DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett	5-26-15

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000253	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Kost, Deps, CMS f.u, Chavis	[X] Prepare reply for appropriate signature DATE DUE 1-8-16 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			Brian,
2.			this does require
3.			action. See tagged
4.			Thx, JP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

[redacted] 6061-52.45

ACTION REFERRAL

TO	DATE
Liggett	5-26-15

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000253	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Kost, Deps, CMS f.u, Chavis	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 20, 2015

Mr. Christian L. Soura, Director
South Carolina Department of Health & Human Services
PO Box 8206
Columbia, South Carolina 29202-8206

Dear Mr. Soura:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of South Carolina's Community Choices Home and Community Based Waiver, control number 0405.R02. This waiver serves frail elders and/or disabled adults who meet state criteria for nursing facility placement but who choose to remain in their homes or communities.

We would like to extend our sincere appreciation to all who assisted in the review process. The state's responses to the CMS recommendations in the draft report have been incorporated in the appropriate section of the report. We found the state to be in compliance with five of the six review components. For those areas in which the state is not compliant, please be sure they are corrected at the time of renewal.

Finally, we would like to remind you to submit a renewal package on this waiver to CMS via the Waiver Management System (WMS) portal at least 90 days prior the expiration of the waiver (June 30, 2016). 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 of services 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 20, 2015

Mr. Christian L. Soura, Director
South Carolina Department of Health & Human Services
PO Box 8206
Columbia, South Carolina 29202-8206

Dear Mr. Soura:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of South Carolina's Community Choices Home and Community Based Waiver, control number 0405.R02. This waiver serves frail elders and/or disabled adults who meet state criteria for nursing facility placement but who choose to remain in their homes or communities.

We would like to extend our sincere appreciation to all who assisted in the review process. The state's responses to the CMS recommendations in the draft report have been incorporated in the appropriate section of the report. We found the state to be in compliance with five of the six review components. For those areas in which the state is not compliant, please be sure they are corrected at the time of renewal.

Finally, we would like to remind you to submit a renewal package on this waiver to CMS via the Waiver Management System (WMS) portal at least 90 days prior the expiration of the waiver (June 30, 2016). 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 of services 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.

We again would like to extend our sincere appreciation to the Division of Community Long Term Care, who provided information for this review. If you have any questions, please contact Kenni Howard at (404) 562-7413 or via email at kenni.howard@cms.hhs.gov.

Sincerely,

Melanie Johnson
for

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

Enclosure
Cc: Michele MacKenzie, Central Office

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 Community Choice Waiver
Control # 0405.R02

May 20, 2015

Home and Community-Based Services
Waiver Review Report

Summary of Finding

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

Suggested Recommendations:

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

State's Response:

As a part of the Phoenix system protocol, state staff meet with Phoenix system programmers weekly to discuss system updates and enhancements. The state will continue these meetings to ensure new and/or revised federal guidelines or regulations affecting sub-assurances are addressed.

CMS Response:

The CMS is in agreement with the state's response and expects the state to continue to meet with Phoenix system programmers to make updates and enhancements as necessary.

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

Suggested Recommendations:

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

State's Response:

The state went live with an e-learning site in November 2014. One module on that site includes service planning. The state will monitor the effectiveness of this module and improve and update all modules as e-learning grows. The state continues to identify areas where additional training is needed and will build modules to meet those needs for all workers.

CMS recommends the state develop additional performance measures that focus more broadly on health and welfare. Some suggested performance measures include:

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

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

State's Response:

In order to collect adequate data to determine the outcomes of Adult Protective Services (APS) referrals, the State recognizes that the current process needs to be modified and is taking steps to accomplish this task.

The State has begun exploring the following options, (others may be explored): 1. Evaluate ways to enhance and/or utilize data collected through the Phoenix system. 2. Even though, due to the Omnibus Act, the Department of Social Services/APS staff can only share limited APS referral information with the DHHS staff and/or provider case managers, the State continues to explore ways to use APS referral information to determine the outcome of APS referrals.

Based on the outcome of these and other options explored, the State will present the revised process and revised performance measures in the waiver renewal application.

The state is taking steps to ensure participants are better informed on how and where they can file complaints regarding case management issues without going through their case manager and will address the improved process changed in the waiver renewal application.

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

State's Response:

The state intends to update performance measure to reflect the modifications to quality measures and reporting at time of waiver renewal.

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

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

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

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

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

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

Reports generated from the Phoenix system for the review period of July 1, 2011 through June 30, 2014 indicated there were 28,664 individuals who applied for the program. Of those, 11,142 (39%) received a LOC evaluation. For the 17,502 (61%) who did not receive a LOC, closures were found to be justified. The largest indicators for closures included applicants who declined participation (27%); applicants died (3%); applicants did not complete the financial application (21%) and 8% were either financially ineligible or were inappropriate after intake. 2% were spread across 16 other indicators with 1% or less. 100% of the participants in the Community Choices waiver had a LOC completed prior to enrollment and receipt of services.

The state uses one performance measure for the sub-assurance that determines if the LOC of enrolled participants is re-evaluated at least annually or as specified in the approved waiver (the number and percent of participants who received a re-evaluation within 365 days of their last LOC determination). For re-evaluations, the Phoenix reports generated found that 14,899 participants had re-evaluations during the review period. 32,102 annual re-evaluations should have been done during the multi-year timeframe. Of those, 31,094 were completed during the specified time period. A special review of the remaining 1,008 was conducted and found that 806 of the re-evaluations had acceptable reasons for being late. Situations such as the participant was hospitalized, out of town or could not be located contributed to the finding. The remaining

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

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

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

Service plans for all waiver participants during the review period of July 1, 2011 through June 30, 2014 were reviewed. One hundred percent (100%) of all participants had needs addressed in their service plans that related to information in the overall assessment, including the home assessment and caregiver support sections of the Phoenix system. Personal goals were not included into the Phoenix system until 2012. A 100% review of individual service plans reviewed for a period of July 20, 2012 – June 30, 2014 revealed that 87% had documentation

percent of service plans revised on or before the annual review due date. The Phoenix system generates checklists that include three questions: (1) did the participant's need change, (2) did the change warrant a service plan update, and (3) was the service plan updated. These are used to generate reports from the Phoenix system to monitor Case Managers' compliance with service plan updates. Phoenix automatically calculates the number of days between the previous service plan development and the current service plan. Any plans greater than 365 days are reviewed. Again, this data is used to generate reports within the Phoenix system to show case manager compliance with the development or revisions of annual service plans.

Phoenix revealed that of 14,807 service plans reviewed, 13,581 (92%) had service plans updated based on need during the review timeframe. The remaining 8% were reviewed more closely to see if there were extenuating circumstances that caused plans to be late or not updated timely. Findings revealed that 81% of those cases had care plan updates, but the case managers were confused on how to answer one of the questions on the checklist, which caused the service plan to show as not updated, when it fact, it had been updated. The revised compliance rate based on the extended review was determined to be 98%.

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

Further findings also indicate that 96% of Community Choices participants' service plans were updated on or before the annual due date. The remaining 4% were mostly found to be completed, but not signed, resulting in a revised compliance rate of 98%. Remediation activities included posting a statewide banner in the Phoenix system as a reminder to case managers to update the service plans.

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

Findings indicate that 74% of participants received services based on type, amount, frequency and duration as identified on their service plan. The remaining 26% were reviewed more closely. Of the 26%, 72% were justified due to the participant choosing other services to meet his/her need; participants declined the service or failed to choose a service provider; participants passed away prior to services being implemented; service implementation was on hold while the participant was out of town; paperwork was in process to implement services at the time the Phoenix report was generated. Adjusting for the above findings, the compliance rate was revised to 93%.

Remediation included using a "Report a Problem" feature in Phoenix so the developer could address system errors; on-going policy and procedure review with providers and case managers; and addressing non-compliance issue in the September 2014 training.

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

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

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

State's Response:

The state went live with an e-learning site in November 2014. One module on that site includes service planning. The state will monitor the effectiveness of this module and improve and update all modules as e-learning grows. The state continues to identify areas where additional training is needed and will build modules to meet those needs for all workers.

While the state cannot apply a specific algorithm to case management provider reviews, there is a standardized process in place that incorporates compliance review, quality assurance review, standardized sanctioning, and identified recoupment. All processes and guidelines are published in provider scopes and on the state agency website. The state has developed a workflow to help streamline and strengthen this process.

Additionally, on page 11, the statement about *100% of all Community Supports service plans* needs to be changed to reflect *100% of all Community Choices service plans*.

CMS Response:

The CMS agrees with the state's e-learning aspect for service planning and encourages the state's continued use of such, along with monitoring the effectiveness of same. Additional e-learning modules should be added as training needs are identified. Based on the state's response, the CMS will expect improved outcomes for case management compliance in this assurance area.

The correction has been made on page 11.

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 Provider Enrollment staff for 100% compliance with performance measures #2 and #3.

The state conducted unannounced on-site reviews for 93 (96%) of the licensed providers. The remaining four providers did not have any service authorizations. Of the 93 providers reviewed, 100% were providing services and had appropriate service authorizations (performance measure # 4).

For performance measure #5, Program Integrity conducted three reviews of licensed providers which constituted 2.4% of all licensed providers. All reviews resulted in provider recoupments.

Performance measure #6 revealed that 81 licensed/certified providers were monitored by case managers on the use of the Care Call system. Case Managers are required to review service delivery monthly and include documentation on checklists via the Phoenix reporting system. Documentation revealed that 100% of all licensed/certified providers were monitored.

There were 18 complaints on licensed/certified providers that triggered ad hoc reviews (performance measure #7). 1% of the complaints warranted the ad hoc reviews and the other 99% were still in the review process at time of the evidence submission. Remediation resulted in recoupment of payment.

Eighteen complaints were logged into the Phoenix system (performance measure #8). 11 (61%) of the complaints were closed and the remaining seven (39%) remained in the review process at the time evidence was submitted.

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

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

reviews were acceptable with no remediation necessary. 3,906 unlicensed providers were monitored by case managers using the Phoenix/Care Call system (performance measure #6). Documentation revealed that 99.6% of all unlicensed providers were monitored during the reporting period.

14 complaints warranted ad hoc reviews (performance measure #7). 100% of the reviews were completed as required.

There were 824 complaints logged into Phoenix's complaint system regarding unlicensed providers (performance measure #8). Eighty five percent or 700 of those complaints have been investigated and closed. The remaining 124 (15%) were still being reviewed at the time of the evidence submission.

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

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

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

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

Performance measure #6 revealed that 255 providers were required to do in-service training for staff during the review period. 207 (81%) providers were compliant with training requirements.

Phoenix Complaint System and monitor the participants' welfare on a monthly basis, or more frequently if indicated. All monitoring activities are entered into the Phoenix system and the participants' electronic files. Central Office staff reviews the Complaint System and the individuals' electronic files to monitor case management follow-up on all cases.
The state uses three performance measure to monitor the health and welfare of waiver participants, as follows: (1) number of abuse, neglect and/or exploitation complaints reported in the complaint system and the percentage of those complaints resulting in referrals to APS; (2) number and percent of referred APS complaints substantiated by APS; and, (3) number and percent of unsubstantiated APS referrals resolved effectively.

Evidence submitted disclosed that during the reporting period of July 1, 2011 – June 30, 2014, 583 Community Long Term Care cases were referred. Of those, 495 (85%) were substantiated and opened. The remaining 88 or 15% were unsubstantiated. The APS status of known cases is monitored monthly by case managers. The results of all monitoring are entered into the Phoenix Complaint System as well as the individual case records.

For the 88 unsubstantiated cases, four had additional follow-up (e.g., adding personal care services, authorizing environmental adaptations) by case managers. Additionally, all unsubstantiated cases are continuously monitored by case managers and/or personal care providers and when warranted, additional referrals are made to APS.

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

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

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

- Number and percent of individuals who report knowing how to report ANE (either through case management questioning or via participant satisfaction surveys)

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

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

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

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

This waiver is operated directly by SCDHHS, through regional offices staffed by SCDHHS employees. No other state or local/regional agency has responsibility for oversight of waiver functions. Therefore, this assurance is not applicable.

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

Because this waiver is operated directly by the Medicaid agency, this assurance is not applicable.

State's Response:

No Response Necessary

CMS Response:

No response necessary.

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

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

As both the administrative and operating authority, the state is charged with ensuring financial accountability of the Community Choices waiver. The state accomplishes this by a number of methods.

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

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

Because the Phoenix system generates and submits claims directly to the MMIS, service codes and billing rates are automatically entered for each claim. This ensures 100% compliance for all performance measures. For the review period reported, 15,641,315 claims were submitted.

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

The state's Care Call has been in place for many years, and CMS has cited it as a "best practice." With both the Care Call system and Phoenix system in place, the state has fully demonstrated compliance with the financial accountability assurance for this waiver program. The CMS has no recommendations at this time.

State's Response:

No Response Necessary

CMS Response:

No response necessary.