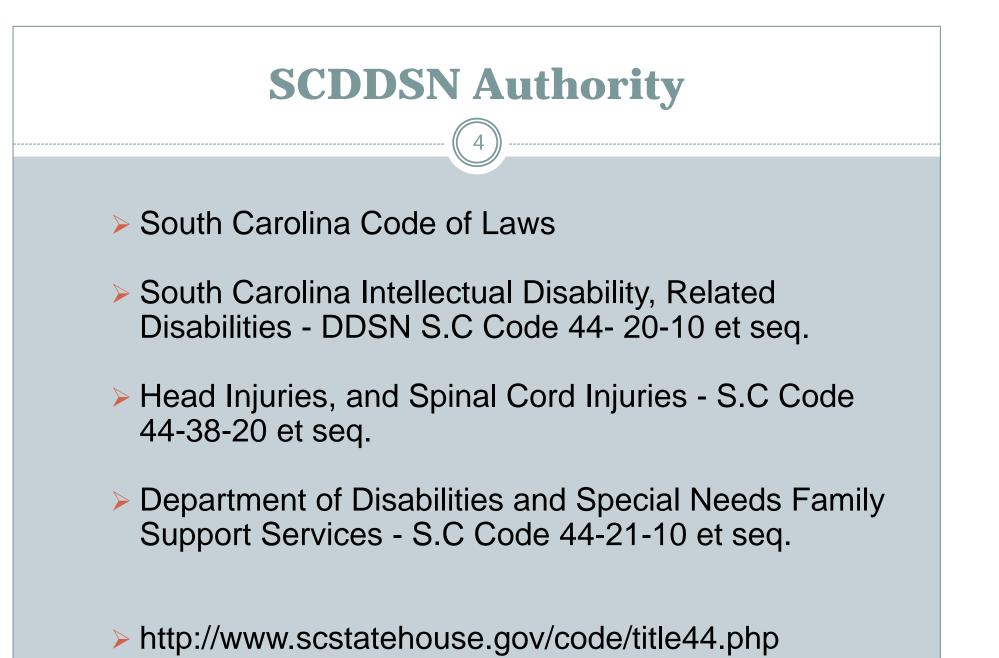
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Beverly A. H. Buscemi, PhD State Director

SCDDSN OVERVIEW

SCDDSN Mission

Assist people with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals; and minimize the occurrence and reduce the severity of disabilities through prevention.



SCDDSN Organizational Structure

- SCDDSN is governed by a seven member commission appointed by the Governor with advice and consent of the Senate
- A Commission member is appointed from each of the seven Congressional districts
- The Commission hires a State Director and provides general policy guidance to the agency
- The State Director is responsible to oversee all agency personnel and resources and provide oversight to the system of services delivered by community service providers

SCDDSN Organizational Structure -Commission

Commission

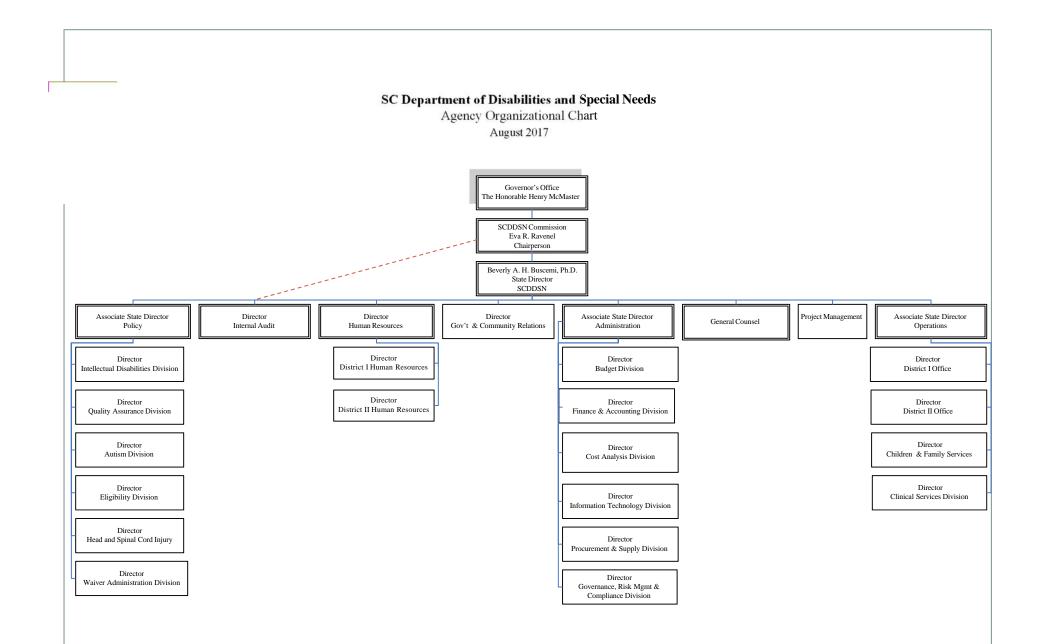


SCDDSN Organizational Structure – Commission

Regularly scheduled Commission meetings are held on the third Thursday of each month at 10:00 AM

The Commission has three standing Committees

- Policy
- Finance and Audit
- Legislative
- Other Committees may be formed as decided by the Chair



SCDDSN Role

- SCDDSN is responsible for developing and implementing a statewide plan of service delivery for those individuals eligible for services
- The Agency is responsible for seeking funding from all available sources to deliver services and advocate for other federal, state and local agencies to provide benefits/services/rights to which SCDDSN consumers are entitled
- SCDDSN establishes provider service requirements, monitors compliance with these requirements and offers technical assistance to providers to assure needs of consumers are being met
- SCDDSN collaborates with other federal, state and local agencies in disability prevention efforts

Four primary groups are eligible for services through SCDDSN –

- Persons with Intellectual/Related Disabilities 63%
- Persons with Autism Spectrum Disorder 26%
- Persons with Head and/or Spinal Cord Injuries 6%
- > High Risk Infants 5 %

> All ages of individuals with eligible disabilities are served

- Birth 6 years 17%
- Seven 21 years 28%
- Twenty-two years death 55%

Intellectual/Related Disability Eligibility Criteria -

- Significantly sub-average intellectual function IQ of 70 or below, and
- Concurrent deficits in adaptive functioning in at least two of the following adaptive skill areas
 - > Communication
 - > Self-care
 - > Home living
 - > Social/interpersonal skills
 - > Use of community resources
 - > Self-direction
 - Functional academic skills
 - > Work
 - Leisure
 - Health and safety

Deficits must occur during the developmental period (prior to age 22 years)

Related Disabilities Eligibility Criteria

- A severe and chronic condition related to intellectual disabilities requiring similar treatment but not including a mental illness (e.g., epilepsy, cerebral palsy)
- Must be concurrent deficits in at least three of the adaptive skill areas listed above

> Autism Spectrum Disorder Eligibility Criteria

- Relies on DSM-5 ASD definition
- Persistent deficits in social emotional reciprocity
- Deficits in nonverbal communications
- Repetitive patterns of behavior
- Symptoms must be present in early life

- Head Injury Eligibility Criteria
 - Insult or injury to skull or brain as documented in medical records
 - Not of a degenerative nature
 - Resulting in impairment in adaptive function

Spinal Cord Injury Eligibility Criteria

- Acute traumatic lesion of neural elements in the spinal canal
- Documented in medical records
- Results in deficits in sensory, motor or major life functions

> High Risk Infant Eligibility Criteria

- Less than 36 months of age
- Has a genetic, medical or environmental history that is predictive of a high risk for future developmental disability

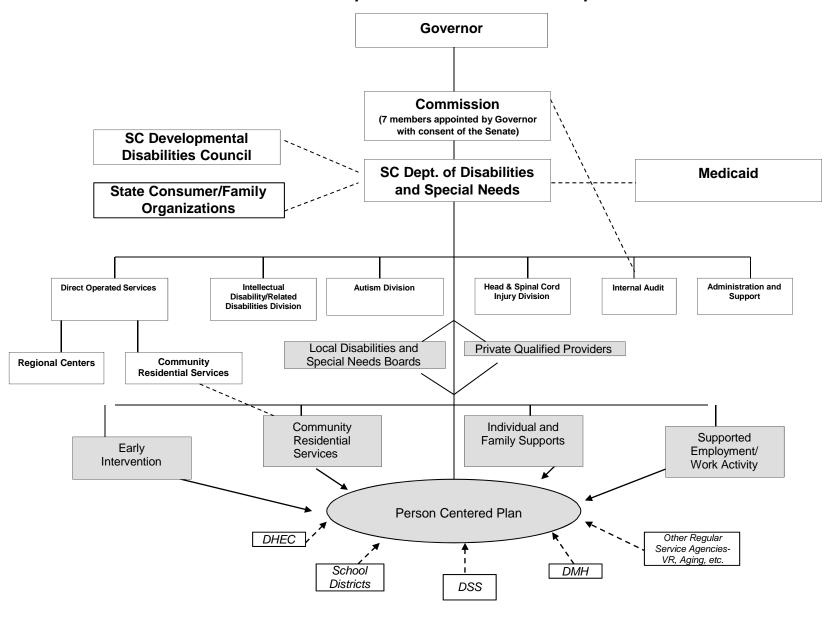


SCDDSN delivers over 98% of services in community settings through local DSN Board (public county based entities) or private service providers

> Services are available in every county in the state

SCDDSN also directly operates five regional centers providing residential services to approximately 670 individuals with the most extensive needs

SCDDSN directly operates several community residential homes



South Carolina Department of Disabilities and Special Needs

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Two Main Types of Providers:

 County-Based Local Disabilities and Special Needs Boards

Creation

County-Based Local Disabilities and Special Needs Boards

- Each is created by state statute and individual local county ordinance
- Most community DSN Boards have a Board of Directors (BOD) that is recommended by the local delegation and appointed by the Governor
- Some BOD are appointed by the County Council and one County Board is a part of the local county government
- Some County Boards serve the SCDDSN population in multiple counties

- Private Entity
- Contracted through State Procurement Request for Proposal process
- Provides additional choice of available providers to individuals and families

Public vs. Private

County-Based Local Disabilities and Special Needs Boards

- Public Entities
 - Combine the best aspects of public accountability with local control and pride of ownership
 - Must comply with FOIA and other aspect of local government

- Private Entities
 - o For Profit
 - o Not for Profit

Accountability

County-Based Local Disabilities and Special Needs Boards

- Accountable through public board appointments and through contracts, standards and state law with state level oversight provided by the Department of Disabilities and Special Needs
- Through contractual arrangements, quality assurance reviews, and licensing inspections to ensure quality and strict compliance with standards

- Accountable through contracts, standards, directives, and state law with state level oversight provided by the Department of Disabilities and Special Needs
- Through contractual arrangements, quality assurance reviews, and licensing inspections to ensure quality and strict compliance with standards

Employees

County-Based Local Disabilities and Special Needs Boards

- Employees are not considered state employees
- The State Director of DDSN does not have direct hiring authority over any of the local DSN Board employees or Board of Directors
- The County-Based DSN Boards are separate independent entities from the State Agency
- The County-Based Boards can participate in the State Retirement System and in State Insurance Plans

- Employees are not considered state employees
- The State Director of DDSN does not have direct hiring authority over any of the private provider employees
- The private providers are separate independent entities from the State Agency

Services

County-Based Local Disabilities and Special Needs Boards

 Provide case management, direct and indirect services and supports to individuals with disabilities

- Currently a private entity cannot provide both direct services and case management
- Entities must choose

State Service Area Coverage

County-Based Local Disabilities and Special Needs Boards

- Provide a fixed local point of initial and continuing contact that is well known to all people with disabilities and their families
- Ensure services are available to individuals and families across all 46 counties in South Carolina

- Determined by the individual provider
- Compliant with State Procurement policies and procedures

Funding and Payment from SCDDSN

County-Based Local Disabilities and Special Needs Boards

- Receive funds from the Disabilities and Special Needs agency in a prospective per person per month payment to provide or purchase services
- The per person per month payment is based on the services needed by the service recipient and is paid in a prospective band payment to the County Board

- Receive funds from the Disabilities and Special Needs agency in a retrospective payment after services are rendered
- The rate paid is equivalent to the payment rate for the DSN County Boards
- There is no cost settlement process for the retrospective payment
- Funds may be recouped if services are not provided in accordance with contractual requirements

Fiscal Agent

County-Based Local Disabilities and Special Needs Boards

- Serve as the fiscal agent for all service recipients that live in the family home in their county
 - Pays other providers for services rendered out of the per member, per month band payment
 - Funds up to a certain percentage not expended on services are returned to the Agency

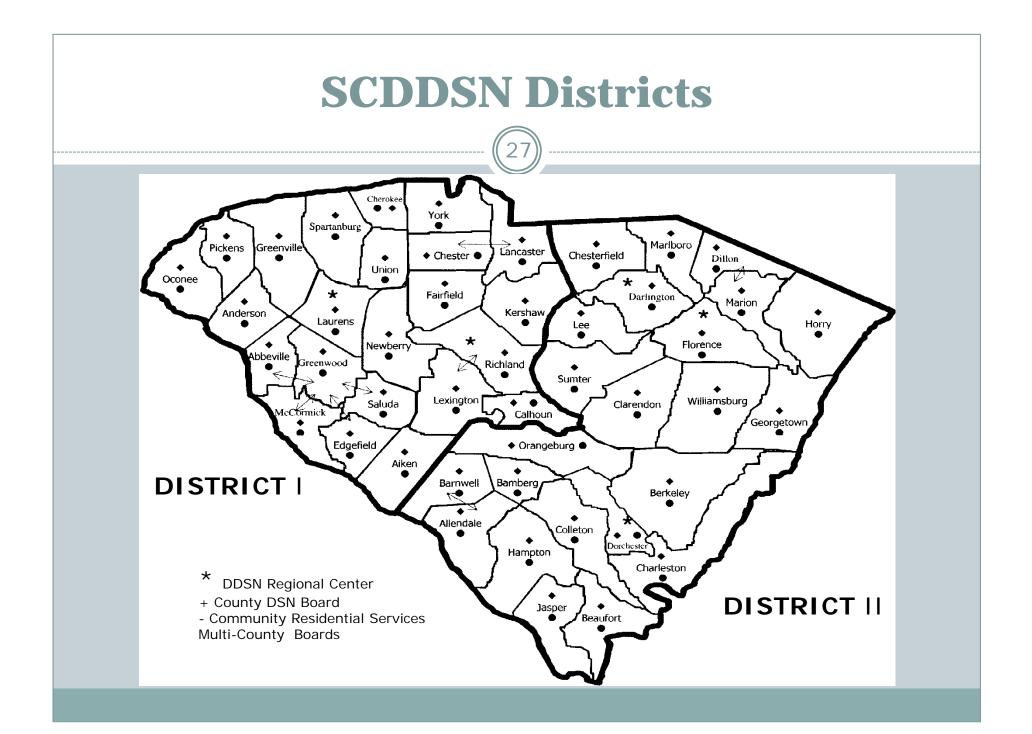
- Receive funds from Department of Disabilities and Special Needs in a retrospective payment after services are rendered
- The rate paid is equivalent to the payment rate for the DSN County Boards
- There is no cost settlement process for the retrospective payment
- Funds may be recouped if services are not provided in accordance with contractual requirements

All DDSN Service Providers

- Contract with existing public and private organizations to provide services for people with disabilities
- Develop and support affiliated consumer and family organizations who monitor service quality and ensure appropriateness of services

Case Managers (DSN Boards and Private Qualified Providers)

 Case Managers serve the role of coordinating services within the DDSN organized healthcare delivery system and those outside of this system such as "regular" services provided by other local health, education, medical, and social service agencies

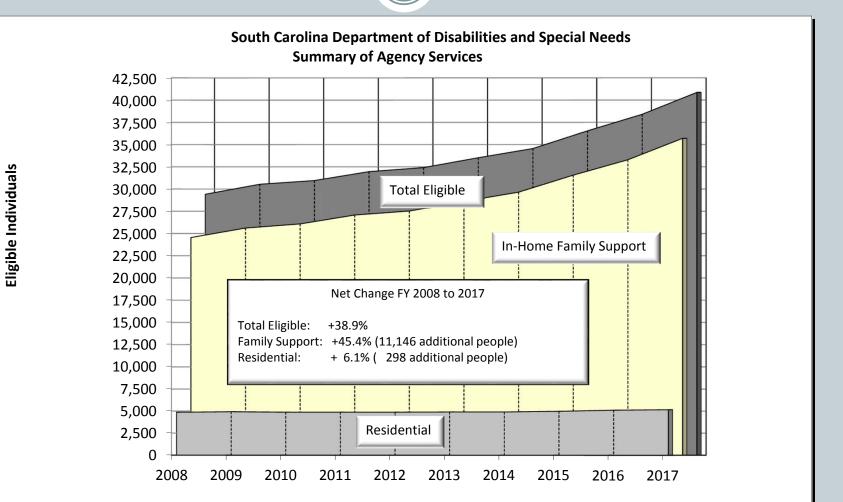


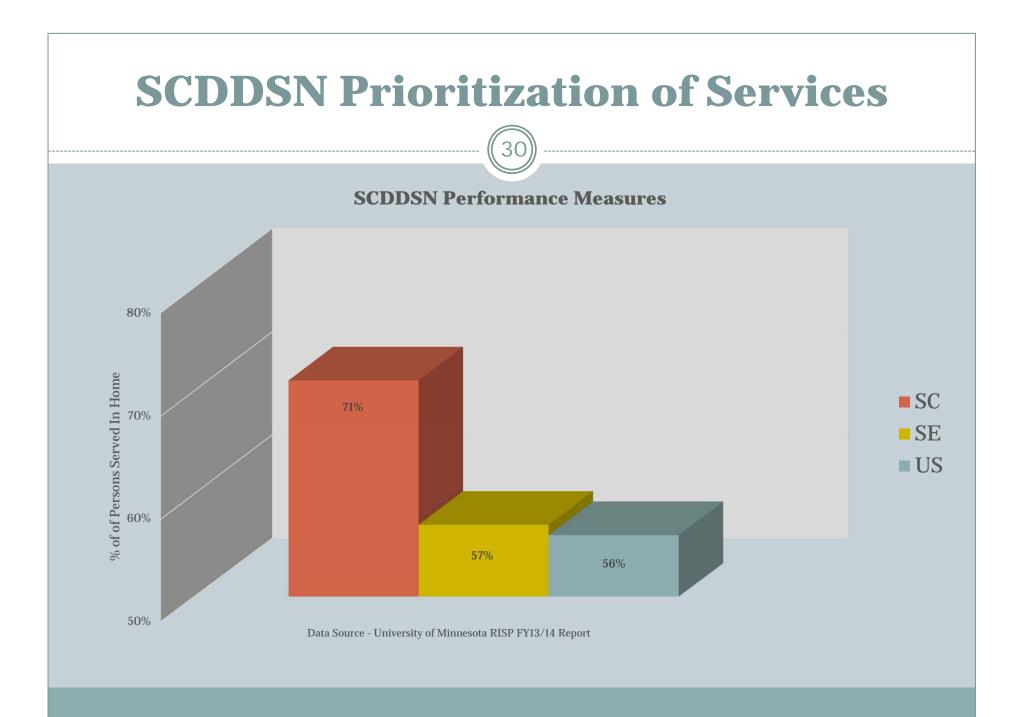
SCDDSN Prioritization of Services

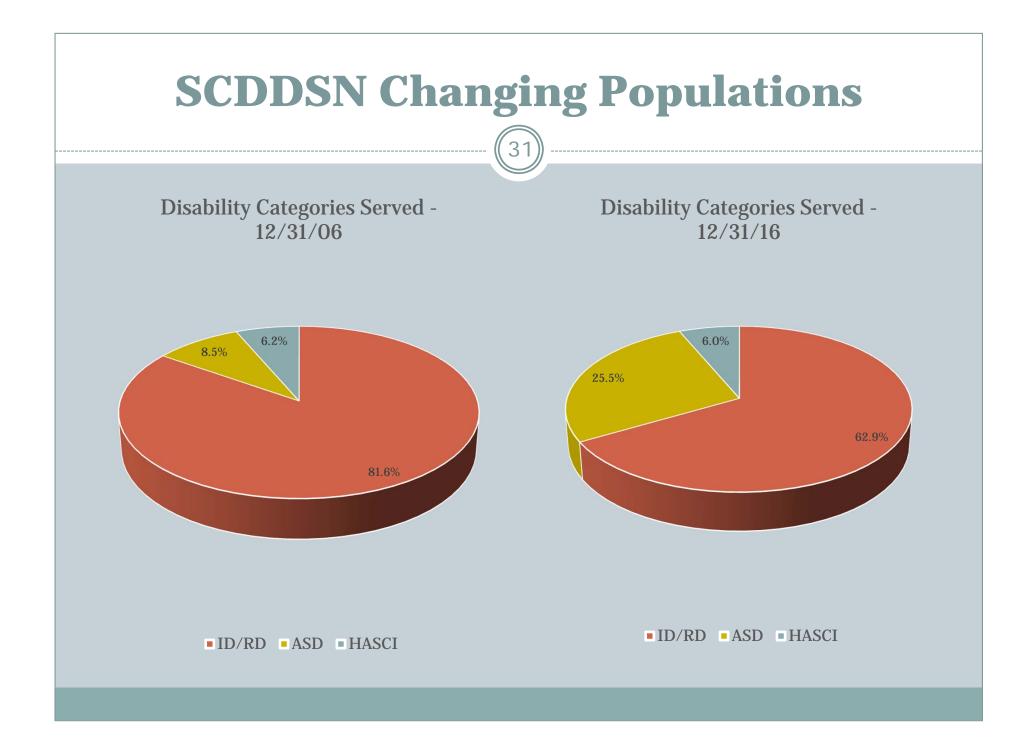
- Emphasis is placed on supporting individuals to live at home with family rather than in out of home settings
 - Primary in-home support service for adults is Day/Employment
 - Primary in-home support service for children is Early Intervention
- The agency strives to provide services in the "least restrictive" setting to promote maximum independence
- Services are intended to respond to documented needs with those in greatest need having first access to services
- Efforts are made to provide services as cost effectively as possible to increase the number of persons who can be served

SCDDSN Prioritization of Services

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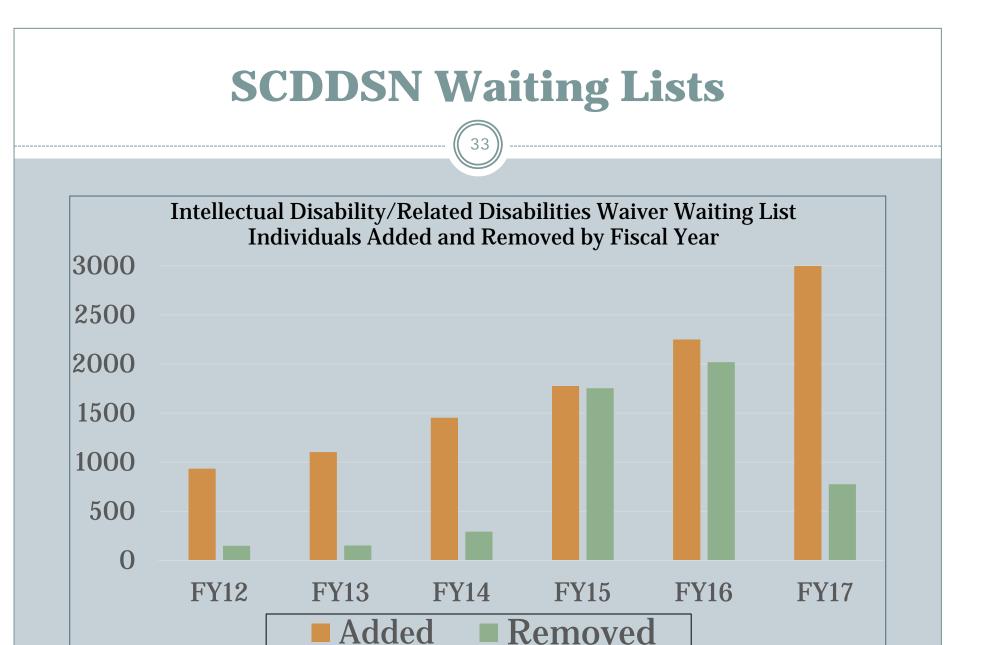
SCDDSN Service Expansion

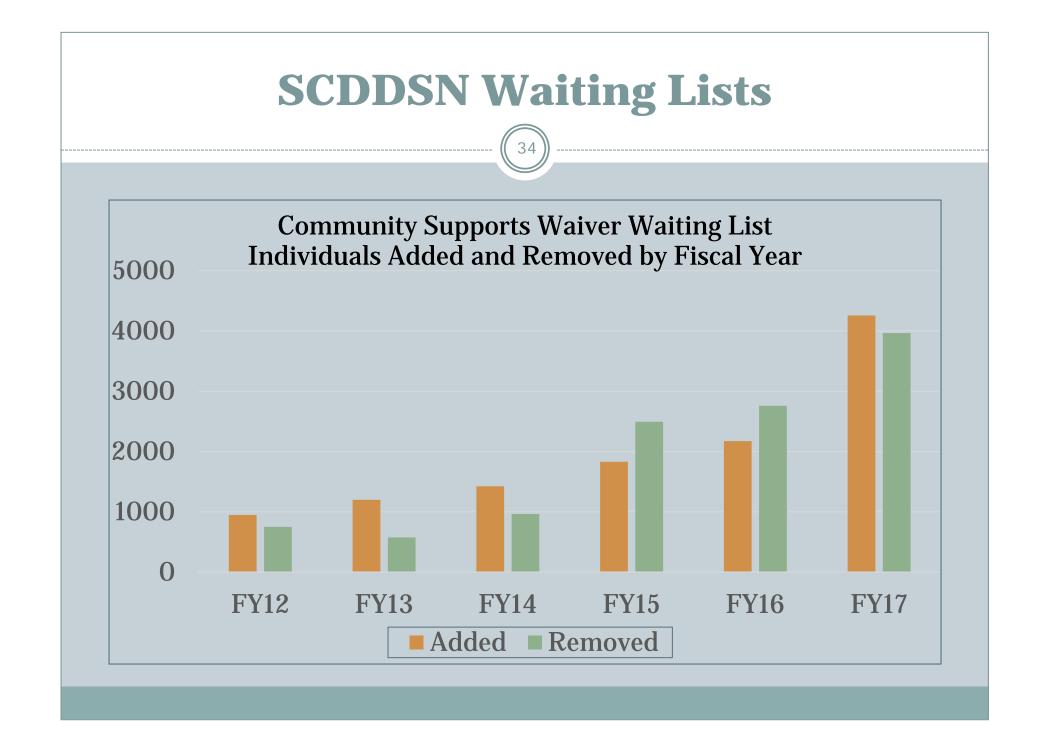
Over the past three years SCDDSN has received over \$26 million in new state funding which has allowed expansion of both in-home and residential services

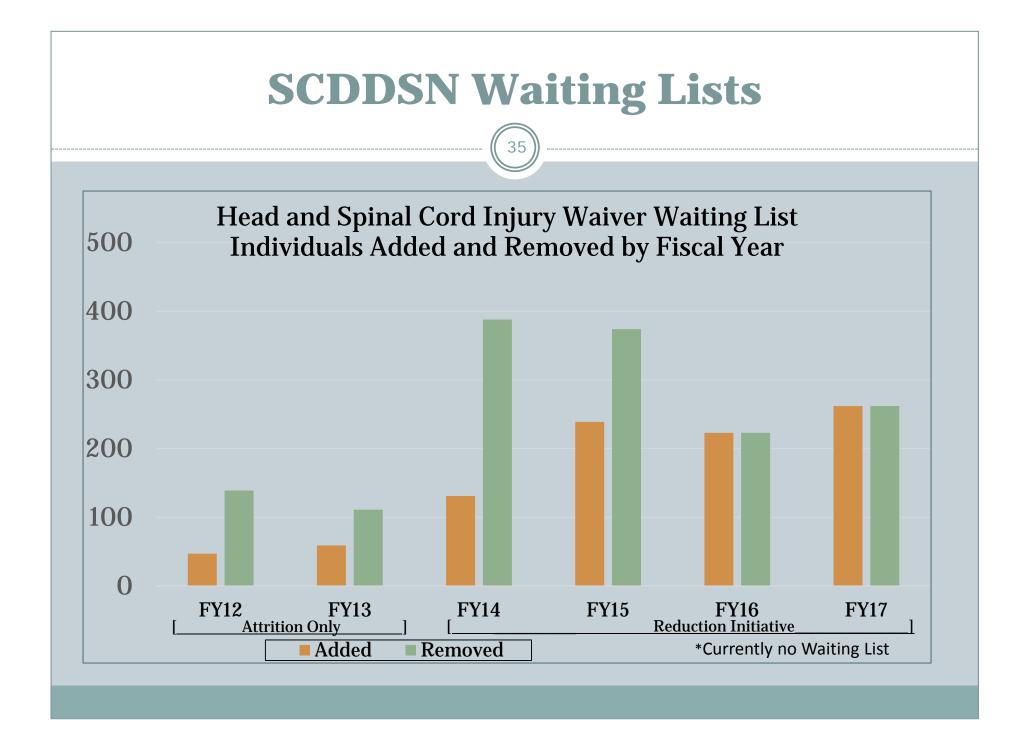
Results in an expansion of in home service capacity for almost 3,300 individuals

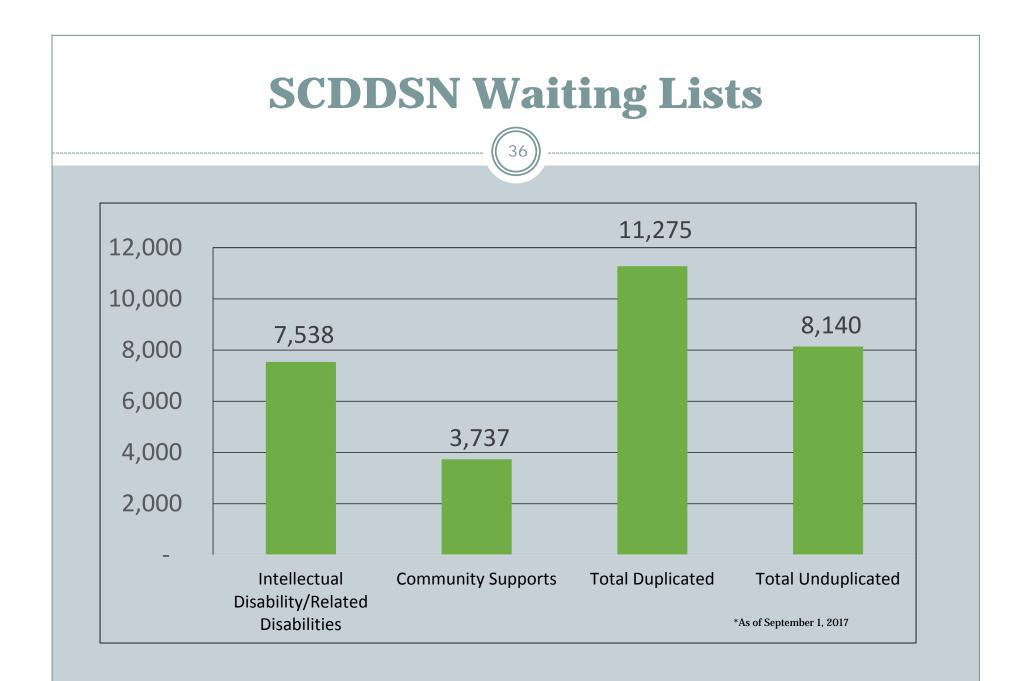
Outcome is an increase in capacity of approximately 400 for residential services

This expansion has resulted in almost 15,000 names removed from waiting lists



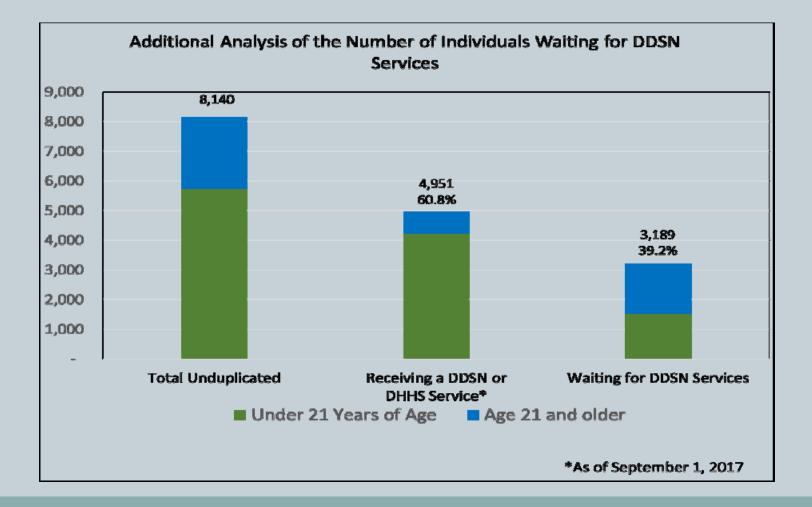


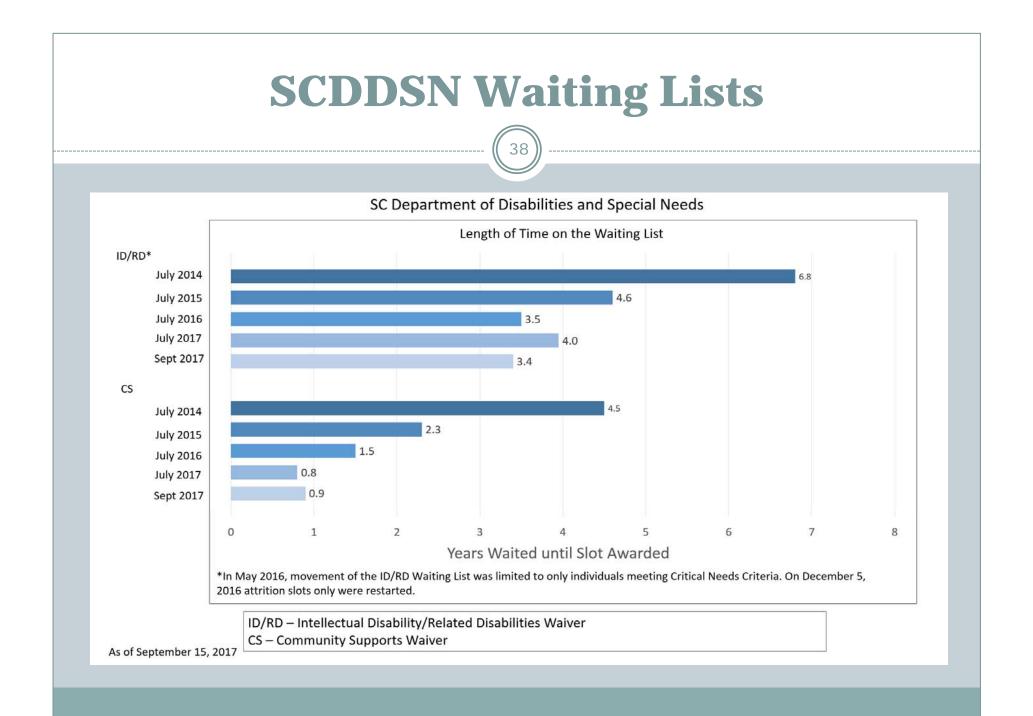




SCDDSN Waiting Lists

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Federal CMS requirements for Home and Community-Based Waiver services require quality assurance and risk management programs that include the following:

- A continuous quality improvement process that includes monitoring, remediation, and quality improvement
- Evidence based and includes outcome measures for program performance
- Evidence of the establishment of sufficient infrastructure for the program

The South Carolina Department of Disabilities and Special Needs recognizes that every organization, no matter how well run, inherently possesses exposure to risk. It also recognizes that management of risk factors requires a broad-based, coordinated managerial approach in order to mitigate any possible loss.

A broad-based agency Risk Management program should fulfill the following purposes:

- 1) Improve the safety and quality of life for consumers and employees
- 2) Conserve financial resources
- 3) Prevent litigation
- 4) Maintain relationships of trust among stakeholders

In order for an agency's Risk Management Program to be effective, the following "tools" need to be available:

- INFORMATION- knowledge, expertise, & commitment of employees; sound policies and procedures; risk incident reporting systems; computerized databases; correction and feedback loops
- ADMINISTRATIVE SUPPORTS- agency organization; well-developed infrastructure; committees of reference; systems of communication, decision making, & follow up; agency mission, vision, and values
- TRAINING PROGRAMS- pre-service training; in-service training; specialty training in consumer rights, behavioral support planning, critical incident reporting, medication administration, driver safety, etc
- QUALITY ASSURANCE/ IMPROVEMENT PROGRAMS- consumer satisfaction; personal outcomes; continuous quality improvement, quality enhancement programs; etc

- Each provider must have a Risk Management Committee which is intended to eliminate, reduce, and/or control exposure to risk, loss and injury
- Areas of focus will include: a) abuse, neglect and exploitation; b) critical incidents; c) medication errors and d) deaths
- Other areas of review may be added as identified by the agency's risk manager (e.g. use of physical restraints, accidents/ injuries, property damage that involves consumers, etc)

- SCDDSN employs a Quality Management system that includes the cycle of design, discovery, remediation and improvement
- SCDDSN contracts with a Quality Improvement Organization, Alliant ASO, to conduct assessments of Targeted Case Management and service providers by making on-site visits as a part of its quality assurance process

- During these visits, records are reviewed, consumers and staff are interviewed, and observations made to ensure that services are being implemented as planned and based on the consumer's need, that the consumer/family still wants and needs them, and that they comply with contract and/or funding requirements and best practices
- SCDDSN has made recent revisions to the Contract Compliance reviews to shift focus to be more outcome focused

* Additional information on the recent changes to the Contract Compliance Review process can be found in the notebooks

- All newly qualified providers are reviewed between three to six months of accepting their first consumer (i.e., during their 12 month probation period)
- Providers who are beyond their first year, will be reviewed at least annually to every 18 months, depending on prior compliance
- Follow-up reviews will be conducted approximately six months following annual – 18 month review

- The provider's administrative capabilities are reviewed to ensure compliance with SCDDSN standards, contracts, policies, and procedures
- Any deficiencies found with the provider's compliance will require a written Plan of Correction that addresses the deficiency both individually and systemically
- A follow-up review will be conducted approximately six months after the original review to ensure successful remediation and implementation of the plan of correction
- Failure to comply with certain performance requirements and failure to correct noted deficiencies may result in the imposition of sanctions by SCDDSN

SCDDSN Risk Management – Quality Assurance Process – Licensing

- SCDHEC licenses all Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
 SCDDSN operated Regional Centers
 - Provider operated Community ICF/IIDs
- SCDHEC licenses all provider operated Community Residential Care Facilities (CRCF)
- SCDDSN contracts with Alliant ASO to conduct licensing inspections of community residential settings of four beds or less

SCDDSN Risk Management – Quality Assurance Process – Licensing

SCDDSN Licensing Inspections

- The primary focus of the Licensing/ Certification review is to assure basic health, safety and welfare standards
- The facility review process must include an on-site review
- During the course of the on-site review if substandard or noncompliant performance is found, the provider will be expected to take immediate corrective action
- As part of SCDDSN's continuing efforts to improve the quality of services to people with lifelong disabilities, followup visits are completed with provider organizations

* Additional information on the DDSN Licensing procedure is located in your notebooks

SCDDSN Risk Management – Quality Assurance Process – Day and Residential Observation

- Approximately 25% of a Provider's Residential Locations and 100% of Day Service locations will have an Observation completed by the Alliant review team
- The Observation may take place at the same time of the Contract Compliance Review or a Licensing Review, or they may take place intermittently throughout the year
- Observation visits will occur without prior notice. If community activities are planned, the observation will not interrupt those plans

SCDDSN Risk Management – Quality Assurance Process

- SCDDSN staff conduct unannounced visits of providers when there is a performance concern
- SCDDSN makes all of its QA and Incident Management data available to SCDHHS in order to demonstrate compliance with CMS Assurances and Sub-Assurances for Health & Welfare, Qualified Providers, and Service Planning

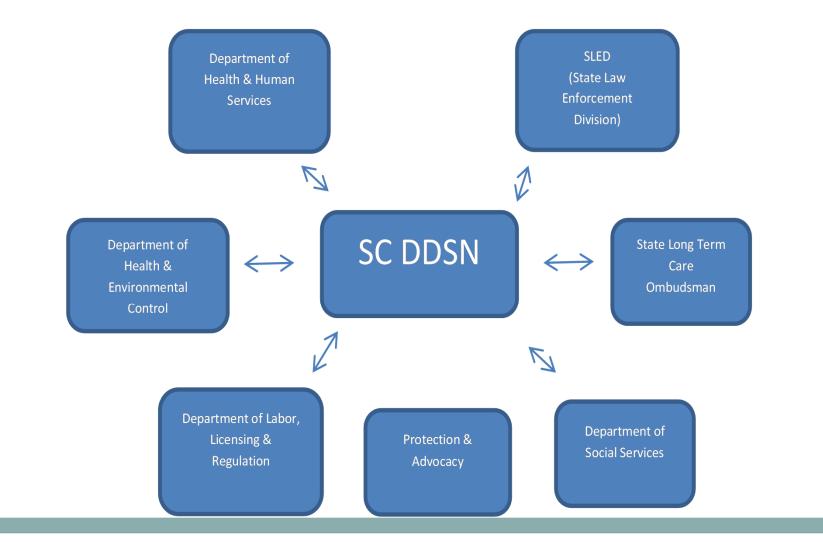
SCDDSN Incident Management Reporting

- SCDDSN follows the procedures for reporting allegations of Abuse, Neglect, and Exploitation according to the procedures outlined in the SC Code of Law for Adult/ Child Protective services and the Omnibus Adult Protection Act
- SCDDSN has a comprehensive system for collecting data related to abuse, neglect, exploitation or other critical incidents
- This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider's management action taken, staff training, risk management and quality assurance activities to provide safeguards for the consumers

SCDDSN Incident Management Reporting

- SCDDSN tracks, trends, and analyzes all Incident Management data through statewide and providerlevel profile reports
- These reports provide raw data with regard to the number of reports made and cases substantiated and also gives a rate per 100 ratio
- The rate per 100 information is especially useful in providing a comparative analysis among providers

SCDDSN Incident Management Reporting and Interaction with other State Agencies



<u>What to Report</u>: Any observed or suspected allegations of abuse, neglect or exploitation

- **Physical Abuse** includes hitting, slapping, burning, kicking, biting, pinching, actual or attempted sexual assault; use of meds outside the standards of reasonable medical practice; or use of a restrictive method or procedure to control behavior except those prescribed by a physician or part of a behavior support plan
- **Psychological Abuse** includes making threats of harm; intimidation causing embarrassment, fear, humiliation, agitation or other forms of emotional stress

• **Exploitation** includes causing or requiring participation in activity or labor that is improper or against the will/wishes of consumer; unlawful use of consumer funds, assets or property of the consumer; improper use of consumer Power of Attorney, guardianship for advantage or profit; causing consumer to make purchases for profit or advantage of the seller or another person through undue influence, coercion or swindling

Where Do You Report ANE Allegations?

General Rule:

Report to SLED's Vulnerable Adults Investigations Unit via the ANE "hotline" 1-866-200-6066, which operates 24 hours a day

Exceptions:

1) Alleged 17 & under victim consumers are reported to SCDSS (referred to the Home Abuse and Neglect Investigation Unit if ANE incident occurs in a residential service location; referred to the local Child Protective Service Office for all other ANE incident locations)

2) Alleged adult victim consumers at a Day Program or in the community not under direct supervision by SCDDSN provider staff are reported to SCDSS through its Adult Protective Services Unit

Promote an Environment to Report

- Mandatory Reporting: SCDDSN employees, volunteers, and providers are "mandatory reporters", which requires them to report ANE allegations within 24 hours, preferably immediately; <u>failure to report can</u> result in criminal charges
- Mandatory Training: SCDDSN employees, volunteers, and provider caregivers are required to be trained in their legal responsibilities to report ANE annually, to include passing a competency test. Consumers are trained annually on ANE reporting and how to report & recognize dangerous situations
- Anonymous Reporting: ANE "hotline" provides for anonymous reporting

How SLED Actions ANE Reports

- A key strength of the ANE reporting process is having an independent law enforcement agency, SLED, serve as the initial "gatekeeper" to assess allegations and fix responsibility for any required investigation by an independent investigative agency
- ANE allegations assessed by SLED as having a potential nexus to criminal conduct:
 - 1) SLED conducts investigation; likely when case is at a SCDDSN ICF Regional Center
 - 2) SLED assigns investigation to local law enforcement: likely when case is at a contract provider
- ANE allegations assessed by SLED as administrative in nature (non-criminal):
 - 1) Assigns case to the SC Office of the Ombudsman
 - 2) Assigns case to SCDSS when an ANE allegations pertains to consumers 17 & under or a consumer adults in a Day Program or in the community not under direct supervision by SCDDSN provider staff
 - 3) SLED creates an intake report "for information only"; the ANE allegation is not referred for independent administrative investigation but requires the SCDDSN service provider to conduct an administrative review and report results to SCDDSN

Immediate Steps to Mitigate Risk to Consumers

- ANE allegation intake reports by SLED are sent as notification to SCDDSN and the impacted SCDDSN service provider
- SCDDSN and provider employees, often direct caregivers, must notify their immediate supervisor or other management within one hour after their initial ANE report to the ANE hotline or appropriate investigative entity
- Upon notification from any source of an ANE allegation, the service provider immediately places the specific staff accused of ANE on leave without pay
- Provider must send an initial report of the ANE allegation to SCDDSN within 24 hours of discovery

Service Provider Conducts an Administrative Review

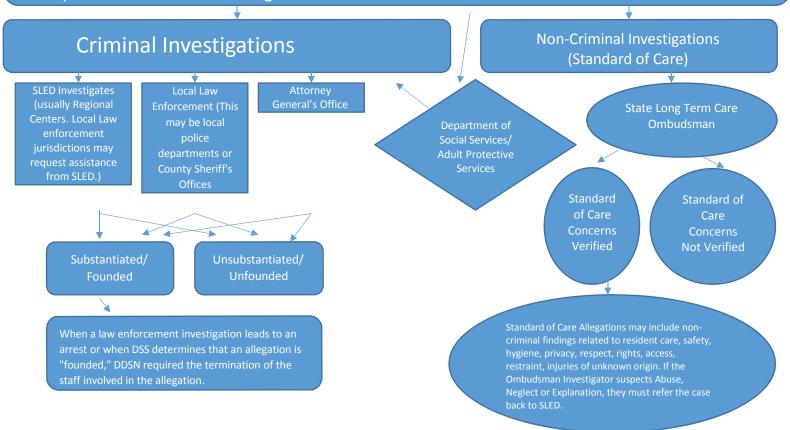
- **Purpose:** Identify issues in policy & procedures to reduce risk of future occurrences; fix administrative accountability; and, if warranted, establishes a basis to bring the employee back to work pending the result of the external independent investigation. Administrative reviews coordinate with external independent investigations. ANE determination rests with the independent investigator
- Cases investigated by law enforcement (potential crime): Provider conducts limited review of business records to assess administrative issues and violations of policy & procedures; no witness interviews
- Cases investigated by non-law enforcement (administrative): Provider conducts full investigation, to include witness interviews, to assess administrative issues and violations of policy & procedures
- Reporting Deadlines to SCDDSN: ICF reports are due in five days; provider reports are due in 10 days

ANE Determinations

- Law enforcement external investigations (criminal nexus): ANE is considered substantiated upon arrest. The alleged subject employee, who is currently on leave without pay, is terminated. For cases not resulting in an arrest, the provider still has the authority & responsibility to impose administrative discipline, if warranted
- Non-law enforcement external investigations (administrative): The investigation concludes with substantiating or not substantiating the ANE allegation. Substantiated ANE allegations generally pertain to employee job performance or personnel misconduct, both of which subject the employee to administrative discipline from the provider ranging from oral admonishment through termination

An Example of the Reporting Process for an Adult in DDSN Residential Services

Allegations of Abuse, Neglect and Exploitation for adults in residential services are called into SLED: Vulnerable Adult Investigations Unit. The SLED agent determines if the intake will be accepted and where the investigation will be vetted.



SCDDSN Provider Dashboard - Public Reporting of Provider Performance

- In February 2017 SCDDSN released a new tool to assist families in choosing a provider and knowing the performance of providers
- The Provider Dashboard includes current information about each of SCDDSN's contracted service provider's performance in a number of key areas
- The dashboard provides
 - Information about any special certification or accreditation
 - > Whether the provider is on a 12 or 18 month review cycle
 - Whether there are any current contract enforcement actions
 - The provider's compliance rates for timely reporting of allegations of abuse, neglect and exploitation or other critical incidents
 - The provider's compliance with submitting timely Plans of Correction for citations noted during the reviews

* Additional information on the Provider Dashboard is provided in the notebooks

SCDDSN Current Challenges

Increase in People Requesting Services

- The agency has made great strides in reducing the amount of time people remain on waiting list for services due to generous funding over the past three years
- The agency continues to maintain waiting lists
 - South Carolina's population continues to grow
 - People with disabilities live longer due to advances in medical treatment
 - SCDDSN serves people "cradle to the grave"
- Most services are not an entitlement and are dependent upon available funding

SCDDSN Current Challenges

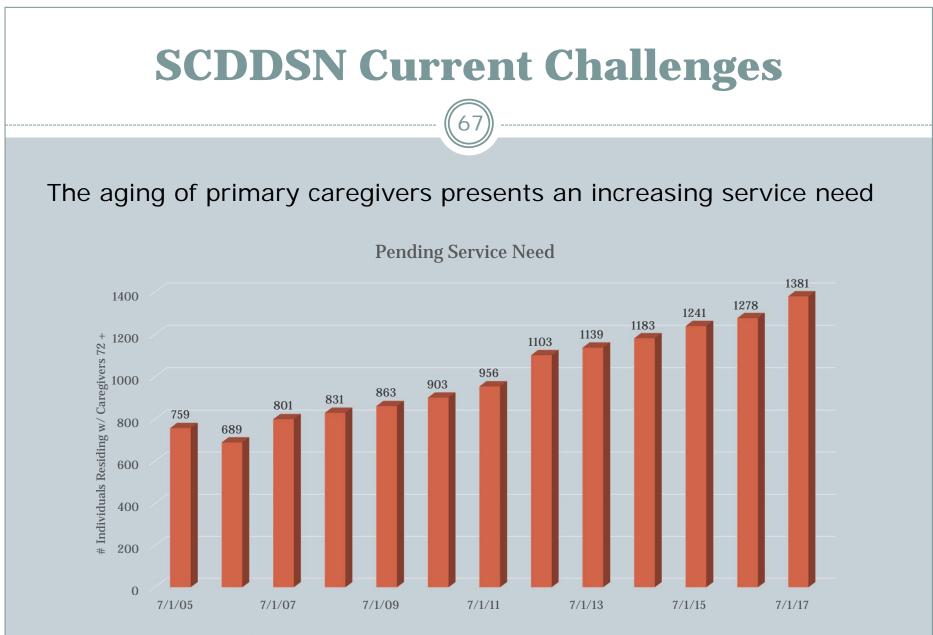
Serving People with Critical Needs

- The number of people identified with critical needs identified as needing residential services is increasing
- Critical need means an individual is in a situation that has potential to jeopardize their health safety or welfare
- Most of these individuals have significant behavior support needs and are considered a safety threat to themselves or others
- Very few existing community service providers will agree to develop new services to support these individual
- The Department continues to experience an increase in the need for high management/forensic residential beds

SCDDSN Current Challenges

Addressing Work Force Issues

- Shrinking work force to supply staff to serve consumers
- Population projections indicate a national work force shortage for personal care positions over the next decade
- Wage compression for existing work force
- Current wages are less competitive
 - Department received \$9M in new funding in FY 2018 to increase direct support professionals hiring wage to \$11.00 per hour
 - Significant step in addressing competitive wages
 - SCDDSN's FY 2019 budget request includes a request for funds to increase the hiring rate to \$12.00 per hour



* Additional information on aging caregivers is available in the notebooks

Final Rule

- Centers for Medicare/Medicaid Services (CMS) has issued new regulations, referred to as the New Final Rule, governing how and where Medicaid waiver services for persons with disabilities can be provided
 - Must be provided in small community integrated settings
 - Must allow opportunities to interact with persons without disabilities
 - Must maximize opportunities for paid employment
 - Must offer individual choice in settings, activities and service

*Summary Handouts on the CMS HCBS Final Rule are in the notebooks

Conflict Free Case Management

- CMS is requiring states to implement Conflict Free Case Management (CFCM)
 - Case management should be provided by separate agency from service providing agency
 - Service provider agency should not determine amount of service required
 - State should monitor recipient satisfaction with CFCM provider

*SCDHHS's "Individual Choice Model" for CFCM is provided in the notebooks

Conflict Free Case Management

- The conflict free case management CMS requirement has infused change into the case management system, as has SCDDSN's increase in funding for waiting list reduction efforts through service expansion
- This has created a short-term capacity issue which presents a current challenge
- The longer term implications are not certain given how SCDDSN relies heavily on case managers to execute a key component of its mission
- SCDDSN has taken preliminary steps towards addressing a conflict in the system by changing the service authorization process

THERAP

- SCDDSN is in the middle of a major, multi-year information technology implementation
- Creates a statewide electronic medical record

Changes to the Funding Mechanisms

- SCDDSN is currently examining its' provider payment system, particularly the band payments to county DSN Boards
- The current funding system uses stabilizing policies such as
 - prospective payments
 - one-time grants
 - residential capital funding
 - Medicaid billing
 - > assumption of financial risks for Medicaid ineligibles & audits
 - > 30 day residential vacancy funding
 - > 80% attendance allowance in adult day & residential
- The current per member per month system for Boards has provided sound financial outcomes with most Boards maintaining positive financial positions over the almost twenty years

SCDDSN Pending System Changes

Changes to the Funding Mechanisms

- As the system continues to evolve to be compliant with the CMS final rule and ensure conflict free service delivery, there is greater potential for individuals receiving services, families, advocates, and private service providers to perceive the role of the DSN Boards as fiscal agents to be conflictual
- The DSN Boards' current function as the fiscal agent is likely to become more demanding and burdensome for both Boards and private providers
- SCDDSN must ensure compliance with CMS and promote a high level of transparency

SCDDSN Pending System Changes

Changes to the Funding Mechanisms

- Over the years the agency has received recommendations from external entities related to revamping the current band system or moving to another payment structure
- While the current funding band system has been determined allowable, these entities suggest that a revised payment methodology could increase transparency and reduce complexity

SCDDSN Future Challenges

- There is much discussion at the national level about significant structural changes to Medicaid
- It is possible these changes will significantly affect South Carolina's service delivery system
- People with disabilities account for 15% of total national Medicaid enrollment but 42% of program spending due to their greater health care needs
- There is a strong likelihood changes to Medicaid will have significant negative impact on people with disabilities



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CHANGES TO THE QUALITY ASSURANCE REVIEW PROCESS FOR FY18

SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS

- Recent reviews of DDSN's Contract Compliance and Licensing Review Process have indicated a need to transition to a format that requires service providers to be "Review Ready at All Times." As a result, DDSN has directed its contracted Quality Improvement Organization (QIO) to make changes to the review process, beginning July 1, 2017.
- SC DDSN contracts with a Federally Recognized Quality Improvement Organization, Alliant ASO, to conduct assessments of service providers by making on-site visits as a part of its quality assurance process.

DDSN Quality Management

CMS Assurances Regulatory Health, Safety, Welfare Assurances

Contract Compliance

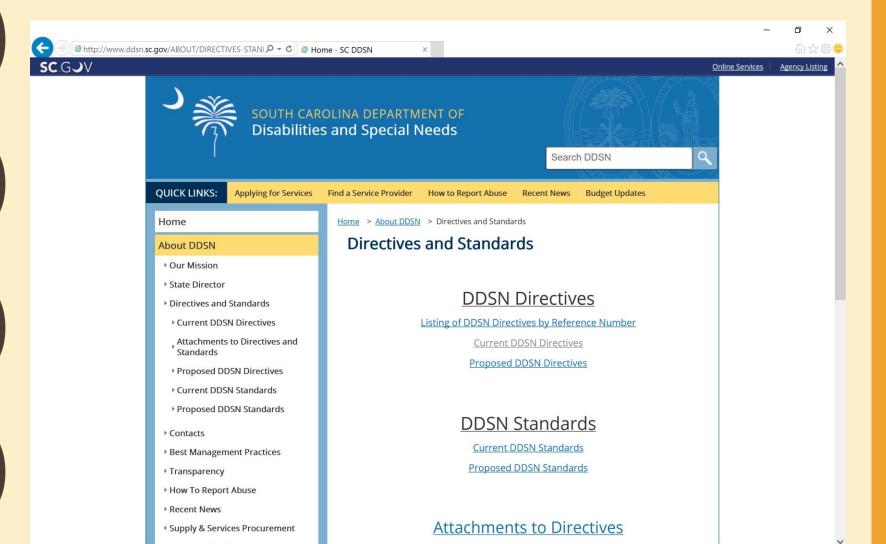
Licensing

Incident Management

Best Practice

Quality Enhancement

KEY INDICATORS ARE BASED ON STANDARDS AND DIRECTIVES



CMS HOME & COMMUNITY BASED WAIVER ASSURANCES

CMS Waiver Assurances

CMS Performance Measures Measurement from Reviews: Contract Compliance Licensing Incident Management

Remediation and Recoupment Dictated by CMS/SCDHHS

- The CCR process includes tasks that seek to ensure that
 - services are being implemented as planned and based on the consumer's need,
 - the consumer/family still wants and needs them, and
 - they comply with contract and/or funding requirements and best practices.
- In addition, the provider's administrative capabilities are reviewed to ensure compliance with DDSN standards, contracts, policies, and procedures.

 Key Indicators are established as the tool for measuring compliance with DDSN's Directives, Standards, and Medicaid rules. DDSN contracts with a federally recognized Quality Improvement Organization to conduct Contract Compliance Reviews of all provider agencies. The frequency of these reviews is typically based on the provider's past performance.

 Key Indicators do not include all of the requirements for providers, only those selected for measurement for that contract period. Providers are still responsible for other requirements even if they are not included in the key indicators.

- The FY18 indicators will include a re-format of all service areas. We are removing the "General Agency" section of the review as a combined score of all service areas. Going forward, each service area will be scored on its own and a part of the overall average.
 - G1 and G2 are now CM Indicators. There is also a section for Waiver Activities.
 - G3 and G4 are now DS1(Day Services) and DS2 (Employment)
 - G5 represents the HASCI Rehabilitation Supports Indicators
 - G6 and G7 are now RS1 and RS2 (Residential Habilitation and Residential Supports: Behavioral and medical)
 - PDD Case Management/ Waiver and EIBI Indicators have also been renamed.

- Individual Record Reviews will begin without prior notice to the Provider Agency for Case Management, Residential and Day Services. The QIO will begin the record review utilizing information available through the electronic record, including Therap and CDSS. Alliant will set up a time to go on-site to review any information that is not required in an electronic format, or the provider may choose to upload the documentation required for review. Intake, Case Management, and Early Intervention Services will be reviewed separately from direct services (Day, Residential, In-Home Supports and HASCI Rehabilitation supports). Administrative Indicators will be separated based on the type of review completed. *All Early Intervention providers and EIBI providers will receive a 7 day notice prior to the individual records review to avoid conflicts with previously scheduled family training or therapy.
- The Provider will receive a 48 hour notice for their Administrative Indicator review. This can be an on-site review or a desk review with the provider uploading required information (provider choice).

- To prepare for the Administrative Review, the Provider will assemble the following information prior to the entrance conference:
 - Human Rights Committee
 - Risk Management Committee Review Documentation
 - Outlier documentation to validate services
 - Verification of Analysis for Critical Incident, Abuse and Death Reporting
 - Quarterly Unannounced Management Reviews in all residential settings
 - HASCI Rehabilitation Supports (if applicable)
 - Residential Admissions, Transfers and Discharges
 - Swallowing Disorder Documentation

 Documentation for the Administrative Records Review (included on prior slide) MUST be available at the time of Alliant's arrival on-site or uploaded by the designated time. Additional time will be given for the personnel records at the time the sample is provided to the provider.

 Individual Record Review and Administrative Indicator Review may occur simultaneously, or they may take place on different dates. The QIO will coordinate the review process to ensure both reviews are completed within 7 business days.

 The provider will be required to submit a full listing of all employees to Alliant within 24 hours of the Administrative Review Notice. Alliant will select the personnel files to be reviewed for preemployment and training requirements and provide a sample prior to their arrival on-site. It is expected that most provider files will be available within 2 hours of the notice provided. If additional time is needed, providers will work directly with the Review Lead to determine additional time needed.

 Since providers have prior knowledge of the information to be reviewed (via Key Indicators), files should be ready when pulled for the review.

- Exit summary will be conducted at the end of the review.
- The Provider will receive a brief, written summary of findings provided by Noon of the next business day.
- The provider may upload additional information to be considered for the review within 48 hours of receipt of the review summary.
- If documentation is accepted for reconsideration, the citation will be removed
- The review is closed after documentation is received and processed

CMS HOME & COMMUNITY BASED WAIVER ASSURANCES

<u>Service Plan Assurance-</u> The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

- **Subassurance-** Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
- **Subassurance-** Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
- **Subassurance** Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.
- **Subassurance** Participants are afforded choice between/among waiver services and providers.

CMS HOME & COMMUNITY BASED WAIVER ASSURANCES

<u>Qualified Providers Assurance</u>- The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

- Subassurance The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- **Subassurance** The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- **Subassurance** The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

CMS HOME & COMMUNITY BASED WAIVER ASSURANCES

Health & Welfare Assurance - The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

- Subassurance -- The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
- **Subassurance** -- The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
- **Subassurance** -- The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
- Subassurance -- The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

- DDSN monitors the results of the QIO reports
 - to monitor overall compliance with quality assurance measures
 - -to ensure appropriate remediation
 - to identify larger system-wide issues that require training and/ or technical assistance
 - to analyze trends that require remediation in policy or standards

Recoupment of Funds Based on CCR

 CMS/SCDHHS Key Indicators marked as "Recoupable"

 CMS/SCDHHS mandates for funding to be recouped due to the provider failing to institute minimal compliance

- Performance Measures in the DDSN operated Home and Community Based Waivers require DDSN and DHHS to be accountable for any services that are not provided in accordance with the Waiver definitions and/or do not meet the minimum thresholds for compliance. DDSN and DHHS staff review any recoupable indicator citations to determine if billable services were, in fact, delivered on the dates determined out of compliance. From there, DDSN Finance staff will issue a reversal of the claim and upon recoupment of the funds from DDSN, DDSN will issue the recoupment to the provider.
- CMS and DHHS have clarified their expectations for recoupment of non-billable services and there has been an increased effort to resolve any outstanding issues.

- During a provider's Contract Compliance Review, all of the applicable Key Indicators are reviewed, including Administrative and Service-Specific indicators. Indicators that are marked with a bold "R" are "recoupable" indicators. When citations are identified for any indicator marked as recoupable indicator, there is a possibility that paid claims will be reversed for any services delivered during the time the indicator was out of compliance.
- The provider has the option to appeal any citation noted in the Report of Findings, including Recoupable Indicators. If a provider does not appeal the citation, or if the citation is upheld during the appeal determination, then services related to the indicator will be subject to the claims reversal process.

- Before the provider is charged back for any paid claims, DDSN Waiver Coordinators and Finance staff review the citation to ensure the claims reversal is warranted. There may be citations that do not result in recoupment.
- DDSN Finance staff also verify the services billed through Medicaid fall within the dates the noted indicator is cited for noncompliance.
- Upon completion of a secondary review, the provider is notified of any reversal of claims for delivered services. DHHS will recoup the amount of the services billed by DDSN. DDSN will then seek payment from the provider of services billed while the indicator was out of compliance.

LICENSING REVIEWS

Alliant ASO completes Annual Licensing Inspections for all Day Programs, Respite Locations, CTH Is, CTH IIs, and SLP IIs contracted for operation by the agency.

Alliant ASO reviews each location using the Residential Licensing Standards or Day Licensing Standards. The Licensing review follows an Inspection, Plan of Correction and Follow-up Review process, similar to the Contract Compliance Review process

LICENSING REVIEW CHANGES FOR FY18

- Reviews will be conducted annually for SLP II, CTH I, CTH II, CIRS, and Respite homes as well as Day Service programs
- Providers will receive same day notification via phone of their upcoming review. Providers are expected to have a staff available at the home on that day.
- Reviews will be based upon DDSN Residential, Day Service, and Respite Standards
- Some documentation may be uploaded for review

DAY & RESIDENTIAL OBSERVATION

- > Approximately 25% of a Provider's Residential Locations and 100% of Day Service locations will have an Observation completed by the Alliant review team.
- The Observation will be a separate review component for FY18. It is no longer a part of the Contract Compliance Review. The Observation may take place at the same time of the Contract Compliance Review or a Licensing Review, or they may take place intermittently throughout the year.

DAY & RESIDENTIAL OBSERVATION

Observation visits will occur without prior notice. If community activities are planned, the observation will not interrupt those plans.

The Tools to be used for the Observation are available on the DDSN Web-site and on the Alliant Portal.

HCBS ASSESSMENTS & THE "FINAL RULE"

Notification of Home and Community-Based Settings Final Rule Assessment

- On behalf of the South Carolina Department of Health and Human Services (SCDHHS) and the South Carolina Department of Disabilities and Special Needs (SCDDSN), the Public Consulting Group, Inc. (PCG), will conduct a review of home and community-based residential and non-residential settings in keeping with the Home and Community-Based Settings (HCBS) requirements outlined in 42 CFR 441.301(c)(5) (effective March 17, 2014).
- PCG will use an assessment tool to evaluate the provider facilities' level of compliance with the HCBS requirements. There is an assessment tool for residential settings and an assessment tool for non-residential settings. A copy of each assessment tool, and a listing of the required documentation may be found at https://msp.scdhhs.gov/hcbs/
- PCG will submit its findings to SCDHHS, which will determine whether your agency is compliant with the HCBS regulations. SCDHHS will notify you of its determination and whether a compliance plan is needed for a setting to meet the HCBS requirements to be able to continue to be utilized as a Healthy Connections home and communitybased setting.

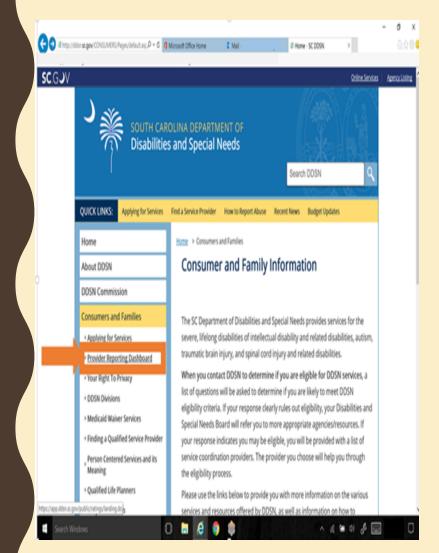
NATIONAL CORE INDICATORS

- National Core Indicators (NCI) is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The purpose of the program, which began in 1997, is to support NASDDDS member agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time, to compare results across states, and to establish national benchmarks.
- The Adult Consumer Survey (ACS) is a face to face conversation completed with a minimum of 400 individuals who are 18 years of age or older and receiving at least one paid service from the state (in addition to case management). Before the survey, Background Information is collected using administrative records, and often with additional information collected from service coordinators / case managers. Background Information includes data such as demographics, personal characteristics, health data and data on employment status and wages.

NATIONAL CORE INDICATORS

- The Adult Family Survey (AFS) is mailed to families who have an adult family member (age 18 and over) with I/DD living in their family's home. The family member with I/DD must be receiving at least one service from the state DD agency, in addition to case management.
- The Family/Guardian Survey (FGS) is mailed to family members or guardians of an adult (age 18 and over) with I/DD living outside of the family home. The family member with I/DD must be receiving at least one service from the state DD agency, in addition to case management.
- The Child Family Survey (CFS) is mailed to families who have a child (under age 18) with I/DD living in the family home. The family member with I/DD must be receiving at least one service from the state DD agency, in addition to case management.

PROVIDER DASHBOARD



- The Provider Dashboard includes current information about each contracted service provider's performance in a number of key areas. Each provider's Contract Compliance Review Scores are posted as an average for the past 3 review cycles since 2013. Individual review scores are also available. For providers operating day or residential services, licensing review scores are also available.
- In addition, the dashboard provides information about any special certification or accreditation, whether the provider is on a 12 or 18 month review cycle, and whether there are any current contract enforcement actions. The provider's compliance rates for timely reporting of allegations of abuse, neglect and exploitation or other critical incidents has also been included, along with the provider's compliance with submitting timely Plans of Correction for citations noted during the reviews.

PROVIDER DASHBOARD

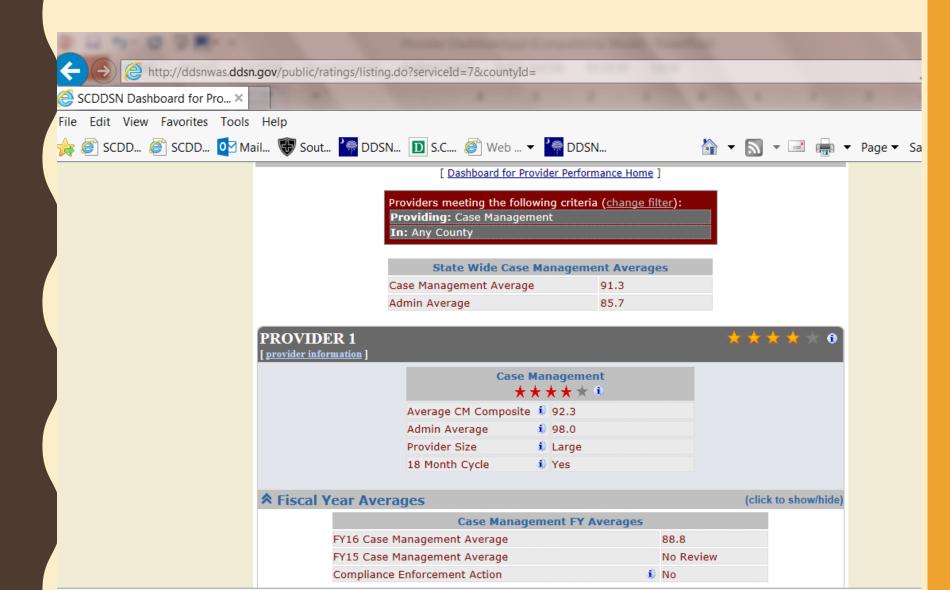
- Data included for each provider:
 - Provider Size
 - 18 Month or 12 Month Review Cycle
 - Special Certifications/ Accreditation
 - Compliance with timely submission of ANE Reports
 - Compliance with timely submission of Critical Incident Reports
 - Compliance with timely submission of Plans of Correction for Citations noted in Contract Compliance Reviews and Licensing Reviews
 - Current Compliance Enforcement Actions and 3 year history of such action
- Data will be updated quarterly.
- Additional data will be available as the reporting tool continues to develop.

PROVIDER DASHBOARD

Detailed information will be available to look at how a single provider performs across all service areas. Indicator compliance scores are listed for all services provided by the agency. Areas covered include:

- Administrative Indicators
- Case Management
- Early Intervention
- Residential
- Day Services
- Employment Services

PROVIDER DASHBOARD



LICENSING SCORES

- For Day Services Licensing, an average was calculated for the provider for each year (if more than one day program), then an average was calculated for the past three years.
- For Residential Licensing, the rates were calculated by taking the number of citations for a particular program type (SLP II, CTH I or CTH II) and dividing by the total number of applicable indicators. Then, based on the proportion of the types of residential locations, a weighted average was established for each year, then a three year average.

PROVIDER DASHBOARD

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	Day Licensing 3 Year Avg	1 97.2			
	Admin Average	1 98.0			
	Provider Size	🚺 Large			
	18 Month Cycle	i) Yes			
★ Fiscal Year Avera	ges		(clic	k to show/hide)	
	Day Services F	Y Averages			
FY16 Day Services Average			96.1		
FY15 Day Services Average			No Review		

SCDDSN - Licensing and Certification

State law requires licensing of certain programs and residential facilities. This licensing relates to the health and safety aspects of facilities and services. The law authorizes the establishment of standards for the qualifications of staff, staff ratios, fire safety, medication management, facility size and construction, storage of hazardous liquids and health maintenance. All Residential and Facility-Based Day programs must be licensed. Licensing activities occur on a regular basis and may involve staff from DDSN, DHEC, and/or the State Fire Marshall's Office. DDSN has contracted with Alliant ASO to conduct licensing inspections. The Application to Operate will continue to be submitted to DDSN, but Alliant ASO will complete the inspection. Upon approval, DDSN will issue the license to the provider to operate the facility.

The primary focus of the Licensing/ Certification review is to assure basic health, safety and welfare standards. Key indicators measure the following:

- The facility's environment promotes the consumers' health and safety.
- The physical plant of each facility, to include fire marshal inspections, HVAC, Water Quality, and Health and Sanitation.
- There must be evidence of Fire Safety training and evacuation, Disaster Preparedness, First Aid supplies and other emergency items.
- Facilities must provide documentation of continuous, coordinated health care, appropriate medical follow-up, and assistance with medications (as indicated in each consumers Plan).
- Facilities must demonstrate understanding and application of all DDSN policies regarding Abuse/ Neglect and Exploitation and Critical Incidents. Any instances of suspected abuse, neglect and/or exploitation as well as concerns relating to health and safety has resulted in appropriate action in accordance with Agency policy.

The facility review process must include an on-site review. During the course of the on-site review if substandard or noncompliant performance is found, the provider will be expected to take immediate corrective action.

Follow-up Visits

As part of SCDDSN's continuing efforts to improve the quality of services to people with lifelong disabilities, follow-up visits are completed with provider organizations. The purpose of the follow-up is to determine whether the plans of correction submitted to Alliant ASO have been implemented for all programs and locations. In order to utilize staff and resources more effectively during this economic time, part of the follow-up process will be an opportunity for providers to submit evidence that the citations have been corrected. Documentation that verifies corrections have been made can be submitted to Alliant ASO prior to an onsite visit. This information should not be a repeat submission of the plan of correction. If the submitted documentation verifies correction, then an onsite review of that standard would not be necessary. The submission of documentation to verify correction of citations is voluntary, but a lack of documentation may necessitate an on-site review.

A report identifying the status of all citations will be issued after the completion of the follow-up survey.

Welcome to the South Carolina Department of Disabilities & Special Needs Provider Dashboard

The Provider Dashboard includes current information about each contracted service provider's performance in a number of key areas. Each provider's Contract Compliance Review Scores are posted as an average for the past 3 review cycles since 2014. Individual review scores are also available. For providers operating day or residential services, licensing review scores are also available. This information was updated September 15, 2017.

In addition, the dashboard provides information about any special certification or accreditation, whether the provider is on a 12 or 18 month review cycle, and whether there are any current contract enforcement actions. The provider's compliance rates for timely reporting of allegations of abuse, neglect and exploitation or other critical incidents has also been included, along with the provider's compliance with submitting timely Plans of Correction for citations noted during the reviews.

In addition to information included in this dashboard, people with disabilities and their families are encouraged to make contact with potential service providers to determine if they are a good fit. Additional questions that may be considered may include the following:

- How can I arrange a visit?
- How would you describe the philosophy and values of your agency?
- May I talk to individuals and families who use your services?
- May I talk with some of your staff? What are the qualifications of the staff that would be supporting me/my relative?
- What is your agency's rate of substantiated allegations of Abuse, Neglect, and/or Exploitation?
- How does your agency coordinate Intensive Behavior Intervention?
- May I have a copy of your annual report?
- For how long have you provided services and supports in this county and in other counties?
- What training do you provide to staff who work directly with individuals? To supervisors?
- How long do staff remain with your agency (by position, by site)?

We hope you will find this provider dashboard useful. If you have any questions, please contact the DDSN Division of Quality Management at <u>gualitymanagment@ddsn.sc.gov</u>

The dashboard can be found at: <u>https://app.ddsn.sc.gov/public/ratings/landing.do</u>

Q & A for Quality Assurance:

Frequently Asked Questions about the South Carolina Department of Disabilities & Special Needs' Quality Assurance Process, including Contract Compliance Reviews, Licensing, and Day/ Residential Observation

DDSN's Contract Compliance Reviews (CCR), Licensing Reviews, and Day/ Residential Observation process are completed by a Federally Recognized Quality Improvement Organization (QIO). Alliant ASO is the current contracted QIO for DDSN.

Contract Compliance Reviews

Review Cycles

What is the criteria for a 12 month verses an 18-month Contract Compliance Review?

The FY18 Review Cycle will be determined by your FY17 (or FY16) Review Scores. If a provider scored at or above 75% Compliance on all areas (Administrative Indicators and Services Indicators), then they will be on an 18 month review cycle. Providers with one or more scores falling below 74.9% Compliance will be on a 12-month review cycle.

Beginning July 1, 2017, DDSN Providers will have a new threshold for qualifying for the 18-month review. For FY18, Providers must score at or above 85% Compliance in all service areas in order to qualify for an 18 month review. Providers scoring below 84.9% Compliance in one or more area will be on a 12-month review cycle.

How do I determine whether I am on a 12 month or 18 month CCR? A provider should review their last Contract Compliance Review Score to determine whether they are on a 12 or 18-month Review Cycle. Please note, the time frames are approximate.

When can I anticipate my report from the CCR review? The Report of Findings will be posted on the QIO Portal within 30 days of the completion of the Contract Compliance Review.

Key Indicators for Contract Compliance Reviews

<u>Are there new Key Indicators for FY18?</u> Providers should refer to the FY18 Key Indicators Crosswalk for new indicators and/or changes to prior indicators. The Key Indicators are based on DDSN Service Standards and Agency Directives or Medicaid Policies/ requirements and may changes from year to year.

Which Key Indicators are applicable to my agency? The Key Indicators are based on DDSN Service Standards, Agency Directives, and Medicaid Policy/Requirements. Each of these documents will state the applicability for different types of providers. In general, Administrative Indicators apply to all agencies, although there may be some indicators that only apply to particular service types.

For FY18, the Key Indicators have been separated for different provider types. On the DDSN Website, there is a set of Key Indicators for Direct Service Providers (Day, Residential, In-Home Support, and HASCI Rehabilitation Supports), a set of Key Indicators for Case Management, Intake, Waiver Administration, and Early Intervention, and a set for Early Intensive Behavior Intervention Providers. There is also a master set of Key Indicators that includes all Administrative and Service Specific Indicators.

What are the required training requirements that are measured in the CCR process? Providers

should ensure that all training requirements outlined in DDSN Directive 567-01-DD are met, in addition to other requirements listed in individual service standards.

What are the employee qualifications requirements that are measured in the CCR

process? Providers should ensure that all pre-employment background check and reference requirements outlined in DDSN Directive 406-04-DD are met, in addition to other requirements listed in individual service standards.

When is a SLED Background Check required versus a Federal Background Check? A direct care

applicant who is unable to verify South Carolina residency for the past 12 months or who will be expected to work directly with children, newborn to 18 years old, shall submit to a Federal Criminal Record Check conducted by the Federal Bureau of Investigation (FBI) prior to employment. The results will include any applicable state law enforcement agency results and the FBI database information. The Federal Criminal Record Check shall be conducted via an electronic fingerprint scan. No other type of criminal background check can be substituted for an FBI database check when a Federal background check is required. Federal Background Checks must be requested as outlined in DDSN Directive 406-04-DD.

What are the requirements for Human Rights Committees? The requirements for Human Rights Committees are outlined in DDSN Directive 535-02-DD: Human Rights Committees.

<u>Are small agencies required to have a Human Rights Committee</u>? Yes. All DDSN Contracted providers must have a Human Rights Committee, or they must have a contractual relationship with another provider to utilize their HRC.

Are small agencies required to have a Risk Management Committee? Yes. All agencies must have a system in place to track, trend and analyze their agency's data and compare it to statewide data.

Review Notification/ Samples for Contract Compliance Reviews

<u>Will I receive prior notification of my review?</u> The Provider will receive a 48-hour notice for their Administrative Indicator review. This can be an on-site review or a desk review with the provider uploading required information (provider choice). This process will apply to the 12/18 month reviews and the Follow-up Reviews.

Individual Record Reviews will begin without prior notice to the Provider Agency for Case Management, Residential and Day Services. The QIO will begin the record review utilizing information available through the electronic record, including Therap and CDSS. Alliant will set up a time to go on-site to review any information that is not required in an electronic format, or the provider may choose to upload the documentation required for review. Early Intervention will have a one week prior notice for review of individual records to avoid conflicts with family training. This process will be the same for 12/18 month reviews and Follow-up Reviews.

Do all my service records/files need to be available? Providers should be "Review Ready" at all times and the records should be accessible for a review. The QIO will review a sample of files from each service type offered by the provider.

What if there is a specific time period that I would like to avoid a review? On a case-by-case basis, the QIO may determine the need to exempt a provider from having a review during a specific time period. For example, a small provider may have a training retreat scheduled for 2 days and request (in advance) that their agency would be excluded from any review for that 2 day period. Generally speaking, if a provider is open for business, they may be subject to a review.

How is a sample determined for the Individual Record Review? DDSN will select a representative sample for each provider. The sample will be statistically significant and generally represent about 5% of the service population. Larger providers may have a smaller sample and smaller providers may have a larger sample and 5% in order to meet minimum review requirements.

When will the provider receive the sample? The provider will continue to receive the sample for staff files (Administrative Review) and individual files (Individual Record Reviews) on the morning of the scheduled review. If the Individual Record Review will take more than one day, the provider will receive the sample for each day on the morning of the review.

What information is needed to begin the Administrative Review? To prepare for the Administrative Review, the Provider will assemble documentation verifying compliance with standards, manuals and policies for each of the Administrative Review sections. This information should be available at the conclusion of the entrance conference and may include, but not be limited, to the following:

- Identification of Human Rights Committee members with their start dates, as well as identification of member composition
- Verification of HRC initial training (for new members during review period) and tabbed ongoing training for all corrective actions
- HRC Minutes
- Risk Management/Safety Committee Meeting Minutes
- Verification of analysis of ANE, CI, & Death/ impending death data and actions taken to prevent future ANE & CI and Death as applicable
- Database of recorded/tracked, analyzed, trended medication errors including corrective actions
- Database of recorded/tracked, analyzed, trended use of restraints
- Documentation of follow-up for consumers referred for GERD/ Dysphagia Consultation
- Verification of quarterly visits to all homes by upper-level management (tabbed by home)
- A list of homes with names of their designated coordinators (staff responsible for the development and monitoring of residential plans)
- Statements of Financial Rights for all residential admissions during the period in review
- Verification that employees are made aware of False Claims Recovery Act & Whistleblower laws annually (verification will be reviewed for the personnel files selected for review)
- Outlier Contracts including 1) Approved staffing grids, 2) Master schedule and corresponding verification/confirmation of staff coverage, and 3) Logs, etc.
- System for 24/7 access to assistance (Service Coordination providers only)
 *The Administrative Indicator Review may be subject to the request of additional information.

How is a sample determined for the Administrative Indicators/personnel files to be

reviewed? Upon notification of the Administrative Review, the Service Provider must submit a listing of all employees to the QIO within 24 hours. This list will include all staff employed during the review period, even staff that are no longer working for the agency. From this list, the QIO will determine the personnel files to be reviewed. The Provider will be notified of the names in the sample on the morning of the Administrative Review start date.

<u>What is the time frame that the files must be available during a CCR?</u> Most files should be available for the QIO to review within 2 hours of receiving the sample. Typically, providers will receive their sample information when the QIO Review Team is in transit and the files should be available upon the team's arrival.

Will DSN Boards have direct services (Day, Residential, In-Home Supports, and HASCI Rehabilitation Supports) reviewed at the same time as Case Management or Early

Intervention Services? No. Based on provider feedback, it was determined that most providers needed prior notification for Early Intervention services due to pre-arranged family training appointments with families. In response, DDSN has restructured the review process by separating Case Management, Intake, Waive Administration, and Early Intervention from other Direct Services. This model will also support the transition to Conflict-Free Case Management

and provide a balanced approach to reporting Administrative Indicator scores for DSN Boards and Qualified Providers that have a smaller number of indicators reviewed. Administrative Indicators will be reviewed and scored for the respective service types at the time of the designated review.

<u>Will Early Intervention Service Providers receive prior notice for reviews?</u> Yes. Early Intervention providers will receive a 48-hour notice for the Administrative Indicator section of their review and a 7-day notice for the Individual Record Review.

Will Early Intensive Behavior Intervention Service Providers receive prior notice for reviews?

Yes. EIBI Service Providers will receive a 48-hour notice for the Administrative Indicator section of their review and a 7day notice for the Individual Record Review.

Since the PDD Waiver is ending, will EIBI Providers continue to be reviewed by the QIO?

Yes. EIBI Service Providers will continue to be reviewed by the QIO through December 2017 or until all PDD Waiver children have been transitioned to the ASD State Plan Services.

Reconsideration/ Appeal- Contract Compliance Reviews

<u>Are DDSN staff available to assist with questions during a review?</u> DDSN staff will not intervene during a provider review. If the provider does not agree with a citation, they may have an opportunity to resolve it during the reconsideration period immediately following the review or by submitting an appeal after the report of findings has been posted to the portal. DDSN staff are not able to see the same documentation available to the review staff while they are completing a review and they cannot provide a response without consideration of all available information.

Will the agency have an opportunity to discuss potential citations and provide additional

documentation if needed? Yes. There is an opportunity for dialogue between the QIO and the Provider each day. In addition, the provider will receive a brief, written summary of findings immediately following their review. The provider will have an opportunity to provide additional documentation for consideration during a 48-hour window, following receipt of the summary.

What if I am not in agreement with the citation? If a provider is not in agreement with a citation noted in the Report of Findings they may choose to appeal the citation.

What is the appeal process and how do I appeal? From the POC template on the QIO Portal, the provider must indicate their intent to appeal the designated citation. There is a check box within the format for this purpose. In addition, the provider must complete the Appeal form (available on the QIO Portal) and upload this document along with any supporting documentation they would like to be considered. Once the Appeal documentation has been uploaded, the QIO will provide documentation of their findings and DDSN program staff for the specific service area will review all available documentation in order to make a determination. Providers will be notified of the Appeal decision within 30 days.

Once a determination has been made by DDSN regarding my appeal, is there another reconsideration process if I am not in agreement with DDSN's determination? The Appeal

decision is determined by DDSN Program Staff working in the specific service area. These staff are likely the same staff that are responsible for the development and monitoring of the service standards and/or the applicable directives and in the best position to determine if the requirements for the standard/directive was, in fact, met. The decision is final. The DDSN Appeal process does not provide any process for a secondary review after the appropriate program staff have made a determination on the citation.

Do I have to provide a Plan of Correction (POC) for each citation? Yes. A Plan of Correction will be required for each citation. The action plan should address both the individual citation and systemic corrections.

<u>What is the time frame to submit a POC?</u> A POC will be due within 30 days of the provider's receipt of the Report of Findings for Contract Compliance Reviews. The due date is noted on the Report of Findings and on the POC format on the QIO portal.

What if my POC is late? Will it affect the follow-up review? Providers will be notified if their POC is not submitted by the due date. Failure to submit a timely POC will not affect the follow-up review.

Follow-up Reviews

When can I anticipate a follow-up review? The purpose of the follow-up review is to ensure remediation of the citation. Typically, this is after the Plan of Correction has been submitted and the targeted action plans have been implemented. Most Follow-up Reviews occur 4 to 6 months after the prior review date.

Will I receive notification of my follow-up review? Providers will receive notice on the date their follow-up review begins. Since the follow-up is specifically targeted towards the prior citations, the follow-up review is limited in scope and size. Most follow-up reviews are desk reviews and the providers may upload documentation of their remediation as it happens. For additional samples or other information needed, the QIO will give the provider 24 hours' notice to upload the documentation.

<u>What will the QIO review during my follow-up review?</u> The QIO will look for documentation that verifies any citations from the prior review were corrected and that the agency took steps to prevent similar citations in the future.

A follow-up review is limited in size and scope. The only indicators reviewed are those with prior citations. An equal number of new records will also be reviewed to ensure systemic remediation.

Will the QIO come on-site for a follow-up review or will they be limited to desk reviews?

Most follow-up reviews will be completed as desk reviews. On-site follow-up reviews may be coordinated with the QIO on a case-by-case basis.

What happens if I continue to have the same citations after my follow-up review? If the

citations are not resolved during the follow-up visit, the provider will complete another Plan of Correction and then be scheduled for a second follow-up visit. In addition, the provider may receive technical assistance from the District Office to assist with the remediation.

Recoupment- Contract Compliance Reviews

Will my agency automatically be charged for any recoupable indicators found out of

compliance? Before the provider is charged back for any paid claims, DDSN Waiver Coordinators and Finance staff review the citation to ensure the claims reversal is warranted. There may be citations that do not result in recoupment.

DDSN Finance staff also verify the services billed through Medicaid fall within the dates the noted indicator is cited for non-compliance. Upon completion of a secondary review, the provider is notified of any reversal of claims for delivered services. DHHS will recoup the amount of the services billed by DDSN. DDSN will then seek payment from the provider of services billed while the indicator was out of compliance.

Licensing Reviews

<u>Will I be notified prior to a Licensing Review?</u> Residential and Day Service Providers will receive same-day notification of all licensing reviews. The QIO will contact the provider in the early morning to let them know that a licensing review will be scheduled for later that same day at the designated locations. The provider can then indicate which location will be the starting point where an agency staff will meet the licensing review staff.

What kind of Residential Settings will be inspected by the QIO? The QIO will conduct licensing inspections for all SLP II, CTH II, CTH I and CIRS locations using the DDSN Residential Licensing Standards.

How frequently will my locations be inspected for Licensing? All DDSN Day and Respite Settings will be licensed annually. SLP II, CTH II, CTH I and CIRS settings will also be licensed annually. DHEC will determine the schedule for licensing inspections for ICFs/IID and CRCFs.

Can my agency arrange to have the licensing review for all residential settings completed at

<u>one time?</u> No. The QIO will complete Licensing Reviews for approximately 30% of a provider's residential service locations at one time.

Will DHEC still inspect ICFs/IID and CRCFs? Yes. DHEC will continue to inspect all ICFs/IID and CRCFs.

Will I need documentation on-site at each residential location? Yes. Providers will need to maintain documentation on-site at each residential service location. Copies are acceptable in lieu of the original documents. Required documentation will include the following:

- Most recent State Fire Marshal Inspection
- Water Analysis If home is on well water
- Health and Sanitation Inspection If licensing for Children
- Policy for disposition of medication
- Key assessments if any form of lockable storage is not available.
- Current MARs and past MARs (90 days)
- Medication Error Reports (current and past 90 days)
- Medication Error Rate (current and past 90 days)
- Self-Administration Assessments (if any individual's Self Administer their own medications)
- SLP Medication storage assessments if medications are not in the apartments.
- Pet Vaccinations If pets are in the home
- Approved Exceptions, if any, as granted by DDSN

Will I need documentation on-site at each Day Service Location? Yes. Providers will need to maintain

documentation on-site at each day service location, to include the following:

- Fire and disaster drills for the last year
- Policy addressing alternate coverage for staff members who are ill
- Most recent fire marshal, electrical systems, HVAC, and sprinkler system inspections
- Monthly vehicle maintenance records (past year)
- Daily vehicle checklists (past 90 days)
- Medication Error Reports (current and past 90 days)
- Medication Error Rate (current and past 90 days)
- Current and past MAR's (past 90 days)
- Policy for disposition of medication
- Written authorization for consumers to be administered medication (all individuals who receive medications)
- Complete Staff list of staff that work in the Day Program
- Staff defensive driver training and fire safety training
- Any approved Exceptions granted by DDSN

Does the Residential Director or a supervisor have to be present? No. Any designated agency staff person may be present at the residential location during a licensing inspection. The Residential Director or House Manager does not have to be present. The provider just needs to have someone available to open the home and remain present during the inspection and to locate the documentation needed for review.

How is the Medication Error Rate calculated? For each service location where medications are given, providers are required to record the monthly error rate expressed as a whole number with three decimal points (number of errors divided by the total number of medications passed for each calendar month) along with the number of errors/events. Error rates are not to be used as a substitute for the actual number of errors/events. For clarification, medications passed will include ALL medications: oral, injections, topical, drops, and breathing treatments. The Consulting Pharmacy can usually provide this information for providers.

What kind of documentation is acceptable to demonstrate remediation? Examples of

documentation that may be submitted for Follow-up Reviews include: 1. Invoice for work performed by a contractor (including the address and/or other identifying information); 2. Receipt for items that needed replacement (with information that would verify placement at the location cited); 3. Photograph of repair/ corrected issue; 4. Training summary and signature sheet; 5. Report from HVAC, Electrical, State Fire Marshal, or Water Quality Inspections and/or 6. Other documentation that would verify corrective action related to the indicator cited. Providers should ensure that any documentation provided clearly demonstrated the action taken was specifically for the location cited.

The Follow-up Review will verify that the provider implemented their POC by targeted completion date. Receipts, work orders, invoices, etc.... must provide enough detail to show that the correction was for the actual citation at the location referenced. The QIO often receives invoices for work that includes the provider administration office for work that could have happened at any location (i.e. pest control, carpet cleaning). Again, providers should ensure that any documentation provided clearly demonstrated the action taken was specifically for the location cited.

Can I use documentation from my agency's quarterly unannounced visits to help

demonstrate remediation? Yes. Providers should keep in mind that many of the items frequently cited during licensing inspections are items that could be acknowledged and corrected during the provider's own quarterly unannounced visits which are required for all residential settings, as required in the DDSN Administrative Standards.

How will my agency know if there were citations during the licensing review? The QIO may

verbally state any finding noted with the provider representative on-site. This dialogue may help with the location of documentation that may have been previously missed, or help explain other circumstances. In addition, the Provider will receive a brief, written summary of findings for each location reviewed no later than noon of the next business day. The Provider may upload additional information for consideration within 24 hours.

The Report of Findings will be posted to the Alliant portal within 30 days from the exit summary. The report will be made available on the Alliant portal to designated provider staff.

Plans of Correction- Licensing Reviews

Do I have to provide a Plan of Correction (POC) for each citation? Yes. A Plan of Correction will be required for each citation. The action plan should address both the individual citation and systemic corrections.

What is the time frame to submit a POC? A POC will be due within 15 days of the provider's receipt of the Report of Findings for Licensing Reviews, unless individual findings are appealed. The due date is noted on the Report of Findings and on the POC format on the QIO portal. If appealing a citation, the Provider must check the appeal box within the Plan of Correction electronic format to initiate further review.

If specific lines on the Plan of Correction are not approved, provider must resubmit the line within 5 days of notification.

What if my POC is late? Will it affect the follow-up review? Providers will be notified if their POC is not submitted by the due date. Failure to submit a timely POC will not affect the follow-up review.

Reconsideration/ Appeal- Licensing Reviews

<u>Are DDSN staff available to assist with questions during a review?</u> DDSN staff will not intervene during a provider review. If the provider does not agree with a citation, they may have an opportunity to resolve it during the reconsideration period immediately following the review or by submitting an appeal after the report of findings has been posted to the portal. DDSN staff are not able to see the same documentation available to the review staff while they are completing a review and they cannot provide a response without consideration of all available information.

Will the agency have an opportunity to discuss potential citations and provide additional documentation if needed? Yes. The provider will receive a brief, written summary of findings on the next business day following their review. The provider will have an opportunity to provide additional documentation for consideration during a 24-hour window, following receipt of the summary.

What if I am not in agreement with the citation? If a provider is not in agreement with a citation noted in the Report of Findings they may choose to appeal the citation.

What is the appeal process and how do I appeal? From the POC template on the QIO Portal, the provider must indicate their intent to appeal the designated citation. There is a check box within the format for this purpose. In addition, the provider must complete the Appeal form (available on the QIO Portal) and upload this document along with any supporting documentation they would like to be considered. Once the Appeal documentation has been uploaded, the QIO will provide documentation of their findings and DDSN program staff for the specific service area will review all available documentation in order to make a determination.

Once a determination has been made by DDSN regarding my appeal, is there another reconsideration process if I am not in agreement with DDSN's determination? The Appeal decision is determined by DDSN Program Staff working in the specific service area. These staff are likely the same staff that are responsible for the development and monitoring of the service standards and/or the applicable directives and in the best position to determine if the requirements for the standard/directive was, in fact, met. The decision is final. The DDSN Appeal process does not provide any process for a secondary review after the appropriate program staff have made a determination on the citation.

Follow-up Licensing Reviews

When can I anticipate a follow-up review? The purpose of the follow-up review is to ensure remediation of the citation. Typically, this is after the Plan of Correction has been submitted and the targeted action plans have been implemented. Most Follow-up Reviews occur 4 to 6 months after the prior review date. The follow-up review will consist of citations noted during the Licensing Review to ensure the successful implementation of the Plan of Correction. Most follow-up reviews are completed via desk review. For desk reviews, providers will be requested to submit supporting documentation within 24 hours.

For multiple citations for the same indicator, there may be a combination of a desk and onsite review. In the event the indicators reviewed remain non-compliant, an additional Plan of Correction will be required and subsequent follow-up reviews will be scheduled.

Will I receive notification of my follow-up review? Providers will receive notice on the date their followup review begins. Since the follow-up is specifically targeted towards the prior citations, the follow-up review is limited in scope and size. Most follow-up reviews are desk reviews and the providers may upload documentation of their remediation as it happens. For additional samples or other information needed, the QIO will give the provider 24 hours' notice to upload the documentation. <u>What will the QIO review during my follow-up review?</u> The QIO will look for documentation that verifies any citations from the prior review were corrected and that the agency took steps to prevent similar citations in the future.

A follow-up review is limited in size and scope. The only indicators reviewed are those with prior citations.

If I have corrected the citation, do I have to wait for the follow-up to upload my

documentation? No. Providers are encouraged to upload verification of the correction as soon as it is complete. This will help avoid last-minute uploads and possible omissions at the time of the follow-up review.

Will the QIO come on-site for a follow-up review or will they be limited to desk reviews?

Most follow-up reviews will be completed as desk reviews. On-site follow-up reviews may be coordinated with the QIO on a case-by-case basis.

What happens if I continue to have the same citations after my follow-up review? If the

citations are not resolved during the follow-up visit, the provider will complete another Plan of Correction and then be scheduled for a second follow-up visit. In addition, the provider may receive technical assistance from the District Office to assist with the remediation.

Day/ Residential Observation

Will the agency receive prior notice for Residential and Day Observation visits? No. The

Observation visits are designed to capture services on a regular day, without preparation. The QIO will arrange for the Observation to take place during regular hours when services are in place. The only exceptions are CTH I locations, which may be pre-arranged.

What happens if the residential setting has plans that interfere with the Residential

Observation? The Residential Observation should not interfere with any scheduled activities. The QIO staff may ask the participants if they would mind having the QIO staff join them on the activity, or they may postpone the observation.

<u>Can the Day Observation take place at the same time as the Day Licensing Review?</u> Yes. The Day Observation may take place at the same time as the Day Licensing Review, but it does not have to be at the same time. The Day Observation does not have to take place at the same time as any other review process.

How will the new Residential Observation differ from the prior Residential Observation that was part of the Contract Compliance Review process? The new Residential Observation process is a completely separate review. It is not connected with the Contract Compliance Review Process and it will not be factored into the scoring for CCR. The tool is the same, but the process is different.

<u>Can the Residential Observation take place at the same time as the Licensing Review or</u> <u>Contract Compliance Review?</u> The Residential Observation may take place at the same time as other reviews, or it can be completely separate. The scheduling will likely vary among various locations.

How many Residential Observations will be completed for my agency? Approximately 25% of a provider's Residential Habilitation Settings will have a Residential Observation. This includes all non-ICF/IID settings.

Provider Dashboard

Where do I find the Provider Dashboard? The Provider Dashboard is located through a link on the DDSN Website. It may be found under the Consumers and Families link and Service Provider link.

Will all the results of my agency's reviews be posted on the provider reporting dashboard?

Yes. Provider Review information will be posted in the quarter after all appeals have been settled. This is usually about six months after the providers review took place.

How often will the Provider Dashboard be updated? The Provider Dashboard will be updated on a quarterly basis. A provider's scores will typically post within 4 to 6 months after the review is completed. This allows for the time for the provider to receive their report, file an appeal, if applicable, and receive results of the appeal.

Does the Provider Dashboard include Follow-up Reviews? Not at this time. Scores included are based on 12 or 18-month Contract Compliance Reviews, annual Licensing Reviews, and Residential and Day Service Observation.

How are the Licensing Review Scores calculated? Day Licensing scores are simple averages, based on the scores for the number of day services locations operated. For Residential Licensing, the rates have been calculated by taking the number of citations for a particular program type (SLP II, CTH I or CTH II) and dividing by the total number of applicable indicators. Then, based on the proportion of the types of residential locations, a weighted average has been established for each year, then a three-year average.

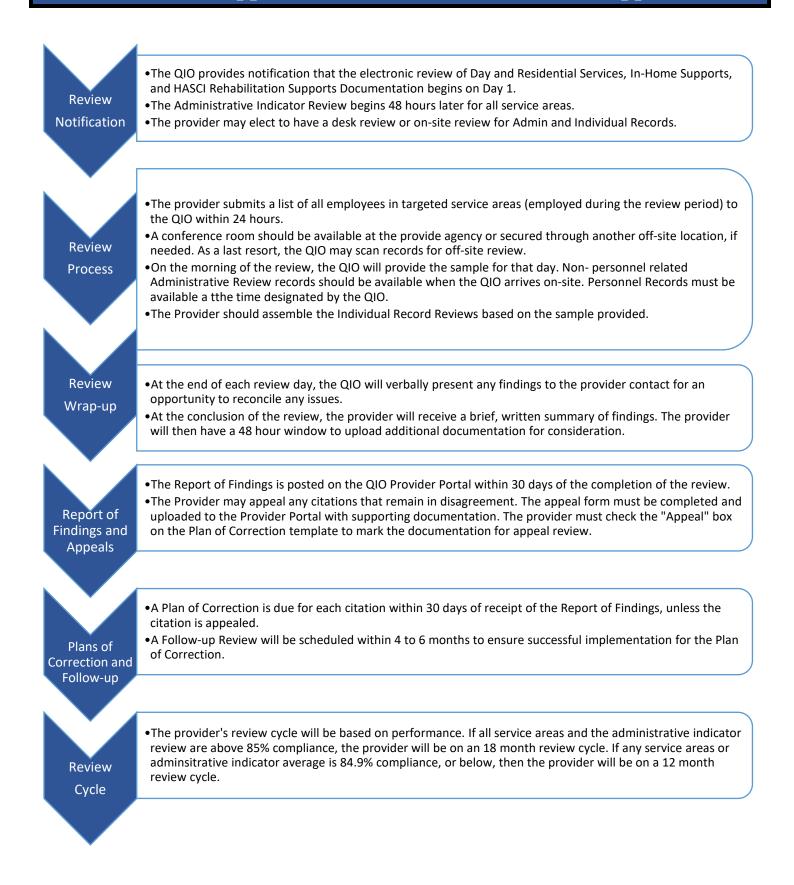
How are the scores for the Timely Completion of a Plan of Correction determined? The scores are based on the number of Plans of Correction submitted on or before the due date compared to the total number of Plans of Correction required. Plan of Correction due dates may be adjusted due to a provider's appeal, but it the citations are upheld on appeal, the Plan of Correction must be submitted by the revised due date.

How are the scores for the Timely Submission of Critical Incident and Abuse, Neglect, and

Exploitation Reports determined? The scores are based on the number of Critical Incident Reports or Reports of Allegations of ANE that are submitted according to the established timeframes. There are indicators for initial reports, which are due within 24 hours or the next business day, and final reports, which are due within 10 business days. This information is compared to the total number of reports submitted in each category for the defined three-year time period. Providers are reminded that the timelines apply to all reports submitted on the system.

What if I do not agree with the data on the Provider Dashboard? Please provide a description of the information you believe to be incorrect and supporting documentation. This information will be reviewed by DDSN Quality Management and written feedback will be provided.

QIO FY18 Review Process for Day and Residential Services, In-Home Supports, and HASCI Rehabilitation Supports



QIO FY18 Review Process for Case Management, Intake, Waiver Services, and Early Intervention Reviews



QIO FY18 Licensing Review Process

	• The QIO provides notification of the Licensing Review for Day, Residential or Respite Services on the day of inspection.
Review Notification	•The provider designates a staff to meet the licensing reviewer on -site at the designated time. The provider may have different staff at each location and the staff does not have to be a supervisor or assigned to work in that location.
\mathbf{V}	•The QIO Staff reviews the location using the DDSN Licensing Standards.
Review Process	•The provide must have required documentation on-site or made available during the time of review, or the documentation must be uploaded to the QIO Portal.
	•At the end of each review, the QIO staff will verbally present any findings for the location to the provider
	contactfor an opportunity to reconcile any issues.
Review Wrap-up	•At the conclusion of the review, the provider will receive a brief, written summary of findings for each location. The provider will then have a 48 hour window to upload additional documentation for consideration.
	• The Report of Findings is posted on the QIO Provider Portal within 30 days of the completion of the review.
Report of indings and Appeals	• The Provider may appeal any citations that remain in disagreement. The appeal form must be completed and uploaded to the Provider Portal with supporting documentation. The provider must check the "Appeal" box on the Plan of Correction template to mark the documentation for appeal review.
\checkmark	•A Plan of Correction is due for each citation within 30 days of receipt of the Report of Findings, unless the citation is appealed.
Plans of Correction nd Follow-	•A Follow-up Review will be scheduled within 4 to 6 months to ensure successful implementation for the Plan of Correction.

QIO FY18 Review Process for Day and Residential Observation

Review lotification	 The QIO will complete unannounced visits to DDSN Contracted Day and Residential Settings. The QIO observation should not interrupt any scheduled activities for the location.
Review Process	•The QIO will use the Day Services Residential Observation Tool and the Residential Services Observation Tool fo this process. The Observation will represent a "snapshot in time" regarding hte operation of the location and th responses provided by staff and program participants.
\checkmark	 At the conclusion of the review, the provider will receive a brief, written summary of findings for an opportunit to reconcile any issues.
Report of Findings	 The Report of Findings is posted on the QIO Provider Portal within 30 days of the completion of the review. The Provider may provide additional information, as needed, in response to the findings.

SCDDSN Summary Of Individuals Living With Aging Caregivers By Residing County - As Of June 30, 2017

<u>Region</u> Coastal	<u>County</u>	<u>Ages 55+</u>	<u>Ages 65+</u>	<u>Ages 72+</u>	<u>Ages 75+</u>	<u>Ages 80+</u>
Coustan	Allendale	33	11	6	5	3
	Bamberg	37	25	14	10	6
	Barnwell	60	28	18	15	10
	Beaufort	133	73	44	33	19
	Berkeley	204	95	47	32	10
	Charleston	340	174	99	71	39
	Colleton	71	41	25	17	7
	Dorchester	143	64	37	29	12
	Hampton	37	19	11	8	5
	Jasper	36	21	14	9	4
	Orangeburg	255	135	83	68	47
		1,349	686	398	297	162
Midlands						
	Aiken	153	80	45	31	15
	Calhoun	45	29	17	11	7
	Chester	33	22	15	10	8
	Fairfield	46	21	14	12	3
	Kershaw	59	27	13	9	4
	Lancaster	54	31	22	17	10
	Lexington	163	81	48	41	23
	Newberry	58	21	11	7	2
	Richland York	335	209	127	92 16	52
	IOIK	<u> </u>	<u> </u>	27	16	<u> </u>
Pee Dee		1,0//	584	339	246	134
I ce Dee	Chesterfield	51	23	10	F	
	Clarendon	34	23	10	5 11	4 7
	Darlington	83	33	14	8	6
	Dillon	49	23	15	3	8 1
	Florence	109	68	35	25	17
	Georgetown	91	49	29	23 21	17
	Horry	173	89	60	42	26
	Lee	19	8	2	1	20
	Marion	48	14	5	5	4
	Marlboro	56	31	14	9	4
	Sumter	104	55	23	18	7
	Williamsburg	71	34	23	19	, 9
		888	449	236	167	95
Piedmont						
	Abbeville	23	13	10	7	5
1	Anderson	165	83	53	35	18
10 A.	Cherokee	64	32	21	18	13
	Edgefield	20	15	6	5	4
	Greenville	411	159	90	74	46
	Greenwood	100	49	25	19	10
	Laurens	108	65	30	24	15
	McCormick	16	9	8	7	3
	Oconee	80	48	22	16	7
	Pickens	115	63	38	29	17
	Saluda	27	16	9	7	4
	Spartanburg	282	141	77	51	29
	Union	57	33	19	15	10
		1,468	726	408	307	181
		4,782	2,445	1,381	1,017	572



The Home and Community-Based Services (HCBS) Final Rule & & Conflict Free Case Management (CFCM)

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What is the HCBS Rule?

- CMS promulgated the HCBS rule on January 16, 2014 with an effective date of March 17, 2014.
 - All states must be in compliance with the HCBS rule by March 17, 2019
- Two Areas of Focus:
 - Person-Centered Service Planning
 - 42 CFR 441.301(c)(1) Process
 - Conflict of Interest Guidelines
 - 42 CFR 441.301(c)(2) Plan Requirements
 - 42 CFR 441.301(c)(3) Review
 - Home and Community Based Settings Requirements
 - 42 CFR 441.301(c)(4) Settings characteristics
 - 42 CFR 441.301(c)(5) Heightened Scrutiny

Independent • Integrated • Individual



Any structure developed must adhere to the following tenet*:

"Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual *must not* provide case management or develop the personcentered service plan[...]"

*42 CFR 441.301(c)(1)(vi)



Why SC needs CFCM*

• When the same entity helps individuals gain access to services *and* provides services to that individual, there is potential for a conflict of interest in:

Assuring and honoring free choice

- A key tenet of PCP and a key requirement for Medicaid is full freedom of choice of types of supports and services and individual providers except where the program has authorized restrictions (such as managed care).
- A case manager's (CM) job is to help the individual and family become well-informed about *all* choices that may address the needs and outcomes identified in the plan.
- If there isn't CFCM, the CM may promote conscious or unconscious "steering."

Overseeing quality and outcomes

- Self-policing occurs when an agency or organization is charged with overseeing its own performance
- Puts the case manager in the difficult position of:
 - Assessing the performance of co-workers and colleagues within the same agency.
 - Potentially having to report concerns to their mutual supervisor or executive director.

• The "fiduciary" relationship

- Incentives for either over-or under-utilization of services.
- Possible pressure to steer the individual to their own organization.
- Possible pressure to retain the individual as a client rather than promoting choice, independence, and requested or needed service changes.

*CMS, Conflict of Interest Webinar, January 6, 2016







South Carolina Dept. of Health & Human Services Proposal:

Multi-year phased-in transition to an Individual Choice Model of a Conflict-Free Case Management System

Allow DSN Boards to still provide case management and still provide services, but not to the same individual.¹ Individuals currently receiving services and case management from the same entity will have to choose which they would like to receive from the current provider: either (1) case management, (2) services or (3) neither. DSN Boards will have to transition a certain percentage of beneficiaries each year within a three (3) year period.

Waiver	Number of Beneficiaries in Need of Transition ²
Community Supports	1704
HASCI	26
ID/RD	3886
Total Beneficiaries	5616

Phase 1:

- 1. SCDHHS will update Waiver Documents' Appendix D-1-b Service Plan Development Safeguards sections to reflect the conflict of interest regulation language (42 CFR 441.301(c)(1)(vi)) compliance transition plan within standard waiver renewal schedule.
 - a. ID/RD Waiver: within current extension timeframe
 - b. Community Supports Waiver: July 1, 2017
 - c. HASCI Waiver: July 1, 2018
- 2. SCDHHS will update waiver policy for new beneficiaries coming into the waiver system to reflect that they must select one entity for case management and a different entity for delivery of any HCB services.
- 3. Providers will identify beneficiaries who currently receive case management and HCB services from them and provide that information to SCDHHS and SCDDSN.
- 4. SCDHHS and SCDDSN will work with providers to ensure administrative separation and conflict mitigation strategies between staff doing case management and staff delivering direct services for current waiver beneficiaries who are still receiving both from a single entity within the transition timeframe.
- 5. SCDHHS and partners will educate beneficiaries and providers about upcoming changes.

¹ While this does allow DSN Boards to continue to provide both case management and provide HCB services, and private providers have been mandated to select between the two, the quasi-governmental status of DSN Boards and their important role as the safety-net provider in a community necessitates this disparity.

² Numbers of beneficiaries receiving case management and HCB services from the same provider; received from SCDDSN on July 19, 2016.

Phase 2:

- 1. SCDHHS will develop and implement a process and establish annual benchmarks for recruitment of sufficient providers of case management and/or service providers within each county based on need.
- 2. Each provider must create a transition plan, to be approved and monitored by SCDDSN that will detail each provider's three year plan to transition a certain percentage of identified beneficiaries each year to the individual choice model for conflict free case management.
 - a. Fiscal Year 1: Providers will need to transition at least 20% of beneficiaries
 - b. Fiscal Year 2: Providers will need to transition at least 30% of beneficiaries
 - c. Fiscal Year 3: Providers will need to transition the remaining % of beneficiaries

Phase 3:

- 1. SCDDSN will monitor each provider's progress in transitioning current waiver beneficiaries to the individual choice model for conflict free case management.
- 2. SCDHHS will receive quarterly reports on transition plan progress from SCDDSN.

Phase 4:

1. All beneficiaries in the waiver programs will have one entity providing case management services and different entity/entities for any waiver services in compliance with 42 CFR 441.301(c)(1)(vi).

Home and Community Based Services (HCBS) Rule

Home and Community Based Settings Overall Requirements

Website for more information:

www.scdhhs.gov/hcbs

How home and community-based settings look in South Carolina will be guided by the requirements outlined in the HCBS Rule. Every home and community based setting must meet the five overall requirements outlined in the HCBS Rule and listed below. SCDHHS will be working with providers as we move forward with the South Carolina HCBS Statewide Transition Plan to ensure settings meet these requirements. Providers need to be compliant with the new HCBS requirements by the end of 2018 to ensure the state's compliance by March 17, 2019.

Home and community-based settings must have all of the following qualities:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community to the same degree of access as individuals not receiving Medicaid HCBS. This includes:
 - Opportunities to seek employment and work in competitive integrated settings
 - Opportunities to engage in community life
 - Opportunities to control personal resources
 - Opportunities to receive services in the community
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
 - The setting options are identified and documented in the person-centered service plan and are based on the individual's:
 - Needs, and
 - Preferences
 - For residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to:
 - o daily activities,
 - physical environment, and
 - with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.