Provider Compliance Review for HCBS Waiver In-Home Providers

Healthy Connections PRIME

Described in this document is the review methodology that the State uses to evaluate Home and Community Based Services (HCBS) waiver in home providers' adherence to their contractual requirements. In-home waiver service providers include: Personal Care Providers, Adult Day Health Care Providers, and In-Home Nursing Providers. The State uses an objective, clear scoring approach leveraging Phoenix that makes clear the elements that go into a provider's score. Providers are informed about the methodology when they sign up to be a provider and receive written documentation of their review outcomes.

On a semiannual basis, the State will share with Medicare-Medicaid Plans (MMPs) the full provider compliance report covering all scored providers.

Review Execution Process

When a review is scheduled, the following steps are taken:

- The reviewer indicates the number of waiver participants to be included. Phoenix then randomly selects participants who have received services during the review period.
- Staff members who have worked with those specific participants are identified for a staff sample.
- The reviewer conducts an unannounced on-site review.

Note: For personal care services, some parts of the review are conducted by Phoenix ahead of the on-site review. For example, personal care services cannot be started until a licensed nurse has done an on-site visit and identified all activities the aide should be doing (e.g., bathing, light housekeeping, errands, transfer). The nurse must then visit within thirty days after the start of services and every four months thereafter. The nurse uses Care Call to document the visits. Phoenix then looks at all records to determine if the visits have been conducted as required before the on-site review.

Review Areas

Providers are reviewed in three major areas, as described in the table below.

Area	Description
Administrative	This includes such items as to whether the provider is maintaining a current license, has an organizational chart, is up to date with liability and Worker's Compensation insurance, and other items.
Service	This includes review of waiver participant records. Based upon the contract, items are selected for evaluation such as nurse supervisory visits (personal care providers), an individual record for each participant, and nurse supervisor sign off on aides' task sheets.
Staff	This review area includes examining individual staff records to ensure that each staff member meets the qualifications and training requirements (and licensure with the nurses), each has an up-to-date TB test, and other items.

Scoring Methodology

Each review question represents a contractual requirement, such as licensure or an individual participant record. Each question is assigned a value of 1 to 3 that reflects the importance of the issue. When the review is completed, Phoenix

calculates the non-compliance percentage for each question based on the times the provider was not in compliance for that question. Each 5% counts as one point. That is then multiplied by the 1 to 3 importance value of the area.

> ***Example***
> 20 participants are sampled for a particular question that has an importance value 3. If 5 of the 20 participant cases show non-compliance by the provider, then the non-compliance rate is 25%. Multiply this by the importance value of 3 would result in a score of 15 for that review question.
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> 25% divided by 5% = 5 → 5 x 3 points for the importance = score of 15

With this scoring methodology, the higher the score the more out of compliance the provider is. When the review is completed, the scores are tabulated by Phoenix and shared with the provider. The provider has an opportunity to contest each question. The compliance officer reviews each challenge makes a decision on each point to determine the final score.

What Scoring Means for Providers

Scores may impact the provider's ability to serve waiver participants. Score benchmarks are at each 100 points, as detailed in the table below.

Score Range	What It Means
0	Full compliance on all questions
1-49	No follow-up from the provider needed
50-99	Requires provider to complete a plan of correction for review and approval
100-199	Suspension from new referrals for one month. Current participants would remain with the provider but the provider would not be able to accept new participants.
200-299	Two-month suspension
300-399	Three-month suspension
400 and above	Contract termination. If terminated; the provider is not able to re-apply or re-enroll as a CLTC provider for 3 years. *

**Note: A history of bad reviews would also result in termination of the provider's contract.*

Review results determine the frequency of reviews. In general, the worse the review the sooner the next review will be conducted.

For More Information

For more information or questions regarding the Provider Compliance Report, please email CLTC at provider-distribution@scdhhs.gov.