DEPARTMENT OF HEALTH AND HUMAN SERVICES
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
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| Myers | 10-6-10 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
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| 1. LOG NUMBER 10-0163 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>cc: Ms. Forlenza, Deps, CMS file | [ ] Prepare reply for appropriate signature<br>DATE DUE _____<br>[ ] FOIA<br>DATE DUE _____<br>[X] Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
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CMS

CENTERS for MEDICARE & MEDICAID SERVICES

# 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 HIV/AIDS Waiver
## Control # 0186.90.R03

**September 30, 2010**

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

September 30, 1010

Emma Forkner, Director
South Carolina Department of HHS
PO Box 8206
Columbia, SC 29202-8206

Dear Ms. Forkner:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) quality review of South Carolina's Home and community Based Waiver Program for individuals with HIV/AIDS, control number SC 0186.90.R03. This waiver serves individuals who are diagnosed with HIV and/or AIDS who meet hospital level of care.

We would like to thank you for your assistance throughout this process and for sending your comments to the draft report. The State's responses to CMS' recommendation have been incorporated in the enclosed final report. We found the State to be in compliance with all assurance review components. However, we are making suggestions that the State may want to consider for an enhanced Quality Improvement Strategy.

Finally, we would like to remind you to submit a renewal package on this waiver through the HCBS web-portal, at least 90 days prior to the expiration of the waiver, September 30, 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 of service 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) 562-7413. We would like to express our sincere appreciation for all who assisted in this review.

Sincerely,

Jackie Glaze

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

Enclosure

CC: Mark Reed, Central Office
Connie Martin, Regional Office

**Executive Summary:**

- South Carolina is the single State agency that retains administrative and operating authority of the State's HIV/AIDS Home and Community-Based Waiver program. This waiver allows for the provision of services to individuals of any age who have been diagnosed with HIV and/or AIDS and who meet hospital level of care. This waiver provides for self direction of services but no recipient centered budget authority. The service package was tailored to meet the special needs of this population. CMS originally approved this waiver in 1988 and it is currently on its fourth renewal which expires on September 30, 1011. As reported through the CMS 372 report, dated October 1, 2007- September 30, 2008, the average number of individuals served is 1,152, with an average annual cost per recipient of $13,503.

- As requested per the CMS interim Procedural Guidance, South Carolina submitted evidence to demonstrate that the State is meeting the program assurances as required per 42 CFR 441. In the October 2, 2009 submission, the State provided an introduction to its overall management strategy, various examples, and summary reports specific to each assurance.

**Summary of Findings:**

- **Summary of Findings**

1. **State Conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State demonstrates this assurance but CMS recommends further improvement.**

   CMS encourages the State to utilize information available from the new Phoenix software to continue with systems improvements.

2. **Service Plans are Responsive to Waiver Participant Needs – The State demonstrates this assurance but CMS recommends further improvement.**

   CMS encourages the State to identify sampling methodology used in annual participant satisfaction surveys.

3. **Qualified Providers Serve Waiver Participants – The State substantially meets the assurance.**

   CMS has no recommendations at this time.

4. **Health and Welfare of Waiver Participants – The State demonstrates this assurance but CMS recommends further improvement.**

   CMS encourages the State to identify additional outcome measures to demonstrate ongoing systemic oversight of the recipient's health and welfare.

5. **State Medicaid Agency Retains Administrative Authority Over the Waiver Program – The State substantially meets the assurance.**

   CMS has no recommendations at this time.

6. **State Provides Financial Accountability for the Waiver – The State substantially meets the assurance.**

   CMS has no recommendations at this time.

**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's assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver.

This review was conducted in accordance with the Interim Procedural Guidance for Assessing HCBS Waivers. Therefore, Regional Office staff did not conduct an on-site visit; review actual case records or conduct interviews with clients, caregivers or providers. Conclusions in this report are based on information submitted by the State to the Regional Office.

| | |
|---|---|
| **State's Waiver Name:** | South Carolina's Home and Community-Based Waiver for Individuals with HIV/AIDS |
| **Operating Agency:** | State Medicaid Agency, the Division of Community Long Term Care Waiver Management |
| **State Waiver Contact:** | Roy Smith, Director, Division of Community Long Term Care Waiver Management |
| **Target Population:** | Individuals diagnosed with HIV and/or AIDS |
| **Level of Care:** | Hospital |
| **# of Participants Approved for Year 4 of the Waiver:** | 1,700 |
| **# of Participants reported on the most recent 372 Report (dated):** | 1,152 (10/1/07 - 09/30/08) |
| **Average Annual per capita costs:** | $13,503 |
| **Effective Dates of Waiver:** | 10/01/06 – 09/30/11 |

| | |
|---|---|
| **Approved Waiver Services:** | Case Management, Personal Care, Attendant Care, Home Delivered Meals, Companion Care, Home Accessibility Adaptations, Nursing Services, Specialized Medical Equipment and Supplies, Prescription Drugs |
| **CMS RO Contact:** | Connie Martin (404)562-7412 |

## I. State Conducts Level of Care Need 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 (LOC) need 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; SMM 4442.6*

**The State demonstrates this assurance but CMS recommends improvements or requests additional information.**
*(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 This Conclusion:**
*(Evidence that supports the finding that the State substantially meets this assurance.)*

All applicants for the HIV/AIDS waiver are reviewed by a Nurse Consultant who applies intake criteria and then assigns the application to a second Nurse Consultant for an assessment. Assessments are keyed into the South Carolina's Division of Health and Human Services (SCDHHS) Case Management System.

The Case Management System reports for the time period of October 1, 2006 forward indicate 100% of applicants have a Level of Care on file. In reviewing a statistically valid sample of the 357 enrollees, 43 did not have Level of Care determinations conducted within 30 days of waiver enrollment. However, approximately one half (20) of these can be explained through updated assessments completed prior to program entry but the Nurse Consultant did not enter updated LOC in the assessment LOC grid (7); program entry date is the date of transfer from one regional office to another instead of the date the applicant entered the program (10); and incorrect assessment/LOC code or other information inadvertently noted on the assessment (3).

The Case Management System generated reports indicated 850 participants had approximately 2700 re-evaluations completed October 1, 2006 – September 14, 2009. Of the 850 participants, 276 had a total of 432 timeliness errors. There are explanations for sixty percent (60%) of the errors, leaving a true 6.4% error rate. The majority were due to late LOC determinations. Other errors were due to inadvertent incorrect data entry or re-evaluation completion during the anniversary month instead of on or before the anniversary date. The State reports the implementation of a significant policy change in May 2007 that no longer allows re-evaluations to be conducted during the anniversary

month; all re-evaluations are now required to be completed prior to or on the anniversary date.

The approved waiver assessment instrument is part of the Case Management System program. The Case Management System program ensures that the approved assessment is used for 100% of applicants. A 3% sample of HIV/AIDS participants is involved in Central Office chart review covering 2007 and 2008. The data is entered into an Excel spread sheet and HIV/AIDS data is scored. The state has a 95% statewide average for using the appropriate process for level of care determination and 82% statewide average for level of care determinations. The 16% LOC determination error is due to LOC determinations submitted prior to receipt of all required information. A Central Office HIV/AIDS Waiver exception may be obtained verbally; however, a copy of the form must be sent and filed in the participant's chart.

**CMS Recommendations:**

The Centers for Medicare & Medicaid Services requires that LOC determinations be completed prior to enrollment into the waiver, and recommends the State set the compliance rate for this assurance at 100%. For those recipients who did not have LOC determination completed at enrollment (23 identified by the State due to lack LOC determinations within 30 days of enrollment), federal financial participation (FFP) should be returned to CMS for any services provided to those recipients. FFP for services provided to waiver recipients should also be returned for those identified whose LOC was past due or outside the 365 day required time-frame for re-evaluation.

It is recommended that the State implement a systems edit (if not already available) to ensure that services are not paid until a LOC determination is on file or if a re-determination of that LOC is outside the 365 days required time-frame.

**State Response:** South Carolina has been working on improving the initial and redetermination level of care processes for the HIV/AIDS waiver. The State has redesigned its automated case management system for all waivers. This web-based system, Phoenix, was scheduled for implementation April 1, 2010. The software has been designed to address many of the issues identified in the CMS draft report.

Our original assessment reported 23 level of care determinations not updated within 30 days of enrollment. Upon further investigation, we found that five should not have been reported in our October 2, 2009 original assessment. South Carolina relies heavily on computerized reporting. Our investigation led us to extensive chart reviews. We found one chart that had a level of care with a typographical error which caused the computerized report to be incorrect; we discovered an eligibility error but not a break in service, and therefore there should not have been a loss in level of care; there was one mistake on our reviewer's part; and we found two computer glitches which created misreporting. Due to the above situations, we are asking to reduce the error rate from 23 cases to 18 cases where initial level of care was not documented within 30 days of entry into the waiver program.

Our original assessment reported there were past due level of care determinations outside of the 365 day required period for re-evaluations. We have identified 27 participants with 35 late levels of care determinations.

We are implementing a retraining initiative with all nurses and case managers that will cover all aspects of level of care determination and timeliness. The training will be conducted statewide by our five regional trainers. They will utilize the Community Long Term Care Level of Care Manual and the CMS HCBs Waiver Assurance online training through the Muskie School of Public Service. All training will be conducted in the month of June.

Phoenix will not allow entry into any of the waiver programs without a level of care within 30 days of enrollment. The software also has a dashboard. This dashboard is personalized for each worker and will show them when participants have re-evaluations due and flag them ahead of time.

CLTC Central Office has already been working, on a one-on-one basis, with regional offices that were identified during chart reviews as needing intervention. This intervention has led to inter-office training for clarification of current policies and procedures. Central Office is sending out statewide directives to clarify policy. Central Office also met with Regional Area Administrators and Lead Team supervisory staff to discuss the HIV/AIDS draft report and the importance of appropriate and timely level of care determinations for all waiver applicants.

Lastly, actions are being taken to assess federal financial participation repayment for services provided to recipients who did not have LOC determination completed at enrollment and waiver participants whose LOC determinations were past due or outside the 365 required time-frames for re-evaluations. In addition, as stated in our original assessment, effective January 2009, the compliance rate for initial and re-evaluation level of care determinations changed to 100%.

**CMS Response:** CMS appreciates South Carolina's commitment to continuously improve and develop quality tools to monitor the waiver assurances. We commend the State on the use of the automated Case Management System. CMS accepts South Carolina's response regarding updates and training implemented to monitor LOC determinations and re-evaluations.

## II. Plans of Care Responsive to Waiver Participant Needs

**The State must demonstrate that it has designed and implemented a system to assure that plans of care for waiver participants are adequate and services are delivered and are meeting their needs.**
*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 this assurance but CMS recommends improvements.**
*(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 This Conclusion**:
*(Evidence that supports the finding that the State substantially meets this assurance.)*

The State's Case Management System program provides a means to ensure that service needs are addressed through the "Wizard" component. This links problems identified in the assessment to the service plan and Case Managers use this component to identify all problems in the assessment and address them in the service plan development.

On a monthly basis, SCDHHS Regional Office senior case management staff review a sample of charts for each case manager. The focus of this review is accurate service plan development. 100% remediation is conducted for any problems identified. All data is entered into an internal QA database and accumulated on a monthly basis. The information is aggregated and shared with each Case Management agency. Any QA indicator which falls below the compliance rate must be addressed in a corrective action plan. The State remediates 100% of all compliance rates which fall below the acceptable compliance indicator (this was 90% in 2007 and was increased to 94% in 2008).

Also, the SCDHHS Regional Office conducts monthly internal quality reviews to assure that service plans are updated/revised at least annually or when warranted by changes in the participant's needs. 100% remediation is done for problems identified. The compliance score for this indicator was initially 90% in 2008 and was changed to 94% in 2009. The Statewide Summary for 2007-2008 reflected an indicator score of 71%. Regional Office Corrective Actions plans were implemented to remediate scores below an acceptable compliance rate. As a system improvement in August 2009, training for supervisory and management staff was conducted to develop an improved understanding of this indicator.

The Case Management System program will not allow service authorizations that do not contain amount, duration, scope and frequency criteria. Care Call reports monitor service delivery. Regional office management staff monitors care call activities and note results on the internal monthly QA tool.

The State ensures that participants are offered a choice between waiver services and institutional care; and, between/among services and providers by having the participant and/or responsible party sign and date a LOCUS form prior to program entry. The LOCUS form indicates the participant's choice of community care or institutional care. Also, a State case manager presents contracted case manager choices to each participant for verbal case management selection. Other service providers are selected at the initial visit made by the chosen case manager. Proper documentation of provider choice is monitored as part of the internal QA process.

Participant and/or responsible party dissatisfaction with provider or services reported through the CLTC complaint system is addressed by CLTC staff and with the appropriate Case Manager for resolution. The State remediated 100% of all complaints of dissatisfaction with provider or services and looks for appropriate resolution. Also, a sample of participants is surveyed yearly for participant satisfaction with service.

**Suggested Recommendations:**

CMS applauds the State for having an effective system to link the problems identified in the assessment with the service plan. A solid framework and oversight structure has been developed that allows South Carolina to achieve 100% compliance. Therefore, in recognizing that all issues are remediated, CMS recommends that the State establishes and maintains a compliance rate of 100% .

CMS encourages the State to validate that all services are delivered in accordance with the service plan in accordance with amount, duration and scope through analysis of the data and to use this information to identify shortfalls and take the appropriate action.

CMS encourages the State to identify the sampling methodology used in the annual participant satisfaction survey.

## III. Qualified Providers Serve Waiver Participants

**The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.** *Authority: 42 CFR 441.302; SMM 4442.4*

**The State substantially meets this assurance**
*(The State has an adequate and effective system for qualifying and monitoring providers, and demonstrates ongoing, systemic oversight of providers.)*

The State requires that potential providers complete an application, meet requirements as outlined in the approved waiver document, and attend a pre-contractual training. The state monitors providers to assure adherence to waiver requirements. The CLTC Compliance Review Officer monitors contracted providers, licensed and non-licensed, to ensure compliance with waiver requirements. The State implements its policies and procedures for verifying that training is provided in accordance with state requirements in the approved waiver.

**Evidence Supporting This Conclusion:**
*(Evidence that supports the finding that the State substantially meets this assurance.)*

The State employs a Registered Nurse (RN) reviewer to conduct on-site periodic reviews of providers. These reviews consist of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all training and certification requirements, tuberculin skin test requirements, ongoing training requirements and any other training requirements as outlined in the contract. The administrative review determines whether all agency administrative requirements (liability insurance, list of officers, emergency backup plans, policy and procedure manuals, etc.) have been met. The participant review verifies whether all requirements relating to the actual conduct of service have been met. The State reported that 100% remediation occurs on issues discovered.

For services monitored by the compliance registered nurse, a report is generated listing all identified deficiencies. The report will also score the review based on a sanctioning scale; the scores will determine if the provider will receive a sanction and if so, the level of the sanction. The scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed. Currently, only Personal Care II and Adult Day Care reviews are being scored. Based upon the severity and number of deficiencies, along with results of prior reviews, sanctions may take place. The State indicated that any and all issues discovered are remediated by sanctions.

There are five types of sanctions:

(1) Corrective Action Plans – This is the least severe sanction and indicates the provider is in substantial compliance with contractual requirements. The provider is required to submit a corrective action plan for correcting deficiencies and avoiding recurrence.

(2) 30-day suspension – This sanction level is moderate and at this level, new referrals are suspended for 30 days. The provider is required to submit a corrective action plan and if approved, the suspension is lifted at the end of the 30 day period.
(3) 60-day suspension – This sanction level is substantial and new referrals are suspended for 60 days. The provider is required to submit a corrective action plan and if approved, the suspension is lifted at the end of the 60-day period.
(4) 90-day suspension – Indicates major and/or wide spread deficiencies. The 90 day suspension of new referrals will only be lifted after an acceptable corrective plan and an acceptable follow-up review is conducted.
(5) Termination – Indicates major and substantial deficiencies, generally coupled with a history of reviews with repeated moderate to major deficiencies. The provider is terminated from the Medicaid program.

The State reports that 100% of providers are monitored with unannounced visits. The frequency of the monitoring is determined by the score of the previous review, but no provider goes longer than 18 months without being reviewed, and the State reserves the right to review any provider at any time, as written in the provider agreement.

In the past, the State did not have an automated system to track the number and severity of sanctions imposed against Providers. However, with system improvements they can now track and trend this process in order to identify problems, remediate issues, and continue to explore other system improvements for enhanced quality in this assurance.

Other services are reviewed by different means. Home delivered meals are monitored by the State Unit on Aging, since all but three providers are part of the aging network. SCDHHS has a formal memorandum of agreement with the State Unit on Aging to perform this function.

Environmental modification services require a contractor's license. Along with ensuring that providers have these licenses, the State employs a reviewer who conducts on-site reviews of a sample of modifications and is available upon request.

Attendant care services are provided by individuals directly employed by participants. SCDHHS has a contract with the University of South Carolina to ensure that attendants meet all requirements to provide services. Individual companion services are provided to participants who are capable of self-directing their care. Participants may discharge companions for any reason.

The State implements its policies and procedures for verifying that training is provided in accordance with state requirements in the approved waiver. Training requirements are monitored as part of the reviews conducted by the compliance Registered Nurse. These include all pre-service requirements, competency evaluations for personal care aides and all ongoing in-service annual requirements. These requirements are specific to the individual services and are included in the service monitoring review. Sanctions taken would include deficiencies in meeting training requirements.

**Suggested Recommendations:**

None

## IV. Health and Welfare of Waiver Participants

**The State must demonstrate that it assures the health and welfare of waiver participants including identification, remediation and prevention of abuse, neglect and exploitation.**
*Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 447.200; SMM 4442.4; SMM 4442.9*

**The State demonstrates this assurance but CMS recommends improvement.**
*(The State's system to assure health and welfare is adequate and effective, and the State demonstrates ongoing, systemic oversight of health and welfare.)*

The Statewide HIV/AIDS Quality Assurance Review, dated 2007 – 2008 indicates that 91% of waiver participants had monthly visits by their Case Manager and 98% had quarterly visits. 91% had appropriate and timely follow-up conducted in response to problems voiced by the client or their personal representative. The State indicates that a follow-up review for 2008 – 2009 has been conducted and they are currently analyzing the data for further improvement in this assurance.

New staff orientation was provided on a four to six month basis until July of 2007. After July 2007, due to frequent hiring of new contract case managers and fewer state case managers, orientation is now conducted every other month to all new contract case managers. Part of the orientation includes training on Adult Protective Services (APS). Also, an APS power point has been developed and is placed on the internal website for training purposes. The State Law, mandatory reporting, importance of referrals and narration are stressed. There is also a Memorandum of Agreement between SCDHHS and South Carolina Department of Social Services (SCDSS) for providing a system for receiving and investigating reports of alleged abuse, neglect and exploitation occurrence to vulnerable adults receiving services.

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

The CLTC complaint system is used to notify Central Office of reported allegations of abuse, neglect and/or exploitation. Reported allegations that are not resolved at the regional office level are discussed for resolution at Quality Assurance Task Force Meetings. Evidence submitted includes a Statewide Summary of the HIV/AIDS Quality Assurance Reviews and copies of Quality Assurance Task Force meeting notes which indicate follow-up on complaints/issues not resolved with Adult Protective Services (APS).

At the time of the submission of this evidence, the State reports that they used a manual tracking "grid" for potential APS issues, provider and/or recipient complaints. These complaints were handled individually as received. With the implementation of the Phoenix system in April of this year, they now have a mechanism to track and trend complaints, which will be broken down by category. APS referrals will also be tracked and trended for appropriateness, timeliness and outcomes.

**Suggested Recommendations**:

CMS encourages the State to utilize their Phoenix system to track/trend complaints and to utilize the information to identify trends and resolution of substantiated reports.

CMS encourages the State to identify additional outcome measures to demonstrate their ongoing systemic oversight of health and welfare. Additionally, it is recommended that the State develop a database to track deaths and monitor occurrence of suspicious nature.

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

SCDHHS retains administrative authority and responsibility for operation of the HIV/AIDS waiver program. Waiver functions are performed by eleven (11) area SCDHHS offices and two satellite offices. Each area and satellite office has state employees (Area Administrators, lead team case managers and lead team nurse consultants and other nurse consultants) that manage and supervise the daily operations of the waiver.

**The State substantially meets this assurance**
*(The State Medicaid agency has an adequate and effective system for administrative oversight of the waiver, and the administration of the waiver program is consistent with the approved waiver.)*

**Evidence Supporting This Conclusion:**
*(Evidence that supports the finding that the State substantially meets this assurance.)*

Initial assessments and level of care determinations are performed by state nurse consultant staff. Initial service plan development is performed by state senior case managers. On-going waiver services are performed by contracted case managers and a limited number of state case managers. Services provided by contracted case managers are monitored by area office supervisory staff and central office staff. Area office state employees are monitored by supervisors and during Central Office quality assurance reviews.

- Attachment 17A: Copy of Statewide Summary for Central Office 2007-2009 QA Review.
- Attachment 20: Copies of regional office monthly internal QA reviews.

**Suggested Recommendations:**

None

## 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; 42 CFR 447.200; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10*

**The State substantially meets this assurance**
*(The State's system for assuring financial accountability is adequate and the State demonstrates ongoing, systemic oversight of waiver finances.)*

As noted, the State Medicaid Agency serves as both the Administrative and Operating Authority for the HIV/AIDS waiver program. The agency has direct responsibility for ensuring financial accountability. This is done in a number of ways.

South Carolina's Care Call system is used for almost all waiver service claims. This is a system in which providers of in-home services make a call to a toll-free number to document service delivery. When payment is based upon the length of stay (personal care, attendant care, etc.), two calls are made to document the start and end time of the service. When payment is not based on length of time in the home (case management, non-reimbursed supervision of personal care aides), a single call from the home documents service delivery.

In cases where the service is not provided in the home and/or where no in-home documentation is required (e.g., adult day care, environmental modifications, home delivered meals), the Care Call system allows claims entry through the phone or web. In these cases, the service is documented and compared with the authorized amount to ensure that billings do not exceed authorized limits and that services were performed as authorized.

Care Call generates claims based upon documented visits. The claim will be based upon authorized services and will be the lesser of the delivered and authorized time (e.g., two hours authorized and 1.5 hours delivered = a claim for 1.5 hours; two hours authorized and three hours delivered = a claims for two hours). This ensures that provider billings do not exceed authorized amounts. It also provides a check to see if the phone call was made from the authorized location.

At this time, Personal Care, Agency Companion, Nursing, Attendant, Individual Companion, Adult Day Care, Adult Day Care Nursing, Adult Day Care Transportation, Home Delivered Meals, Case Management and Home Modifications are billed through the Care Call system. In all cases, no claim can be submitted that is not supported by a service authorization. It is planned that at some point all waiver claims will process through the Care Call system. Currently, for services not part of the Care Call system, South Carolina has developed a system which checks to ensure that the participant is enrolled in the waiver and is Medicaid eligible at the time of the service. Case Managers review service delivery with participants on a monthly basis to ensure that claims are appropriate and that authorized services are being delivered.

In addition to the financial accountability offered by the Care Call system, the State also employs a licensed Registered Nurse who conducts on-site reviews with personal care,

companion, and nursing providers. The reviews consist of three components: staffing review, administrative review and participant review. These reviews have been automated for a number of years. Since April 2008, personal care reviews have been scored based upon number and seriousness of deficiencies. Provider sanctions are based upon these scores. The review schedule is based upon results of prior reviews and every provider receives an on-site review at least every 18 months.

Also, CLTC and Program Integrity work closely with the Medicaid Fraud Control Unit for South Carolina's Attorney General's Office. Any suspected fraud is referred to this unit for investigation. This unit has used data given to them to initiate criminal investigations against several providers.

**Evidence Supporting This Conclusion:**
*(Evidence that supports the finding that the State substantially meets this assurance.)*

- State's written explanation and documentation submitted
- Most recent 372 report

**Suggested Recommendations:**

None