2020 External Quality Review

SOUTH CAROLINA SOLUTIONS

Submitted: August 7, 2020

Prepared on behalf of the
South Carolina Department
of Health and Human Services

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. The purpose of this review was to determine the level of performance demonstrated by South Carolina Solutions (Solutions). This report contains a description of the process and the results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

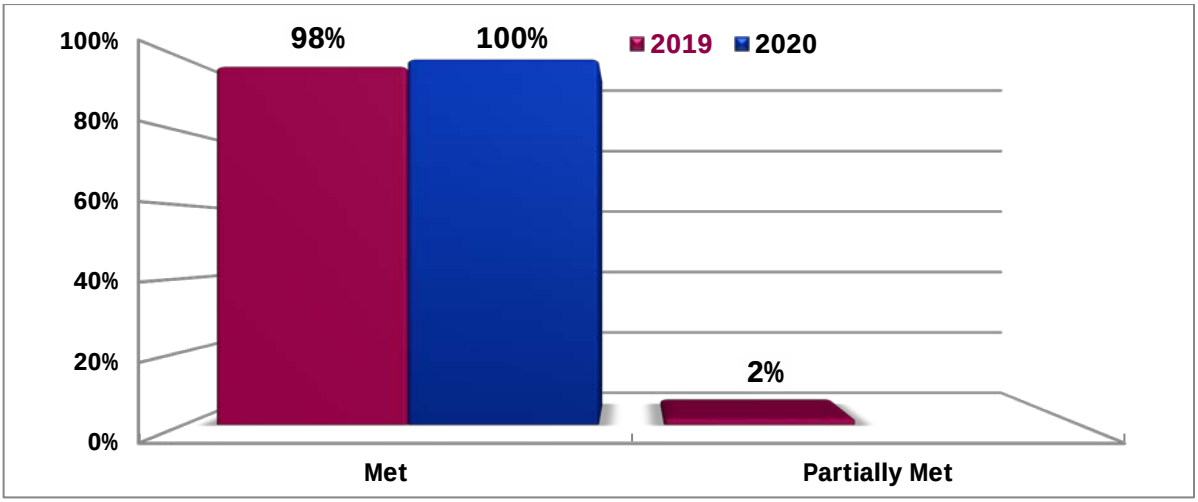
- Determine if Solutions was in compliance with service delivery as mandated in their contract with SCDHHS
- Provide feedback for potential areas of further improvement
- Assure that contracted health care services are actually being delivered and are of good quality

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review included a desk review of documents and an onsite teleconference.

Overall Findings

The 2020 annual EQR shows that Solutions has met all the requirements for this EQR. The following chart provides a comparison of Solutions' current review results to the 2019 review results.

Figure 1: Annual EQR Results



An overview of the findings for each section follows. Details of the review, as well as specific strengths, weaknesses, and recommendations can be found further in the narrative of this report.

Administration:

South Carolina Solutions (Solutions) is a subsidiary organization of Community Health Solutions of America (CHS). The CHS Corporate Board of Directors (BOD) governs the organization and adopts rules, policies, procedures, and other directives for the orderly operation of the organization. Solutions' Executive Director ensures the goals and objectives of SCDHHS, CHS, and Solutions are aligned, and the Program Operations Manager oversees day–to–day operations. Staffing appears to be sufficient to conduct required activities with no vacancies noted.

Solutions' policies are reviewed annually and as needed for regulatory and process changes. Staff are informed of new and revised policies and must attest that they have read the policy.

Policies have been developed to address requirements and processes for screening and verifying the qualifications of clinical staff; however, no formal policy defining the requirements for non-clinical staff was identified. CCME recommended a revision to the Clinical Staff Credentialing and Re-Credentialing policy to clarify the staff to whom the policy applies and to clearly describe how Solutions meets the requirement for background checks in states other than South Carolina in which an employee has resided within the last 10 years. Personnel files reflect appropriate processes are followed to verify employee information, conduct required screenings, and document initial and ongoing training.

The Compliance Program is applicable to all CHS lines of business and complements the established policies and procedures detailing Compliance requirements, appropriate business conduct, and processes to prevent and detect fraud, waste, and abuse (FWA). Compliance and FWA training are provided to employees at the time of hire and annually thereafter.

Solutions has an extensive set of policies and procedures detailing methods to secure devices and to protect participant data. Systems backups are scheduled regularly and routinely tested. The business continuity plan is a thorough, multi-phase plan that guides the workforce through the resources and processes to mitigate interruptions if an incident occurs. Solutions' disaster preparedness was tested during a recent weather event—operations were maintained before and after the event with no loss of data.

Provider Services:

The review of the Provider Services section includes the review of policies, the Provider Manual, and program materials that address provider education. Solutions' Program Operations Coordinator is responsible for conducting initial provider orientation and education within 30 days of provider contracting into the network. Policy CHS.PM.MCCW.01.01, Provider Orientation/Training, discusses the process for onboarding new providers to Solutions' network. Solutions' website includes a link to download the Provider Manual, as well as information about credentialing, reporting FWA, language services, and a link to the list of SCDHHS provider manuals.

The review found that Solutions continues to meet all the requirements in the Provider Services section.

Quality Improvement:

Overall, Solutions performed well in the Quality Improvement section of the EQR. During this review period, Solutions met all the requirements. Their program continues to operate under a plan of continuous improvement. The Strategic Quality Plan 2020 describes the program's structure, scope, goals, and functions.

Quality improvement projects are developed for opportunities identified for improvements. Solutions had two projects underway. Those include Care Plan Streamlining and Care Advocate Outreach. Both projects have been closed and replaced with the Emergency/Disaster Preparedness and URAC Re-Accreditation projects.

The Compliance & Quality Management Committee (CQMC) is responsible for the development and implementation of the QI Program. Voting members include the Chief Medical Officer, Executive Vice President of Compliance, Clinical Quality Programs Manager, and Care Coordinator Team Leads. The Chief Medical Officer serves as the chairperson for the meetings.

Solutions evaluated the QI Program and summarized the results of this evaluation in the Annual Report: Quality and Performance Improvement Calendar Year 2019.

Care Coordination/Case Management

CCME's assessment of Care Coordination/Case Management includes a review of the program description, policies, Provider Manual, case management files, and Solutions' website. The Waiver Program Description outlines the purpose, goals, objectives, and staff roles. Policies define how Case Management services are operationalized to service participants. The Program Manager oversees the day-to-day operations of the program

and the Medical Director works closely with the Care Coordinator Team Leads and is responsible for clinical oversight and decision-making.

As identified in previous EQRs, issues with documentation of team conferences and the Waiver Administrator's phone number were noted. The number provided for the Waiver Administrator on the MCCW Rights and Responsibilities document is incorrect. Although team conferences remain an optional service, documents such as the Provider Manual, Waiver Program Description, and member materials do not describe that team conferences are optional and conducted upon request.

The Waiver Program Description and policies appropriately document care management processes and service provided. Case Management files indicate Care Coordinators and Care Advocates follow policies to conduct care coordination activities.

Table 1: Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2019 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2019	33	0	0	0	0	33
2020	34	0	0	0	0	34
Provider Services						
2019	5	0	0	0	0	5
2020	5	0	0	0	0	5
Quality Improvement						
2019	7	0	0	0	0	7
2020	7	0	0	0	0	7
Care Coordination/Case Management						
2019	14	1	0	0	0	15
2020	15	0	0	0	0	15

METHODOLOGY

The process used by CCME for the EQR was based on CMS developed protocols for Medicaid MCO/PIHP EQRs and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects. Solutions is not required by contract to conduct performance improvement projects or collect performance measures. Therefore, for this review, those activities were not conducted.

On June 08, 2020, CCME sent notification to Solutions that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Solutions to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Solutions on June 22, 2020 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider educational materials, and the Quality Improvement and Care Coordination/Case Management Programs. Also included in the desk review was a review of care coordination/case management and personnel files.

The second segment was an onsite review conducted via teleconference on July 14, 2020. The onsite teleconference focused on areas not covered in the desk review or needing clarification. Onsite activities included an entrance conference, interviews with administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following sections and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between Solutions and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. We identify areas of review as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated" on the tabular spreadsheet (Attachment 2).

A. Administration

South Carolina Solutions (Solutions) is a subsidiary of Community Health Solutions of America (CHS). The CHS Corporate Board of Directors (BOD) governs the organization, and directs activities to maintain compliance with state, federal, and other regulatory requirements. Solutions' Executive Director ensures the goals and objectives of SCDHHS,

CHS, and Solutions are aligned. The Program Operations Manager oversees the day-to-day operations of Solutions, and the Medical Director is responsible for clinical oversight and decision-making. Solutions' Organizational Chart delineates lines of responsibility within the organization. No position vacancies are noted, and staffing appears to be sufficient to conduct contractually required activities.

Adequate processes are noted for policy development, review, and revision. Solutions' policies are reviewed annually and as needed for regulatory and process changes. The Compliance and Quality Management Committee (CQMC) is involved in the policy review process, and final approval of all policies is granted by the Executive Director/Chief Medical Officer. All policies are maintained on a shared drive for staff access and within the Healthicity™ platform used for policy management. Staff are informed of new and revised policies and must attest that they have read the policy.

Policies have been developed to address requirements and processes for screening and verifying the qualifications of clinical staff. During discussion, Solutions staff confirmed Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing and Re-Credentialing applies only to clinical staff; however, the "Scope" of the policy states it applies to all workforce members. Also, the policy does not clearly describe how Solutions meets the requirement for background checks in states other than South Carolina in which an employee has resided within the last 10 years. Solutions staff reported background checks for alternate states are conducted by HireRight®, an external screening services company that has been engaged to conduct pre-employment background checks, drug screenings, etc. Along with this finding, CCME could not identify a separate policy defining the requirements for non-clinical staff. CCME's review of personnel files confirmed appropriate processes are followed to verify employee information, conduct required screenings, and document initial and ongoing training.

The Compliance Program applies to all CHS lines of business and complements the established policies and procedures detailing Compliance requirements, appropriate business conduct, and processes to prevent and detect fraud, waste, and abuse (FWA). Compliance and FWA training are provided to employees at the time of hire and annually thereafter.

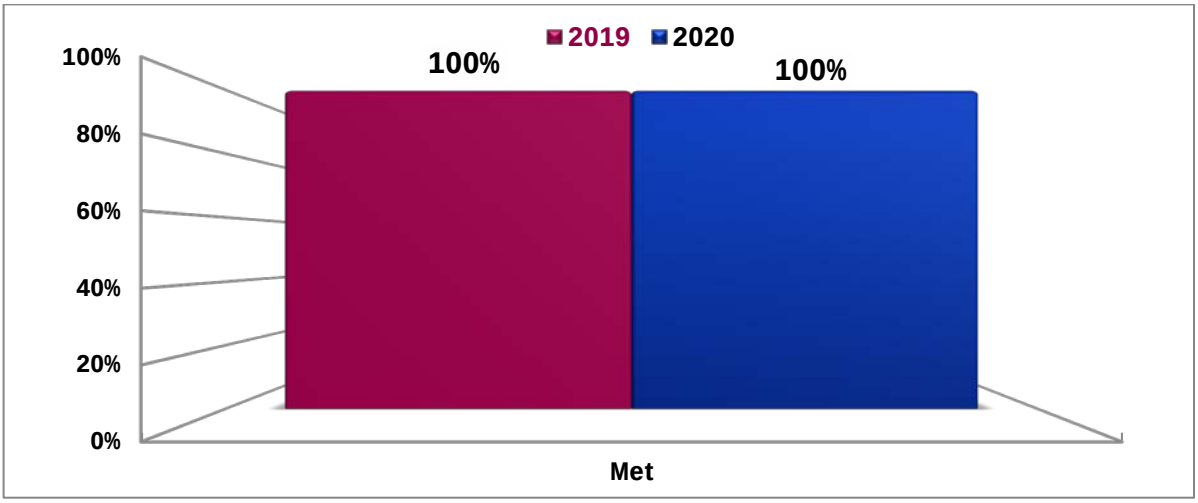
Data Systems and Security

Solutions collects little participant data, and most of the collected data is entered into the State of South Carolina's case management system. Solutions relies on the State to ensure information stored within its case management system is secure. An extensive set of policies and procedures detail methods to secure devices and to protect participant data.

Regularly scheduled backups and testing of those backups are routine for CHS, including Solutions. The business continuity plan is a thorough, multi-phase plan that guides the workforce through the resources and processes to mitigate interruptions if an incident occurs. During a recently endured natural weather event, Solutions' disaster preparedness was tested—operations were maintained before and after the event, and there was no loss of data.

As noted in *Figure 2: Administration Findings*, 100% of the standards for the Administration section of the review were scored as "Met."

Figure 2: Administration Findings



Strengths

- CHS conducts frequent data backups that are tested weekly to verify each backup's integrity.
- Strong physical security implemented at the organization's datacenters limits access by using badges and biometric controls.
- Extensive IT security policies are frequently reviewed and revised. Each policy incorporates a dated version history.
- Information about fraud, waste, and abuse is placed prominently on Solutions' website and includes methods of reporting suspected or actual fraud, waste, and abuse to the Compliance Officer, the SCDHHS Medicaid Fraud and Abuse Hotline, and the South Carolina Attorney General Medicaid Fraud Unit.

Weaknesses

- Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing and Re-Credentialing addresses requirements for obtaining criminal background checks for clinical staff.

However, although the title of the policy indicates it applies to clinical staff, the policy "Scope" section states the policy applies to all workforce members.

- Policy CHS.CRED.MCCW.03.06 does not address the requirement that background checks for states other than South Carolina be conducted when an employee has resided out-of-state within the last 10 years. Onsite discussion revealed that background checks for states other than South Carolina are conducted by HireRight®.
- A policy addressing the requirement for criminal background checks for non-clinical staff was not identified.
- Policy CHS.CM.MCCW.05.02, Chart Review Process states at least two ride-along audits will occur within a 12-month period for each care coordinator. However, Policy CHS.CM.MCCW.05.01, Medically Complex Criteria-Onsite Supervisory Visits states each Care Coordinator is supervised during a home visit at least annually by the Care Coordinator Lead or a clinical designee. Onsite discussion confirmed supervisory visits are conducted at least twice each year.

Recommendations

- Revise the "Scope" of Policy CHS.CRED.MCCW.03.06 to indicate the policy applies only to clinical staff.
- Include in a policy or other document the process for obtaining criminal background checks for non-clinical staff.
- Update Policy CHS.CRED.MCCW.03.06 to include that Care Coordinator background checks for states other than South Carolina in which an employee has resided within the last 10 years are conducted by HireRight.
- Revise Policy CHS.CM.MCCW.05.01, Medically Complex Criteria-Onsite Supervisory Visits to reflect the correct frequency of Care Coordinator supervision during a home visit.

B. Provider Services

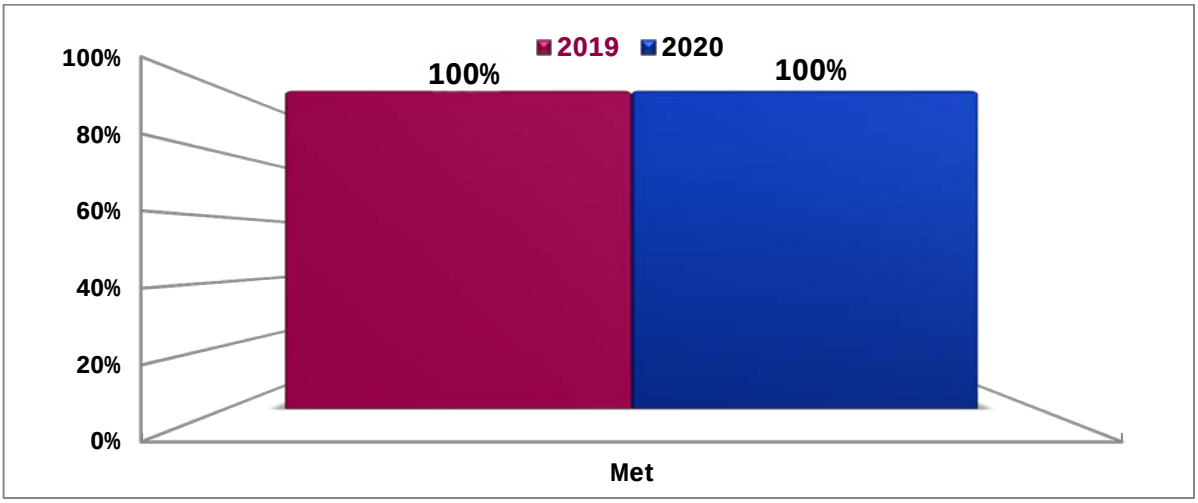
Solutions' Program Operations Coordinator is responsible for conducting the initial provider orientation and education within 30 days of provider contracting into the network. Policy CHS.PM.MCCW.01.01, Provider Orientation/Training discusses the process for onboarding new providers to Solutions' network. Provider orientation includes an overview of the organization, staff and duties, SCDHHS contractual relationship, an overview of the Medically Complex Children's Waiver (MCCW) program, and contractual requirements.

Solutions' website includes a link to download the Provider Manual, as well as information about credentialing, reporting FWA, language services, and a link to the list of SCDHHS provider manuals. The 2020 Provider Manual provided with the desk materials,

page 20, and Policy CHS.QM.ALL.01.10, Complaint and Grievance Process, provided information regarding the member/participant grievance process. However, the definition of grievance is incorrect. The Provider Manual and Policy CHS.QM.ALL.01.10 indicates a grievance is an expression of dissatisfaction about any matter other than an "action." Per *42 CFR 438.400 (b),* a grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. Also, the definitions for action and appeal in policy CHS.QM.ALL.01.10, Complaint and Grievance Process are incorrect.

Figure 3: Provider Services Findings, reflects Solutions continues to meet all requirements in Provider Services.

Figure 3: Provider Services Findings



Strengths

- Provider education resources are available in the Provider Manual and on the Solutions website.

Weaknesses

- The definition of a grievance in the Provider Manual and in Policy CHS.QM.ALL.01.10, Complaint and Grievance Process is incorrect.

Recommendation

- Update the definition of a grievance in the Provider Manual and in Policy CHS.QM.ALL.01.10. Remove the term "action" and replace with "adverse benefit determination."

C. Quality Improvement

Solutions' Quality Improvement (QI) Program operates under a plan of continuous improvement. The Strategic Quality Plan 2020 describes the program's structure, scope, goals, and functions.

Quality improvement projects are initiated when opportunities to correct or improve are identified. Solutions had two projects underway, including Care Plan Streamlining and Care Advocate Outreach. The goal for the Care Plan Streamlining project was to decrease the time spent updating monthly care plans. The analysis of this project showed documentation time decreased for one quarter. Results were presented to the Corporate Compliance and Quality Management Committee (CQMC) for recommendations. The project failed to produce meaningful data and therefore, the committee recommended closing the project.

The goal for the Care Advocate Outreach project was to identify customer service gaps. No patterns in gaps in care were identified. The project was closed with the outreach calls added as part of the routine Care Advocate workflow. The new projects recently initiated include Emergency/Disaster Preparedness and URAC Re-accreditation.

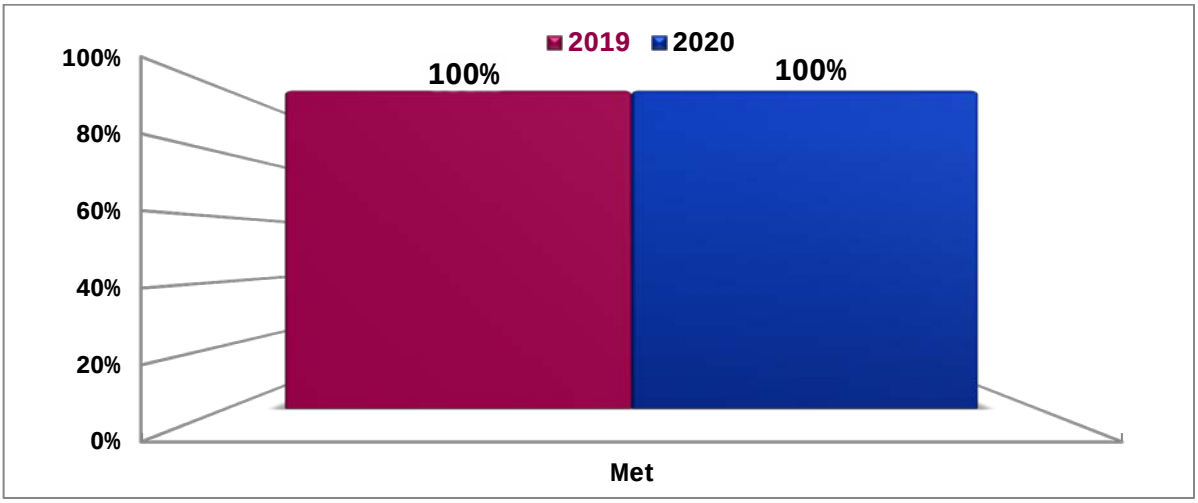
Annually, Solutions develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2019 and 2020 QI Work Plans. There were two areas noted as needing revisions or updates.

The Compliance & Quality Management Committee (CQMC) is responsible for the development and implementation of the QI Program. Voting members include the Chief Medical Officer, Executive Vice President of Compliance, Clinical Quality Programs Manager, and Care Coordinator Team Leads. The Chief Medical Officer serves as the chairperson for the meetings.

Solutions evaluated the QI Program and summarized the results of this evaluation in the Annual Report: Quality and Performance Improvement Calendar Year 2019.

Overall, Solutions performed well in the Quality Improvement section of the EQR. During this review period, Solutions met all standards for Quality Management as indicated in *Figure 4: Quality Improvement Findings.*

Figure 4: Quality Improvement Findings



Strengths

- Overall, Solutions performed well in the Quality Improvement section of the EQR and met all requirements.

Weaknesses

- Areas noted on the 2020 QI Work Plan that should be updated included:
  - Revision of Program Materials had an estimated completion date of 12/3/2017 and 2/1/2018.
  - The quarterly updates were not included for the Clinical Documentation Improvement Activity even though quarterly monitoring is conducted.
- It was noted in the CQMC meeting minutes the designated chairperson was not present for the 1st, 3rd, and 4th quarter (2019) meetings and an alternate or replacement was not named.
- The following issues were noted as errors in the Annual Report: Quality and Performance Improvement Calendar Year 2019:
  - Section D, Quality Improvement Projects and Corrective Action Plans, states "MCCW managed three Quality Improvement Plans (QIPs)." However, only two projects were documented.
  - Section II. Satisfaction Measures, A. Member Complaints (page 4) indicates in 2019 two complaints were logged. Both complaints occurred in quarter 4. However, the table on page 5 shows three complaints were logged in quarter 4.

- Section III. Compliance, B. Program Integrity Compliance, number 6 (page 6) states "Annual HIPAA/HITECH internal assessment was completed at the end of 2016 to assess compliance with the Affordable Care Act changes to HIPAA/HITECH.

Recommendations

- Update the 2020 QI Work Plan and correct the errors identified.
- Designate an alternate chairperson for the CQMC meetings when the chairperson cannot attend the meeting. Note in the meeting minutes the replacement.
- Correct the errors identified in the Annual Report: Quality and Performance Improvement Calendar Year 2019.

D. Care Coordination/Case Management

The MCCW Program Description outlines the framework for the program's goals, scope, and lines of responsibility. Solutions uses enhanced care management techniques to ensure comprehensive, coordinated care for all participants with various chronic health conditions.

Overall, no major issues were identified. Minor documentation issues were noted, such as errors in Policies 01.02, Medically Complex Criteria-Assessment and CHS.CM.MCCW.01.03, Growth and Development which states, "Medically complex children, as defined by the MCC waiver, are children with a serious illness or condition expected to live at least 12 months."

As in previous EQRs, issues with documentation of Team Conferences and the Waiver Coordinator's telephone number are identified. The MCCW Rights and Responsibilities document informs members they have the right to complain to the MCCW Administrator about services received. However, the number provided for the MCCW Administrator (1-803-898-0079) rings to a different SCDHHS staff person. CCME attempted to obtain the number from Solutions' website but it is not posted.

Team conferences (TC) remain an optional service that can be requested by the PCP or the Responsible Party (RP). However, documents such as the Provider Manual 2020, Waiver Program Description, and member materials do not indicate that team conferences are optional, when they are determined, and who can request them.

The review of Case Management (CM) files indicate Care Coordinators and Care Advocates follow policies as outlined. The files also reflect Care Coordinators interact with participants at required intervals by phone and in-person. From an exception in March 2020, SCDHHS suspended home visits until further notice due to restrictions related to COVID-19. Care Coordinators completed Monthly Calls instead.

Overall, Solutions performed well in the Care Coordination/Case Management section of the EQR and met all requirements.

Figure 5: Care Coordination/Case Management Findings, show 100% of the standards received a "Met" score.

Figure 5: Care Coordination/Case Management Findings

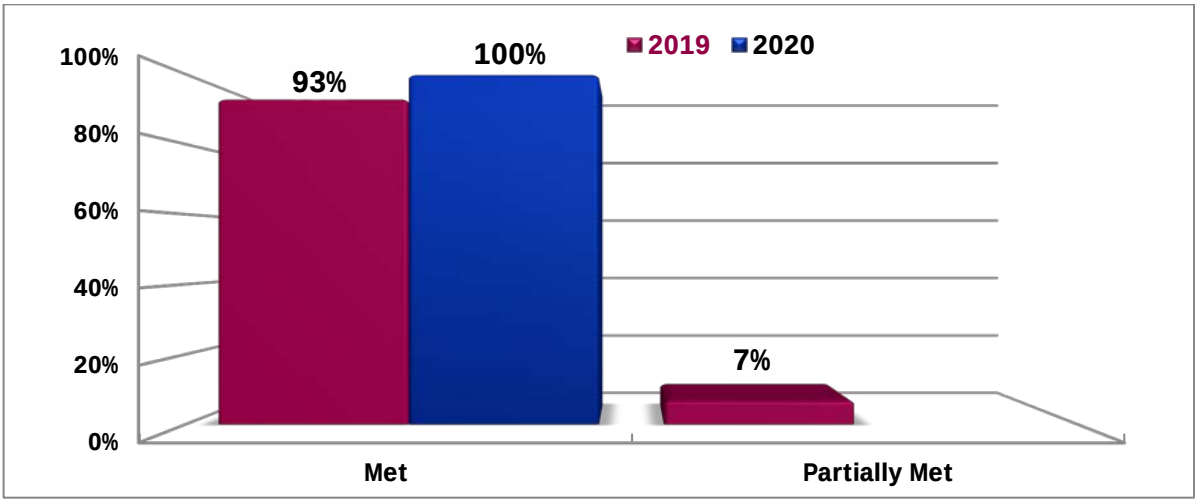


Table 2: Care Coordination/Case Management Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Policies and procedures and/or the program description address the following:	Processes for following up with participants admitted to the hospital and actively participate in discharge planning.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Consistent collaboration between Care Coordinators and Care Advocates is evident in the files reviewed.

Weaknesses

- Errors in definitions were noted on page one of Policies 01.02, Medically Complex Criteria-Assessment and CHS.CM.MCCW.01.03, Growth and Development, which state,

"Medically complex children, as defined by the MCC waiver, are children with a serious illness or condition expected to live at least 12 months."

- The telephone number listed on the MCCW Rights & Responsibilities document for the MCC Waiver Administrator (1-803-898-0079) rings to a different SCDHHS staff person and contact information for the Waiver Administrator is not posted on the website.
- The Provider Manual, Waiver Program Description, and member materials do not indicate that team conferences are optional and can be requested by the PCP or RP, nor how they are determined.

Recommendations

- Correct the error in Policies 01.02, Medically Complex Criteria-Assessment, and CHS.CM.MCCW.01.03, Growth and Development, to reflect the MCC waiver definition of medically complex children in the *SCDHHS Contract, Article II* by replacing the word "live" with the word "last."
- Edit the MCCW Rights and Responsibilities document to include the correct telephone number for the MCC Waiver Administrator and consider posting the Waiver Administrator's contact information on Solutions' website.
- Work with SCDHHS to update materials related to team conferences, such as the Waiver Program Description, Provider Manual, and member materials to reflect that team conferences are optional and can be requested by the PCP or RP, and how they are determined.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
1320 Main Street, Suite 300, Columbia, SC 29201 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

June 08, 2020

Dr. Bobbie Freeman
SC Solutions
PO Box 1763
Columbia, SC 29202

Dear Dr. Freeman:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2020 External Quality Review (EQR) of South Carolina Solutions is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of the Medically Complex Children's Waiver program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services. The CCME EQR team plans to conduct the onsite visit via teleconference on **July 14th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **June 22, 2020.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow organizations under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer. An opportunity for a conference call with your staff, to describe the review process and answer any questions, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosures
cc: SCDHHS

External Quality Review

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. If this is a corporate organizational chart, please identify those persons who are responsible for overseeing South Carolina Solutions activities. *From the organizational chart, we will randomly select personnel files to be submitted for review and provide a list of the file components needed.*

3. A description of any updates or changes in requirements disseminated by SCDHHS.

4. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

5. A current provider list/directory as supplied to members.

6. A copy of the current Compliance Plan or policies and procedures addressing compliance, fraud, waste, and abuse.

7. A description of the Quality Improvement, Care Coordination/Case Management Programs.

8. The Quality Improvement work plans for 2019 and 2020.

9. The most recent reports summarizing the effectiveness of the Quality Improvement, Care Coordination/ Case Management Programs.

10. A committee matrix for all committees. For each committee please include the following:
    a. A copy of the committee charter. Include the committee's responsibilities, meeting frequency, and the required voting quorum.
    b. Membership list and indicate which members are voting members. Include the professional specialty of any non-staff members.

11. Minutes of all meetings for all committees reviewing or taking action on SC Solutions-related activities from July 2019 to May 2020. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

12. A complete list of all members enrolled in the care coordination/case management programs from July 2019 to May 2020. Please include open and closed case files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care coordination or case management services. From these files we will randomly select specific files for review.

13. A copy of staff handbooks/training manuals, orientation and educational materials.

14. A copy of written information provided to new participants.

15. A copy of materials used for initial provider training/orientation.

16. A copy of any member and provider newsletters, educational materials, and/or other mailings.

17. A copy of the provider handbook or manual, if applicable.

18. A sample provider contract.

19. Please provide a completed Information Systems Capabilities Assessment (ISCA) form. Areas on the ISCA form not applicable to your organization maybe marked as N/A.

20. A copy of the Business Continuity/Disaster Recovery Plan.

21. A copy of the most recent disaster recovery or business continuity plan test results.

22. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.

23. A description of the data security policy with respect to email and PHI.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org**

- **submitted in the categories listed**

B. Attachment 2: Tabular Spreadsheet

CCME Data Collection Tool

Plan Name:	**SC Solutions**
Collection Date:	2020

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION/ORGANIZATION ACTIVITIES						
I A. General Approach to Policies and Procedures						
1. Policies and procedures are organized, reviewed, and available to staff.	X					The Policy and Procedure Management Policy (CHS.ADM.ALL.01.01) defines processes for policy development, review, and revision. Discussion with South Carolina Solutions (Solutions) staff confirmed policies are reviewed annually and as needed for regulatory and/or process changes. The policy review process includes the Compliance and Quality Management Committee (CQMC), and final approval of all policies is granted by the Executive Director/Chief Medical Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policies are housed on a shared drive for staff access and within the Healthicity™ platform. Staff are informed of new and revised policies and must sign an attestation that they have read the policy.
I B. Organizational Chart / Staffing						
1. The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities:						Solutions' Organizational Chart clearly delineates lines of responsibility within the organization. No vacancies are noted, and staffing appears to be sufficient to conduct required activities.
1.1 Administrative oversight of day-to-day activities of the organization;	X					Solutions is a subsidiary organization of Community Health Solutions of America (CHS). Dr. Barbara Freeman, who serves as the Chief Medical Officer and Executive Director, ensures the goals and objectives of SCDHHS, CHS, and Solutions are aligned. The Program Operations Manager, Jessica Drennan, oversees the day to day operations of the Solutions, and the Medical Director, Dr. James Stallworth, is responsible for clinical oversight and decision-making.
1.2 Pre-assessment;	X					Onsite discussion confirmed Care Coordinators conduct preassessment screening activities for individuals applying for the Medically Complex Children Waiver (MCCW).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Care coordination and enhanced case management;	X					Solutions has 11 Care Advocates and 38 Care Coordinators. With the current population of 1451 participants, Care Coordinators carry and average caseload of 40-50 participants.
1.4 Provider services and education	X					The Program Operations Manager conducts provider services and education functions.
1.5 Quality assurance;	X					Nancy DiGioacchino is Executive Vice President – Compliance and Quality. Kristine Scozzari is the Director of Quality Services and Samantha Gabbard is the Quality and Compliance Program Coordinator.
1.6 Designated compliance officer.	X					Nancy DiGioacchino serves as the Compliance Officer.
2. The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, the following are included:						
2.1 Criminal background checks are conducted on all potential employees.	X					Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing and Re-Credentialing addresses requirements for obtaining criminal background checks for clinical staff. During review of Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing and Re-Credentialing CCME noted the title of the policy indicates it applies to clinical staff; however, the policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						"Scope" section states the policy applies to <u>all</u> workforce members. This was discussed during the onsite teleconference and Solutions staff agreed this could cause confusion and will consider changing the scope of the policy. The policy does not address the requirement that background checks for states other than South Carolina in which an employee has resided within the last 10 years are conducted. Onsite discussion revealed that background checks for states other than South Carolina are conducted by HireRight®, a screening services company that has been engaged to conduct pre-employment services, including background checks, drug screenings, etc. A policy addressing the requirement for clinical background checks for non-clinical staff was not identified. Onsite discussion revealed the process is detailed in the "Recruiting Process – Non Clinical Positions" flow document. Review of this document confirmed the requirement for a background check for non-clinical staff. *Recommendation: Revise the "Scope" of Policy CHS.CRED.MCCW.03.06 to indicate the policy applies only to clinical staff. Include in a policy or other document the process for obtaining*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						criminal background checks for non-clinical staff. Update Policy CHS.CRED.MCCW.03.06 to include that Care Coordinator background checks for states other than South Carolina in which an employee has resided within the last 10 years are conducted by HireRight.
2.2 Verification of nursing licensure and license status.	X					Processes for verification of nursing licensure and status are addressed in Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing and Re-Credentialing.
2.3 Screening all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs.	X					Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting states the Human Resources Department performs an initial of exclusion status and the Compliance Department, via HireRight, conducts monthly exclusion monitoring to ensure employees, vendors, contractors, and providers have not been sanctioned or excluded from participating in any federal or state health care program. CHS.COMP.ALL.02.01a, Agency Exclusion Search Document displays the exclusion searches conducted, including the Office of Inspector General's List of Excluded Individuals/Entities, Medicare Opt Out List, Preclusion List, System for Award Management, Social Security Administration's Death Master File, South Carolina and Florida state exclusion lists, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Ensuring Care Coordinators meet all contract requirements.	X					Requirements for Care Coordinators are included in the MCCW Program Description and in the Care Coordinator job description.
2.5 Ensuring staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a participant's Person-Centered Service Plan.	X					The Employee Handbook, page 11, states, "Outside employment that constitutes a conflict of interest is prohibited." Staff are educated about this requirement during orientation and are required to sign a Conflict of Interest statement. Outside employment by staff members is reviewed by the Compliance and Human Resources departments and the Executive Director.
3. Employee personnel files demonstrate compliance with contract and policy requirements.	X					South Carolina State Law Enforcement Division (SLED) background checks were found in most personnel files reviewed; however, two Care Advocate files did not include the SLED background check. Onsite discussion confirmed the background checks for Care Advocates are conducted by HireRight and these files would not contain a separate SLED check. None of the personnel files reviewed contained evidence of Fraud, Waste, and Abuse (FWA) training and several did not reflect current Health Insurance Portability and Accountability Act (HIPAA) training; however, evidence of completion of these trainings was provided after the onsite.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						With the supplemental information received, all files reflect compliance with contractual and policy requirements.
I. C. Governing Board/Advisory Board						
1. The Organization has established a governing body or Advisory Board.	X					The Community Health Solutions of America Corporate Board of Directors (BOD) includes the CHS Chief Executive Officer, CHS owners, and additional stakeholders. The BOD governs the organization and responsibilities include directing company activities to maintain compliance with state, federal, and other regulatory requirements and adopting rules, policies and procedures, and other directives for the orderly operation of the organization.
2. The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined.	X					Section III of the Strategic Quality Plan describes corporate and local leadership roles and responsibilities, committee structure, and lines of reporting.
I. D. Contract Requirements						
1. The organization carries out all activities and responsibilities required by the contract, including but not limited to:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday.	X					Solutions' website and the Provider Manual indicate normal business hours are 8:00 am to 5:00 pm Monday through Friday.
1.2 Adherence to contract requirements for holidays and closed days.	X					
1.3 Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS.	X					Policy CHS.CM.MCCW.05.01, Medically Complex Criteria-Onsite Supervisory Visits lists criteria for onsite supervision of staff. Each Care Coordinator is supervised during a home visit at least annually by the Care Coordinator Lead or a clinical designee. If requested by DHHS, the ride along will occur within 5 business days. Policy CHS.CM.MCCW.05.02, Chart Review Process states at least two ride-along audits will occur within a 12-month period for each care coordinator. Solutions staff confirmed during the onsite that supervisory ride-along is conducted at least twice yearly for each Care Coordinator. *Recommendation: Revise Policy CHS.CM.MCCW.05.01, Medically Complex Criteria-Onsite Supervisory Visits to reflect the correct frequency of Care Coordinator supervision during a home visit.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Organization and participant record retention and availability as required by the contract.	X					Policy CHS.ISP.ALL.11.45, Record Retention Destruction defines requirements for record retention. The policy states documentation of protected health information is retained for a minimum of 6 years. Records involved in any open investigation, public records request, audit, or litigation are not destroyed or disposed of until there is a resolution to the situation.
1.5 Participant materials written in a clear and understandable manner, and are available in alternate formats and translations for prevalent non-English languages.	X					Review of member materials confirms they are written to be easily understood. Some include Spanish translation and/or information about how to obtain the information in alternate languages.
1.6 Processes are in place to ensure care coordination services are available statewide.	X					
I. E. Confidentiality						
1. The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy.	X					Policy CHS.ISP.ALL.11.21, Security & Privacy Training Awareness Requirements and Reminders states HIPAA Security and Awareness Training ensures all staff are aware of security policies and procedures and general principles of information security. All staff receive training regarding HIPAA and information security policies and procedures prior to being granted access or use of electronic PHI, when responsibility is increased, when promoted or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reassigned, and when systems or security policies and procedures change. The policy includes the topics of training and training methodologies. A host of related policies provide information about violations of information security, authorized and unauthorized disclosures, actions taken because of a breach of confidentiality, etc.
I. F. Data Systems/Security						
1 Policies, procedures and/or processes are in place for addressing data, system, and information security and access management.	X					Solutions collects little participant data, and most of the data it does collect is entered into the State of South Carolina's case management system. Solutions relies on the State to ensure information stored with the case management system is secure. To protect participant data, Solutions' workforce is required to adhere to an extensive set of policies and procedures that detail how devices and data are to be used. To verify the policies and procedures are adequate, the organization performs scheduled reviews of data access logs.
2. The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented.	X					In addition to regularly scheduled and tested backups, Solutions is included within CHS' business continuity. The business continuity plan is a thorough, multi-phase plan that guides the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						workforce through the resources and processes to mitigate interruptions if an incident occurs. Finally, the Solutions office in Columbia, SC recently endured a hurricane that tested its disaster preparedness. Operations were maintained before and after the event, and there was no data loss.
I G. Compliance and Program Integrity						
1. The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following:						
1.1 Written policies, procedures, and standards of conduct comply with federal and state standards and regulations.	X					The Compliance Program (Compliance Plan) states Solutions/CHS has established a set of business conduct policies based on the company's core values. These principles form the Code of Ethical Conduct and are used as a guide to support a "fundamental commitment to fostering an ethical work environment." Various policies describe processes to guard against, identify, investigate, and report suspected fraud, waste, and abuse (FWA).
1.2 A compliance committee that is accountable to senior management.	X					The Strategic Quality Plan indicates the Compliance and Quality Management Committee is comprised of management from all departments and functional areas to enable interdepartmental coordination, implementation

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of policies and procedures, quality improvement activities, and other directives from the BOD.
1.3 Employee education and training that includes education on the False Claims Act, if applicable.	X					Policy and Procedure CHS.COMP.ALL.01.03 Fraud and Abuse Prevention Training is applicable to all workforce members of Community Health Solutions of America, Inc. Compliance training is provided to all employees, contractors, agents, and the Board of Directors upon hire and annually thereafter. Policy CHS.COMP.ALL.01.01, False Claims Act confirms employees are informed of the Federal False Claims Act and related-state specific statutes, whistleblower protection provisions, and internal procedures for the prevention and detection of fraud and abuse.
1.4 Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers.	X					The Compliance Plan addresses effective communication, which is the responsibility of the Compliance Officer. The Compliance Officer is available to all staff, and attends staff meetings, corporate events, and other functions to encourage open communication. An “open-door” and “non-retaliation” policy is supported.
1.5 Enforcement of standards through well-publicized disciplinary guidelines.	X					Solutions/CHS links behavior to specific disciplinary actions. If warranted based on the severity of the issue and the employee’s actions, intermediate disciplinary actions may be bypassed, and an employee may be terminated. Intermediate actions include, but are not limited

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to, education and retraining, suspension without pay, or demotion.
1.6 Provisions for internal monitoring and auditing.	X					Auditing activities are conducted to identify issues and trends, leading to process improvement/best practices recommendations and corrective action planning. The Compliance Officer creates and executes an audit calendar on a quarterly basis and to identify areas to be audited based on risk, past findings, and new guidelines. The Compliance Officer reports high-risk issues identified through the audit process to the CEO and BOD.
1.7 Provisions for prompt response to detected offenses and development of corrective action initiatives.	X					Responses to detected offenses and development of corrective action plans are described in the Compliance Plan and in Policy CHS.COMP.ALL.01.04, Fraud & Abuse Investigations. The "Objectives" section of the Compliance Plan emphasizes the goal of minimizing risk through early detection and reporting. Leadership develops corrective action plans related to oversight of personnel involved in incidents and correcting any contributing operational problems resulting in a violation.
1.8 A system for training and education for the Compliance Officer, senior management, and employees.	X					The Compliance Plan addresses annual compliance training which includes FWA, HIPAA, privacy, the code of ethics and standards of conduct, disciplinary standards, and the Conflict

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of Interest Statement and Attestation. The training references regulatory citations and examples. The training concludes with a test for each module—the passing rate for each test is 80%. Employees are required to pass all modules in the training and attest that they understand the material. Separate specialized training is also provided when related to an employee's role and specific job responsibilities. This training is provided annually, whenever requirements change, upon hire, or when an area has shown vulnerability to risk. Policy CHS.PM.MCCW.01.01, Provider Orientation/Training states provider orientation includes information about FWA.
1.9 Processes for immediate reporting of any suspicion or knowledge of fraud and abuse.	X					The Compliance Plan states new employee training emphasizes the duty of employees to identify and report actual or suspected violations, the Company's policy on non-retaliation, and the Company's no-tolerance policy on harassment. Various policies and other documentation, such as the Employee Handbook, etc., include information about anonymous reporting, whistleblower protections, and the no-retaliation policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The organization reports immediately any suspicion or knowledge of fraud or abuse.	X					The Compliance Officer is responsible for reporting misconduct to state regulatory agencies, Medicaid Fraud Control Unit, Department of Insurance, and/or law enforcement. When appropriate, CHS will report fraud to law enforcement and/or regulatory authorities and will pursue legal action and recovery of assets or restitution. Policy CHS.COMP.ALL.01.04, Fraud & Abuse Investigations states, "Upon conclusion of the investigation and within ten (10) business days of discovery of the suspected fraud and abuse, the Compliance Officer, their designee, or a member of the Executive Committee, will report to appropriate clients, agencies / integrity programs to comply with state, federal and contract requirements."

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
1. The organization formulates and acts within policies and procedures related to initial and ongoing education of providers.	X					Policy CHS.PM.MCCW.01.01, Provider Orientation/Training discusses the process for onboarding new providers to Solutions' network. Solutions' Program Operations Coordinator provides orientation for new providers within 30 days of contracting into the network.
2. Initial provider education includes:						Solutions' Provider Manual 2020 provided with the desk materials contained detailed information used to educate new providers. Page 20 of the Provider Manual, and Policy CHS.QM.ALL.01.10, Complaint and Grievance Process, provided information regarding member/participant grievance process. However, the definition of grievance is incorrect. The Provider Manual and Policy CHS.QM.ALL.01.10 indicate a grievance is an expression of dissatisfaction about any matter other than an "action." *Per 42 CFR 438.400 (b)*, a grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The definitions for action and appeal in policy CHS.QM.ALL.01.10, Complaint and Grievance Process are also incorrect. *Recommendation: Update the definition of a grievance in the Provider Manual and in Policy CHS.QM.ALL.01.10. Remove the term "action" and replace with "adverse benefit determination."*
2.1 Organization structure, operations, and goals.	X					Per policy CHS.PM.MCCW.01.01, Provider Orientation/Training, provider orientation includes an overview of the organization, staff and duties, SCDHHS contractual relationship, an overview of the Medically Complex Children's Waiver (MCCW) program, and contractual requirements.
2.2 Medical record documentation requirements, handling, availability, retention, and confidentiality.	X					Solutions requires providers to maintain all participant records for at least 13 years. The standards and requirements for medical record documentation are contained in the Provider Manual.
2.3 How to access language interpretation services.	X					Providers are informed in the Provider Manual, page10, that language services are provided along the phone numbers for obtaining these services.
3. The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures.	X					Per policy CHS.PM.MCCW.01.01, Provider Orientation/Training, updates are provided annually and as needed to network providers.

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IIV. QUALITY IMPROVEMENT						
III A. The Quality Improvement (QI) Program						
1. The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants.	X					Solutions' Quality Improvement (QI) Program operates under a plan of continuous improvement. The Strategic Quality Plan 2020 describes the program's structure, scope, goals, and functions. Quality improvement projects are developed for opportunities identified for improvements. Solutions had two projects underway, including Care Plan Streamlining and Care Advocate Outreach. The goal for the Care Plan Streamlining project was to decrease the time spent updating monthly care plans. The analysis of this project showed documentation time decreased for one quarter. Results were presented to the Corporate Compliance and Quality Management Committee (CQMC) for recommendations. The project failed to produce meaningful data and therefore, the committee recommended closing the project. The goal for the Care Advocate Outreach project was to identify customer service gaps.

STANDARD	SCORE					COMMENTS
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						No patterns in gaps in care were identified. The project was closed, and the outreach calls were added as part of the routine Care Advocate workflow. The new projects recently initiated include Emergency/Disaster Preparedness and URAC Re-accreditation.
2. An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity.	X					Annually, Solutions develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2019 and 2020 QI Work Plans. Areas noted on the 2020 QI Work Plan that should be updated included: •Revision of Program Materials had an estimated completion date of 12/3/2017 and 2/1/2018. •The quarterly updates were not included for the Clinical Documentation Improvement Activity even though quarterly monitoring is conducted. *Recommendation: Update the 2020 QI Work Plan and correct the errors identified.*
III B. Quality Improvement Committee						
1. The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Compliance & Quality Management Committee (CQMC) is responsible for the development and implementation of the QI Program. Voting members include the Chief

STANDARD	SCORE					COMMENTS
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						Medical Officer, Executive Vice President of Compliance, Clinical Quality Programs Manager, and Care Coordinator Team Leads. The Chief Medical Officer serves as the chairperson for the meetings.
2. The QI Committee meets at regular intervals.	X					The CQMC meets at least quarterly. A review of the minutes showed the committee met at regular intervals.
3. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting and document committee discussion points and decisions. The minutes provided with the desk materials indicated the required quorums were met for each meeting. However, it was noted the designated chairperson was not present for the 1st, 3rd, and 4th quarter (2019) meetings and an alternate or replacement was not named. *Recommendation: Designate an alternate chairperson for the CQMC meetings when the chairperson cannot attend the meeting. Note in the meeting minutes the replacement.*
III C. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Solutions evaluated the QI Program and summarized the results of this evaluation in the Annual Report: Quality and Performance Improvement Calendar Year 2019. The

STANDARD	SCORE					COMMENTS
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						following issues were noted as errors in the report: •Section D, Quality Improvement Projects and Corrective Action Plans, states "MCCW managed three Quality Improvement Plans (QIPs)." However, only two projects were documented. •Section II. Satisfaction Measures, A. Member Complaints (page 4) indicates in 2019 two complaints were logged. Both complaints occurred in quarter 4. However, the table on page 5 shows three complaints were logged in quarter 4. •Section III. Compliance, B. Program Integrity Compliance, number 6 (page 6) states "Annual HIPAA/HITECH internal assessment was completed at the end of 2016 to assess compliance with the Affordable Care Act changes to HIPAA/HITECH. *Recommendation: Correct the errors identified in the Annual Report: Quality and Performance Improvement Calendar Year 2019.*
2. The annual report of the QI program is submitted to the QI Committee.	X					The annual evaluation is submitted to the CQMC for review and approval.

IV. CARE COORDINATION/CASE MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. Care Coordination/Case Management						
1. The organization formulates and acts within written policies and procedures and/or a program description that describe its care coordination and case management programs.	X					The Medically Complex Children Waiver (MCCW) Program Description gives an overview of how Solutions provides the statewide waiver program for pediatric members with chronic physical and health conditions. Policies such as CHS.CM.MCCW.01.01, Intake/Admissions Policy and Policy CHS.CM.MCCW.02.01, Care Coordination Process outline processes and requirements for staff to provide Enhanced Primary Care Case Management (PCCM) services.
2. Policies and procedures and/or the program description address the following:						
2.1 Structure of the program.	X					Solutions is contracted with SCDHHS to provide care coordination for the MCCW program. The Provider Manual and MCCW Program Description describe the program structure indicating an enhanced Primary Care Case Management model. A dedicated clinical Care Coordinator (CC), an experienced registered nurse, manages participants, acts as liaison between family and providers, and is supported by a Care Advocate (CA). The plan of care is directed by board-certified pediatricians.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Lines of responsibility and accountability.	X					Lines of responsibility and accountability within the MCCW Program are detailed in the Waiver Program Description and on the Organizational Chart. Additionally, the Provider Manual describes provider responsibilities and includes a link to the SCDHHS Healthy Connections Provider Manual.
2.3 Goals and objectives of Care Coordination/Case Management.	X					The goals and objectives of Care Coordination/Case Management are listed in the MCCW Program Description. Additionally, the Provider Manual and website have information on the program's goals and objectives.
2.4 Intake and assessment processes for Care Coordination/Case Management.	X					Policy CHS.CM.MCCW.01.01, Intake /Admissions Policy outlines the intake process for the MCCW Program and the Children's Private Duty Nursing Program for children meeting intake criteria. The referral process for children not meeting the intake criteria is also described. Policy CHS.CM.MCCW.01.02, Medically Complex Criteria-Assessment describes the process and purpose of conducting ongoing assessments using the Medical Evaluation Assessment tool. CCME identified terminology errors on page one of Policy CHS.CM.MCCW.01.02, Medically Complex Criteria-Assessment and Policy CHS.CM.MCCW.01.03, Growth and Development. The policies state, "Medically complex children, as defined by the MCC waiver, are children with a serious illness or condition expected to live at least 12 months." The *SCDHHS*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Contract refers to individuals with chronic conditions "expected to last more than 12 months". *Recommendation: Correct the error in Policy 01.02, Medically Complex Criteria-Assessment and Policy CHS.CM.MCCW.01.03, Growth and Development to reflect the MCC waiver definition in SCDHHS Contract, Article II by replacing the word "live" with "last."*
2.5 Providing required information to participants at the time of enrollment.	X					Policy CHS.CM.MCCW.02.01, Care Coordination Process indicates the Care Coordinator completes the admission packet at the start of the care coordination process. The admission packet includes information and/or forms such as Freedom of Choice, authorization to disclose health information, admission agreement, and local and state-wide resources the family can access. The Notice of Privacy Protection is located on the Authorization to Disclose Form. The MCCW Rights and Responsibilities document informs members they have the right to complain to the RN Coordinator or the MCCW Administrator about services received. During the onsite teleconference, CCME reported the telephone number listed for the MCC Waiver Administrator (1-803-898-0079) rings to a different SCDHHS staff person. CCME attempted to obtain contact information for the Waiver Administrator from Solutions' website but no

STANDARD	SCORE					COMMENTS
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						information is listed. This issue of the MCCW Rights and Responsibilities document having non-working telephone number for the Waiver Administrator was identified during the 2019 EQR with recommendations to correct it. *Recommendation: Edit the MCCW Rights and Responsibilities document to include the correct telephone number for the MCC Waiver Administrator that provides participants with a means to contact SCDHHS for complaints when needed. Consider posting the Waiver Administrator's contact information on Solutions' website, under the "Links and Other Helpful Information" section with other links to SCDHHS.*
2.6 Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable.	X					Processes and procedures for staff contact and interaction with members, such as monthly phone calls and in-home visits, are described in Policy CHS.CM.MCCW.02.01, Care Coordination Process, and Policy CHS.CM.MCCW.01.08 Care Planning, and the Waiver Program Description. During the onsite teleconference, the process and procedure for team conferences (TC) were discussed. Solutions staff explained that TCs remain an optional service that can be requested by the PCP or the Responsible Party (RP). CCME identified the Provider Manual, Waiver Program Description, and member materials do not indicate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						team conferences are optional and can be requested by the PCP or RP, nor when it is determined. *Recommendation: Work with SCDHHS to update materials related to team conferences, such as the Waiver Program Description, Provider Manual, and member materials to reflect that team conferences are optional and can be requested by the PCP or RP, and how they are determined.*
2.7 Processes to develop, implement, coordinate, and monitor individual Person-Centered Service Plans with the participant/caregivers and the PCP.	X					Policy CHS.CM.MCCW.01.08, Care Planning, and the Provider Manual describes processes for developing individual Person-Centered Service Plans (PCSP).
2.8 Processes to ensure caregiver/parent participation in and understanding of the Person-Centered Service Plan.	X					Policies CHS.CM.MCCW.01.06a, MCCW Rights and Responsibilities, and CHS.CM.MCCW.01.04, Consent for Case Management/Freedom of Choice, address caregiver participation in and understanding of the PCSP. Additionally, the caregiver signs the PCSP Signature Page document to indicate their involvement in the development of the PCSP.
2.9 Process to regularly update and evaluate the Person Centered Service Plans on an ongoing basis.	X					
2.10 Processes for following up with participants admitted to the hospital and actively participate in discharge planning.	X					Policy CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment states, "The CC assists hospital personnel, the responsible party, and the physician with discharge planning and coordination of services to ensure continuity of care."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Processes for reporting suspected abuse, neglect, or exploitation of a participant.	X					
2.12 A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided.	X					Policy CHS.CM.MCCW.04.01, Medically Complex Criteria-Down Time describes procedures used to provide care in the event of a power outage or connectivity issue. Policy CHS.CM.MCCW.04.02, Medically Complex Criteria-Back Up Service Provision describes procedures used in the event the Care Coordinator and/or Care Advocate is unable to provide care.
3. The organization provides a written, formal evaluation of the Person Centered Plan to SCDHHS every 6 months or upon request.	X					Policy CHS.CM.MCCW.02.01, Care Coordination Process indicates Care Coordinators complete all documentation and paperwork within Phoenix which can be accessed by Solutions and SCDHHS staff. Additionally, Policy CHS.CM.MCCW.01.08, Care Planning/Monthly Summary Report explains the Person-Centered Service Plan is reviewed and updated twice a year with the semiannual and annual visits.
4. The organization conducts Care Coordination and Case Management functions as required by the contract.	X					Sampled files indicate Care Coordinators and Care Advocates conduct case management activities as outlined in policies. Preadmission screenings and participant intake assessments are consistently completed within timeframe and required forms are reviewed and signed by the Responsible Party. Files reflect quarterly, semi-annual, and annual visits are completed in the home or natural environment. In March 2020, SCDHHS suspended home visits until

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						further notice due to restrictions related to COVID-19 and CCs completed Monthly Calls instead. Consistent communication and collaboration between Care Coordinators and Care Advocates are noted, as well as appropriate communication with SCDHHS waiver representatives for approvals and signatures. Monthly Summary Reports of Annual Visits are faxed to PCPs for review and signatures as per policy. Discussions during the onsite teleconference revealed, in addition to receiving Monthly Summary Reports, PCP and CC collaboration can occur via email and phone calls with the office staff.