DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett	2-4-15

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000176	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Kosh, Deps, CMS file	[X] Prepare reply for appropriate signature DATE DUE 3-4-15 [ ] 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.			
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

January 30, 2015

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

Dear Mr. Soura:

Enclosed is the draft 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. We found the state to be in compliance with five of the six review components. For those non-compliant assurances, the state must show compliance at the time of renewal in order for CMS to approve the waiver renewal. As such, we included necessary recommendations for program improvements in one of the assurances. We have included some suggestions for program improvements in two of the six assurance areas. We suggest you address these prior to the renewal in order to meet the assurances and maximize the quality of the waiver program.

Please review the draft report and submit your comments within ninety (90) days of receiving this letter. Your response will be incorporated into the final report, which will then become a public document. Should we receive no response from you by the 90th day (April 30, 2015), this draft report becomes a final document. We are available to discuss the report and to provide technical assistance. Please do not hesitate to let us know how we may be of assistance.

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,

Jackie Glaze

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

Draft Report

Home and Community-Based Services Waiver Review
South Carolina Community Choice Waiver
Control # 0405.R02

January 30, 2015

Home and Community-Based Services
Waiver Review Report

Executive Summary

The South Carolina Department of Health and Human Services is authorized under §1915(c) of the Social Security Act to provide home and community based services through the Community Choices Waiver for frail elders and people with physical disabilities. All individuals must meet nursing facility level of care (LOC). Services offered are designed to provide individuals the choice of remaining in their homes as an alternative to nursing home placement.

As requested per the CMS Interim Procedural Guidance, South Carolina submitted evidence to document adherence with program assurances as required per §42 CFR 441.302. In its September 16, 2014 submission, the state provided an overview of processes, systems and summary reports for each federal assurance. The state's review addressing each assurance was for fiscal years of July 1, 2011 through June 30, 2014. The most recent 372 report, submitted January 4, 2013 shows 14, 262 individuals enrolled with an average per capita cost of $14,333 annually. This waiver is effective from July 1, 2011 through June 30, 2016.

The South Carolina Department of Health and Human Services (SCDHHS) administers and operates this waiver program. Program operations are based on policies and procedures that address federal assurances and state regulations. The state conducted 100% review using its automated Phoenix data system. Phoenix is a case management monitoring and billing system designed to ensure authorized case management is conducted. The system also prompts case managers through automated tickler files to perform activities timely.

The state uses contracted Medicaid entities to provide Case Management functions. All new case managers are required to attend orientation that includes training on all aspects of case management activities. Competencies are tested after orientation training and again after 90 days. Policies and procedures, scopes of service, and PowerPoint trainings are also posted on-line and additional interactive on-line training is being created that will include vignettes and case scenarios. Regional trainers are also utilized for on-going field training to evaluate contacts, home visits and case management documentation.

SCDHHS developed a Quality Assurances Task Force in 2006 which includes pertinent waiver staff. This Task Force meets regularly and discusses topics such as quality assurance chart review results; case management agencies; service providers' growth and/or concerns and any sanctions taken; Phoenix system reports; Adult Protective Services reports; and appeals and other QA activities. The outcome from these meetings is used to address any needed program updates, policy changes and to identify training needs.

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.

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.

III. **Qualified Providers Serve Waiver Participants: The state substantially meets this assurance**

Suggested Recommendations:

The state utilizes multiple performance measures to ensure that only qualified individuals and/or agencies are allowed to provide services to waiver participants. The state's scoring algorithm and sanction policies appear to be appropriate based on the severity of findings. The CMS suggest that the state considers amending performance measures #2, #3, #4 and #5 in the qualified provider section as they measure a number of actions the state conducts but do not provide actual data on the performance of providers.

IV. **Health and Welfare of Waiver Participants: The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed**

Suggested Recommendations:

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

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)
- 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.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program: The state substantially meets this assurance

Suggested Recommendations:

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

VI. State Provides Financial Accountability for the Waiver: The State substantially meets this assurance

Suggested Recommendations:

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.

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.

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 & 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. This assessment also serves to inform CMS in its review of the state's request to renew the waiver.

State's Waiver Name:	Community Choices Waiver
Operating Agency:	SC Department of Health & Human Services
State Waiver Contact:	Roy Smith, Program Manager II
Target Population:	Frail Elders and Disabled Adults
Level of Care:	Nursing Home
Number of Waiver Participants:	14,262 (per most recent 372 submitted)
Average Annual Per Capita Costs:	$14,333
Effective Dates of Waiver:	July 1, 2011 – June 30, 2016
Approved Waiver Services:	Adult Day Health Case Management Personal Care, Levels I and II Respite Adult Care Home Services Adult Companion Services Adult Day Health Transportation Attendant Care Community Residential Personal Assistance Home Accessibility Adaptations Home Delivered Meals Nursing Home Transition Services Personal Emergency Response Systems Specialized Medical Equipment and Supplies Telemonitoring
CMS Contact:	Kenni Howard

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

0.6% of the cases (202) was not justified for being late and recoupment of funds was warranted and completed. Therefore, the compliance rate for re-evaluations is 99%.

For the sub-assurance that speaks to the approved assessment instrument being used and applied appropriately, the state utilizes two performance measures: (1) the number and percent of all LOC determinations completed using the appropriate forms/instruments as required by the Medicaid Agency, and (2) The number and percent of all LOC determinations where LOC was applied appropriately. The state's Phoenix system includes the approved assessment instrument. Phoenix ensures that 100% of applicants are assessed using the appropriate forms and methods. Phoenix also provides a LOC recommendation which is coded against the state's LOC criteria and applies that code to each assessment. A 100% review of Community Choices participants revealed that 99% of the LOC determinations (47,538 reviewed during the reporting period of July 1, 2011 through June 30, 2014) agreed with the LOC decisions generated through the Phoenix system. 78% of the remaining 1% was justified in that the LOC decision determined by state medical staff and case managers incorrectly selected medical ineligibility.

Remediation in all cases of non-compliance included financial recoupment and on-going policy and procedure reviews with providers and case managers. The case management scope of service was also updated to include training, remediation strategies, and sanction guidelines for non-compliance with policy, procedures and waiver requirements.

It appears the state has an adequate system in place to assure the LOC criteria is applied appropriately for all applicants who apply to the waiver program. Additionally, the Phoenix system contains a tickler system to alert case managers of upcoming actions to be completed, and assures that reassessments are completed as required.

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

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 to accommodate any new and/or revised federal guidelines or regulations that will assist the state in meeting all LOC sub-assurances in the future.

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 present to show that personal goals were discussed and addressed. A sample of the remaining 13% revealed that 22% of those cases were justified due to the participant's desire not to share personal goals and/or inability to express personal goals due to severe intellectual disability or late stage dementia.

Remediation included technical assistance from Truven Health who made recommendations as to how the state could assure personal goals were discussed with participants. The state added additional questions to an already existing case manager check list and data collection started in July 2012. Additionally, a banner message was incorporated into the Phoenix system that reminds case managers to inquire about personal goals. As additional remediation, the state held training in September 2014 with field management staff, followed by statewide training, and regional trainers continued addressing the personal goals issue. Additional reviews

of service plans found that 100% of all plans revealed that caregiver supports and home/environmental needs were appropriately addressed.

For the sub-assurance that measures if the state monitors service plan development in accordance with its policies and procedures, the state uses two performance measures: (1) number and percent of service plans completed in Phoenix and team staffed within required timeframes and (2) number and percent of service plans developed that involved participants and/or caregivers in the process.

A 100% report of all Community Supports service plans (44,047) was reviewed during the reporting period. 39,668 (90%) were completed in Phoenix and the service provider team was staffed within required timeframes. A further sampling of the non-compliant 10% revealed approximately half of those plans were completed but not signed by either the case manager or SCDHHS reviewer. Based upon the further review, the adjusted compliance rate was determined to be 95%.

Remediation included financial recoupment of funds for instances when late service plan development was identified. Additionally, ongoing training and review of policies and procedures was conducted with providers and case managers.

Of the 44,047 plans reviewed for the second performance measure, 30,968 (77%) were found to have been developed involving the participant and/or caregivers. This is measured by an electronic signature of the participant and/or caregiver on the service plan. For the 23% without a signature, further review found that 39% had valid reasons for no signature (death, declining to enroll in the waiver, issues with Phoenix). The state is reporting an adjusted compliance rate of 86%.

Remediation included reporting Phoenix system errors via a "Report a problem" feature. Additionally, the Case Manager Scope of Service has been updated to include training, remediation strategies and sanction guidelines for non-compliance with policy, procedure and waiver requirements.

For the sub-assurance that determines if service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs, the state uses two performance measures: (1) number and percent of service plans updated as needed and (2) number and 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.

99% of service plans reviewed found that participants received all services identified on the service plan. The remaining 1% included reasons such as the participant declining services, the case manager inadvertently answering the check list question wrong, or participant services being placed on hold during short term hospitalization/rehab. In all cases, the case managers followed-up with providers when services were not delivered as authorized and took appropriate steps to correct problems. This revises the compliance rate to 100% and therefore, no remediation was required.

The state uses two performance measures for the sub-assurance that the participant was offered choice between waiver services and institutionalization and between/among services and providers. The first performance measure is the number and percent of participants with an appropriately completed service choice form that offered choice of institutional care or waiver

services. The second performance measure states the number and percent of participants afforded choice of all qualified waiver service providers.

A 100% sample of Community Choices participants was reviewed to ensure that each had an appropriately completed freedom of choice form (called LOCUS in South Carolina). Findings revealed that 83% had an appropriately completed form on file in Phoenix that offered a choice between waiver and institutionalization. A sampling of the remaining 17% was reviewed further and found that the majority had the appropriate hard copy forms in the case record, but they had not been scanned into Phoenix or they were scanned into the incorrect section of Phoenix. Since the LOCUS is obtained with the initial waiver admission, many of the participants were enrolled prior to the electronic signature availability and/or scanning was required.

Remediation included sending e-mails to field management staff requiring all hard copy LOCUS forms to be scanned into the Phoenix system immediately and on-going policy and procedures reviews with providers, case managers and nurse consultants. In cases where the LOCUS forms cannot be identified, staff and case managers were required to obtain a signed copy at their next face-to-face visit with the recipient.

Participants and/or caregivers are required to sign a Phoenix generated copy of the service plan which indicates that they participated in its development and that they were provided a choice of services and service providers. The form also states that the participant may choose to change service providers at any time. These forms are required to be signed at the initial visit after service plan development and at the first quarterly visit after the annual service plan development.

Of 40,442 service plans reviewed during the multi-year time frame, 30,968 (77%) had an appropriately completed service plan agreement indicating the participant was given a choice of all qualified waiver service providers. The remaining 23% of service plans were reviewed in depth and 39% of them were justified in that the participant passed away before signing the service plan; the participant declined to participate in the program after the service plan was developed but before services were started; Phoenix system errors; and the Phoenix report was generated prior to signatures being obtained on service plan agreements. Accordingly, the adjusted compliance rate was 86%.

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.

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 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.)

Potential providers are required to submit a completed enrollment application online which is screened by a contracted entity within the Provider Enrollment area. Provider Enrollment is tasked with verifying the applicant has no state or federal exclusions and also conducts site visits (if necessary) to ensure providers meet all other agency and program criteria. After completion of the screening process and site visits, provider applications are sent to the state for processing. Approved applicants are required to attend a mandatory pre-contractual meeting prior to being issued a provider agreement.

Licensed providers (Adult Day Care and Respite) are licensed by the Department of Health and Environmental Control (DHEC). The state is notified by DHEC if any licenses are changed and/or terminated. All licensed providers are required to show proof of such prior to completing the online application in addition to meeting other requirements outlined in the provider application and must attend the pre-contractual training. The state employs a licensed Registered Nurse to conduct periodic site visits to all licensed providers.

Provider reviews include administrative, service and staffing components. The administrative review determines all administrative requirements (policy/procedure manuals, organizational charts, liability insurance to date, etc.) have been met. The service review is to verify all requirements related to actual provision of services have been met. The staffing reviews sample staff members of various levels to ensure individual licenses are current, required tuberculin skin tests are up to date, first aid certifications are current and any other requirements as outlined in the contract.

To ensure that providers initially and continually meet required licensure and/or certification standards prior to furnishing waiver services, the state utilizes eight performance measures: (1) number and percent of potential providers who meet the initial application criteria; (2) number and percent of potential provider applicants that meet initial contractual requirements; (3) number and percent of potential providers that receive on-site visits as required; (4) number and percent of providers monitored on an ongoing basis via unannounced on-site visits; (5) number and percent of Program Integrity post-payment reviews done on a random basis, by complaint, and/or as required of waiver program staff; (6) number and percent of providers monitored by case managers through the use of Care Call; (7) number and percent of specialized ad-hoc reviews done in response to specific complaints about providers;

and, (8) number of complaints and percent of those that were acted on and logged in the state's Phoenix system. The same performance measures are used to evaluate non-licensed or non-certified providers as well.

During the review period (July 1, 2011 – June 30, 2014), there were four licensed providers who applied and all met the initial criteria for 100% compliance. All four licensed providers met initial contract requirements and all four had on-site visits by an area office administrator or by 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.

Other services are reviewed by different means. Home Delivered Meals are monitored by the State Office of Aging, since all but three providers are part of the aging network. There is a formal Memorandum of Agreement (MOA) between SCDHHS and the State Unit on Aging. In addition, case managers consult with participants monthly to ensure that meals are being delivered as authorized and that they are satisfied with the service.

Environmental modification services require the provider to be a licensed contractor. In addition to the contractor being required to meet the initial provider requirements, the state employs a review Registered Nurse who conducts on-site reviews of environmental modifications to ensure all state building codes and regulations are followed. If deficiencies are found, suspensions of new referrals or recoupment of payment is initiated, depending upon the severity of the deficiency. The contractor is provided the opportunity to correct any deficiency prior any sanctions and they must be completed within a certain timeframe.

Attendant care services are provided by individuals directly employed by the participant through the consumer directed option. There is a contract between SCDHHS and the University of South Carolina to ensure all attendants meet specified requirements prior to providing services. The University uses Registered Nurses to assess attendants and ensure they are competent to provide all needed care. Additionally, case managers consult monthly with the participant to ensure that the service is adequate and being provided as identified on the service plan.

Individual attendant and companion services are provided to participants who are capable of self-direction. Participants may terminate companions or attendants for any reason at any time. Allegations of inappropriate actions that are reported are investigated and could result in recoupment of payments or termination from the Medicaid program.

To ensure that non-licensed/non-certified providers adhere to waiver requirements, the state uses the same eight performance measures as for licensed/certified providers. The Community Long Term Care Compliance Review Officer monitors contracted providers to ensure compliance with all waiver requirements. When the reviewer identifies situations, actions are taken to rectify those areas of concern.

For performance measure #1, the state reported there were 135 provider applicants during the reporting period and 100% met the initial application criteria and attended mandatory training prior to the issuance of a provider contract and the provision of services. Additionally, for performance measure #2, all 135 applicants met initial contractual requirements.

For performance measure #3, 118 providers (92%) received an on-site review by an area office administrator. Effective December 13, 2013, providers were required to submit their enrollment applications on-line. After the initial assessment of the online application, provider enrollment

schedules and conducts an on-site visit. To avoid duplication of efforts, area administrators do not conduct on-site visits to all providers.

Program Integrity post-payment reviews (performance measure #5) are conducted on a random basis. 54 reviews of 444 (12%) applicable unlicensed providers were conducted during the review period. Thirty four resulted in recoupment of provider payments and the remaining 20 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. 48 (19%) did not complete training as required and appropriate corrective action plans and/or sanctions were imposed according to the state's scoring algorithm.

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 utilizes multiple performance measures to ensure that only qualified individuals and/or agencies are allowed to provide services to waiver participants. The state's scoring algorithm and sanction policies appear to be appropriate based on the severity of findings. The CMS suggest that the state considers amending performance measures #2, #3, #4 and #5 in the qualified provider section as they measure a number of actions the state conducts but do not provide actual data on the performance of providers.

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 does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

Evidence Supporting This Conclusion:
(Evidence that supports this conclusion is weak and not complete. Additional information is required to comply with the assurance.)

Evidence submitted indicates that the South Carolina Department of Social Services, Adult Protective Services Division (SCDSS/APS), by state statute, is the investigative authority for all cases that involve suspected abuse, neglect and/or exploitation (ANE). The SCDHHS has a Memorandum of Agreement with this agency to share Community Long Term Care data as allowable. The SCDSS reports any referrals of suspected ANE for waiver participants to SCDHHS. Case Managers are also required to enter all referred cases of potential ANE into the 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)
- 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.

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.

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.

South Carolina has an Electronic Visit Verification (EVV) system, known as Care Call, which is used to document delivery of services performed in the participants' homes. In-home service providers make a toll free call or use smart phone technology to document their service delivery. The Care Call system is accessed to document when the service begins and again when the service ends. Payment is based on the time spent providing the service to the participant. When the service does not required a specific amount of time spent with the participant, Care Call is accessed only once to document the service delivery (e.g., delivery of meals, home modifications). Information from Care Call is electronically transmitted to the Phoenix system.

For services that are not delivered in the participants' homes, and/or when no in-home documentation is required, documentation of service delivery is completed through the Phoenix system. For all services other than respite, Phoenix compares the amount of service documented to the services that have been authorized to ensure billings do not exceed authorization limits. Phoenix also ensures that services are delivered as authorized (e.g., if services are authorized for Tuesday/Thursday, the system will not pay for services delivered on other days).

Claims are generated based upon service delivery documented in the Care Call and Phoenix systems. Claims based on authorized services are always the lesser of the delivered and authorized times (e.g., 2 hours authorized and 1.5 delivered would generate a claim for 1.5 hours, whereas 2 hours authorized and 3 hours delivered would generate a claim for 2 hours). This method ensures that providers do not exceed authorized amounts. Case Managers also review service delivery with the participants on a monthly basis to ensure that authorized services are being delivered.

Additionally, the state employs a licensed Registered Nurse who conducts on-site reviews with personal care, companion, adult day health and nursing providers. The reviews consist of three parts: staffing; administrative; and participant. The participant component looks at a sampling of participant records and the reviewer verifies that all requirements related to the conduct of service provision have been met. This includes verifying that services were provided as authorized, documented appropriately and paid correctly.

These reviews are automated and are scored based on the number of and seriousness of any deficiencies. Since 2008, approximately 23% of providers have received sanctions which included suspension of new referrals. Multiple providers have been required to submit corrective action plans. The provider review schedule is based upon results of previous reviews, but every provider receives an on-site review at least every 18 months.

The SCDHHS Program Integrity Unit monitors services; responds to complaints and allegations of inappropriate or excessive billing by Medicaid providers; and collects and analyzes provider data to identify any billing exceptions and deviations. If trends indicate the need, the Program Integrity Unit may audit payments to service providers.

Recoupments of payments are made if any provider records or documentation does not support billing of the service.

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.