


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Waldrop</i>	DATE <i>4-6-11</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER  100460	<input checked="" type="checkbox"/> Prepare reply for the Director's signature DATE DUE <i>6-27-11</i>
2. DATE SIGNED BY DIRECTOR  <i>cc: Mr. Spect, Depo, CMS file</i> 	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action

APPROVALS <small>(Only when prepared for director's signature)</small>	APPROVE	* DISAPPROVE <small>(Note reason for disapproval and return to preparer.)</small>	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
61 Forsyth Street, SW, Suite 4120  
Atlanta, Georgia 30303-8909



March 31, 2011

**RECEIVED**

Anthony E. Keck, Director  
Department of Health and Human Services  
P.O. Box 8206  
Columbia, SC 29202-8206

APR 06 2011

Dear Mr. Keck:

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of South Carolina's Medically Complex Children's Home and Community Based Waiver, control number 0675 that serves children under the age of 18, who otherwise would require placement in a Nursing Facility (NF) or Intermediate Care Facility/Mentally Retarded (ICF/MR). Thank you for your assistance throughout this process. The State's responses to CMS' recommendations have been incorporated in the appropriate sections of the report.

We found the State to be in compliance with all six of the assurance review components. We have also identified recommendations for program improvements in five of the assurance areas.

Finally, we would like to remind you to submit a renewal package on this waiver to CMS Central and Regional Offices at least 90 days prior to the expiration date of the waiver, December 31, 2011. Your waiver renewal application should address any issues identified in the final report as necessary for renewal and should incorporate the State's commitments in response to the report. Please note the State must provide CMS with 90 days to review the submitted application. If we do not receive your renewal request ninety days prior to the waiver expiration date we will contact you to discuss termination plans. Should the State choose to abbreviate the 90 day timeline, 42 CFR 441.307 and 42 CFR 431.210 require the State to notify recipients thirty days before expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter sixty days prior to the expiration of the waiver.

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

Sincerely,

*Jackie Glaze*  
Jackie Glaze

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

Enclosure

cc: Ellen Blackwell



**U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services**

**Region IV  
FINAL Report**

**Home and Community-Based Services Waiver Review  
South Carolina Medically Complex Children's Waiver  
Control #0675  
March 31, 2011**

**Home and Community-Based Services  
Waiver Review Report**

## **Executive Summary**

The South Carolina Department of Health and Human Services (DHHS) is authorized under §1915(c) of the Social Security Act to provide home and community based services under the Medically Complex Children's Program serving children under the age of 18 who meet the Nursing Facility (NF) level of care (LOC) or Intermediate Care Facility/Mentally Retarded (ICF/MR) LOC. These children have a chronic physical/health condition that is expected to last longer than 12 months and meet medical criteria defined by the State, documenting the dependency upon comprehensive medical, nursing and health supervision or intervention. The services offered in this waiver include: Care Coordination, Incontinence Supplies, Pediatric Medical Child Care and Respite Care. The average number of individuals served in the program as of June 1, 2010 was 140 individuals. The approximate average cost per month (year-to-date) per person is \$9,840.

As requested per the CMS Interim Procedural Guidance, South Carolina submitted evidence to document adherence with program assurances as required per 42 CFR 441. In its submission of October 29, 2010, the State provided an overview of processes, instrument(s), systems and summary reports for each Federal assurance.

### **Summary of Findings:**

1. **State Conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State demonstrates the assurance but CMS recommends improvements or requests additional information.**
  - CMS recommends developing specific performance measures to assess accuracy of LOC decisions. CMS also recommends the State describe the methodology for determining sample sizes used for monitoring processes to ensure the outcomes are statistically valid.
2. **Service Plans are Responsive to Waiver Participant Needs – The State demonstrates the assurance but CMS recommends improvements or requests additional information.**
  - Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.
3. **Qualified Providers Serve Waiver Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information.**
  - CMS requested the State provide results of monitoring of other provider types, e.g., In-home Skilled Respite and Pediatric Medical Day Care (PMDC).
4. **Health and Welfare of Waiver Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information.**
  - DHHS reported no instances identified through the State audit. In addition to official reports of abuse, neglect and exploitation, the State may want to consider developing performance measures to identify and track complaints and grievances as they are first reported through resolution.

5. **The State Medicaid Agency Retains Administrative Authority Over the Waiver Program -The State demonstrates the assurance but CMS recommends improvements or requests additional information.**
  - CMS recommends taking and maintaining minutes of the meetings held with waiver service providers for monitoring purposes.
6. **State Provides Financial Accountability for the Waiver – The State demonstrates the assurance but CMS recommends improvements or requests additional information.**
  - CMS recommends the State develop and implement additional performance measures to capture data related to monitoring outside of the MMIS/financial system.
  - The State may also wish to include performance measures related to documentation maintained by providers to support amounts billed. It is also recommended the State pull a statistically valid sample of paid claims data to review at least annually.

**Introduction:**

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that State assurances are met. The assessment also serves to inform CMS in its review of the State's request to renew the waiver.

<b>State's Waiver Name:</b>	Home and Community-Based Waiver for Medically Complex Children (MCC)
<b>Operating Agency:</b>	South Carolina Department of Health and Human Services
<b>State Waiver Contact:</b>	Maria J. Platanis
<b>Target Population:</b>	Children from birth to 18 years of age with a chronic physical and/or health condition expected to last longer than 12 months
<b>Level of Care:</b>	Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR)
<b>Number of Waiver Participants:</b>	140 (as of June 2010)
<b>Average Annual per capita costs:</b>	\$ 9,840
<b>Effective Dates of the Waiver:</b>	January 1, 2009 – December 31, 2011
<b>Approved Waiver Services:</b>	Children's medical day care, respite, care coordination and incontinence supplies.
<b>CMS Contact:</b>	Connie Martin

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

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

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

### **Evidence Supporting This Conclusion:**

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

The State utilizes a comprehensive assessment tool for both levels of care to determine the participant's medical, psychosocial and functional abilities. Evidence submitted to support a LOC assessment and determination are as follows:

- ICF/MR LOC Staffing Report with DHHS Waiver Administrator/RN and Physician Consultant verifying criteria met as part of a 100% review;
- ICF/MR LOC Protocol;
- ICF/MR LOC DDSN Consumer Assessment Team (CAT) Monthly Log;
- DHHS Master spreadsheet of applicant NF LOC completion dates;
- Completed NF LOC Form, Completed ICF/MR Form, Corresponding MMIS screen reflecting MCC waiver enrollment date, Corresponding MMIS screen reflecting MCC waiver enrollment date;
- DHHS MCC Waiver Technical Assistance Review (TAR) Report of findings related to initial LOC determinations; and
- DHHS MCC Waiver Quality Assurance Review (QAR) Report of findings related to LOC determinations.

The State has demonstrated enrolled participants are re-evaluated at least annually or more frequently if warranted. The same assessment team that conducts the initial LOC determinations also conducts the re-evaluations of LOC. The Care Coordination staff conducts the re-evaluation using the same 1718 tool as the initial LOC. The State operates an electronic system (Phoenix System) that maintains NF LOC which includes LOC determination dates.

The Phoenix System identifies upcoming LOC re-evaluations due dates based on the date of the prior year's LOC. Enrolled participants are re-evaluated at least annually or more frequently if warranted. Evidence to support a re-evaluation of LOC is provided for all applicants at least annually and all participants' LOC were completed prior to the 365<sup>th</sup> date of the previous LOC are as follows:

- DDSN CAT Team ICF/MR Log representing the ICF/MR LOC re-evaluation dates;
- DHHS Master List of NF and ICF/MR LOC re-evaluations which occurred prior to the 365<sup>th</sup> day;
- Completed re-evaluations of LOCs determinations and the corresponding initial LOC reflecting timeliness;



- TAR Report of MCC waiver with findings related to annual LOC re-evaluation determinations; and
- QAR Report with findings as related to annual LOC re-evaluation determinations.

Nursing Facility LOC determinations are conducted by trained licensed RN staff utilizing the standardized comprehensive assessment tool (1718 Form). The tool identifies skilled needs and functional deficits.

ICF/MR determinations are conducted by a medical director, licensed nurse and the Consumer Assessment Team (CAT) consisting of qualified psychologists. A standardized instrument is used to gather assessment information necessary for ICF/MR LOC determinations, as well as re-determinations, capturing three main components: diagnosis of mental retardation or a related disability, behaviors requiring supervision and services needed for acquisitions of behaviors necessary to function with as much self-determination and independence as possible and /or to prevent deceleration or regression of optimal functional status. The State has submitted the following evidence to substantiate these instruments are appropriately applied:

- Completed NF and ICF/MR LOC instruments, which are maintained in the MCC waiver participant's case record; and the corresponding Medicaid Management Information System (MMIS) data identifying the waiver enrollment date;
- TAR Report of MCC waiver with findings related to NF and ICF/MR LOC determinations were made using the correct instrument; and
- QAR Report with findings as related to LOC determinations using the correct instrument.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 89 percent of waiver enrollment was within 30 days of the initial NF & ICF/MR LOC. The LOC re-evaluation was dated and signed within 365 of the prior evaluation. The State has also conducted remediation by updating policies and training to ensure waiver applicants are enrolled into the waiver prior to LOC expiration.

One hundred percent of sampled cases used appropriate instruments. However, there are no indications from State monitoring if the instruments were applied appropriately.

**Suggested Recommendations:**

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

CMS recommends developing specific performance measures to assess accuracy of LOC decisions. CMS also recommends the State describe the methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid.

**State Response:** The State has incorporated the usage of the Phoenix Data Entry System (Phoenix) for the LOC determinations. Phoenix requires specific LOC criteria to be met prior to determination and only allows the waiver to be entered if the LOC determination was completed within 30 days. Additionally, the State conducts a 100% review for designated review periods. Any errors found during the review are addressed immediately.

**CMS Response:** CMS accepts the State's response, but recommends for future reviews the State identify the designated review periods to ensure the sample sizes are valid.

## II. Service Plans are Responsive to Waiver Participant Needs

**The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.**

*Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7 Section 1915(c) Waiver Format, Item Number 13*

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

### **Evidence Supporting This Conclusion:**

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

The plan of care (POC) is the fundamental tool the State uses to ensure the health and welfare of the children in the Medically Complex Children's Waiver. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

The Care Coordination Service Organization (CSO) staff is responsible for developing care coordination plans based on the comprehensive assessment of the participant's medical needs, problems and strengths. Problems are identified, interventions are outlined and initiated and goals are set. The care coordination plan includes a statement of the participant's needs, related to a goal, with a specific service to meet the need including the amount, frequency and duration of the service. The completed care coordination plan is submitted to the Nurse Administrator, who is also the Waiver Administrator, for review and approval. The State submitted the following evidence that individual care coordination plans are reviewed to assure that all participants' needs and goals are addressed:

- Completed care coordination plan which is maintained in the MCC waiver participant's case record, and reviewed and approved by the Waiver Administrator.

The University of South Carolina conducts a survey by telephone interview of the waiver participant/responsible party, inquiring about the assistance of the care coordinator and services coordinated by the waiver.

The State conducts annual on-site reviews and reports initial findings back to the Nurse Administrator. If the report shows deficiencies, those providers are to respond with a written plan of correction. Service plans are updated and/or revised at least annually or when warranted by changes in the waiver participant's needs. The State submitted the following annual assessments conducted in the States computerized Phoenix system where each participant's electronic record is maintained:

- An example of a completed annual 1718 assessment;
- DHHS Master List of participants who received an annual re-assessment in accordance with State policy;
- TAR Report – Technical Assistance Review Report providing results of State audit; and
- QAR Report – Quality Assurance Review Report.

The CSO is responsible for creating a new service plan within 365 days of the initial care coordination plan. The State utilized the same methods for monitoring the care coordination plan updates/revisions as used for monitoring of the care coordination plan development. Changes to the care coordination plan are made as needed by the care coordinator with the results of monitoring or when information is obtained from the participant, his/her guardian, and/or service providers indicate the need for a change to the care coordination plan.

A monthly contact by telephone or an in-person visit must be made by the Care Coordinator to assess and re-evaluate the on-going needs of the child. Monthly contacts and quarterly visits must be documented using the Care Call System. Eighty-seven percent (360 of 415) contacts were completed. When no monthly contact was conducted, it was due to no response from the recipient. A policy was created to address non-compliance by a participant.

The initial care coordination plan is required to be approved by the Waiver Administrator. The service plan included in the electronic case record in Phoenix is also required to be signed and dated indicating approval by the nurse administrator. The following documents were provided as evidence that the State monitors the development of care coordination plans in accordance with waiver policy and procedures:

- Completed Phoenix Service Plan; and
- QAR Report

The State requires care coordinators have a waiver participant's parent or legal guardian complete a Freedom of Choice Form indicating their choice between waiver services and institutional care. Parents or legal guardians are informed in writing prior to waiver enrollment of waiver services and provided with a list of qualified waiver and non-waiver Medicaid service providers in their area.

The University of South Carolina is responsible for conducting a survey by telephone interview of the waiver participant/responsible party, inquiring about the access of appropriate services and supports in the community.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 74 percent of initial service plans were signed and dated by the waiver administrator. The State's remediation was to update policies to ensure the approval of service plans are approved prior to waiver enrollment.

The State's metrics also indicated 100 percent of re-evaluations were signed and dated by the waiver administrator. No remediation was needed.

**Suggested Recommendations:**

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

In response to this draft report, please explain other than changing a policy, what systemic change was implemented to prevent the recurrence of failing to have 100% of initial plans signed and dated by the waiver administrator.

Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.

**State Response:** In addition to updating and revising the policy, the State implemented and now requires that all service plans be completed using the Phoenix System. The Phoenix System monitors to ensure all service plans are signed by the waiver administrator. The State conducts a 100% review on all plans of care on a continuous basis using the Phoenix System.

**CMS Response:** CMS accepts South Carolina's response but requests the State analyze and trend data for remediation and systems improvement.

### **III. Qualified Providers Serve Waiver Participants**

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

*Authority: 42 CFR 441.302; SMM 4442.4*

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

#### **Evidence Supporting This Conclusion:**

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

The State verifies providers initially and continually met required licensure and/or certification standards prior to their furnishing waiver services. Care Coordinators employed by the CSO must be licensed Registered Nurses with a minimum of three years experience working with medically complex children.

The State reports that it monitors non-licensed/non-certified providers to assure adherence to waiver requirements. However, the Quality Management Chart states all providers are licensed or certified. Once the State confirms the provider meets all Medicaid standards and qualifications, the approved provider may enroll with DHHS to provide waiver services. The State is responsible for conducting annual provider reviews to ensure providers continue to meet criteria to render waiver services.

The State conducts reviews and provides technical assistance to the CSO, the Care Coordination provider. DHHS completes quality assurance reviews of providers and submits the findings to the CSO and the waiver administrator provides technical assistance and follows up as necessary. The following evidence provides documentation of the State's monitoring, training and actions taken when the CSO has not met requirements.

- TAR Report provides results of monitoring performance measures for qualifications;
- QAR Report provides results of monitoring performance measures for monitoring;
- Training activity agendas; and
- Training Session to review/update MCC policy.

The State reviewed the licenses of the eight nurses comprising nursing staff and Nurse Administrator. Metrics show 100 percent (8 out of 8) were licensed Registered Nurses.

#### **Suggested Recommendations:**

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

In addition to results submitted on audits for case management providers, please provide results of monitoring of other provider types, e.g., In-home Skilled Respite and Pediatric Medical Day Care. Please explain the outcome of policies, procedures and forms that were developed for implementation on July 1, 2010, and whether they meet the performance measure.

**State's Response:** Pediatric Medical Day Care (PMDC) was implemented on July 1, 2010. The Care Coordinator is able to authorize the PMDC service using the Phoenix System. Authorization is then accepted by the provider. The State runs reports through the Care Call System to verify services were provided as authorized.

Before implementation of the PMDC, providers were required to show proof of State Licensure, Certifications, and experience in pediatric nursing care, etc. The State also conducted background checks for direct care staff, PPD Tuberculin testing of all direct care staff.

In-home Respite services implementation has been delayed until approximately April 2011, due to the need for a waiver amendment regarding a service/rate change.

**CMS Response:** While the State submitted requirements, policies, procedures and forms for the implementation of PMDC, CMS recommends the State provide results of monitoring in the future by identifying performance measures. CMS also recommends the State provide results of meeting performance measures when in-home respite is implemented.

#### **IV. Health and Welfare of Waiver Participants**

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

*Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9*

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

#### **Evidence Supporting This Conclusion:**

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

The State identifies, addresses and seeks to prevent instances of abuse, neglect, and exploitation. DHHS QA staff monitors health and welfare concerns through the quality assurance process which includes case record reviews of critical incidences, abuse and neglect reports. The DHHS Program Integrity Division also investigates reports of abuse, neglect, exploitation, and fraud via a toll free hotline.

Based on the South Carolina Code of Laws, the SC Department of Social Services (DSS) is the investigative agency for children under 18 years of age. Upon enrollment into the waiver, all participants are given the DSS Abuse hotline information on how to report abuse. When the DHHS or the CSO receives reports of alleged abuse, the initial response is to ensure the child is protected. The DHHS/CSO does not allow the alleged perpetrator to provide any services until the investigation has been completed. A report is completed by the Care Coordination staff and reviewed by the Waiver Administrator. DSS is alerted and the service provider is requested to remove the alleged perpetrator from the child's environment. Upon completion of the investigation, the next action taken is dependent upon the results.

The following evidence supports the conclusion that the State seeks to address and prevent occurrences of abuse, neglect and exploitation on an ongoing basis:

- QAR Report;
- MCC Abuse Report Form;
- Abuse Hotline handout to participants; and
- South Carolina Solutions Admission Agreement Form.

Of 140 participants the State reviewed 57 case records. There were no critical incidents reported (including mortality and injuries) for the sample of records chosen.

**Suggested Recommendations:**

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

DHHS reported no instances identified through the State audit. In addition to official reports of abuse, neglect and exploitation, the State may want to consider developing performance measures to identify and track complaints and grievances as they are first reported through resolution.

**State Response:** Participants are notified of their right to complain through a participant's rights and responsibilities statement which is reviewed and signed at the initial visit by the Care Coordinator and the responsible party. Complaints are then logged into the Phoenix System via an electronic complaint by the Care Coordinators. The complaint is sent electronically to the waiver administrator to be addressed with the Care Coordination Staff. If warranted the complaint is sent to quality assurance and provider Compliance. The Phoenix Complaint Log, implemented in August 2010, documents the actions taken toward reaching a resolution of the complaint.

**CMS Response:** While the State's response addressed the process of how participants are notified of their right to complain and the procedures the State follows in processing complaints, including logging complaints and the tracking of those complaints through the Phoenix System, the response did not include performance measures to show results of monitoring complaints.

**V. State Medicaid Agency Retains Administrative Authority over the Waiver Program**

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

*Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7*

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

**Evidence Supporting This Conclusion:**

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

The waiver is both administered and operated by the Medical Assistance Unit as a component of the State Medicaid Agency. The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by local/regional non-State agencies and contracted entities.

The State engages in routine oversight of the MCC waiver program by enforcing the terms and conditions of the waiver service contracts. Meetings are held with waiver service providers to discuss specific waiver issues identified through State oversight. In addition, DHHS conducts monthly staff meetings with the CSO and the Care Coordination staff.

The State also engages in routine oversight by conducting technical and/or quality assurance reviews annually. Aggregated discovery and remediation reports relating to each of performance measures are reviewed and addressed.

DHHS has submitted the following evidence to support their ongoing administrative authority and to establish it is consistent with the approved waiver application:

- Service contract between DHHS and the CSO for Care Coordination Services;
- ICF/MR LOC Quality Management Process;
- Quality Assurance Review Report;
- Technical Assistance Review Report; and
- Copy of DHHS and the CSO Care Coordination staff meeting agenda which occur on a monthly basis or more often as needed to discuss various policy updates and training for the contractor.

**Suggested Recommendations:**

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

CMS recommends taking and maintaining minutes of the meetings held with waiver service providers for monitoring purposes.

**State Response:** The State will develop policies and procedures to take and maintain minutes of meetings held with waiver service providers for monitoring purposes. Implementation will be immediate following the updating of policy in March 2011.

**CMS Response:** CMS accepts the State's response.

**VI. State Provides Financial Accountability for the Waiver**

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

*Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10*

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

**Evidence Supporting This Conclusion:**

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

The State assures claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. DHHS Fiscal staff, Audit staff and Program Integrity staff conduct ongoing monitoring of finances on a monthly basis.

As part of the ongoing monitoring process, State Quality Assurance (QA) staff compares services billed and paid to the POC to ensure services rendered were specified in the POC. The QA process is also used to monitor paid claims data and participant utilization reports. Cost reports are developed to ensure that funds are being applied and used properly by analyzing financial records maintained by the State, sub-state entities and providers. All findings are used to determine needed improvements as well as corrective actions.

Once a service is authorized in the Phoenix system, the authorization is sent to the Care Call system to be utilized by service providers. Care Call tracks all services with codes and sends them to MMIS for payment. Claims must meet all applicable criteria to be submitted to MMIS for payment at which time the billing code determines the rate of reimbursement. Cost reports are developed to ensure that funds are being applied and used properly.

The following documents provide evidence that the State monitors claims to assure they are coded and paid accurately:

- MCC Waiver Cost report;
- Phoenix Service Provision (service authorization);
- Care Call Service Monitoring Reports;
- Care Call Time and Attendance Report;
- Care Call Resolution Report;
- MMIS claims data; and
- Participant case record audit.

The State pulled paid claims data for the month of August 2010. All claims were reviewed and there were no claims returned as denied.

**Suggested Recommendations:**

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

CMS recommends the State develop and implement additional performance measures to capture data related to monitoring outside of the MMIS/financial system. For example, measures may include the number and percentage of claims with scope, frequency and amounts specified in the POC.

The State may also wish to include performance measures related to documentation maintained by providers to support amounts billed.

It is also recommended the State pull a statistically valid sample of paid claims data to review at least annually.

**State Response:** The State Medicaid Agency serves as both the Administrative and Operating Authority for the MCC waiver program. It has direct responsibility for ensuring financial accountability. South Carolina's Care Call system is used for almost all waiver service claims. In-home service providers call toll free to document service delivery. Care Call generates claims based upon documented visits. The claim is based upon authorized services and will be the lesser of the delivered and authorized time, i.e., two hours authorized and 1.5 hours delivered will result in a claim for 1.5 hours. This ensures providers do not exceed authorized amounts. The State also employs a quality assurance reviewer to conduct reviews of waiver service providers. The reviews consist of staffing qualifications reviews, administrative reviews and



participant record reviews. The State plans to use statistically valid sample sizes for reviews. The additional performance measures stated above are being implemented and will be incorporated in the upcoming MCC Waiver Renewal document.

**CMS Response:** CMS accepts the State's response, but recommends the additional performance measures referenced in CMS' Draft Report.