# Promising Practices in Long Term Care Systems Reform: South Carolina's Services for Older People and People with Physical Disabilities

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# SOUTH CAROLINA'S SERVICES FOR OLDER PEOPLE AND PEOPLE WITH PHYSICAL DISABILITIES

As home and community-based support systems continue to grow and evolve, states are examining whether their current systems reflect fundamental participant and community values. A number of states are concluding that they need to put in place systemic reforms to ensure that their home and community-based support systems promote dignity, independence, individual responsibility, choice, and self-direction.

Systemic reforms are simultaneously addressing multiple aspects of community long term support systems in order to improve responsiveness to participants' needs and preferences. These initiatives are developing entirely new ways of designing, organizing, and managing community-based supports as a system rather than as a random collection of uncoordinated individual services. In some cases, this has required states to make fundamental changes to the administrative infrastructure of their home and community-based support programs.

Two design features in particular have repeatedly emerged as essential components of systemic reform initiatives:

- *Single Access Points* which provide people with a clearly identifiable place to get information, advice and access to a wide variety of community supports; and
- *Person-Centered Services*, which place participants, not services or providers, as the central focus of funding and service planning.

The Centers for Medicare and Medicaid Services contracted with Medstat to examine approaches nine states took to developing Single Access Points and Person-Centered Services to assist persons with disabilities to live productive and full lives in person-centered community settings. We conducted on-site interviews with state officials, advocacy organizations, and local program administrators and extensively reviewed written documents on policy proposals, administrative rules, and program evaluations. The emphasis of the resulting nine case study reports is on identifying transferable models that can be adapted for replication in other states and communities across the country, while acknowledging that some aspects of state systems may be unique to each state's culture, history and traditions.

## Overview of South Carolina's Community Supports

In South Carolina, older people and people with physical disabilities access institutional and community Medicaid supports through a single access point, and have increasing opportunities to direct their own services. South Carolina is one of the first in the country to operate a Medicaid home and community-based services waiver under the Centers for Medicare and Medicaid Services' Independence Plus initiative. The state has been particularly innovative in using information technology to improve the quality of community supports and participants' access to services. A case management information system allows Medicaid waiver case managers to spend more time assisting participants

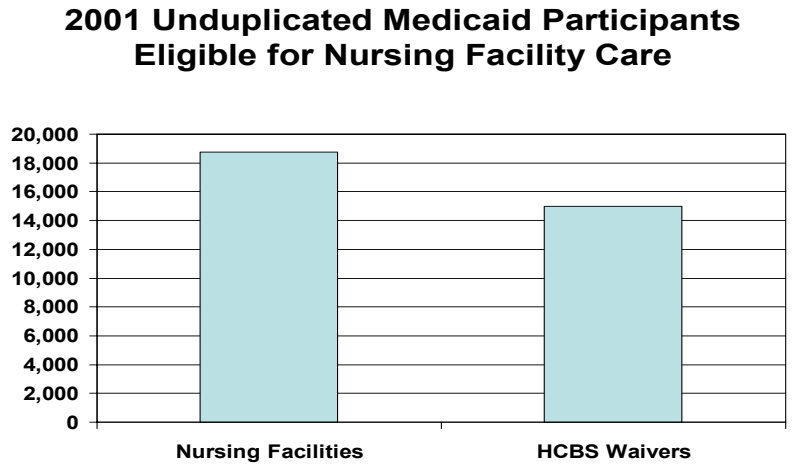
and enables the state to quickly monitor the quality of case management. It is also the first state in the country to use a telephone monitoring system to identify when in-home services providers miss visits or leave early. People will soon be able to use an online database of home and community based services providers as part of comprehensive information and referral system.

South Carolina's Department of Health and Human Services (DHHS), the state's Medicaid agency, administers virtually all publicly funded long-term care for older people and people with physical disabilities. DHHS has two bureaus overseeing services for older people, including long-term care services. The Bureau of Long Term Care Services (BLTCS) is responsible for almost all Medicaid long-term care policy, combining Medicaid institutional and community services policy in one organization. The Bureau of Senior Services (BSS) is the state unit on aging as defined in the federal Older Americans Act. It administers services authorized by that law through a network of Area Agencies on Aging and their providers (the Aging Network).

**Medicaid Supports**

BLTCS determines state policy for nursing facilities and home and community-based services (HCBS) waivers. People access these waivers through 13 regional DHHS offices, which are single access points for Medicaid long-term care. Registered nurses at these offices determine functional eligibility for both HCBS waiver recipients and Medicaid-eligible nursing facility residents.

South Carolina operates four Medicaid HCBS waivers that are alternatives to nursing facility services. The three waivers that operated in 2001 served nearly 80% the number of Medicaid nursing facility residents served in that year, due to increases in waiver participants during the late 1990s. Since 1996, the number of waiver participants increased 91%, from 7,785 people to 14,889 people. At the same time, the number of nursing facility residents increased only 17%, from 16,102 to 18,859. This report focuses on two waivers that serve a broad population of older people and people with physical disabilities.



The **Elderly/Disabled (E/D) Waiver** covers an array of Medicaid community services for older people and adults with physical disabilities eligible for nursing facility care. The E/D waiver provides case management, personal care, respite care, adult day health care, environmental modifications, specialized medical equipment and supplies, personal emergency response systems, companion services, self-directed attendant care, home delivered meals, and incontinence supplies. In 2001, 14,431 people received waiver services at a cost of $78 million.

The **Choice Waiver (SC Choice)** is a new self-directed option for people eligible for the E/D Waiver. This waiver offers the same services as the E/D waiver, and additional services which allow participants greater flexibility in planning their services and employing their own providers. BLTCS developed this waiver under the Centers for Medicare and Medicaid Services' Independence Plus initiative to assist states in offering self-directed services. This waiver is available as a pilot in three counties in northwest South Carolina, including the city of Spartanburg. The waiver started July 1, 2003, and can serve a maximum 300 people this year.

In addition to these two waivers for older people and people with physical disabilities, BLTCS offers HCBS waivers targeting people with HIV/AIDS and adults who use mechanical ventilators. BLTCS also determines eligibility for, but does not directly operate, a small HCBS waiver that serves people with brain and/or spinal cord injuries. A separate state agency, the Department of Disabilities and Special Needs, operates this waiver and a waiver that serves people with developmental disabilities. BLTCS also administers the Medicaid home health benefit, the Medicaid hospice benefit, the Program for All-Inclusive Care for the Elderly (PACE), a state-funded supplement to SSI for people in community residential facilities, and a Medicaid personal care benefit for people in these facilities.

**Aging Network Supports**

Participants access Older Americans Act Services through ten regional Area Agencies on Aging (AAAs) and local Councils on Aging (CoA) that operate in each of South Carolina's 46 counties. CoAs provide most Aging Network services under contract with their regional AAA. AAAs work directly with older people and their families in providing information, referral, and assistance and in three programs: the Long Term Care Ombudsman Program, the Family Caregiver Support Program, and a health insurance counseling program.

In state fiscal year 2002, over 25,000 people used Older Americans Act services, which include: congregate meals, home delivered meals, transportation, health promotion, legal assistance, home care services, nutritional counseling, and a program that helps people identify environmental home safety and medication risks. BSS also administers the state-funded Eldercare Trust Fund, which provides seed grants for local demonstration projects.

## Evolution of Community Long Term Care Services

The Medicaid and Aging Network supports evolved separately. The Medicaid E/D Waiver grew out of a state-funded research and demonstration project initiated in three counties in 1979. The program was expanded statewide under a Medicaid HCBS Waiver in 1983. From the beginning, participants received eligibility assessments and initial service authorization from DHHS employees or contractors who worked at regional offices of state government. In contrast, the local organizations that manage and provide Aging Network services are independent of state government. Area Agencies on Aging are typically part of regional councils of governments. Most county Councils on Aging are independent not-for-profit agencies, although some are county government organizations.

In 1997, South Carolina's legislature moved the administration of the Aging Network from the Governor's office into DHHS. This move sparked improved coordination between Aging Network and Medicaid services at both the state and local levels. State level coordination increased further in 1999, when the Bureau of Senior Services and the Bureau of Long Term Care Services were combined into one agency within DHHS, the Office of Senior and Long Term Care Services.

The state has systematically obtained input from participants and advocates, and often used this input to improve services. For example, the Governor and senior DHHS management held a series of open, public Senior Forums in 13 locations throughout the state after the Office of Senior and Long Term Care Services started in 1999. Two common needs older people identified at these forums were help paying for prescription drugs and information about available community services. In response to this input, South Carolina started a prescription drug program in 2002, one of the first Medicaid "Pharmacy Plus" waivers under Section 1115 of the Social Security Act. South Carolina also is improving its information and assistance system.

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Stakeholders provided additional input through the South Carolina Home and Community-Based Services Task Force, also called the Olmstead Task Force because the Governor established it in 2000 after the Supreme Court decision, *Olmstead v. L.C.* The Olmstead Task Force performed a comprehensive review of services for people with disabilities, with recommendations for improving the service system.

The task force established workgroups for three state departments that serve people with disabilities. The DHHS workgroup included participants, family members, advocates, providers, and state staff. The workgroup held five focus groups to obtain additional input from older people and people with disabilities, including one focus group in a nursing facility. In addition, the whole task force held four public hearings and allowed an additional public comment period after a draft report was available.

DHHS developed its 2001 Centers for Medicare and Medicaid Services Real Choice Systems Change Grant to address two recommendations from the task force: a centralized information and referral system and increased options for people to direct their own services. Many members of the task force and its DHHS workgroup are now on the advisory committee for the Real Choice grant. South Carolina hosted another round of forums for older people and people with disabilities in May 2003, to inform efforts under the Real Choice grant. The four forums encouraged public comment on policy recommendations to improve the information and referral system and to increase participant choice and control over services.

## Single Access Points: Facilitating Individuals' Access to Needed Supports

South Carolina has long had a single access point for Medicaid long-term services, the 13 regional DHHS offices. To increase people's knowledge about the regional DHSS offices and other resources, the state is developing a comprehensive information and referral system. The system will build on the Aging Network's information and referral experience and include information about Medicaid home and community-based services, Aging Network services, and support providers that offer these and other services. The state expects this system to empower people to make informed choices about their services, whether they use publicly funded supports or pay for their own assistance.

The information and referral system development builds on lessons learned from an earlier initiative to establish a single entry point for both Medicaid and Older Americans Act long-term supports, called Senior Access. This initiative established county Councils on Aging (CoAs) as local the single access points in the pilot counties, moving the access point for Medicaid HCBS from the regional DHHS office to the CoA. CoAs notified the regional DHHS office if a person needed assessment for Medicaid home and community-based services. CoAs and regional DHHS offices each worked with more people, because many people worked with both agencies when they may otherwise have contacted only one agency. The legislature did not provide additional funding for this change, however, and eventually people faced delays in obtaining services. The state stopped Senior Access in September 2001, when the state began implementing the information and referral system.

### Information and Referral

The new information and referral system, SC Access, has two major components:

- a searchable, online database with detailed information about available services; and
- a network of information and referral specialists to help people find the information they need and obtain services.

The state's goal is to create a situation in which there is "no wrong door" to the right services; people will learn about all available supports regardless of how they contact the

community support system. The state's Real Choice Systems Change Grant funds part of SC Access' development.

The state decided to improve its information and referral system after stakeholder feedback from the Senior Forums and the Olmstead Task Force revealed that many people did not know about available services and wanted more information. The Aging Network already provided information and referral support, but some people did not know about the Area Agencies on Aging and county Councils on Aging. An online database with service information was also available, but it was not widely used and some considered it difficult to navigate.

**Online Database—**The online database will contain information about services for older people, people with physical disabilities, and people with cognitive disabilities. As part of this effort, four full-time state staff in the Bureau of Senior Services are contacting providers to verify, update, and expand on the information on the currently available database.

**Using the online database, people will be able to find provider information by service category, exact service name, or condition.**

The database will enable people to find information about available providers in their city or county, with the option to search by service category, exact service name, or condition. Since the terms used for services or categories may be unfamiliar to the general public, users will be able to quickly identify definitions before they search the database. The system will first display a list of providers in the area, with phone numbers and links to provider Web sites. People can then select particular providers for more details such as service hours, eligibility requirements, public and private payment sources the provider accepts, and the process for obtaining services from that provider.

The state will test the Web site in the three counties that are the pilot area for SC Choice (Spartanburg, Cherokee, and Union). Coordinating SC Access with the SC Choice pilot will allow the state to evaluate the degree to which the Web site meets participants' needs. Statewide implementation of the Web site is planned by the end of 2003.

**Information and Referral Specialists—**To start a network of information and referral specialists, the state required each Area Agency on Aging (AAA) to use Older Americans Act funding for an information and referral specialist. The public can reach the specialists by calling a toll free telephone number in each region for information and referral or by visiting the specialist at his or her office at the AAA. The specialists can access online information for people who do not have Internet access, and can answer questions about the online database. These specialists may also contact providers for participants. All specialists will be certified by the Alliance of Information and Referral Systems.

The state provides ongoing training to these specialists, and will train local Council on Aging (CoA) staff. Most people currently receive information about services from the CoA in their county, and training will make it easier for CoAs to provide comprehensive information about services.

In addition to improving information about available supports, SC Access will improve the state's information about services people need. South Carolina will track how often users search for services, and track the questions asked to specialists answering the toll free numbers. The state can identify unmet needs based on information people request, and develop initiatives to address these needs.

SC Access also provides an opportunity for DHHS to develop stronger relationships with other agencies that serve people with disabilities. Services funded by the Department of Mental Health and the Department of Disabilities and Special Needs are already listed on the current online database, and the new database will also provide comprehensive information about these services. DHHS also will provide training for information and referral specialists with expertise regarding services for people with developmental disabilities and for people with mental illness.

**Assessment**

BLTCS staff based in the regional DHHS offices assess functional eligibility for nursing facility and Medicaid HCBS waiver services. Regional office staff from another bureau of DHHS determine Medicaid financial eligibility. For the waivers that are the focus of this report, the Elderly/Disabled Waiver and SC Choice, prospective participants are placed on a first-come, first-serve waiting list when they contact the regional DHHS offices. People who have lived in a nursing facility for 90 days and people on a waiting list for an organ transplant can bypass the waiting list and are assessed immediately.

When the person comes to the top of the waiting list, registered nurses at the DHHS offices assess functional eligibility for Medicaid nursing facility and HCBS waiver services. The assessment includes information about the participant's functional, cognitive, and psychobehavioral status, medical conditions, treatments, nutrition, and current medications. The nurse enters information from the assessment into South Carolina's Case Management System, so case managers can access this information quickly.

## Person-Centered Services

This series of case studies on state long term supports initiatives focuses on two primary components of systemic reforms. The first, as described in the previous section of this report, is a single access point designed to provide an identifiable place where people can get information, objective advice, and access to a wide range of community supports. The other essential component is a system of person-centered services that places participants, not services or providers, at the center of funding and service planning.

Person-centered services systems, as presented in the following sections of this report, have two key features. First, by financing a wide range of support options, they enable persons to make meaningful choices about their living arrangements, the supports they receive, and the manner in which services are provided. Second, by designing person-centered quality

management and information systems, the state enhances its ability to achieve intended participant outcomes and program goals.

**Person-Centered Support Options**

South Carolina is increasing the choices available to participants by giving more people the option to hire their paid caregiver and to choose supports that are not typically available. Currently, most people receive services from traditional provider agencies. This section first describes South Carolina's case management process for Medicaid HCBS waiver services, which ensures people can make meaningful choices among traditional and self-directed services. Second, it explains the state's options for self-directed services, including the new SC Choice waiver.

**Case Management—**The state allocates case management resources so participants can quickly receive services once they are able to join the waiver. More experienced case managers prepare an initial service plan, and other case managers provide ongoing case management. South Carolina established this process in 1999, when the state dramatically reduced its waiting list due to a sharp increase in funding from the state legislature. To maintain this increased level of funding in subsequent years, DHHS needed to enroll thousands of new participants in the waiver by the end of the fiscal year.

After an assessment establishes eligibility for waiver services, participants confer with a senior case manager to develop an individualized service plan. The senior case manager reviews options for services and providers with the participant and helps the person choose supports that best fit individual preferences and address needs identified in the assessment.

**Senior case managers help participants quickly access services, then participants choose another case manager for ongoing support.**

Case managers enter the service plan into the state's Case Management System. The Case Management System also helps case managers work with the participant to develop the service plan. The system automatically displays potential problems a participant faces, as indicated by assessment data, enabling case managers to quickly identify issues that may affect the person's ability to live independently in the community. For each potential problem, the case manager identifies an intervention and a goal against which to measure the intervention's success.

The senior case manager also facilitates the participant's choice of case manager for ongoing support. This case manager may be a DHHS employee, an independent contractor, or an employee of an agency under contract with the state to provide case management. To complete the transition, the senior case manager gives the participant an enrollment packet containing a variety of information about participant rights, authorized services, the service plan, the procedure for filing complaints, and information about the case manager who will be working with them on an ongoing basis. The ongoing case manager contacts each participant at least once a month via telephone and once every three

months in-person. The case manager also must conduct a reassessment yearly or if the person's condition changes significantly.

**Self-Directed Services—**South Carolina established its first self-directed options for older people and people with physical disabilities in 1995 by adding self-directed services to the Elderly/Disabled Waiver. In response to stakeholder input generated in 2002 by the Olmstead Task Force, the state created a new waiver with expanded options for self-direction. The state also offers participant and family-directed services within the Aging Network through its operation of the National Family Caregiver Support Program.

The Elderly/Disabled (E/D) Waiver offers self-direction in two services: attendant care and companion services. In 2001, 547 people used attendant care and 259 people used companion services. People can hire their own support worker for either service and use other waiver services offered by provider agencies.

When using these services, participants have primary responsibility for hiring, training, and supervising their attendants or companions. Participants must also develop a backup plan with their case manager for emergencies or circumstances when the provider cannot work as scheduled. Participants can also designate a representative to take these responsibilities.

The state contracts with the Center for Disability Resources (CDR) at the University of South Carolina to help people use self-directed services and to review the quality of these services. Participants can choose a provider from a registry of independent attendants and companions maintained by CDR or may nominate their own, including family members who do not live with the participant. CDR trains and certifies all attendants and works with participants and case managers to develop each participant's backup plan.

If the person chooses to use attendant care, a registered nurse from CDR observes the attendant working with the participant. The nurse must certify the attendant-participant working relationship before the attendant can be paid to work for the participant. Certifying the provider-participant relationship is not required for companion services, because companions do not provide hands-on support. They provide supervision and socialization, and may help with routine household tasks. The CDR nurses also provide ongoing quality assurance, visiting participants throughout the state to ensure attendants and companions meet the participants' needs and to provide supplementary training if needed.

The regional DHHS offices train all attendants and companions to submit claims as independent providers, including use of the Care Call electronic monitoring system described later in this report. South Carolina is currently developing a fiscal management services function for the E/D Waiver to help participants and their providers with required taxes and other financial responsibilities.

The Choice Waiver (SC Choice), a Medicaid HCBS waiver that started July 1, 2003, offers more flexibility for people who direct their own services. The waiver is one of the first four Medicaid waivers approved under the Centers for Medicare and Medicaid Services'

Independence Plus initiative, which assists states that want to offer self-directed options. The waiver is currently available to a maximum of 300 people in a northern South Carolina pilot area (Spartanburg, Cherokee, and Union counties), the same pilot area used for the new information and referral system. The state will choose a second pilot area for SC Choice later in 2003. The table on the following page summarizes the differences between SC Choice and the E/D Waiver, which are explained below.

Current E/D Waiver participants in the pilot area can switch to SC Choice by calling their case manager or the regional DHHS office. People who start receiving waiver services can choose SC Choice or the E/D Wavier. After the assessment, the senior case manager who helps participants develop their initial services explains both waivers and participants choose a waiver.

SC Choice participants receive an individual budget each six months, based on the cost of waiver services that would be authorized under the E/D Waiver. The individual budget is calculated as a percentage of the cost of approved E/D Waiver services, because E/D Waiver participants typically do not receive all of their authorized services. Within this budget, SC Choice participants may use funds for self-directed services and for traditional E/D waiver services.

SC Choice participants will have more flexibility and responsibility in supervising their paid caregivers. In addition to employing their own provider (called a personal care assistant under this waiver), people can purchase assistive technology devices, appliances, or other items that address their needs within the budget. SC Choice participants also can negotiate a payment rate with their personal care assistant and use any cost savings toward other items or services.

The person determines the service plan through a person-centered planning process with assistance from a care advisor and from additional people chosen by the participant. During this process, the participant identifies personal outcomes he or she wants to achieve, and paid and non-paid supports that will help the participant achieve these outcomes. Each person must have an emergency backup plan for situations when a participants' personal care assistant cannot work as scheduled. The care advisor must approve the plan to ensure it meets the participant's health and safety needs identified in the assessment.

Unlike the E/D Waiver, providers do not need to be trained and screened by the University of South Carolina's Center for Disability Resources (CDR). Instead, the care advisor and participant determine what training the provider needs. The state offers criminal background checks to participants to help them screen providers. CDR conducts these checks for the E/D Waiver's self-directed services.

The care advisor then trains the participant on several skills necessary or useful in directing one's services, including:

- budget management,
- hiring and managing workers,

- using the SC Access Web site,
- what the participant can do if he or she is not satisfied with a provider, and
- proper techniques for the participant's personal care assistant or informal caregiver to provide hands-on support, if necessary.

The state assures the quality of SC Choice services by requiring more intensive involvement of a support coordinator, called a care advisor. Care advisors must visit each participant in-person at least monthly to monitor the quality of supports and provide additional training or assistance if necessary. If there are problems with the person's services, such as a backup plan that is not working well, the care advisor and participant will revise the service plan. Since care advisors provide more intensive assistance than case managers in the E/D Waiver, they have lower caseloads. State staff plan for care advisors to have an average caseload of 50 participants, while the average caseload for E/D Waiver case managers is 80 participants.

CDR trains all care advisors in person-centered planning and support coordination. The training includes the role of a care advisor, empowering participants to make decisions, monitoring quality and participant satisfaction, use of the SC Access Web site, and coordination with the fiscal management services provider.

**Differences between South Carolina's Self-Direction Options: E/D Waiver and SC Choice**

| | E/D Waiver | SC Choice |
|---|---|---|
| Supports brokerage | Traditional waiver case manager. Minimum contact is monthly phone call and quarterly in-person visit. | Care advisor, trained in person-centered planning. Minimum contact is monthly in-person visit. |
| Service planning | Participant chooses from menu of services, working with a case manager. | Participant leads person-centered planning process with care advisor and others the participant invites. |
| Budget management | Expenditures are based on frequency and duration of services from the menu. | Participant has flexibility to choose supports within an individual budget, with support of a care advisor and the fiscal management service. |
| Supplies & equipment purchasing | Not self-directed; through traditional providers | Self-directed; through traditional or non-traditional providers |
| Quality assurance | State oversight for E/D waiver as described in Quality Assurance section. Also, CDR screens providers for criminal background, trains providers, and approves participant-provider relationship for hands-on services. | State oversight for E/D waiver as described in Quality Assurance section. Also, care advisor and participant determine provider training and approve providers. Criminal background screening available. |

SC Choice participants also will have more options for purchasing equipment and supplies than E/D Waiver participants. The state is developing a convenient way for participants to purchase items from providers who typically are not Medicaid providers, such as retail stores. If a participant's service plan calls for purchasing a common item or service that can meet his or her needs, like a microwave, the service plan will identify the item or service. The participant will then choose a provider, obtain a statement of the cost from the store, and send the price quote to his or her care advisor. The care advisor then contacts the provider so it can sign a one-page provider agreement that specifies the minimum requirements of a Medicaid provider (Attachment A). This streamlined provider agreement is only used for providers of items and services purchased from providers that do not traditionally provide Medicaid services.

Acumen, a subcontractor to the waiver's fiscal management services provider, will then issue a check to the store for the cost of the item. The check (Attachment B) also specifies the minimum requirements of a Medicaid provider. Acumen will send the check to the care advisor. The care advisor sends the check to the participant, who purchases the item.

A private contractor, GovConnect, provides fiscal management services for SC Choice. The contractor collects information about in-home services through an electronic monitoring system it operates for the state, Care Call, which is described below. The contractor pays for other services and items in the service plan based on information from the care advisor and participant. Using this information, it bills the Medicaid Management Information System and pays the personal care assistants after withholding taxes, unemployment insurance premiums, and other employer-related expenses.

South Carolina's 2001 Real Choice Systems Change Grant is supporting the design of the waiver and an evaluation of the pilot sites. The evaluation will use interviews with participants, their families, care advisors, and other people involved in the pilots to identify implementation challenges and recommend program changes. This evaluation will help the state improve program implementation before the state expands SC Choice to a second pilot area and, eventually, statewide.

The state contracted with the University of South Carolina (USC) School of Public Health for the evaluation and for technical assistance. To increase awareness of the waiver, the state and USC School of Public Health gave presentations about it to potential participants, service providers, local social services organizations, and advocacy groups in the pilot area. The state also created a local advisory committee to advise the state regarding outreach to participants and to collect input regarding the waiver from local participants, advocates, providers, and other stakeholders.

The state and the USC School of Public Health also developed a brochure for participants and a manual for participants to use once they join the waiver. The manual provides information about the responsibilities participants have under the waiver, such as managing a budget and hiring and supervising workers. A focus group of participants and family

members from the pilot area reviewed all materials to ensure they were easy to understand and comprehensive.

The National Family Caregiver Support Program (FCSP) is enabling South Carolina to expand self-directed options in the Aging Network. The national program is available for people caring for a relative age 60 or older, and for grandparents age 60 or older caring for minor children. The state offers participants and caregivers more choice and control over FCSP funds by administering this benefit through regional Area Agencies on Aging (AAAs), instead of at local Councils on Aging (CoAs) that are the primary service providers for most Aging Network supports.

Each AAA employs a Family Caregiver Advocate who coordinates the program. This person helps the caregiver and family member complete an enrollment form that requests information on the family member's health and social needs, and awards a voucher for services. While the exact rules for how much assistance people receive varies by AAA, families generally receive a few hundred dollars per year. The state encourages AAAs to provide small amounts of money for each family in order to reach a high number of people. During the nine months of state fiscal year 2002 in which the program operated, families received 1,851 vouchers for respite and other supplemental services.

Families can use the voucher to purchase services or items that reduce the caregiver's burden or that increase the independence of the person who needs supports. Respite care and assistive technology are common supports purchased using the voucher. The caregiver and family member select the provider, which may include family members. People interviewed stressed the importance of the program's flexibility, saying that flexibility allows families to focus funds where they have the most benefit. State staff encourage Family Caregiver Advocates to assist people in leveraging the vouchers with other formal and informal resources. For example, the program may purchase supplies for a ramp while the person and family recruit volunteers to build it.

The Family Caregiver Advocates also provide information and referral to further assist participants and caregivers, working with the information and referral specialists hired under SC Access. This assistance allows the program to have a greater impact than the small vouchers it awards, because the program connects people to other resources that offer support the person may need, such as home and community-based services providers, CoAs, and local social service organizations. In this capacity, the Family Caregiver Advocates often serve as a resource for CoAs, to help people who need more services than a CoA can offer.

When determining the role of the Family Caregiver Advocate, the state drew lessons from a federal Alzheimer's Demonstration program called Project COPE (Care Options and Public Education). As part of the demonstration, South Carolina AAAs coordinated respite and caregiver support for people with Alzheimer's disease and their families. The AAAs noticed that when the people and caregivers experienced challenges, caregivers often turned to their contact person at the AAA. The AAA often could help people solve problems, at times preventing unwanted institutional placement. While the Alzheimer's

demonstration is no longer active, this problem-solving expertise was built into the jobs of the Family Caregiver Advocates.

**Person-Centered Systems Management**

South Carolina is a leader in using information technology to collect more data regarding home and community-based services and to provide these services more efficiently. The state also has developed a comprehensive quality assurance system, which includes several process reviews to monitor the services people receive.

**Information Systems—**The state currently uses two information systems. The Case Management System supports the case managers' day-to-day work and provides quality assurance information. Care Call is a telephone monitoring system that provides a record of in-home services visits to track the assistance people receive and to identify missed or shortened visits.

The Case Management System (CMS) was developed in 1991 and has been revised several times since then to incorporate new information technology and to improve its support for participants. CMS includes intake and assessment data for everyone who receives Medicaid long-term supports through a waiver or in a nursing facility. CMS also contains case management information for participants in the Medicaid HCBS waivers DHHS operates, including the Elderly/Disabled Waiver and SC Choice. The wide range of supports for which CMS is used allows the state to track participants' status as they move through different settings in the long term care system.

CMS has several features that make it easier for case managers to assist participants. For example, the service plan module imports information from the assessment that indicates a participant's needs. Rather than search the entire assessment to identify a person's service needs, the case manager can read the list of potential problems and can click on a particular need to view related information from the assessment. The case manager and participant then identify a goal related to the issue and an intervention to reach that goal.

**The Case Management System tracks information assessments, service plans, and other contact with participants, families, and providers.**

Case managers also record their case notes – information from contact with participants, family members, and providers – in CMS. The electronic entry of case notes allows case managers to quickly review all available information about the person. This capability is particularly valuable when a case manager is filling in for a colleague on vacation and when a person has a new case manager.

CMS enabled South Carolina to require case managers to telecommute in 2002. Telecommuting increased participants' access to case managers, because the state supplied case managers with cellular phones at the same time. Participants can call the case manager directly, rather than calling a switchboard and often needing to leave a message. South Carolina provides each case manager with a laptop to record information into CMS,

and a fax machine for written communication with providers when hard copies are necessary. Each week, or more often if necessary, case managers go to the DHHS regional office to exchange information between their laptop and the CMS database at the regional office. They export assessments, service plans, and case notes to the CMS database, and download intake and demographic information for their participants. The state plans to move toward a Web-based system so case managers can exchange information with the CMS database in real time. The addition of case notes, as well as service plans, to CMS was essential for telecommuting. When this information was stored in paper files, case managers needed to store them in centrally located files so other case managers could access them if necessary.

In addition to providing case managers more information, CMS reports information on Medicaid long-term care services, including quality assurance indicators. The state regularly generates CMS reports to:

- Measure whether people receive Medicaid HCBS waiver services in a timely manner;
- Identify the number of people on a HCBS waiver waiting list;
- Measure demographic characteristics of participants, such as age, race, and gender;
- Present cost and utilization information, both statewide and for particular regions and particular services; and
- Verify case managers provide the assistance the state requires (e.g., monthly contact with participant, annual reassessment, and development of service plans that meet participant's needs identified in the assessment).

The state also has developed a report to identify people whose health and safety are particularly at risk if an emergency or disaster occurs. If a disaster occurs, the state will use this list to contact each participant and his or her case manager, providers, and informal support circle to learn the participant's status and, if necessary, to find assistance so the person can be safe.

State staff emphasized the importance of collaboration between the central and regional offices in developing this software. Each regional office is represented on a committee that plans enhancements to CMS, and central and regional staff mentioned several instances in which ideas from individual case managers or their supervisors were added to the system. This collaboration has been particularly important in major changes, such as the initial requirement to use the system in 1991 and the addition of case notes to the system in 2001.

CMS is currently a Microsoft Access data system. Each the state's 13 regional DHHS offices maintains a database, and sends an update of the database to the state's central office nightly. CMS is separate from the state's Medicaid Management Information System, which processes claims for long-term care as well as for other Medicaid services.

Care Call is an electronic monitoring system that creates a record of each in-home services visit paid by Medicaid HCBS Waivers administered by DHHS. South Carolina developed this system in response to several complaints from participants that provider staff often did

not assist participants as scheduled, and often did not provide as much assistance as the provider billed to Medicaid. Before Care Call became active in November, 2002, participants signed a daily activity log for provider staff indicating the number of hours the direct support worker supported the person and the tasks the provider performed. Several participants told case managers that provider staff pressured them to indicate more hours than the provider worked, or to indicate the provider worked on a day when he or she did not.

Care Call provides independent verification that providers were in a person's home for a specific period of time. When direct support workers arrive at the participants' home, they must call a toll-free number that connects to the Care Call database. The provider checks in at the start of the visit, entering an identification number unique to each provider employee. The provider calls again at the end of the visit. Care Call identifies the participant based on his or her home telephone number, and automatically records the provider staff person, and the visit's start and end times.

**Care Call provides independent verification that providers were in a person's home for a specific period of time**.

Care Call makes billing easier for providers, in addition to monitoring direct support providers' time. On a weekly basis, Care Call automatically transfers data to MMIS. This data transfer includes all the data necessary for claims submission, so providers no longer need to complete hard copy forms or bill electronically themselves. Providers receive a weekly hard copy of their claims, which they can use to verify their staff are working as scheduled. Providers can also subscribe to the Care Call Web site in order to receive their data electronically and in real time.

Case managers have access to information in Care Call, which is also exported to CMS. Case managers also can access the Care Call database in real time via the Internet to learn the status of a participant's services. For example, if a provider has missed previous visits, the case manager can check the database and find out immediately if the worker misses another visit. The case manager then would contact the participant and the provider to implement the participant's plan for backup support.

Automatic billing decreases administrative time and expenses for the providers, especially for providers employed by participants, who do not have billing staff. The information that self-directed providers enter on the telephone acts as their time card, so paper time cards are not required. The Care Call contractor also provides fiscal management services for SC Choice, and withholds necessary taxes and insurance before paying self-directed services providers under this waiver.

Once a contractor was selected, the state implemented Care Call in less than a year. However, the state had laid the groundwork for Care Call for several years by mentioning the possibility of an electronic monitoring system at annual conferences for waiver providers. The state also changed its Medicaid provider agreements with waiver providers years ago to require use of an electronic monitoring system when one was developed.

**Quality Assurance –** South Carolina has developed a thorough system of process measures for its waiver quality assurance to review whether case managers and providers meet minimum standards. In addition to the system described below, the state recently added an external review to its quality management approach through contracts with the University of South Carolina. One contract, with the Center for Disability Resources, focuses on process. Two people review compliance to policies and procedures at regional DHHS offices and at the county boards that operate waivers for the Department of Disabilities and Special Needs. The second contract is with the School of Social Work to develop a participant satisfaction tool.

Case Manager Review starts at the regional DHHS offices. Each month, senior case managers review 10% of participant records to ensure case managers completed and documented monthly contacts with participants. Case management supervisors perform a more in-depth monthly review of two participants' records for each case manager (2.5% of total participants). The reviews include verification that:

- the case manager contacts each person monthly as required,
- the service plan addresses identified needs, and
- the case manager has reassessed participants and updated their service plans as appropriate.

Case management supervisors also annually visit one or two participants per case manager in person to ask them about the assistance the case manager is providing.

Case managers are notified of problems when they are identified, and receive training if they do not meet requirements 80% of the time in any review. If a case manager does not improve, disciplinary action or removal from case management may occur. Each regional office reports findings quarterly to the central office.

State central office staff conduct a second level of review at each regional office annually. A three-person team – a registered nurse, a social worker, and the head of the waiver quality management unit – reviews a random sample of 5% of participants' records. The central office review covers some of the same processes reviewed by area supervisors. Central office staff also review whether the regional office handles participant complaints appropriately and follows state policies and procedures (e.g., hiring case managers and assessors that meet state standards). The team also reviews whether private waiver case management agencies and independent case managers fulfill contract requirements.

Each year the central office distributes findings from its reviews to all regional offices. If a private case management provider or a regional office does not meet a given standard 80% of the time, the office or provider must develop a corrective action plan. Central office staff then approve the plan and monitor its implementation.

Provider Review is conducted by the central office. Before serving waiver participants, provider agencies must submit written documentation indicating they meet provider requirements, especially financial requirements and possession of liability insurance. After

reviewing this documentation, a registered nurse visits the provider to verify additional requirements are met, such as staff qualification standards and physical space requirements (e.g., for adult day health care or respite). A new provider cannot provide waiver services until it meets these standards and passes both reviews.

Subsequent on-site reviews occur within 30 days after the provider serves its first waiver participant, and annually thereafter. If an existing provider does not meet standards, the state may require a corrective action plan, prohibit the provider from serving new waiver participants until problems are addressed, or terminate the provider's contract, depending on the potential harm to participants.

This review process is not used for providers of self-directed care, who are approved by care advisors (SC Choice) or the University of South Carolina's Center for Disability Resources (E/D Waiver) as described in the Self-Directed Services section.

## Lessons Learned

South Carolina has taken great strides to:

- improve the quality of home and community-based services using information technology,
- increase participants' control over their supports, and
- enhance available information about supports so participants are empowered to make choices that fit their needs and preferences.

Other states can draw several lessons from South Carolina's efforts.

*Value of information technology* – South Carolina has tapped the potential for information technology in a variety of ways to improve the administration of home and community-based services. Since creating the Case Management System (CMS) in the early 1990s, CMS has made the administrative tasks of case management easier, allowing case managers to spend more time with participants. The state improved CMS over the years to: create further process efficiencies, collect more data for quality assurance review, and analyze data for program management. The new CareCall system increases the accountability of direct service providers and streamlines the provider billing process.

*Integrated system administration* – Since 1997, DHHS has consolidated administration and policy development for almost all publicly funded long-term support for older people and people with physical disabilities. This merger sparked efforts to improve coordination at the local level so people can access their services easily, such as the information and referral system the state is developing (SC Access). Another advantage of this combined administration is that initiatives related to different funding streams reflect common goals. For example, South Carolina is increasing self-direction opportunities within both Medicaid home and community based services waivers and the Aging Network.

*Change may cost more initially* – South Carolina's first effort to improve access for older people, Senior Access, illustrates some of the challenges states face in creating a single access point for multiple funding streams. Without additional funding, this initiative attempted to consolidate the intake and assessment functions of two separate entities: county-level Councils on Aging in the Aging Network and regional DHHS offices that administer Medicaid HCBS waivers. Both organizations assumed additional duties without possessing the resources to perform them. People experienced delays in receiving services as a result, and the state eventually stopped the initiative.

*Local program staff involvement in policy* – South Carolina has long involved local staff in policy development and implementation, especially local Medicaid staff who are state employees. Regional DHHS office administrators meet regularly with each other and the central office to discuss the waivers and particular initiatives to improve them. Case managers and supervisors are involved on internal committees managing particular initiatives, such as changes to the Case Management System. Local staff are also able to suggest changes to the central office when problems are identified. For example, the state developed Care Call after case managers communicated participant complaints about providers leaving early or not showing up.

*Stakeholder participation* – Public input from participants and advocates in the Governor's Senior Forums and in the Olmstead Task Force provided a direction for DHHS that included expanding self-directed services and developing a new information and referral system. The state has pursued this direction as funding has become available, collecting feedback on their plans periodically through public forums and the advisory committees.

# Appendix A

## SC Choice Waiver: Sample Provider Agreement

Date: _____

Executed between the **South Carolina Department of Health & Human Services (DHHS)**, **Community Long Term Care** and

_____.
Provider

Street Address
_____

Telephone Number _____ _____

The provider agrees to accept check(s) for items or services purchased for individuals served through Community Long Term Care. Financial management services are being provided for individuals served through Community Long Term Care through Acumen Fiscal Agent. Acceptance and endorsement of the check(s) will signify that the provider agrees to the following terms and conditions:

1. Agree to keep records of the service(s) or purchase(s).
2. Agree to provide only the service(s) or item(s) authorized on the check(s).
3. Agree to accept the check(s) as payment in full for the service(s) or item(s) purchased.
4. Agree no additional charges will be made or accepted from the individuals.
5. Agree to refund Acumen in full in cases of overpayment.
6. Agree to provide DHHS or its designee information regarding the service(s) or purchase(s).

_____ _____
DHHS Representative Provider

# Appendix B

# SC Choice Waiver: Sample Check

## Language on Check Stub:

Endorsement of this check signifies the provider will follow these terms and conditions:

1. Agree to keep records of this service or purchase for three (3) years.
2. Agree to provide only the service or item authorized on the check.
3. Agree to accept this check as payment in full for the service or item purchased.
4. Agree no additional charges will be made or accepted from the participant.
5. Agree to refund Acumen in full in cases of overpayment.
6. Agree to provide SC DHHS or its designee information regarding this service or purchase.

Regular Acct 12345678901

Bank Name
Bank City, US 00000-0000 **3391**

Acumen Fiscal Agent, LLC
PO Box 123
Fiscaltown, US 45678

Date
7/10/03

One Hundred Twenty-Three Dollars and 45/100

Amount

**PAY TO THE ORDER OF**

$123.45

Retail Store
1111 Sunset Blv'd
Anytown, SC 22222

Payment in full for Brand X Microwave Oven Serial No. 54321

_____
Acumen

"003391" "12345678901:2345678901

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