2019 External Quality Review

SOUTH CAROLINA SOLUTIONS

Submitted: August 8, 2019

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

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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 *2019 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:

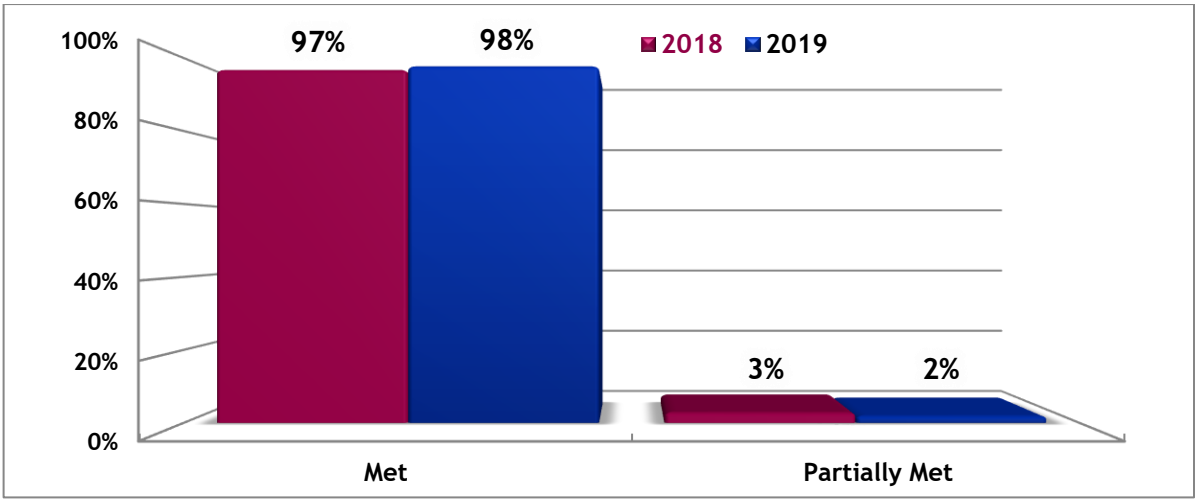
- Determine if Solutions was in compliance with service delivery as mandated in their contract with SCDHHS
- Provide feedback for potential areas of further improvement
- Assure that contracted health care services are actually being delivered and are of good quality

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 visit.

Overall Findings

The 2019 annual EQR review shows that Solutions has achieved a "Met" score for 98% of the standards reviewed. As the following chart indicates, 2% of the standards were scored as "Partially Met." The provides a comparison of Solutions' current review results to the 2018 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, any applicable quality improvement items, and recommendations can be found further in the narrative of this report.

Administration:

South Carolina Solutions (Solutions), a subsidiary of Community Health Solutions (CHS) of America Inc., is governed by the corporate Board of Directors (BOD). Corporate-level oversight of operations is provided by the Acting Executive Director/Chief Medical Officer and administrative oversight of day-to-day program activities is provided by the Program Operations Manager in South Carolina. Care Coordinator Leads and the Care Advocate Lead provide direct oversight and supervision of Care Coordination staff. The Care Coordinator to participant ratio is approximately 1:50 and there are no current staffing vacancies. Appropriate processes are in place to ensure staff meet all requirements, and personnel files confirm compliance with contractual and policy requirements.

The Compliance Program has been developed to ensure all employees understand the organization's commitment to comply with governing laws, regulations, contracts, and other requirements. Staff education about compliance requirements and fraud, waste, and abuse (FWA) is provided at the time of hire and annually. Information resources for compliance and FWA information include the *Compliance Program* document, *Fraud Prevention Plan*, *Code of Ethical Conduct*, *Employee Handbook*, and associated policies and procedures. Compliance and FWA education for network providers is provided within 30 days of contracting. CCME's review determined participants and families/responsible parties are not provided with information related to FWA, and Solutions staff agreed that it would be beneficial to participants and their families/responsible parties to receive this information.

Processes and guidelines to securely and responsibly manage data are detailed in policies and procedures, and the documentation indicates Solutions meets and/or exceeds SCDHHS's requirements. Solutions performs backups daily and recovery tests weekly. The *Continuity of Operations Plan* guides staff during a time of emergency.

Provider Services:

Solutions' Program Operations Coordinator conducts initial provider orientation and education within 30 days of the provider contracting into the network. The *Provider Manual* is used for provider education. A copy of the manual is given to providers during orientation and is available for download from the Solutions website. The manual contains detailed information on various topics including, but not limited to, expectations for interaction with Care Coordinators, referrals to the Medically Complex Children's Waiver (MCCW), fraud, waste, and abuse (FWA), language services, standards for medical record documentation, and contact information for key Solutions staff. Updates are

provided annually and as needed to network providers. Solutions' website includes information about credentialing, reporting FWA, language services, and a link to the list of SCDHHS provider manuals.

Quality Improvement:

Solutions' *Strategic Quality Plan 2019* (SQP) describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The plan is developed annually and is designed to provide the structure and key processes for ongoing improvement of care and services. The Corporate Compliance and Quality Management Committee (CQMC) is accountable for the development and implementation of the SQP. Membership includes the Chief Medical Officer, Executive Vice President of Compliance and Quality, Operations Manager, Medical Director, and Director of Quality Services. The CQMC meets no less frequently than quarterly. Attendance for each meeting is documented on the minutes. However, the minutes did not indicate which member chaired the meeting, which members were considered voting, and which were the non-voting members or visitors.

Quality improvement projects or focused studies are conducted when opportunities for improvements are identified. The projects are discussed during the CQMC meetings and updates provided. Care Advocate Calls, which focuses on member satisfaction with the program and Care Plan Streamlining are the projects currently underway. The Care Plan Streamlining project started as a pilot project in November 2018 and has now been implemented throughout the organization.

Care Coordination/Case Management:

CCME's assessment of Care Coordination/Case Management includes review of the program description, policies, *Provider Manual*, case management files, and the Solutions website. The *MCCW Program Description* outlines the purpose, goals, objectives, and staff roles for Primary Care Case Management (PCCM). Policies define how case management services are operationalized to service participants. The Medical Director, Dr. James Stallworth, provides oversight of clinical activities.

As previously identified in the 2018 EQR, Team Conferences are not conducted on a regular basis. During the onsite, Solutions verbalized barriers encountered with executing Team Conferences and reported SCDHHS has approved Team Conferences as an optional service conducted upon request. CCME did not identify how Solutions educates and informs staff, providers, or participants about the changes made regarding this service.

CCME could not determine how Solutions staff follows up with participants admitted to the hospital and how staff participates in discharge planning. Policy

CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment, did not describe the process; however, onsite discussions revealed how staff monitor participants who are hospitalized.

Overall, review of the Care Coordination/Case Management program indicates staff follow policies as outlined and appropriately provide services in the program.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2018 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2018	35	0	0	0	0	35
2019	33	0	0	0	0	33
Provider Services						
2018	6	0	0	0	0	6
2019	4	0	0	0	0	4
Quality Improvement						
2018	7	0	0	0	0	7
2019	7	0	0	0	0	7
Care Coordination/Case Management						
2018	13	2	0	0	0	15
2019	14	1	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. SC Solutions is not required by contract to conduct performance improvement projects or collect performance measures. Therefore, for this review those activities were not done.

On May 20, 2019, CCME sent notification to Solutions that the Annual EQR was being initiated. Solutions requested the review be delayed due to scheduling conflicts. SCDHHS was notified and approved Solutions' request. On June 13, 2019 CCME resent the notification to Solutions to initiate the review (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 27, 2019 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, 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 files.

The second segment was an onsite review conducted on July 26, 2019 at the Solutions office located in Columbia, SC. The onsite visit 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

CCME's review of Administration includes policy and procedure development and management, staffing, governance and leadership, general contractual requirements, confidentiality, data systems and security, compliance and program integrity, and a review of personnel files.

South Carolina Solutions (Solutions) is a subsidiary organization of Community Health Solutions (CHS) of America Inc. The corporate Board of Directors (BOD) provides corporate governance and oversight for Solutions. Its membership includes the CHS Chief Executive Officer, CHS owners, and other appointed stakeholders. Dr. Barbara Freeman, located in Florida, is the Acting Executive Director and Chief Medical Officer, providing corporate-level oversight of day-to-day operations. The Program Operations Manager, located in South Carolina, provides administrative oversight of the day-to-day program activities. Direct oversight and supervision of Care Coordinators is provided by three regional Care Coordinator Leads. Oversight of Care Advocates is provided by the Care Advocate Lead. There are no vacancies in Care Coordinator or Care Advocate positions, yielding a Care Coordinator to participant ratio of approximately 1:50.

Review of policies and other documentation along with onsite discussion with Solutions' staff confirmed processes are in place to ensure staff meet required qualifications and are not excluded from participation in Federally-funded health care programs. CCME's review of personnel files revealed compliance with contractual and policy requirements.

The Compliance Program is applicable to all CHS lines of business and its purpose is to ensure all employees have a full understanding of the organization's commitment to comply with laws, regulations, contracts, and other requirements that govern the organization. The *Compliance Program* document, along with the *Fraud Prevention Plan*, *Code of Ethical Conduct*, and policies and procedures provide detailed information to staff regarding requirements, processes, consequences for violations, reporting methods, etc. Training about compliance and fraud, waste, and abuse (FWA) is provided to employees at the time of hire and annually thereafter. Network providers receive compliance and FWA training at the time of contracting. CCME reviewed materials provided to participants and could not identify information about FWA. Solutions staff confirmed this is not a component of new participant education or materials and agreed that it would be beneficial to participants and their families/responsible parties to receive information about FWA and how to report suspected incidents of FWA.

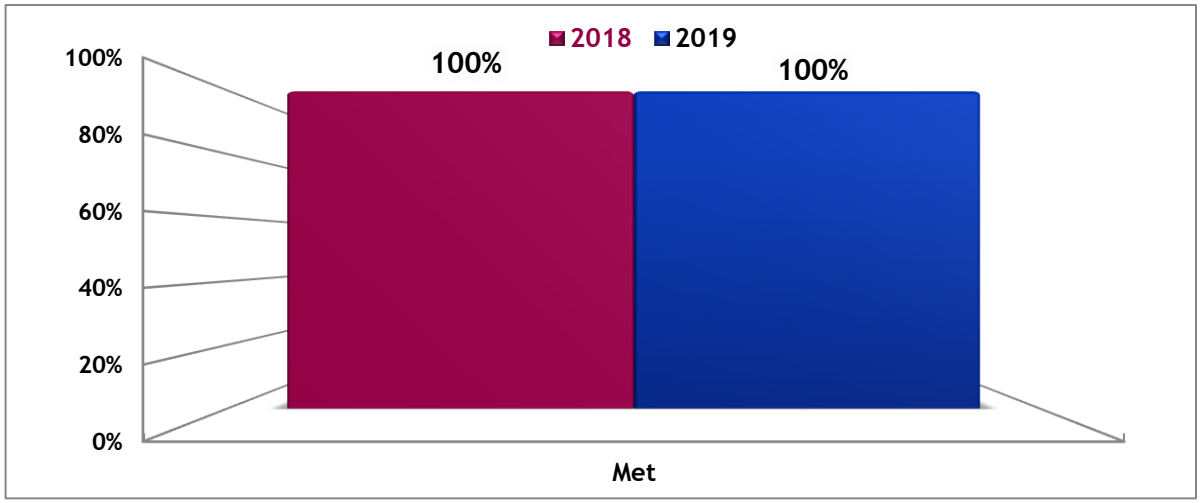
Data Systems and Security

Solutions' policies and procedures thoroughly and precisely document processes and guidelines to securely and responsibly manage data. The documentation indicates Solutions meets and/or exceeds SCDHHS's requirements.

Solutions leverages its parent organization's capabilities for data backup and recovery. Backups are performed daily, and recovery tests are performed weekly. Additionally, Solutions' *Continuity of Operations Plan* is in place to guide staff during a time of emergency.

As illustrated in *Figure 2: Administration Findings*, Solutions achieved scores of "Met" for 100% of the standards in the Administration section of the review.

Figure 2: Administration Findings



Strengths

- Staff are regionalized throughout the state and processes are in place to review and adjust staff assignments to ensure coverage for all participants.
- Solutions and its parent organization have clear, specific, and well-organized information systems policy documentation. Each policy and procedure includes a revision history that indicates documentation is routinely reviewed and updated.

Weaknesses

- Information provided to educate participants, responsible parties, and families about FWA or how to report suspected FWA could not be identified in the new member materials. Onsite discussion confirmed members are not educated or provided with information specific to FWA identification or reporting.

Recommendations

- Work with SCDHHS to develop educational information about FWA (definition, identification, reporting, etc.) that can be provided to participants, responsible parties, and families.

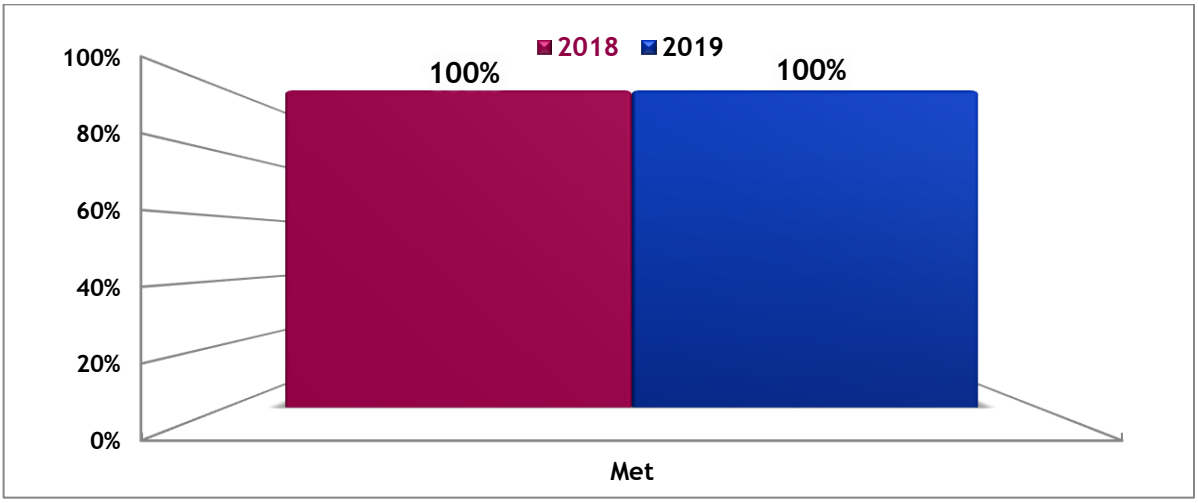
B. Provider Services

Solutions has established processes for initial and ongoing provider education for network providers, described in *Policy CHS.PM.MCCW.01.01, Provider Orientation/Training*. The Program Operations Coordinator conducts initial provider orientation and education within 30 days of the provider contracting into the network. The *Provider Manual*, given to providers during orientation, contains detailed information on various topics including, but not limited to, expectations for interaction with Care Coordinators, referrals to the Medically Complex Children's Waiver (MCCW), fraud, waste, and abuse (FWA), language services, standards for medical record documentation, and contact information for key Solutions staff. Updates are provided annually and as needed to network providers.

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.

As reflected in *Figure 3, Provider Services Findings*, 100% of the standards in Provider Services received a "Met" score.

Figure 3: Provider Services Findings



Strengths

- The *Provider Manual* is thorough and details information providers need to understand and operate within the requirements of the Medically Complex Children's Waiver and Solutions.

C. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed the *Strategic Quality Plan 2019 (SQP)*, committee structure and minutes, QI work plans, policies, procedures and the QI

program evaluation. Solutions' SQP describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The plan is developed annually and is designed to provide the structure and key processes for ongoing improvement of care and services.

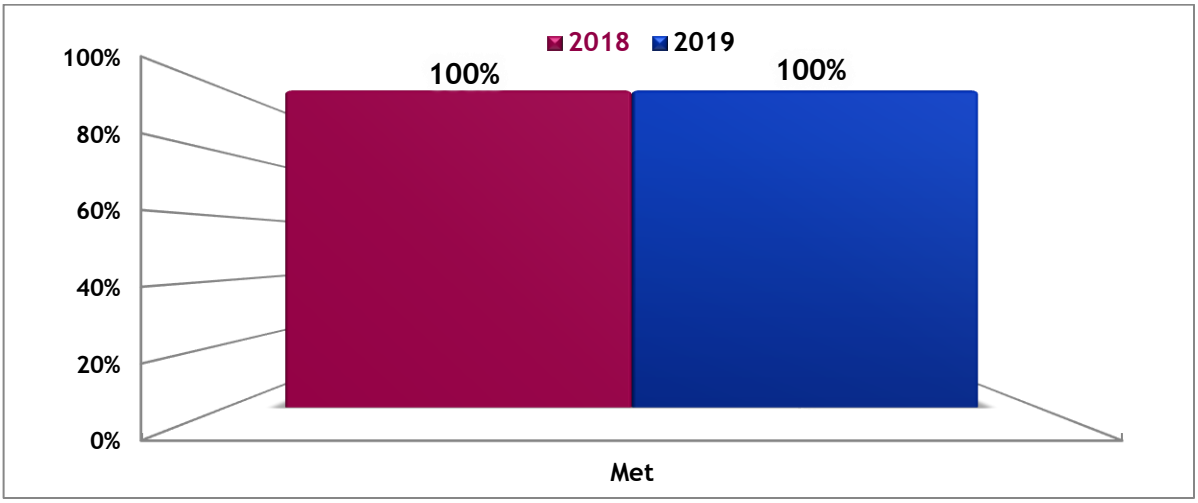
The Board of Directors provides strategic direction and ultimate authority for the QI Program. This board has delegated the operational responsibility for the program to The Corporate Compliance and Quality Management Committee (CQMC). The CQMC is accountable for the development and implementation of the SQP. Membership includes the Chief Medical Officer, Executive Vice President of Compliance and Quality, Operations Managed, the Medical Director, and the Director of Quality Services. The CQMC meets no less frequently than quarterly. Solutions provided copies of the minutes for meetings held in August 2018, October 2018, March 2019 and the agenda for the June 2019 meeting. Attendance for each meeting is documented on the minutes. However, the minutes did not indicate which member chaired the meeting, which members were considered voting, and which were the non-voting members or visitors.

Quality improvement projects or focused studies are conducted when opportunities for needed improvements are identified. The projects are discussed during the CQMC meetings and updates provided. Care Advocate Calls, which focuses on member satisfaction with the program and Care Plan Streamlining were the projects underway. The Care Plan Streamlining project started as a pilot project in November 2018 and has now been implemented throughout the organization.

Annually the QI program is evaluated and updated as needed. Solutions provided the *Annual Report: Quality and Performance Improvement Calendar Year 2018*. The annual evaluation provides a summary of the quality improvement efforts and opportunities for the upcoming year.

During this review period, Solutions has met all the standards for Quality Management as indicated in *Figure 4: Quality Improvement Findings*.

Figure 4: Quality Improvement Findings



Strengths

- Focused studies and quality improvement projects are conducted and reported to the CQMC throughout the year.
- A work plan is developed annually and updated at least quarterly.

Weaknesses

- The CQMC meeting minutes did not indicate which member chaired the meeting, which members were considered voting, and which were the non-voting members or visitors.

Recommendation

- The CQMC meeting minutes needs to indicate who chairs the committee and which members are considered voting members vs non-voting members.

D. Care Coordination/Case Management

The Medically Complex Children's Waiver (MCCW) Care Management Program Description and policies document case management processes and services provided. However, CCME identified where documentation can be improved for certain services and processes and provided recommendations to address it.

During 2018, Solutions received approval from SCDHHS to have Team Conferences as an optional service that can be conducted when requested by the provider or participant. The *Provider Manual* and *Policy CHS.PM.MCCW.01.01, Provider Orientation/Training,* states providers are obligated to participate in Team Conferences. However, information on optional Team Conferences are not documented for staff, providers, or participants to be aware of and educated on the change.

CCME identified issues with how participants are informed of their right to file a grievance or complaint. The website and the MCCW Right and Responsibilities form have limited information regarding the participant complaints process and lists a non-working telephone number for participants to call the MCCW Administrator.

Review of *Policy, CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment,* describes discharge processes from the waiver program and not from an inpatient facility. During the onsite visit, Solutions adequately described the process and communication which occurs between the Care Coordinator Lead and the hospital representatives while participants are inpatient and how the assigned Care Coordinator is kept informed. Solutions staff indicated this process will be captured in a policy or other document.

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 by phone and in-person, and appropriately monitor care plans. Onsite discussions revealed Solutions implemented a new documentation format, which changed from a Care Plan template to a Monthly Summary template, in an effort to streamline the process and reduce redundant charting.

Figure 5, Care Coordination/Case Management Findings show 93% of the standards received a "Met" score; 7% were scored as "Partially Met."

Figure 5: Care Coordination/Case Management Findings

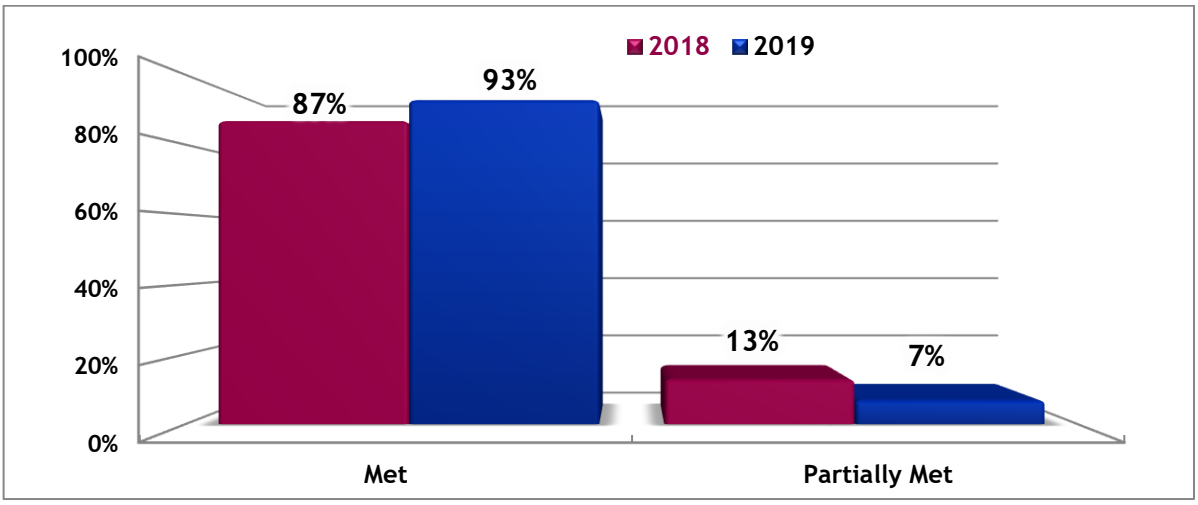


Table 2: Care Coordination/Case Management Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Care Coordination/Case Management	Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Met	Partially Met
	File review confirms the organization conducts Care Coordination and Case Management functions as required by the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- Consistent collaboration between Care Coordinators and Care Advocates is evident in the files reviewed.
- Files reflect communication between Care Coordinators and SCDHHS is appropriate when potential service risks are identified.

Weaknesses

- The website and the MCCW Rights and Responsibilities form do not define nor describe what a complaint is or give details about the filing process. Additionally, the telephone number provided for the MCCW Waiver Administrator,1-803-898-0079, gives an automated message stating, "the number you dialed is not a working number".
- There is no information documented for participants, providers, and staff explaining that conducting Team Conferences is optional and no longer a required service. Also, page 4 in the *Provider Manual* describes providers are obligated to participate in biannual Team Conferences and *Policy CHS.PM.MCCW.01.01, Provider Orientation/Training*, notes it as an obligation.
- *Policy CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment*, does not describe Solution's in-patient follow-up and discharge planning processes for participants admitted to the hospital.

Quality Improvement Plan

- Ensure Solution's processes for following up on participants admitted to the hospital and participating in discharge planning are captured in *Policy CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment*, or another document.

Recommendations

- Edit the website and the MCCW Rights and Responsibilities form to define what a complaint is, provide examples of circumstances for making a complaint, and provide a working telephone number for the MCCW Administrator on the website and the MCCW Rights and Responsibilities form.
- Update the following documents to reflect Team Conferences are optional services that can be requested by providers or participants: The *Provider Manual*, *Policy CHS.PM.MCCW.01.01, Provider Orientation/Training*, and *Policy CHS.CM.MCCW.02.01, Care Coordination Process*.

ATTACHMENTS

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

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

June 13, 2019

Dr. Bobbie Freeman
SC Solutions
15 Medical Park, Suite 300
3555 Harden St. Extension
Columbia, SC 29203

Dear Dr. Freeman:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2019 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 on **July 18th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **June 27, 2019.**

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.

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 participants 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 participants demographics including total enrollment and distribution by age ranges, sex, and county of residence.

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

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 2018 and 2019.

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. Participant list and indicate which participants are voting participants. Include the professional specialty of any non-staff participants.

11. Minutes of all meetings for all committees reviewing or taking action on SC Solutions-related activities in June 2018 to June 2019. 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 participants enrolled in the care coordination/case management programs from June 2018 to June 2019. 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:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. Policies and procedures are organized, reviewed, and available to staff.	X					Policies are organized by department within the organization and reflect the most recent revision date. *Policy CHS.ADM.ALL.01.01, Policy and Procedure Management* defines processes for developing new policies as well as maintaining and revising established policies. All policies and procedures are reviewed annually and when changes in contractual, regulatory, or accreditation requirements occur.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities:						Onsite discussion confirmed there are currently no open or temporary positions.
1.1 Administrative oversight of day-to-day activities of the organization;	X					SC Solutions staff reported during onsite discussion that Dr. Barbara Freeman is the Acting Executive Director, and Jessica Drennan, Program Operations Manager, provides administrative oversight of the day-to-day activities of the program. Staff reported that the organization has not yet determined if the Executive Director position will be filled or eliminated. Dr. Freeman also serves as Chief Medical Officer and Dr. James Stallworth is Medical Director.
1.2 Care coordination and enhanced case management;	X					Care Coordinator Leads provide oversight of the Care Coordinators and the Care Advocate Lead oversees the Care Advocates.
1.3 Provider services and education;	X					Provider services outreach and education are conducted by Jessica Drennan, Program Operations Manager.
1.4 Quality assurance;	X					Nancy DiGioacchino is the Executive Vice President of Compliance and Kristine Paradis is the Director of Quality Services.
1.5 Designated compliance officer.	X					Nancy DiGioacchino is the Compliance Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The criminal background check is conducted at the time an applicant accepts an offer of employment; however, the offer is contingent upon successfully passing pre-employment criminal background check and other pre-employment requirements. Onsite discussion confirmed the background check is nationwide and a nationwide Social Security Number trace is also conducted.
2.2 Verification of nursing licensure and license status.	X					*Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing and Re-Credentialing* defines processes for nursing licensure verification. Prior to the hire date, the Human Resource Department (HR) obtains copies of applicable license information from the candidate and verifies licensure through the applicable state licensing board. On the hire date, the Credentialing Specialist verifies licensure through the state licensing board, maintains a copy of the verification documentation, and logs the state, license number, and expiration date. Employees are reminded about licensure renewal 30 days prior to the license expiration date. If not renewed by the expiration date, the employee will be suspended pending license

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						renewal. Employees are required to notify their manager or department head of any adverse licensure changes within 3 business days.
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 Human Resources staff conduct initial exclusion reviews and Compliance Department staff conduct ongoing exclusion reviews monthly to ensure employees and subcontractors have not been sanctioned or excluded from participating in any federal or state health care program. *Attachment CHS.COMP.ALL.02.01a, Agency Exclusion Search Document* lists agencies, databases, and other queries conducted for staff and subcontractors.
2.4 Ensuring Care Coordinators meet all contract requirements.	X					Once a signed offer letter is received from the candidate, validation is conducted for nursing licensure and exclusion checks are conducted. Tuberculosis (TB) testing reports, CPR certification, motor vehicle reports, automobile insurance coverage, and a picture identification are collected. Once all documentation is collected, the candidate is cleared for employment by Credentialing and Human Resources staff. On an ongoing basis, annual TB testing is required, semi-annual motor vehicle reports are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducted, and annual proof of automobile insurance coverage is collected. For staff with a previous positive TB skin test, an annual physician report is required along with repeat x-rays every 5 years.
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					At the time of employment, staff must sign the employee *Confidentiality/Privacy Agreement* confirming their agreement that that during the term of employment, the employee must not engage in any other employment, occupation, consulting, or other business activity related to the business in which the Company is involved or engage in any other activities that would be considered a conflict of interest. The Employee Handbook states, "Outside employment that constitutes a conflict of interest is prohibited."
3. Employee personnel files demonstrate compliance with contract and policy requirements.	X					Upon initial personnel file review, four of ten files examined did not contain evidence of current driver's license and one file contained no evidence of verification of the employee's driver's license. Updated information was provided during the onsite and confirmed each employee's driver's license is current and valid.
I. C. Governing Board/Advisory Board						
1. The Organization has established a governing body or Advisory Board.	X					The Corporate Board of Directors (BOD) meets quarterly and its membership includes the Community Health Solutions of America (CHS) CEO, owners of CHS, and other appointed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						stakeholders. The BOD's responsibilities include: •Defining the organization's mission, goals, and objectives and allocating resources for the implementation and operation of the *Strategic Quality Plan* •Adopting rules, policies, procedures, and other directives for operation of the organization •Initiating and directing the implementation of the Quality Management Program •Directing activities to ensure compliance with state, federal, and other regulatory requirements
2. The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined.	X					
I. D. Contract Requirements						
1. The organization carries out all activities and responsibilities required by the contract, including but not limited to:						
1.1 Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday.	X					
1.2 Adherence to contract requirements for holidays and closed days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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* states each care coordinator is supervised by the Care Coordinator Lead or a clinical designee during a home visit at least annually. If requested by DHHS, the supervisory visit will occur within 5 business days.
1.4 Organization and participant record retention and availability as required by the contract.	X					*Policy CHS.ISP.ALL.11.45, Record Retention Destruction* describes processes and requirements for records maintenance and defines the record retention timeframe as 6 years from the date of final payment under the contract or completion of the contract, whichever is later. Records involved in any open investigation, public records request, audit, or litigation are not destroyed until there is a resolution of 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					Onsite discussion confirmed SC Solutions does not produce member materials. These are provided to SC Solutions by SCDHHS. Many participant materials include information on obtaining the information in alternate languages and the phone number to obtain language assistance.
1.6 Processes are in place to ensure care coordination services are available statewide.	X					Care Coordination staff are regionally located throughout the state. Care Coordinator caseloads are approximately 1:50, and processes are in place to reassign staff as needed to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ensure coverage for all participants. The *South Carolina Solutions Medically Complex Children Waiver Program Description* states consistent, objective means are used to measure the program's performance. Participant access to care through Care Coordinator adherence to outreach timeframes, timeliness of visits, assessments, and care planning is monitored and complaints about the program are tracked.
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					HIPAA Security and Awareness Training is provided to ensure all staff understand security policies and procedures and general principles of information security. *Policy CHS.ISP.ALL.11.21, Security & Privacy Training Awareness Requirements and Reminders* describes processes for confidentiality training which is provided to new staff before access to protected health information is granted and to current staff annually and when responsibilities are increased, when promoted or reassigned, and when information systems and security policies change. The policy defines the topics covered in training. *Policy CHS.ISP.ALL.11.12, Information Security & Privacy; Sanction Policy* informs staff of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						responsibility to report known or suspected Health Insurance Portability and Accountability Act (HIPAA) violations; the levels of HIPAA violations with examples; sanctions and disciplinary actions that may result from HIPAA violations; and examples of activities that do not constitute HIPAA violations.
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					The documentation provided by Solutions shows it meets and/or exceeds SCDHHS's requirements. Their policy and procedural documentation are thorough and provide concise guidance to manage data securely and responsibly.
2. The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented.	X					Solutions leverages the capabilities of its parent organization for data backup and recovery. Those capabilities include backups that are performed daily and recovery tests that are performed weekly. Additionally, Solutions has a "Continuity of Operations Plan" to guide staff during a time of emergency.
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:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Written policies, procedures, and standards of conduct comply with federal and state standards and regulations.	X					The *Code of Ethical Conduct* defines business ethics, workplace conduct, and compliance for all employees. The *Compliance Program* document details the compliance plan that applies to the Premier Family of Companies, Community Health Solutions of America, Inc., and affiliates. Associated policies and procedures provide additional details about processes to guard against fraud, waste, and abuse (FWA). The *Compliance Program* document defines methods of reporting compliance issues or violations to the Compliance Hotline and states caller may remain anonymous. Reports may also be made through the online web-based Compliance Manager by Healthicity™. The *Fraud Prevention Plan* defines the goals, objectives, scope, structure, roles, responsibilities, and activities for the detection and prevention of FWA. *Policy CHS.COMP.ALL.01.02, Identifying Provider Fraud* outlines methods to identify and address potential provider fraud and abuse. *Policy CHS.COMP.ALL.01.05, Reporting Mechanisms* outlines methods available to staff, members, clients, network providers, vendors and others to report suspected fraud or abuse

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2019 *Provider Manual* states providers are expected to comply with FWA policies found in the SCDHHS *Healthy Connections Physicians Provider Manual*, and includes contact information to report concerns to CHS, to the SCDHHS Medicaid Fraud and Abuse Hotline, and to the SC Attorney General Medicaid Fraud Unit. Information provided to educate participants' responsible parties/families about FWA or how to report suspected FWA could not be identified in the new member materials. Onsite discussion revealed the participant materials do not include specific information about FWA and agreed it would be beneficial for participants to receive this information. *Recommendation: Work with SCDHHS to develop educational information about FWA (definition, identification, reporting, etc.) that can be provided to participants' responsible parties/families.*
1.2 A compliance committee that is accountable to senior management.	X					The Quality & Compliance Management Committee (QCMC) meets at least quarterly and reports to the BOD. QCMC membership includes the Compliance Officer and senior staff responsible for functional areas and shared services departments.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Employee education and training that includes education on the False Claims Act, if applicable.	X					
1.4 Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers.	X					
1.5 Enforcement of standards through well-publicized disciplinary guidelines.	X					
1.6 Provisions for internal monitoring and auditing.	X					
1.7 Provisions for prompt response to detected offenses and development of corrective action initiatives.	X					The *Fraud Prevention Plan* addresses processes for responding to suspected or identified offenses. Identified issues are reported to the Compliance Officer who will direct the investigation and, upon conclusion of the investigation, report to appropriate state and/or federal agencies according to contract requirements. All incidents of suspected fraud and abuse are reported to the CQMC for review. The BOD is notified as appropriate. Additional information about procedures for investigating offenses is provided *in Policy CHS.COMP.ALL.01.04, Fraud & Abuse Investigations*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 A system for training and education for the Compliance Officer, senior management, and employees.	X					The *Compliance Program* document addresses processes and requirements for initial and ongoing Compliance training and education for staff. *Policy CHS.PM.MCCW.01.01, Provider Orientation/Training* indicates provider orientation and training occurs within 30 days of contracting and providers are updated with any changes to the program at least annually. New provider orientation includes FWA and the *Provider Manual* includes information about FWA.
1.9 Processes for immediate reporting of any suspicion or knowledge of fraud and abuse.	X					
2. The organization reports immediately any suspicion or knowledge of fraud or abuse.	X					At the conclusion of an investigation and within 10 business days of discovery of the suspected fraud and abuse, the Compliance Officer (or designee) or a member of the Executive Committee will report to appropriate clients, agencies and/or integrity programs to comply with all state, federal and contractual 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,* defines processes for initial provider orientation and education conducted by the Program Operations Coordinator within 30 days of contracting into the network.
2. Initial provider education includes:						
2.1 Organization structure, operations, and goals.	X					The *Provider Manual* contains detailed information and is used to educate providers about: •The MCCW's purpose, interaction with Care Coordinators, medical evaluation assessments, and referrals to the MCCW •Contractual obligations •Fraud, waste, and abuse •The SCDHHS *Physician Provider Manual* •Contact information for key Solutions personnel Additional topics covered in initial provider education include: •Solutions' staff roles and responsibilities •The SCDHHS and Solutions contractual relationship

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Medical record documentation requirements, handling, availability, retention, and confidentiality.	X					The *Provider Manual* includes requirements for medical record storage, retention timeframes, and requirements for release of medical records. The manual provides a detailed list of documentation required in each medical record.
2.3 How to access language interpretation services.	X					The *Provider Manual* includes information that SCDHHS provides free assistance and language services, such as interpreters, sign language interpreters, written information in other formats, and Text Telephone (TTY) services, to those whose primary language is not English and those with disabilities. Toll-free telephone numbers to access language and TTY services are included in the *Provider Manual* and on the SC Solutions website.
3. The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures.	X					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	
III. 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 has established a Quality Improvement Program with the goal of improving the health outcomes for each enrolled member. The *2019 Strategic Quality Plan* was provided with the desk materials. The plan is developed annually and is designed to provide the structure and key processes for ongoing improvements of care and services. Quality improvement projects or focused studies are conducted when opportunities for needed improvements are identified. The projects are discussed during the CQMC meetings and updates provided. Care Advocate Calls, which focuses on member satisfaction with the program and Care Plan Streamlining. The Care Plan Streamlining project started as a pilot project in November 2018 and has now been implemented throughout the organization.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The 2018 and 2019 Quality Work Plans were provided with the desk materials. The work plans included the goal or QI activity, interventions, start date, estimated completion date, responsible party, and update or comment field. The work plans are developed annually and updated at least quarterly.
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 Board of Directors (BOD) oversees the SQP and, in turn, delegates the day-to-day management to the Compliance & Quality Management Committee (CQMC). The CQMC is accountable for the development and implementation of the SQP. Membership includes the Chief Medical Officer, Executive Vice President of Compliance and Quality, Operations Managed, the Medical Director, and the Director of Quality Services.
2. The QI Committee meets at regular intervals.	X					The CQMC meets at least quarterly.
3. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes for the CQMC are maintained. Solutions provided copies of the minutes for meetings held in August 2018, October 2018, March 2019 and the agenda for the June 2019 meeting. Attendance for each meeting is documented on the minutes. However, the minutes did not indicate which members were considered voting and which were the non-voting members. Also, the minutes do not indicate who chairs the meeting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: The CQMC meeting minutes needs to indicate who chairs the committee and which members are considered voting members vs non-voting members.
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 provided the *Annual Report: Quality and Performance Improvement Calendar Year 2018.* The annual evaluation provides a summary of the quality improvement efforts and opportunities for the upcoming year.
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					SC Solutions has policies in place to describe its care coordination program such as *CHS.CM.MCCW.01.01, Intake/Admissions Policy* and *Policy CHS.CM.MCCW.02.01, Care Coordination Process*. The *MCCW Program Description* gives an overview of the goals, staff roles, objectives, and performance measures of the program.
2. Policies and procedures and/or the program description address the following:						
2.1 Structure of the program.	X					The *MCCW Program Description* and the *Provider Manual* outlines the structure of the program, indicating Solutions delivers an Enhanced Primary Care Case Management (PCCM) program where board-certified pediatricians guide and direct the plan of care for medically complex or chronically ill children and the Care Coordinators are experienced registered nurses who provide case management services.
2.2 Lines of responsibility and accountability.	X					The *Program Description* defines oversight within the program and the *MCCW Organization Chart* indicates lines of responsibility. The Program Manager, Jessica Drennan, oversees the day-to-day operations of the program and the Medical Director, James Stallworth,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						is responsible for clinical oversight and decision-making and works closely with the Care Coordinator Team Leads. Provider responsibilities are briefly highlighted in the *MCCW Provider Manual* which also includes a link to the *SCDHHS Healthy Connections Provider Manual*, for a complete list of provider responsibilities and requirements.
2.3 Goals and objectives of Care Coordination/Case Management.	X					Care Coordination/Case Management goals and objectives are listed in the *Program Description*, *Provider Manual*, and on the website. Polices such as *CHS.CM.MCCW.01.08, Care Planning,* and *CHS.CM.MCCW.02.01, Care Coordination Process* reflect objectives to develop, implement, coordinate, and monitor the Person-Centered Service Plan as noted in the MCCW contract.
2.4 Intake and assessment processes for Care Coordination/Case Management.	X					*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. *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 and describes the referral process for children not meeting the intake criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 Providing required information to participants at the time of enrollment.	X					Solutions provided a sample Preadmission Screening packet consisting of materials reviewed with participants at time of enrollment such as the Admission Agreement, Authorization to Disclose, and Rights and Responsibilities forms. CCME did not identify information related to the participant grievance process. During the onsite, Solutions revealed the MCCW Rights and Responsibilities form includes information on how participants can make grievance complaints to their RN Care Coordinator or call the MCCW Administrator. Upon review, the form indicates participants can complain about treatment and services received; however, it does not define nor describe what a complaint is or give details about the filing process. CCME notes the Solutions website posts similar information regarding participant complaints. It would be helpful for participants to know circumstances for making a complaint, such as if they feel discriminated against, dissatisfied with care or services provided by a vendor, and know parameters for when complaints can be filed. Additionally, when CCME dialed the number provided for the MCCW Administrator,1-803-898-0079, an automated message stated, “The number you dialed is not a working number”. *Recommendation: Edit the website and the MCCW*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Rights and Responsibilities form to define what a complaint is, provide examples of circumstances for making a complaint, and provide a working telephone number for the MCCW Administrator.
2.6 Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable.	X					Care Coordinators interact with participants once a month by phone and have four in-person visits a year. *Policy CHS.CM.MCCW.02.01, Care Coordination Process* and *Policy CHS.CM.MCCW.01.08, Care Planning* describes and outlines processes and procedures for staff interaction with participants. *Appendix B (3) in the Waiver Contract* lists Team Conferences as a required service. Solution's Master Policy List indicates *Policy CHS.CM.MCCW.02.03 Team Conference*, has been archived and the current *Policy CHS.CM.MCCW.02.01, Care Coordination Process*, no longer references requirements for Team Conferences. However, page 4 in the *Provider Manual* describes providers are obligated to participate in biannual Team Conferences and *Policy CHS.PM.MCCW.01.01, Provider Orientation/Training* notes it as an obligation. Onsite discussions revealed Solutions received approval from DHHS in 2018 to have Team Conferences as an optional service and is no longer required. DHHS representatives onsite confirmed this change and stated participants and providers must be made aware Team Conferences are an option that can be requested. *Recommendation: Update the following documents to reflect Team Conferences are optional services that can be requested by providers or participants: the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Manual, Policy CHS.PM.MCCW.01.01, Provider Orientation/Training, and Policy CHS.CM.MCCW.02.01, Care Coordination Process.
2.7 Processes to develop, implement, coordinate, and monitor individual Person-Centered Service Plans with the participant/caregivers and the PCP.	X					Solutions defines processes for developing individual Person-Centered Service Plans in *Policy CHS.CM.MCCW.01.08, Care Planning* and the *Provider Manual*. The initial and annual summary of care are faxed to the Primary Care Physician (PCP) for review and signature. Monthly, the Care Coordinator will review the summary of care with the family during contact with the Responsible Party (RP). Additionally, the Care Coordinator will fax the summary to the PCP for quarterly and semi-annual review and/or revision.
2.8 Processes to ensure caregiver/parent participation in and understanding of the Person-Centered Service Plan.	X					*Policy CHS.CM.MCCW.01.04, Consent for Case Management/Freedom* of Choice, states documentation of the agreement to participate in the MCCW Program is required.
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* describes processes and procedures for discharging or disenrolling a participant from the MCCW Program for instances such as when the participant no longer meets Level of Care eligibility, ages out at 18 years old, is hospitalized, or out-of-state for 30 consecutive days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME did not identify discharge planning processes for participants admitted to the hospital. During the onsite, Solutions described their process for following up on participants who are hospitalized. The Care Coordinator Lead will be informed of the participant's hospital status and remain in contact with the hospital discharge planner. *Quality Improvement Plan: Ensure processes for following up on participants admitted to the hospital and participating in discharge planning are captured in Policy CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment, or another document.*
2.11 Processes for reporting suspected abuse, neglect, or exploitation of a participant.	X					Page 1 of *Policy CHS.CM.MCCW.01.12, Child Protective Services* describes the process for staff to report suspected neglect or abuse to the local Department of Social Services (DSS). It states, "the CC will review the Child Protective Services Information and CPS Contact forms with the RP during the Pre-Admission Screening (PAS) visit and annually…".
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The organization provides a written, formal evaluation of the Person-Centered Plan to SCDHHS every 6 months or upon request.	X					Care Coordinators complete all documentation and paperwork within Phoenix which can be accessed by Solutions and SCDHHS staff, as *Policy HS.CM.MCCW.02.01, Care Coordination Process,* indicates. Additionally, review of participant files reflects semiannual documentation of the Person-Centered Service Plan in Phoenix.
4. The organization conducts Care Coordination and Case Management functions as required by the contract.	X					The file review reflects Care Coordinators and Care Advocates follow process outlined in policies, such as *CHS.CM.MCCW.02.01, Care Coordination Process,* and *CHS.CM.MCCW.01.08, Care Planning*. Collaboration between Care Coordinators and Care Advocates is consistently noted, as well as appropriate communication with SCDHHS for approvals and signatures. In several files CCME observed case management documentation in three templates: a Care Plan, a Monthly Summary, and a Service Plan. During the onsite, Solutions reported in the later part of 2018 the case management documentation process transitioned from a lengthy Care Plan to a streamlined Monthly Summary. The Service Plan template contains goals and interventions, is reviewed by SCDHHS representatives, and will remain unchanged. Care Advocates consistently fax the Monthly Summary/Care Plan for Annual Visits to PCPs for review and signatures as per policy; however, signed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						copies were rarely noted in the files. Solutions revealed PCPs are not consistent in responding to reviews of the Annual Visit Monthly Summary despite follow-up efforts from staff. Documentation in 12 out of 15 files indicate Team Conferences were not conducted or offered. As noted above in Standard 2.6, Team Conferences are optional and no longer a required service.