**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Myers | 11-16-09 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 11224 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>cc: Ms. Forkner, Deps, CMS files | [X] Prepare reply for appropriate signature<br>DATE DUE 2-1-10 |
| | [ ] FOIA<br>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
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

November 10, 2009



Emma Forkner, Director
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29201

Dear Ms. Forkner:

Enclosed is the draft compliance report for South Carolina's Community Choice Waiver for Frail Elders and Persons with Physical Disabilities, control # 0405.R01. This review was conducted based upon evidentiary-based information submitted by your office on July 15, 2009. Please review this report and provide any comments to this office no later than February 10, 2010. The State's comments will be incorporated into the final report.

We wish you continued success in your Home and Community Based Waiver (HCBW) program and look forward to working with you in the future. If you have any questions or need assistance, please contact Kenni Howard at 404-562-7413.

Sincerely,

Joyce C. Wilkerson for

Mary K. Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Mark Reed, 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 Assessment of South Carolina's Community Choice Waiver for Frail Elders and Persons with Physical Disabilities**
**Control # 0405.R01**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

# South Carolina Community Choices Waiver Assessment
# Control # 0405.R01

**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.

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|---|---|
| **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:** | Frail Elders and Physically Disabled Individuals |
| **Level of Care:** | Nursing Facility |
| **# of Participants Approved for Year 4 of the Waiver:** | 16,250 |
| **# of Participants reported on the most recent 372 Report (dated):** | 14,603 (7/1/07-6/30/08) |
| **Effective Dates of Waiver:** | 07/01/06 – 06/30/11 |
| **Approved Waiver Services:** | (1) Case Management<br>(2) Personal Care<br>(3) Attendant Care<br>(4) Home Delivered Meals<br>(5) Adult Companion Care<br>(6) Chore Services<br>(7) Adult Day Health Care |

| | |
|---|---|
| (8) | Adult Day Health Care Nursing |
| (9) | Personal Emergency Response System |
| (10) | Nursing Home Transition Services |
| (11) | Home Accessibility Adaptations & Appliances |
| (12) | Specialized Medical Supplies & Equipment |
| (13) | Respite (institutional, in home, community) |

**CMS RO Contact:** Terrie Morris

**Report Drafted by:** Kenni Howard, RN

**Date Report Issued:** November 10, 2009

## Background and Description of the Waiver:

South Carolina was granted a waiver of Section 1902(a)(10)(B), "amount, duration, and scope of services," requirements of the Social Security Act in order to provide home and community based services to frail elders and persons with physical disabilities who meet Nursing Facility level of care. The eligibility groups covered are those individuals with Medicaid coverage through SSI; low income families with children as provided in §1931 of the Act; those aged or disabled individuals who have income at 100% of the Federal poverty level; working individuals with disabilities who buy into Medicaid as provided in §1902(a)(10)(A)(ii)(XIII) of the Act; disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group); and, those individuals eligible under 42 CFR §435.217. South Carolina operates this waiver statewide.

## 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*

All waiver referrals go through an intake process. Intake criteria are applied by a Nurse Consultant and the case is assigned to a Nurse Consultant for assessment. Assessments are keyed in to the South Carolina's Division of Health and Human Services (SCDHHS) Case Management System (CMS). Individuals who meet the eligibility requirements may enroll for Community Choices. A Nurse Consultant verifies that the applicant is Medicaid eligible, meets Level of Care (LOC) and desires to participate in the waiver program. Justification for LOC determination is documented in the narrative and/or narrative checklist and on the assessment form.

Enrolled participants are re-evaluated at least annually or more frequently if warranted. The assigned contracted case manager completes the assessment within 365 days from the last completed assessment. The same assessment tool used for initial assessments and LOC determination is used for re-evaluations. The approved waiver assessment instrument is part of the Case Management System.

### The State substantially meets this 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.)*

The Case Management System generated reports for the time period of July 1, 2006 forward indicate 100% of applicants have a Level of Care on file. Of the 6,684 enrollees reviewed, all had Level of Care determinations conducted within 30 days of waiver enrollment. The CMS generated reports indicated 35,143 re-evaluations were completed

between July 1, 2005 and June 3, 2009. A 3% sample (1,054) of records was reviewed for timeliness. On this sample, 86% of the re-evaluations were timely and completed within 365 calendar days. Of the 144 re-evaluations that were not timely, 108 were completed during the month, but not completed before or on the anniversary date. In May 2007, SCDHHS made a significant policy change which no longer allows for re-evaluations to be conducted during the anniversary month. All re-evaluations are required to be completed prior to or on the anniversary date.

The approved waiver assessment instrument is part of the CMS program. CMS ensures that the approved assessment is used for 100% of applicants. A 3% sample of Community Choices participants is included in Central Office chart reviews covering 2007 and 2008. The state has a 95% average for using the appropriate process for LOC determination and a 94% statewide average for Level of Care determinations.

## Evidence Supporting Conclusions:

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

- Attachments 1A &1B: Instructions and sample Nurse Consultant quality assurance review tools that address Team Staffing, Checklists and Assessments/Levels of Care completed timely.
- Attachment 2: Samples of Nurse Consultant completed checklists and assessments to support Level of Care determination and Medicaid eligibility.
- Attachment 3: CMS generated report showing that of 6,684 participant that entered the Community Choices Program (July1, 2006 – June 3, 2009), all had assessments completed within 30 days of entry.
- Attachment 4: CMS generated report that shows participants who had re-evaluations completed timely.
- Attachment 5: Copies of SCDHHS Community Choices policies and procedure revisions to address timeliness of participant re-evaluations and team staffing with State employees for LOC determinations.
- Attachment 6A: Copy of SCDHHS Community Long Term Care (CLTC) Regional Trainers/Teachers Guide.
- Attachment 7: Copy of CLTC Orientation (assessment & LOC training)
- Attachment 8: Copy of CLTC Case Management Training
- Attachment 9: Copy of CLTC Case Management Orientation – Quality Assurance handout.
- Attachment 10: Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Review.
- Attachment 11: Sample of SCDHHS Annual 2007-2008 Quality Assurance Reports and Regional Office Corrective Action Plans.
- Attachment 12A and 12B: Instructions and copies of regional office monthly internal quality assurance reviews.
- Attachment 13 & 14: Quality Assurance Task Force Meeting Agenda and Notes regarding LOC concerns and follow-up.
- Attachment 15: Copies of emails, to/from regional office lead team case manager, regarding LOC concerns.

## 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*

SCDHHS is responsible for developing participant service plans based on the comprehensive assessment of the participant's medical needs, activities of daily living, psycho-behavioral information, instrumental activities of daily living, and the individual's strengths. Each problem addressed on the service plan includes goals, objectives and interventions. The State CMS program has a component (the "Wizard") that links problems identified in the assessment to the service plan. Case Managers use this component to identify all problems in the assessment and it gives the option of addressing them in the service plan.

Regional office monthly internal QA reviews, quarterly accumulated and internal QA review data and CO yearly reviews are used to monitor the updating of service plans annually or when warranted by changes in participants' needs.

The CMS program will not allow service authorizations that do not contain the 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.

Each participant or responsible party signs and dates a LOCUS form prior to program entry. The LOCUS form indicates participant's choice of community care or institutional care. Signature and date of LOCUS forms are monitored during regional office internal monthly quality assurance reviews and CO annual quality assurance reviews. A State case manager presents contracted case manager choices to each participant for verbal case manager selection. Other service provider selections may be made with state or contracted case managers. At the case managers' and participants' initial visit, the participant signs and dates a choice form confirming verbal provider selections.

### The State substantially meets this assurance

*(The State has an adequate and effective system to assure that all aspects of Plan of Care requirements are addressed; has an adequate and effective system for monitoring Plans of Care; has a system for assuring that participants are afforded choice between/among waiver services and providers; and demonstrates ongoing, systemic oversight of POCs.)*

Service plan development and updates are discussed during new case managers' orientation and training with regional trainers. Central Office annual reviews and regional office monthly internal reviews of service plans ensure participant needs are met.

On a monthly basis, the SCDHHS Regional Office senior case management staff review one to four files for each case manager, to ensure accurate service plan development. Any problems that are found are recorded on the internal QA tool and discussed with the appropriate case manager. Any QA tool indicator that falls below the 90-94% compliance rate must be addressed in a corrective action plan.

### Evidence Supporting Conclusions:

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

- Attachment 16: Copy of assessments, service plans and service plan wizard requirements.
- Attachment 9: Copy of LCTC Case Management Orientation – Quality Assurance handout.
- Attachment 6B: Copy of SCDHHS Regional Trainers Teaching/Training Guide.
- Attachment 10: Copy of Statewide Summary for Central Office 2007-2008 Quality Assurance Reviews.
- Attachment 12B: Copy of regional office monthly internal QA reviews.
- Attachment 17A and 17B: Instructions for distribution of quarterly case managers' accumulated internal QA scores and sample of quarterly case managers accumulated regional office internal QA scores.
- Attachment 18: Regional Trainers meeting minutes that address scheduling of training.
- Attachment 19: Sample of Care Call Reports
- Attachment 20: Copies of "Options" handouts
- Attachment 21: Copies of CLTC complaints
- Attachment 22: Copy of "2008 Annual Survey of CLTC Consumer Experience and Satisfaction" report.

## 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 verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards. The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State employs a licensed Registered Nurse to conduct on-site reviews periodically based on past performance of the following services: Personal Care I; Personal Care II; Agency Companion; Medicaid Nursing; and, Adult Day Care.

Other services are reviewed by different means. Home delivered meals are monitored by the State Unit on Aging through a formal memorandum of agreement with the SCDHHS. 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. Attendant care services are provided by

individuals directly employed by participants. SCDHHS has a contact with the University of South Carolina to ensure that these attendants meet all requirements to provide services.

The CLTC Compliance Review Officer monitors contracted providers to ensure compliance with contractual requirements. This individual is responsible for identifying and rectifying situations where providers do not meet requirements.

## 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 employed Registered Nurse review consists 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 that all agency administrative requirements (liability insurance, list of officers, emergency backup plans, policy and procedure manuals, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

For services monitored by the compliance registered nurse, a report is generated listing all deficiencies identified. 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. For other services, a report is generated listing all deficiencies identified. Based upon the severity and number of deficiencies, along with results of prior reviews, sanctions may take place.

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, generally coupled with a history of reviews with repeated moderate to major deficiencies. The provider is terminated from the Medicaid program.

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.

### Evidence Supporting Conclusions:

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

- Detailed description of scoring system and calculating process for sanctioning levels.

## 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*

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). The purpose of the agreement is to identify those programs and services operated or contracted for operation by CLTC that should report alleged abuse, neglect or exploitation to SCDSS; a provision of a system for generating reports of alleged abuse, neglect and exploitation with vulnerable adults receiving services from CLTC; and, establish a cooperative relationship for the purpose of training and technical assistance to CLTC staff and/or its contractors.

### The State substantially meets this assurance

*(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 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 Supporting Conclusions:

(Evidence that supports the finding that the State substantially meets this assurance.)

- Attachments 7 & 8: CLTC Orientation agendas and CLTC Case Management Training topics.
- Attachment 23: CLTC Orientation APS information.
- Attachment 24: Copy of APS internal website power point presentation.
- Attachment 25: MOU between SCDHHS and SCDSS
- Attachment 21: Copies of CLTC Complaint forms
- Attachments 13 & 14: Copies of QA Task Force Meeting Agendas and notes regarding allegations of abuse, neglect and/or exploitation.

# 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 Community Choice 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.)*

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.

## Evidence Supporting Conclusions:

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

- Attachment 10: Copy of Statewide Summary for Central Office 2007-2009 QA Review.
- Attachment 12B: Copies of regional office monthly internal QA reviews.

## 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*

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

First, 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.

### 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.)*

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 all 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 come through the Care Call system. Currently, for service 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.

Also, the Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to CLTC service providers. Recoupments of funds are made when provider records do not support billings of services.

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

- Attachment 19: Care Call reports.
- Most recent 372 report.