THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Appellate Case No. 2014-002513

Richard Stogsdill,.....Petitioner,

v.

South Carolina Department of Health and Human Services.....Respondent.

REPLY TO RESPONDENT'S RETURN TO MOTION TO VACATE ORDER AND TO SUPPLEMENT THE RECORD

Patricia Logan Harrison, Esq.
611 Holly St.
Columbia, SC 29205
803-256-2017

Attorney for Petitioner

Jurisdiction of the South Carolina Supreme Court. On page 8 of Respondent's Return, DHHS asks this Court to supplement the record "if the Court takes jurisdiction of the matter..." But, this Court already has jurisdiction to hear and rule upon Stogsdill's motion, because the remittitur was sent in error, in violation of Rule 221(b) of the South Carolina Rules of Appellate Procedure. That Rule provides that the remittitur "...*unless otherwise ordered by the court* shall not be sent to the lower court or administrative tribunal until fifteen (15) days have elapsed ...since the filing of the opinion, order, judgment, or decree of the court finally disposing of the appeal." The January 20, 2016 order of this Court did not "otherwise" order that the remittitur be sent before fifteen days passed.

This Court's order disposing of Stogsdill's appeal was filed and mailed on January 20, 2016, the remittitur was mailed by the clerk's office that same day, and Stogsdill filed his motion to vacate fourteen days later, on February 3, 2016, within fifteen days. SCRAP Rule 221(b).

The remittitur is not a court order, but it is a document sent to the lower court by the clerk. Jean Hoefer Toal, Amelia Waring Walker and Margaret E. Baker, "*Appellate Practice in South Carolina*" at 393 (3d Edition). When the remittitur is "sent down by mistake, error, or inadvertence of the appellate court" jurisdiction is not properly transferred to the lower court. Toal et al at 122 and 393. Even if the remittitur had not been prematurely sent, if jurisdiction resided now in the South Carolina Court of Appeals, under SCRAP Rule 204(b) this Court would have the authority to certify Stogsdill's case for review, because the issues in his motion involve concerns of tremendous public interest.

Given the circumstances of this case, the misleading allegations made at oral argument, the incomplete records DHHS provided to the Court and the admissions in Respondent's Return, this Court should grant Stogsdill's motion to vacate its order of January 20, 2016 and allow the

parties to take depositions, to supplement the record and to file supplemental briefs.

The "Side Issue" of Complying with the Order of the Court of Appeals. Respondent considers this Court's concern as to whether the State has complied with the Court of Appeals' September, 2014 order to be nothing more than a "side issue." Return at 1 and 3. The State thinks that compliance with a court order is "not germane to the promulgation issue." Id. at 3 to 4. But, Respondent's continued disregard for the Medicaid Act's "reasonable promptness," "reasonable standards" and "amount and duration and scope" mandates - not to mention its disregard for an appellate court order - demonstrates well why it is so important for this Court to order Respondent and its agent, DDSN, to promulgate regulations.

The Return shows that, that once again, DDSN and DHHS have changed the rules in the middle of the stream, without notifying the public what the new rules are, in order to defeat a waiver participant's claim. Even while these agencies are under the microscope of appellate review, they have stubbornly refused to provide the services Stogsdill needs in the amount, duration and scope required to avoid the risk of institutionalization.

Respondent convinced the federal district judge to dismiss Stogsdill's federal claims on the grounds of abstention. *Stogsdill v. Keck,* Case No. 3:12-cv-007 (S.C.D.C. Nov. 10, 2014), pending appeal to the United States Court of Appeals for the Fourth Circuit. (Note typo in motion to vacate: Stogsdill's federal lawsuit was filed in 2012, not in 2014.)

Respondent has a history of treating compliance with court orders as a "side issue" that is not worthy of the agencies' attention. Federal law requires the State to issue a final administrative order determining eligibility for services within 90 days, in order to comply with the Medicaid Act's "reasonable promptness" mandate. 42 U.S.C. 1396a(a)(8), 42 C.F.R. 431.244(f), 42 C.F.R. 435.911. The Fourth Circuit so instructed DHHS and DDSN in *Doe v. Kidd I,* 501 F.3d 348, 356.

But, like the order of the Court of Appeals in this case, and this Court's order in Doe's parallel state case, Respondent ignored that federal order, as well as the Fourth Circuit's ruling in *Doe v. Kidd II,* Case No. 10-1191 (4th Cir. March 24, 2011) (Unpublished). *See* http://www.ca4.uscourts.gov/oral-argument/listen-to-oral-arguments, oral arguments in *Doe v. Kidd III* heard on January 27, 2016. DHHS promised to provide residential habilitation services to Doe in 2003, but then failed to provide those services until 2014. As in this case, Respondent treated its obligation to provide the services the Fourth Circuit ordered as a side issue, even after the Fourth Circuit ruled that DHHS and DDSN had abdicated their duty to provide residential habilitation services to Doe with reasonable promptness. *Doe v. Kidd II* at 17-18.

Another example of Respondent's disregard for court orders is found in its response to this Court's order involving that same plaintiff.[1] This Court ordered DDSN to change its eligibility criteria on December 28, 2011 so as to take into consideration evidence of age of onset of "mental retardation" up to age 22. *Jane Doe v. DHHS*, 398 S.C. 62, 727 S.E.2d 605 (2011). But, on September 25, 2013, nearly two years later, the Director of DDSN wrote that she

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[1] An example of Respondent's disregard for orders its own hearing officers and the Court of Appeals' order in *Stogsdill v DHHS* (prohibiting caps on services for persons at risk of institutionalzation) is found in *B.W. v. DHHS*. The 2013 Order of DHHS Hearing Officer Hutto (now Deputy Director of DHHS) requiring DDSN and DHHS to provide the number of hours ordered by the physician and finding that Respondent was in violation of her due process rights is found at Supplemental Appendix ("SA") at 00520. When counsel asked DDSN and DHHS to enforce this Order, and to reassess B.W. without regard to the waiver caps, as required by *Stogsdill v. DHHS*, counsel for DDSN, Tana Vanderbilt responded that it was not required to comply with that order, because "DDSN is not a party to the case in front of the DHHS Hearing Officer. Therefore DDSN has not been ordered to do anything in that matter." Exhibit 1. Again, DHHS and DDSN have treated their obligation to provide the services ordered as a side issue. B.W. still has not received the services ordered in 2013 that are the subject of her 2007 "fair hearing" appeal. The ALC has ignored her 2014 petition to compel DHHS to comply with Ms. Hutto's order. (B.W. was forced to file a second administrative appeal, now pending in the Court of Appeals, when DHHS refused to pay for an oximeter cable.)

was *considering* changing DDSN's eligibility criteria, not because Court's ordered DDSN to do so, but because of DHHS decided to amend the ID/RD waiver eligibility criteria:

> Dr. Buscemi reported that DDSN understands that DHHS will submit as part of the ID/RD waiver renewal changing the developmental period to be defmed (sic) as up to age 22. *DDSN wants to wait until that is submitted and official* but likely we will recommend DDSN's eligibility requirements change to be consistent with the waiver documents. DDSN will bring this to the Commission for consideration at a later date.

Exhibit 2 at 6. What? This Court's order was not sufficient to make the change "official"? DDSN will consider whether it will comply with this Court's 2011 order in *Jane Doe v. DHHS* at some later date? As in this case, Respondent has treated *this* Court's order as a side issue and ignored it for four years, continuing to evaluate applications for services using the age 18 onset criteria.

Finally, in 2014, the South Carolina Legislative Audit Council reported DDSN's failure to comply with this Court's order to be something more than a side issue. LAC thought that DDSN's failure to comply with this Court's order was germane to the promulgation of regulations issue. In June, 2014, LAC reported to the General Assembly that DDSN still was using the age of onset criteria that this Court found to be in violation of state law in 2011. Exhibit 3. The Legislative Audit Council reported:

> In the current directive (last updated in October 2013), the standard for eligibility for a determination of ID remains an onset age of 18. In addition, the CAT applied the age 18 standard as recently as August 2013. While the case cited above was specific to a Medicaid waiver, the effect of the general age of onset directive is that all applicants who do not meet the age 18 cutoff will be denied eligibility for DDSN services. The applicant would never get to the point of examination for waiver eligibility.
>
> *In its opinion, the Supreme Court majority noted that DDSN's commission has the authority to promulgate regulations that define ID in the context of waiver services, but it has not.* DDSN is currently involved in litigation regarding whether it must promulgate regulations related to eligibility. While we do not assert that it must promulgate regulations, the commission has statutory authority to promulgate regulations, should it wish to further clarify agency operations.

> If the DDSN commission deems the DSM criteria for ID to be the most appropriate for use in South Carolina, there are steps the commission can take, including promulgating a regulation specifically defining the age of onset and working with SCDHHS and the federal Centers for Medicare and Medicaid Services to amend affected waiver documents.

Exhibit 3. Even after the LAC report, DDSN still did not change its eligibility criteria until October, 2015. Even then, it replaced its "age 18" language with "during the developmental period," without reference to the age 22 criteria required by this Court. Exhibit 4.

This game plan of treating court orders as "side issues," not worthy of Respondent's attention has worked for these agencies for years, depriving those few waiver participants who have the stamina to reach the Judicial Branch of their hard-fought victories. The "fair hearing" process will continue to be a long and painful exercise in futility for the most vulnerable citizens of South Carolina, their families and advocates unless this Court vacates its January 20, 2016 order and requires Respondent and DDSN to promulgate regulations in compliance with the South Carolina Administrative Procedures Act.

The "fair hearing" process has been a "heads we win, tails you lose" game rigged by the Executive Branch for many years.[2] It is no wonder that no private attorneys are accepting these

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[2] According to the lates annual report of the South Carolina Administrative Law Court, the "average" number of days to reach a final administrative decision in a Medicaid case is 276 days. See page A-4 at http://dc.statelibrary.sc.gov/bitstream/handle/10827/20331/ALC_Annual_Accountability_Report_2014-2015.pdf?sequence=1&isAllowed=y
That Executive Branch agency has self-imposed a 180 day "objective" for disposing of Medicaid cases - double the number of days allowed by federal regulations. Id. It only "disposed" of four Medicaid cases in FY 2015, meeting its "objective" in only 25% of those cases (down from "disposing" of ten cases in FY 2014, meeting its objective in 50% of those cases, taking an average of 270 days per "disposed" case.) But, that report does not mention how long those cases that were not "disposed" of have been pending at that agency. For example, *B.W. v. DHHS*, a fair hearing filed in 2007, is on its third round at the ALC.

cases that drag on for years, only to be dismissed when the client nears the finish line. Stogsdill will continue to be at risk not only of institutionalization, but also retaliation, as will thousands of other DDSN clients and their families if his case is dismissed. Exhibit 5. Stogsdill requests an order allowing the parties to supplement the record and to file briefs on these issues.

Supplementing the Record. Respondent argued throughout oral arguments before this Court on November 17, 2015 that its efforts to assess Stogsdill were thwarted by Stogsdill's counsel. See video portal at http://www.judicial.state.sc.us/SCvideo/caseNameSearchVideo.cfm (*Stogsdill v. DHHS*, Case No. 2014-2513). But, DHHS now admits that "The Petitioner followed the process for receiving an assessment." Return at 4. DHHS admitted that the "normal assessment" procedure involves the DDSN Service Coordinator establishing the level of services. Id. It is undisputed now that Stogsdill fully complied with that "normal assessment" process.

Respondent's counsel himself opened the door to this Court's consideration of events that occurred after the record was closed. Fundamental fairness requires that Stogsdill should be allowed to supplement the record to demonstrate that the violations he has complained of since February, 2009 are not just "side issues," but that those violations are continuing. The State's establishment of new binding norms demonstrates that this Court should order these agencies to establish reasonable standards through the promulgation of regulations, in compliance with the South Carolina Administrative Procedures Act. Otherwise, waiver participants will continue to be forced to relitigate these issues for years, only to be hamstrung by the DDSN/DHHS "gotcha" routine at the end of the case.

The "Nurse Exception" to the "Normal Assessment" Process. Respondent states in

its Return that the "nurse exception has led to the current level of services." Return at 7. DDSN established this "nurse exception" to the "normal assessment process" in 2010, but it has not promulgated that binding norm as a regulation. Exhibit 6. Under this policy a "centralized nurse review" determines the "appropriate amount of nursing." SA 000538. This process requires service coordinators around the State to send their requests for nursing services to DDSN nurse Vivian Koon, who is the only person in the State having authority to approve DDSN nursing hours. This practice is contradicted by the testimony of DDSN and DHHS officials, who have testified that no deference is given to the opinions of medical professionals, because the DDSN waiver programs are not based on a "medical model." Supplemental Appendix ("SA") at 488-496. See also the 2014 deposition of Kara Lewis taken in Stogsdill's federal case. SA at 00383. The end result of the "nurse exception" game is that waiver recipients can only receive however many hours RN Koon decides she wants them to receive, in her unfettered discretion, without regard to physicians' orders, so long as she does not exceed the waiver caps.[3]

The DDSN service coordinator was allowed to visit with Stogsdill in his home on July 16, 2014. SA at 00185. She requested medical records on August 4, 2014, which were promptly provided by Stogsdill's guardian on August 5 and August 12, 2014. SA at 00186 -

[3] In *B.W. v. DHHS*, the hearing officer (now Deputy Director of DHHS) wrote that prior to 2010 "there was no nursing review at the agency to see if participants were getting the services they needed." SA at 00538. The "nurse exception" rule requires the service coordinator to provide a physician's order, but the "centralized nurse" "determines how many hours are needed." Id. If a treating physicians' order exceeds the waiver limits, "the SCDDSN centralized nurse would not give any deference to that medical order." SA at 00539. The form used by DDSN "does not allow the doctor to designate a recommended number of nursing hours" and when a doctor orders more hours "the centralized nurse would 'not consider it.'" Id.

00187. The information Stogsdill's service coordinator sent to Nurse Koon is contained in the Supplemental Appendix at 00209-00287. Also included is a summary of hospital and emergency room visits when Dr. Munn ordered nursing services. SA at 00478-00479.

Nurse Koon, informed the service coordinator that Stogsdill's nursing hours had been approved on August 21, 2014. SA at 00187. But, then, on September 8, 2014, Nurse Koon informed Richard's service coordinator that she only authorized Stogsdill to receive 14 hours a week of nursing services, without explanation of why she reduced the number of hours ordered by his physician by 42 hours a week. SA at 00188.

Stogsdill's attorney objected to the limitations on nursing hours. SA at 00415. Respondent failed to provide a written notice informing him of his right to appeal that decision (required by 42 C.F.R. 431.210) or the reasons for denying 42 hours a week of nursing services (also required by that federal regulation). On October 16, 2014, the Director of the Kershaw County Disabilities and Special Needs Board attempted to reduce his personal care hours, then he tried to replace RN services with LPN services. SA at 00190 and 00207, 417-419. The service coordinator's records document her contact with Stogsdill's physician that same day. Id.

Stogsdill's guardian also cooperated with his service coordinator to assess his need for personal care, respite and adult companion hours immediately upon receipt of the orders of the Court of Appeals. SA at 00423-00474. The service coordinator was allowed into Stogsdill's home to assess him in his home environment. SA at 0003.

DDSN made no other attempt to reassess Stogsdill's hours (nursing and other hours) until May, 2015 - eight months after the Court of Appeals issued its order. SA at 00480-00484.

After the initial "assessment," Nurse Koon informed Stogsdill's service coordinator that "they will not review his nursing hours until his scheduled review is due, which isn't until 2017." SA at 00484. Even after the Court of Appeals issued its decision, Respondent filed a new waiver amendment in 2015 that *still* does not implement the decision in *Stogsdill v. DHHS* by establishing an exception to the waiver caps, nor do any of the waiver amendments contain any standards for determining medical necessity. See http://ddsn.sc.gov/Documents/SC.0237.R05.00%20IDRD%20PROPOSAL%20DRAFT%20August%203,%202015.pdf.

The record should be supplemented after Stogsdill has the opportunity to conduct discovery and the parties should be allowed to file supplemental briefs.

Respondent's Demand to Allow Dr. Tan Platt and Jennifer Jaques Into Stogsdill's Home to "Assess" His Need for Services. DDSN written policies contain no written policy requiring a waiver participant to submit to a physical examination by the Medical Director of DHHS (Dr. Tan Platt) and an unlicensed social worker employed by DDSN (Jennifer Jaques).[4] But, in June, 2015, Respondent established a new binding norm - demanding that Stogsdill submit to a physical examination in his home by the Medical Director of DHHS and an unlicensed social worker. Dr. Platt is on the faculty of the University of South Carolina School

[4] According to the South Carolina Department of Labor, Licensing and Review, Ms. Jaques is not a licensed social worker. State employees who perform services commonly within the definition of "social work" do not have to be licensed "if the services are performed within the course of and scope of their employment with the State" and they have been specially trained to perform those services, but such State employees who are not licensed may not be identified "in any way as a social worker." S.C. Code of Laws 40-63-290(5). The "Stogsdill Assessment" at SA 00040 refers to Ms. Jaques as a "social worker" and even the Return describes her as such on pages 4 and 9, in violation of that statute.

of Medicine, where he is the director of administration and finance in the family medicine department. Exhibit 7. He is also the Medical Director of the South Carolina Department of Health and Human Services, while he receives compensation as the medical director of Epworth Children's Home and Babcock Center, both of which contract with DHHS through DDSN. He is also an associate medical director for Companion HealthCare.

Stogsdill's counsel was not provided the name of the physician and social worker on the "team" assigned to assess Richard until after they had completed their "assessment." SA at 00018. Respondent declined Stogsdill's offer to make his physician available through a deposition and declined his request to depose the State's physician and social worker.

The State Medicaid Manual is the policy manual published by CMS for the administration of the Medicaid Program. This federal manual provides the following standard for obtaining a medical assessment:

> 2902.8 Claimant's Right To A Different Medical Assessment (42 CFR 431.240(b)).-- An appeal on medical issues may involve a challenge to the Medical Review Team's decision regarding disability; or there may be disagreement about the content of reports concerning the appellant's physical or mental condition or the individual's need for medical care requiring prior authorization. *When the assessment by a medical authority, other than the one involved in the decision under question, is requested by the claimant and considered necessary by the hearing officer, obtain it at agency expense. The medical source should be one satisfactory to the claimant.* The assessment by such medical authority shall be given in writing or by personal testimony as an expert witness and shall be incorporated into the record. (Emphasis added.)

But, Respondent has refused to consider having Stogsdill's needs assessed by an independent physician that is satisfactory to Stogsdill, in violation with this federal standard. Neither DDSN nor DHHS have promulgated regulations to determine how medical necessity is determined.

Respondent admits on page 5 of the Return that Dr. Platt and Ms. Jaques did not review

the medical records which Stogsdill's guardian provided to his service coordinator. The transcript they so cleverly refer to as being "available to the team," leading the reader to believe that the "team" actually read those transcripts, does not exist. SA at 00021-00022. Stogsdill requests that this Court order Dr. Platt and Ms. Jaques to submit to depositions, and he agrees to make his treating physician available to be deposed by Respondent. The parties should be allowed to supplement the record and to file supplemental briefs on these issues.

The Role of CMS. At oral argument and in its brief, DHHS argued that it was just following federal law, as it is mandated to do, when it established caps on home-based services. Return at 4. Even in its Return, DHHS continues to attempt to mislead this Court by claiming that CMS "unilaterally" and "frequently" changes its interpretation of the Medicaid Act. At oral argument, Respondent informed this Court that CMS has made changes to the waiver document "on a dime." Return at 5. But, the record does not contain an iota of evidence that CMS has changed its interpretation of the Medicaid Act or the ADA in any way that would support of Respondent's position or that CMS has imposed arbitrary limitations on service limits.[5]

There is absolutely nothing in the record to suggest that capping services was CMS' idea. Indeed, in 2009, Congress drastically increased the amount CMS paid to South Carolina to provide waiver services, thereby increasing the federal matching rate from 70% to 80%,

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[5] Stogsdill, on the other hand, has presented evidence that CMS has not changed its position in any way, and that CMS relies upon private enforcement of the Medicaid Act. SA at 000288-364. In its Return, DHHS now admits that the only enforcement authority CMS has is to withhold federal funds. Return at 5. Respondent admits in the Return that CMS "often defers to private efforts at enforcement." Id. But, Respondent has thwarted those efforts at every turn, without regard to the consequences that result from their artful trickery and deceit.

specifically so that the State could *avoid* reductions in services.

Stogsdill began this long litigation journey by joining other affected waiver participants who filed a petition on December 23, 2009 asking this Court to prevent DDSN and DHHS from transferring federal stimulus funds intended to maintain services into a rainy day account. *Karen W. v. Sanford,* filed in this Court on December 23, 2009. We now know that while Respondent and DDSN told DDSN Commissioners and the public that it was necessary to reduce home-based services due to budget reductions, the truth is that DHHS allowed more than $225 million in state funds to "lapse" during FY 2010, thereby losing the federal 80% matching rate on those funds. Exhibit 8 at page 4.

In June/July of 2010, the United States Office of Inspector General completed its investigation of DDSN, finding that, during this time that services were being reduced, DDSN overbilled the federal government by $9,962,995.00 in FY 2010. Exhibit 9 at page ii. OIG agreed to allow South Carolina to repay the $7,923,570 it owed by reducing its cost report in a subsequent year. Id. at 5. But, in a bizarre memo dated July 30, 2009, Director Buscemi informed the DDSN Commision, providers and advocates that DDSN had sailed through that OIG audit with no findings of "improprieties." She reported that no written report would be issued by OIG and that:

> We feel very positive that this investigation/audit validates DDSN processes, methodologies, and actions taken to carry out our mission of providing quality services to South Carolinians with Disabilities.

Exhibit 10. It is impossible to explain the basis for this memo that was still posted on the DDSN website on February 22, 2016, because OIG reported that:

> The State agency claimed unallowable room-and-board costs because neither the State agency nor the Department had adequate controls to (1) ensure that the Department followed either applicable Federal law and guidance or its own guidance or (2) detect errors or misstatements on the local DSN boards' cost reports.

Exhibit 9 at 3. OIG found "no improprieties," according to Dr. Buscemi, but it reported that DDSN overbilled Medicaid by more than $9.9 million in 2010. Again, DDSN uses artful language to deceive. Contrary to the impression made by Dr. Buscemi's July 30, 2009 memo, OIG also ordered DDSN to repay the federal government $4.8 million, the federal share of the $6.7 million that DDSN overbilled Medicaid in FY 07-09. Then, in 2015, OIG issued another report showing that South Carolina never repaid the federal government for the $9,962,995 it overbilled Medicaid in FY 2010 ($7,923,570 federal share). Exhibit 9 at 5. OIG also required South Carolina to repay an additional $1,599,525 it overbilled Medicaid in FY 2010 by claiming unallowable costs. Id. at 6.

The decision to reduce Stogsdill's home-based services was a scheme conceived in the dark by a handful of agency bureaucrats, without input from or notice to the General Assembly, local DSN Boards or the persons affected. Record at 914. It was based on a false claim that funds were not available to pay for services Stogsdill and others need to remain in their homes.

What the record shows is that DHHS falsely informed CMS on the cover sheet of the 2010 Medicaid waiver application that the reason minor changes were being made in the waiver program was budget reductions, when the truth was that the cost of the program increased by tens of millions of dollars once home-based services were capped. Nearly a quarter of a billion dollars was transferred from DHHS to a rainy day fund during FY 2010, and the next year, the State's surplus funds accounts were magically fully funded. Exhibit 9 and http://www.cg.sc.gov/publicationsandreports/Documents/Press/2011YearEndPressRelease.pdf

Exhibit 11. By the end of FY 2011, the State of South Carolina was sitting on $123 million in surplus funds (cover of Exhibit 11), the general fund was fully funded at $166,325,183 (page 7) and the capital reserve fund was fully funded at $110,883,445 (however, $3,200,000 of those funds were transferred to an "undesignated" fund).

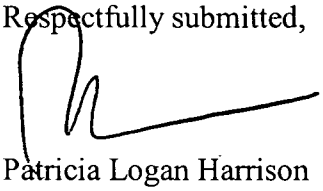
Conclusion. In December of 2009, Stogsdill first came to this Court asking for relief ten months after requesting additional services to replace those he lost when he graduated from high school. After dragging Stogsdill through six years of litigation, Respondent still has not performed the assessment ordered by the DHHS hearing officer in November, 2009, or the assessment ordered by the South Carolina Court of Appeals in 2014. Stogsdill requests that this Court will vacate its January 20, 2016 order for the reasons set forth in the motion and will order the taking of depositions, supplementation of the record and the filing of supplemental briefs.

Justice Hugo L. Black wrote that "Rules of practice and procedure are devised to promote the ends of justice, not to defeat them...Orderly rules of procedure do not require sacrifice of the rule of fundamental justice." *Hormel v. Helvering*, 312 U.S. 552 (1941). It would be unjust for the State to allow Respondent to defeat Stogsdill's appeal through trickery and deceptive manipulation of the facts. This Court has a special duty to protect and zealously guard the rights of parties like Stogsdill, who are under a disability. Toal at 238.

Stogsdill requests that this Court will vacate its January 20, 2016 order for the reasons set forth in his motion and this Reply. He requests order requiring Respondent and DDSN to promulgate regulations for the administration of DDSN and Medicaid programs. Until regulations are promulgated, Stogsdill requests an order requiring DHHS to provide those

services ordered by his treating physician. He recognizes that it is normally not the role of this Court to monitor services, but it was through Respondent's own shenanigans that his federal lawsuit was dismissed, based on Respondent's misleading arguments that he has a remedy in the state administrative process. It is within the equitable powers of the federal court to style "any appropriate remedial relief." *Doe v. Kidd I* at 18-19, citing *Alexander v. Hill*, 707 F.2d 780, 783 (4th Cir. 1983) (permitting a district court to exercise its broad equitable powers in fashioning a remedy to address the continuing failure of a state to comply with Medicaid regulations) and *Smith v. Miller*, 665 F.2d 172, 175 (7th Cir. 1981) (concluding that no provision of the Medicaid Act or the Constitution restricts the authority of the courts to award equitable relief). Stogsdill also requests an order finding that the state administrative appeals process is not "a remedial scheme that is sufficiently comprehensive . . . to demonstrate congressional intent to preclude the remedy of suits under § 1983" or suits under the ADA and the Rehabilitation Act. *Doe v. Kidd I* at 355.

Respectfully submitted,



Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
pharrison@loganharrisonlaw.com

February 22, 2016

Exhibit 1

Email of Tana Vanderbilt

Patricia Logan Harrison

From: "Vanderbilt,Tana G." <TVanderbilt@ddsn.sc.gov>
Date: Friday, November 13, 2015 11:55 AM
To: "'Patricia Logan Harrison'" <pharrison@loganharrisonlaw.com>; "Jack Lawrence" <jlawrence@lawrencelonon.com>; <huttob@scdhhs.gov>
Subject: RE: Brook Waddle - Critical Need for Services

DDSN was not a party to the case in front of the DHHS Hearing Officer. Therefore DDSN has not been ordered to do anything in that matter.

From: Patricia Logan Harrison [mailto:pharrison@loganharrisonlaw.com]
Sent: Wednesday, November 11, 2015 2:03 PM
To: Chaka; Jack Lawrence; huttob@scdhhs.gov; Ron Kuebler; Vanderbilt,Tana G.; tippybrook@yahoo.com; Sandra Waddle; Alicia Trax; David Pridgen; John Gragnani
Subject: Brook Waddle - Critical Need for Services
Importance: High

Chaka, you requested that I provide you with a summary of the hours and services we have requested. The hearing officer, Elizabeth Hutto, who is now a deputy director of DHHS, ordered DDSN and DHHS to provide **84 hours a week of LPN services and 28 hours a week of RN services**, which must be "continued through the final result of this appeal." Brook's physician also ordered that Brook receive **PCA services at all times when a nurse is not present.** Ms. Hutto also ruled that Sandra was entitled to be paid for the hours she provides and that she can provide any of the hours that would be provided by a PCA or the LPN, but that she would be paid at the rate set in the order. (I gave my copy of Ms. Hutto's order to Jack and I'm out of town, but my recollection is that it was something over $11 an hour and may have been tied to the rate paid for PCA services). I am copying Beth on this email to remind her that DHHS has ignored her order and that our appeal has been languishing in the Administrative Law Court for more than a year. Perhaps in her current position, she can inquire as to why DHHS legal counsel has not been keeping DHHS officials informed about the status of her litigation and the dangers resulting from the deterioration in Brook's condition, including the development of a decubitus ulcer and more lengthy stays resulting from UTI's that could reasonably been avoided if RN services had been provided as Ms. Hutto ordered.

We are asking that Sandra be **immediately paid the amount ordered by Ms. Hutto** and that she be paid for ongoing services during the appeal. None of the money the order found Sandra to be entitled to receive has been paid.

Ms. Hutto's order also provided for Brook to receive a **new speech device**, which still has not been provided. As Sandra told us yesterday, she did obtain the necessary doctor's order and it was transmitted to DHHS. I hope that we've got it worked out now to keep you in the loop on these things. It is a tragedy that DHHS is letting these people suffer when the technology is out there to radically improve their lives and their health with a speech device. I'm also sending this email to my contacts at Tobii and I would appreciate your contacting them about the speech device. The information Ms. Veldeer provided to you, I believe is different from what Tobii and DHHS need. (Again, I'm not blaming you for the shortcomings of the state agency, but we appreciate your help.) Rob Kuebler, who is qualified provider of **speech services** has agreed to provide the speech services Brook will need after she receives the device. I am also copying him on this email.

The request for a suitable **bed** has come up since 2012, but the reasonable promptness provision of the Medicaid Act requires that the bed be provided promptly. As Sandra and the LPN told us yesterday, Brook is developing the first decubitus ulcer she's gotten at home – because the bed does not fit. Also, please make sure that the bed that is ordered has electronic lift up and down, which is critical for Sandra to be able to lift Brook from the bed to her wheelchair.

We also appreciate your checking into the status of Brook's **wheelchair.** It breaks my heart that her weight has doubled since she came home and the wheelchair she received in 2007 just does not fit or meet her needs anymore. As Sandra has said, it is all she can do to keep Brook alive at home. Because the hours ordered have not been provided, she has been unable to get out into the community, which has contributed to her depression and the weight gain from lying in bed all day and night. I understand that the wheelchair process was started at G'ville Hospital, but if you can check on it, I'd appreciate it. My experience has been that, although the waiver does not pay for the basic wheelchair, under assistive technology, waiver funds have been used for upgrades not allowed under State Plan Medicaid.

Also, the South Carolina Court of Appeals ruled that caps cannot be applied when the person is at risk of institutionalization. We are asking that you transmit our request that the waiver pay for all **prescription drugs** not covered by "regular" Medicaid.

Would you please send me the notice CLC received stating that respite caregivers will soon be paid more than $11 an hour? We are also requesting that you pass on to DDSN and DHHS that limiting participants to three respite providers probably violates 42 USC 1296a(a)(3) by limiting choice. Also, please pass on to them that requiring families to provide worker's compensation coverage to respite caregivers violates the balance billing provision of the Medicaid Act. If a respite caregiver is hurt on the job, I expect that the Worker's Compensation Commission will find, as they did in cases in Richland and Kershaw that, for purposes of Worker's Comp, the Charles Lea Center is the employer responsible for paying injured workers. Again, I realize that this is not within the service coordinator's authority to decide. This is why DDSN cannot meet its obligations under the ADA, the Rehab Act and the Medicaid Act by substituting respite services for PCA services.

As we discussed, I realize that service coordinators, in reality, cannot authorize more than the caps. (Although Janet Priest testified under oath that only service coordinators have the authority to authorize services). All we are asking you to do, which I appreciate your willingness to do, is to pass on these requests for services and equipment to the proper decision makers and to advocate for Brook as best you are able. It does not seem that we've had that from service coordinators in the past and I admire and appreciate your commitment to serving the people DDSN is getting a lot of money to serve. Also as we discussed, DDSN and DHHS have in the past refused to take action when I tell them directly what my clients need and they continually require that we make these requests to the service coordinator and follow the "normal procedure."

To make sure that DDSN does not later claim not to know what has been requested, I am copying this email to Tana Vanderbilt, general counsel for DDSN. I want to make sure that she has <u>personal knowledge</u> of her agency's decision to refuse to comply with Ms. Hutto's order, failure to provide services and equipment with reasonable promptness, and failure to disregard the caps, as required by

Stogsdill, so as to insure her involvement in the decision making process.

I hope that this has covered everything you needed from me. If not, please advise. Chaka, thank you again for your efforts. I hope that before too long, Brook will be able to email you herself with her Tobii speech device to thank you.

Trisha Harrison

Exhibit 2

SCCDSN Minutes 9/25/2014

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

MINUTES

September 25, 2014

The South Carolina Commission on Disabilities and Special Needs met on Thursday, September 25, 2014, at 10:00 a.m. at the Department of Disabilities and Special Needs, Midlands Center, 8301 Farrow Road, Columbia, South Carolina.

The following were in attendance:

COMMISSION

Present:
Christine Sharp, Chairperson
Eva Ravenel, Secretary
Bill Danielson
Katherine Davis
Katherine Finley
Harvey Shiver

Absent:
Fred Lynn, Vice Chairman

DDSN Administrative Staff
Dr. Buscemi, State Director; Mrs. Susan Beck, Associate State Director, Policy; Mr. David Goodell, Associate State Director, Operations; Mr. Tom Waring, Associate State Director, Administration; Mrs. Tana Vanderbilt, General Counsel (For other Administrative Staff see Attachment 1 – Sign In Sheet).

Guests

(See Attachment 1 Sign-In Sheet)

Coastal Regional Center (via videoconference)

(See Attachment 2 Sign-In Sheet)

Pee Dee Regional Center (via videoconference)

(See Attachment 3 Sign-In Sheet)

Whitten Regional Center (via videoconference)

(See Attachment 4 Sign-In Sheet)

York County DSN Board (via videoconference)

(See Attachment 5 York County Sign-In Sheet

News Release of Meeting

Chairperson Christine Sharp called the meeting to order and Commissioner Eva Ravenel read a statement of announcement about the meeting that was mailed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Invocation

Commissioner Bill Danielson gave the invocation.

Executive Session

On motion of Commissioner Katherine Davis, seconded and passed, the Commission entered into Executive Session to discuss a personnel matter and contractual matters.

Enter into Public Session

The Commission entered into Public Session. It was noted that no action was taken in the Executive Session.

Adoption of the Agenda

The Commission adopted the September 25, 2014 Meeting Agenda by unanimous consent. (Attachment A)

Approval of the Minutes of the August 21, 2014 Commission Meetings

The Commission approved the minutes of the August 21, 2014 Commission Meeting by unanimous consent.

Public Input

Mr. John Cocciolone of the Greenville County DSN Board spoke on behalf of the Greenville County DSN Board.

Mrs. Mary Poole of the York County DSN Board spoke on behalf of the SC Disability Service Provider Coalition.

Mrs. Linda Lee of Prosperity, SC spoke on behalf of the Whitten Center Parents' Club and PADD.

Report from DSN Boards

Mr. Jimmy Burton spoke on behalf of the SC Human Service Providers Association.

Commissioners' Update

Chairperson Christine Sharp spoke of events in her district.

Finance and Audit Committee Report

Commissioner Bill Danielson, Chairperson of the Finance and Audit Committee, stated the Committee met prior to the Commission Meeting. The Committee presented the recommendation to make changes to the charter. On motion of Commissioner Bill Danielson, seconded and passed the Commission approved the recommended changes to the Finance and Audit Committee Charter. (Attachment B)

Mr. Kevin Yacobi gave an update on the HUD room and board fee issue. An accounting firm has been hired to review fees charged by providers with HUD homes. The review will be conducted in two phases. The first phase will be to review financial records for all providers with room and board fees for CTH II and CRCF residences. The second phase will be to visit the sites with HUD properties where concerns were noted during the phase one screening. The timeline for the beginning of this review is mid to late October. Dr. Buscemi stated the Office of the Inspector General (OIG) will be kept apprised of this review. The scope of work will review the 24-month period from July 1, 2012 through June 30, 2014. Additionally, DDSN has amended its Room and Board policy. The amended policy will go into effect immediately with an effective date of July 1, 2014. If a payback to the consumers is required, it will be done in a manner which does not affect the consumers' Medicaid eligibility. Mr. Yacobi stated of the 24 boards receiving HUD funding, 18 are being reviewed due to the fact they operate CTH IIs and CRCFs (the six not being reviewed operate ICFs/IID which do not charge consumer room and board fees).

Direct Support Professionals Recognition Week

Mrs. Lois Park Mole spoke of Governor Haley's acknowledgement of the importance of direct support staff by issuing a special proclamation honoring direct support professionals the week of September 7 -14, 2014. The American Network of Community Options and Resources (ANCOR) spearheaded the campaign to recognize these valuable employees on a national level. South Carolina joins forty-four other states in proclaiming this important recognition. (Attachment C)

Waiting List Report

Mrs. Susan Beck provided a detailed report of the HASCI waiting list including a monthly report on the Critical Needs List. There is no HASCI waiting list at this point because every individual from the list has been offered a slot if contact information was accurate and the individual was responsive. Currently enrolled in the waiver as of 09/22/14 are 702 individuals. While the total number of individuals on the Critical Needs List has grown somewhat due to the expanded definition of "critical need," the number of individuals being removed from the list each month has also increased from about 14 to 25. (Attachment D)

Dr. Buscemi spoke of the HASCI eligible individuals that have been determined to be ineligible for the HASCI Waiver. A state-funded package will be made available to these individuals.

Reduction Efforts

Dr. Buscemi stated that currently 675 new Community Supports slots have been awarded and 525 new ID/RD slots have been awarded. Two-hundred additional ID/RD slots will be released in October. DHHS is looking at developing two different waivers, one to serve individuals requiring residential and extensive nursing and the other which will provide services to individuals with less intensive needs.

Dr. Buscemi reported on the Day Services stating that DHHS pays DDSN at two different rates (based on whether individual is enrolled in ID/RD or CS waiver). DDSN asked that those rates be consistent. DHHS agreed to this back in April and a contract has been signed. However, the new rate has not in fact been paid because DHHS has not changed the rate in MMIS (their computerized payment system). DDSN discussed this with DHHS executive staff earlier this week. DHHS will prioritize getting this changed in MMIS. The will allow DDSN to change the Day Service rates to give the providers some financial relief.

Dr. Buscemi spoke of person-driven residential expansion. DDSN is in the process of developing a letter to include in the packet that will be sent to consumers who are placed on DDSN's Critical Needs list to better explain this new process. Advocates and families are giving input into the development of the letter and the "check list."

Computerized Medical Records

Dr. Buscemi stated that Therap was awarded the contract to provide computerized medical records for DDSN. Therap came and gave a price for full implementation that was better than what DDSN estimated for just phase one of the implementation. The new records system will be able to accommodate a provider that wants to direct bill to SCDHHS. The current system, CDSS, was built for billing services. The residential day component will be implemented in

February. DDSN is paying for the system and providers will use the system at no cost. Within the implementation stages of the rollout of the new system, providers that want to direct bill can purchase the billing component from Therap. This system will do so much more than the current system. A small implementation was done at the Saleeby Center. The purchase of tablets/infrastructure will be shared between the providers and DDSN. We are not sure of the dollar amount needed at this time. Therap will give families access to more information and the communication aspect will be much better. Dr. Buscemi stated a business agreement will be signed. It was suggested that DDSN look into an entity/company that will purchase old equipment.

Department of Transportation Grant

Mr. Tom Waring stated DDSN applied for grant funding for purchase of vehicles - two adaptive buses and two mini vans - needed in caring of individuals at the regional centers. On motion of Commissioner Eva Ravenel, seconded and passed, the Commission approved that DDSN receive the funding in the amount of $127,000 with DDSN participating with match funding.

Spending Plan

Mr. Tom Waring presented and explained in detail the Spending Plan for FY 2014-2015. Discussion followed. Questions were asked about the CLOUD program. Chairperson Christine Sharp requested that a presentation on CLOUD be given in at a future date. On motion of Commissioner Katherine Davis, seconded and passed, the Commission approved the FY 2014-2015 Spending Plan in the amount of $581,531,461. (Attachment E)

Budget Request FY 2015-2016

Mr. Tom Waring presented the Budget Request FY 2015-2016. Mr. Waring explained each requested item and dollars recommended for FY 2015-2016. Mr. Waring also discussed the three pending issues that could have an impact on the department in the next fiscal year. Mr. Waring requested Commission approval of the budget to meet the budget submission deadline to the Governor's Office by October 1, 2014. Discussion followed. On motion of Commissioner Bill Danielson, seconded and passed, the Commission approved the Budget Request FY 2015-2016 with amending Program No. 2 to reflect funding for 1,600 at-home individuals and 125 Residential. (Attachment F)

State Director's Report

Dr. Buscemi reported that she will be presenting to the Senate Health and Human Services Subcommittee on October 7, 2014 at 1:00 p.m. in the Gressette Building.

Dr. Buscemi spoke of the CMS Final Rule joint meetings with DHHS held in various parts of the state. Three sessions have taken place thus far with five more to go. Chairperson Christine Sharp attended the one held in Anderson.

Dr. Buscemi stated that DDSN is holding an open meeting tomorrow at 10:00 a.m. at the Babcock Center for any interested providers to discuss possible changes to the current contract compliance process. DDSN is considering changing the Alliant cycle length to reflect more frequent visits if a provider scores poorly in a specific service area, not just the combined overall score. This has already been discussed with the family and advocacy groups and they are supportive of the proposed changes. Another issue to be discussed in the meeting is the possibility of changing the license frequency of residential homes serving adults from the current two years to one year. This was a recommendation of the 2014 LAC report as well as a recommendation of the Public Consulting Group hired by DDSN. The change will have a fiscal impact. DDSN is currently discussing this possible change with Alliant. This possible change was discussed with families and advocates and they were supportive of the one-year licensing.

Dr. Buscemi stated that a Case Manager Forum will take place October 20, 2014 from 10:00 a.m. – 1:00 p.m. at the Babcock Center. The meeting is being held in response to provider comments, feedback, and requests. The changes to MTCM and necessary subsequent changes to the DDSN eligibility determination process. DDSN is soliciting questions ahead of time which will be compiled and answered in a future presentation. The forum will also give providers/case managers an opportunity to ask further questions. DDSN is planning to hold a subsequent training developed from information learned in this meeting.

Dr. Buscemi reported that DDSN staff met earlier this week with Federal staff from OSEP along with First Steps and the SC School for the Deaf and Blind to discuss the BabyNet program. There will be further meetings with OSEP staff to discuss SC specific system issues.

Dr. Buscemi reported that DDSN understands that DHHS will submit as part of the ID/RD waiver renewal changing the developmental period to be defined as up to age 22. DDSN wants to wait until that is submitted and official but likely we will recommend DDSN's eligibility requirements change to be consistent with the waiver documents. DDSN will bring this to the Commission for consideration at a later date.

Dr. Buscemi spoke of the newly formed provider group, the SC Disability Service Provider Coalition. The Commission was copied on their letter to me and my response to them. DDSN has a meeting scheduled with them next week to learn more about their new coalition.

Next Regular Meeting Date

Chairperson Christine Sharp announced the next regular Commission Meeting is scheduled for Thursday, October 23, 2014 with the starting time to be determined. The meeting will be held at the Babcock Center.

Adjournment

With no further business, Chairperson Christine Sharp adjourned the meeting.

Submitted by,

Sandra J. Delaney

Sandra J. Delaney

Approved:

Eva Ravenel

Commissioner Eva Ravenel
Secretary

Attachment 1

SC COMMISSION ON DISABILITIES AND

Commission Meeting

September 25, 2014

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. John Cocciolone — GREENVILLE DSN BOARD
2. KEVIN YACOBI — DDSN
3. SHONDALA HALL — "
4. Leanne Johnston — SCHSP
5. Mary Poole — YCBDSN
6. Deborah & Heather McPherson — Richland County
7. Ralph Courtney — Aiken Co. Bd [illegible]
8. Liz Meeks — Charleston DSN Board
9. Jimmy Burt — BURTON CENTER
10. JAY ALTMAN — Chester-Lancaster
11. Lisa Weeks — DDSN
12. Ron Lofts — Orangeburg DSN
13. Nancy McCormick — P+A
14. Lee Bishop — SCDDC
15. Amelia Hartman — SCDDC
16. Ray Miller — SC DDC
17. Philip Clarkson — BIA SC
18. [illegible] Johnson — Babcock
19. Lisa Park Mohr — SC DDSN
20. Shondala Hall — SCDDSN

Exhibit 3

June 2014 LAC SCDDSN

SOUTH CAROLINA GENERAL ASSEMBLY

Legislative Audit Council

LAC

June 2014

S.C. Department of Disabilities and Special Needs' Process to Protect Consumers from Abuse, Neglect, and Exploitation, Administrative Issues, and a Follow Up to Our 2008 Audit

Eligibility, Involuntary Admissions, and Consolidation of Regional Centers

Our requestors had questions about eligibility and involuntary admissions to DDSN. We also determined that we should review the possibility of consolidating the regional centers. We found that DDSN needs to review and revise its directives on eligibility to be consistent with state law. We found, however, that DDSN is complying with state law and has qualified employees evaluating individuals for involuntary admissions. Lastly, we found that DDSN has reviewed the feasibility of consolidating regional centers; however, state law could hinder the agency from using its property most efficiently.

Process for Becoming Eligible for DDSN Services

Members of the General Assembly requested that the LAC review DDSN's process for determining a person's eligibility for services, including if the process complies with state law, if it is different for applicants with severe behavioral issues, and if any conflicts of interest exist. With two exceptions, the agency's eligibility process complies with state law, does not differ for people with severe behavioral issues, and presents no conflicts of interest. We found that DDSN's residency requirement for applicants for services is narrower than the statutory residency requirement and that the agency's current criteria for determining intellectual disability eligibility is inconsistent with the S.C. Supreme Court's interpretation of state law regarding a waiver for which consumers with an intellectual disability could qualify.

In order to become eligible for DDSN services, a person or his family member calls a central information and referral line. The exceptions to this are if the person is under 2 years 11 months of age or is already being served by the state's BabyNet program. The information and referral line is operated by the University of South Carolina's Center for Disability Resources.

The screeners that staff the information and referral phone line ask about the person's background, residency, previous diagnoses, and observed delays. If the screener determines that the person is likely to be eligible for DDSN services, the applicant chooses a service coordination provider to complete the next step of the eligibility process. Service coordinators are either DSN board employees or private providers. If the screener determines that the person is not likely to become eligible for services, the screener refers the person to other sources of help. According to a staff person, even if the screener believes that the person is not likely to become eligible, if he would like to continue with the eligibility process, the screener sends him through the process.

DDSN centralized the screening process because the agency found that, despite the use of the same standards and training, screening services were substantially inconsistent across the state. In addition, screening centrally removes the first step of the process from the organizations that provide most of the services, reducing the chance for conflicts of interest.

Within seven days, the chosen service coordinator should make contact with the applicant and begin collecting the documentation required to determine the applicant's disability and if he is eligible for DDSN services. According to an agency official, this function will be performed by DDSN employees in the future.

When the information is gathered, the service coordinator forwards the completed package to DDSN's Consumer Assessment Team (CAT). The consumer assessment team is a group of psychologists employed by the agency to review each applicant's packet and make a determination. They do not meet with applicants face-to-face, but, if more information is required to determine eligibility, they ask the service coordinator to assist the applicant with obtaining additional assessments. Following the determination, the consumer assessment team sends an eligibility determination letter to the service coordinator. If the person is found not to be eligible for services, there is an appeals process. During FY 10-11 through FY 12-13, the CAT received 9,690 requests for eligibility determination, and determined that 7,899 of those applicants were eligible for DDSN services.

Age of Onset

DDSN's eligibility directive is inconsistent with an S.C. Supreme Court ruling. Though DDSN was not a party to the case, the Medicaid waiver at issue in the case is administered by DDSN. S.C. Code §44-20-30(12) defines intellectual disability (ID) as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." DDSN's eligibility directive provides ID diagnostic criteria consistent with the American Psychiatric Association's fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM- 4). These criteria include a requirement that the deficits in functioning that define ID be present by the age of 18. While the agency's published directive states that these criteria are based on the fifth and current edition of the manual, the fifth edition does not include a specific age of onset; rather it states that the onset of intellectual and adaptive deficits must occur during the *developmental period.*

On December 28, 2011, the S.C. Supreme Court held that, when taken together, lack of additional criteria in the state's Medicaid waiver application, the broad definition of ID in S.C. Code §44-20-30(12) and use of an onset cutoff age of 22 in a regulation promulgated by the agency indicate that the proper legal standard for ID includes an onset cutoff age of 22, not 18. The court also held that the agency's policy conflicted with law and should be disregarded. In November 2013, the S.C. Department of Health and Human Services (SCDHHS — state Medicaid agency to which applicants must appeal waiver-related decisions) directed DDSN to continue the eligibility process for the petitioner, apply the age 22 standard, and issue a new notice of approval or denial.

In the current directive (last updated in October 2013), the standard for eligibility for a determination of ID remains an onset age of 18. In addition, the CAT applied the age 18 standard as recently as August 2013. While the case cited above was specific to a Medicaid waiver, the effect of the general age of onset directive is that all applicants who do not meet the age 18 cutoff will be denied eligibility for DDSN services. The applicant would never get to the point of examination for waiver eligibility.

In its opinion, the Supreme Court majority noted that DDSN's commission has the authority to promulgate regulations that define ID in the context of waiver services, but it has not. DDSN is currently involved in litigation regarding whether it must promulgate regulations related to eligibility. While we do not assert that it must promulgate regulations, the commission has statutory authority to promulgate regulations, should it wish to further clarify agency operations.

If the DDSN commission deems the DSM criteria for ID to be the most appropriate for use in South Carolina, there are steps the commission can take, including promulgating a regulation specifically defining the age of onset and working with SCDHHS and the federal Centers for Medicare and Medicaid Services to amend affected waiver documents.

Exhibit 4

SCDDSN Eligibility Criteria 11/07/2008

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Susan Kreh Beck
Associate State Director
Policy
Thomas P. Waring
Associate State Director
Administration

SOUTH CAROLINA Department of Disabilities AND Special Needs

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

COMMISSION
William O. Danielson
Chairperson
Fred Lynn
Vice Chairman
Eva R. Ravenel
Secretary
Mary Ellen Barnwell
Katherine W. Davis
Gary C. Lemel
Vicki A. Thompson

Reference Number:	100-30-DD
Title Document:	Eligibility Diagnostic Criteria, Screening and Eligibility/Care Coordination Processes for Eligibility, and Appeal Procedures
Date of Issue:	November 7, 2008 (Created from Existing Policy)
Effective Date:	November 7, 2008
Last Review Date:	October 28, 2015
Date of Last Revision:	October 28, 2015 **(REVISED)**
Applicability:	Individuals Applying For DDSN Services, DSN Boards, Contracted Service Providers, DDSN Regional Centers & Other Interested Parties

I. Introduction

The following Departmental Directive sets forth the policy, process and procedures used in the determination of eligibility for services and supports through the South Carolina Department of Disabilities and Special Needs (DDSN).

Criteria designated within South Carolina Code of Laws indicate seven (7) different categories of eligibility under the authority of DDSN:

Intellectual Disability;
A Related Disability to Intellectual Disability;
High Risk Infant;
Autism Spectrum Disorder;
Head Injury (i.e., traumatic brain injury);
Spinal Cord Injury, and Similar Disability.

Some individuals may meet DDSN eligibility criteria under more than one (1) category. In such situations, DDSN will consider which DDSN division offers the most appropriate resources and service models to address the needs of the particular person and his/her family. Individuals with primarily medical conditions such as Diabetes, Hypertension, Stroke, Multiple Sclerosis, Parkinson's Disease, Cancer, etc., do not meet DDSN eligibility criteria under any category unless other qualifying conditions are met.

II. Criteria for Intellectual Disability

A. Definition

S.C. Code Ann. § 44-20-30 defines "Intellectual Disability" as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

B. Diagnostic Criteria

DDSN evaluates referred individuals in accordance with the definition of Intellectual Disability outlined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition, (DSM-5).

Intellectual Disability refers to substantial limitations in present functioning. Diagnosis of intellectual disability based on the DSM-5 definition requires the following three (3) criteria be met:

1. Significantly sub-average intellectual functioning; an IQ of approximately 70 or below on an individually administered intelligence test (for infants, a clinical judgment of significantly sub-average intellectual functioning);

2. Concurrent deficits in present overall adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his/her age by his/her cultural group) with deficits in at least two (2) of the following adaptive skills areas:

    - communication,
    - self-care,
    - home living,
    - social/interpersonal skills,
    - use of community resources,
    - self-direction,
    - functional academic skills,
    - work,
    - leisure,
    - health, and safety;

3. The onset of intellectual disability is during the developmental period.

There must be concurrent deficits in intellectual and adaptive functioning that fall approximately two (2) or more standard deviations below the mean on standardized measures (approximately 70 or below) in order to meet criteria for diagnosis of intellectual disability. However, a score of 70 on any intelligence and/or adaptive test does not equate to a diagnosis of intellectual disability.

DDSN relies on qualified providers to administer psychological testing to applicants. This includes testing conducted by school psychologists and other professionals who regularly administer psychological tests to persons with disabilities. The tests are then analyzed by the DDSN Consumer Assessment Team to determine if they are reliable and valid, and to determine whether they are consistent and congruent with other psychological tests, school records including academic achievement scores, placement in special education & Individualized Education Plan data, medical reports, psychiatric and mental health records, family history, and other pertinent information. In order to ensure the reliability and validity of the tests administered to applicants, only standardized measures are used to determine if criteria for intellectual disability are met. Therefore, DDSN maintains a list of all approved psychometric tests that must be used for eligibility purposes.

In the event that assessment results are unavailable or updated assessment information is needed, DDSN will arrange for testing to take place at a location convenient to the applicant.

III. Criteria for Related Disability

A. Definition and Diagnostic Criteria

S.C. Code Ann. § 44-20-30 and 42 CFR 435.1009 defines eligibility for DDSN services under "Related Disability" as follows:

A severe, chronic condition found to be closely related to intellectual disability or to require treatment similar to that required for persons with intellectual disability and must meet all **four** (4) of the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability and requires treatment or services similar to those required for these persons;

2. The related disability is likely to continue indefinitely;

3. It results in substantial functional limitations in three or more of the following areas of major life activity:

   - self-care,
   - understanding and use of language,

Exhibit 5

Affidavits of Thomas, Pruitt & Davenport

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

LENNIE SCHLAGER MULLIS, Plaintiff, vs. DAVID ROTHOLZ, in his official capacity; et al. DEFENDANTS.	**Case No.: 6:10-cv-02319-TMC** **AFFIDAVIT OF SENATOR DAVID THOMAS**

PERSONALLY appeared before me, David Thomas, who after being duly sworn, deposes and says as follows:

1. I have served in the South Carolina Senate since 1985.

2. I represent District 8 in Greenville County and I practice law as a partner with Moore, Thomas & Taylor in Greenville.

3. I introduced a bill to provide $3 million beginning in 2006 to the South Carolina Department of Disabilities and Special Needs (DDSN) to provide services for children who have autism (PDD) and the legislature increased this amount was increased at the request of the agency to $7.5 million the following year. http://lac.sc.gov/LAC_Reports/2008/Documents/DDSN.pdf at page 58, which is incorporated herein by reference.

4. The South Carolina Legislative Audit Council audit of DDSN reported that only $10,454 of the $3 million of funds allocated for the PDD program in FY 2007 and only $661,463 of the $7.5 million provided to DDSN in FY 2008 were spent for the intended purposes. Id.

5. If these funds had been matched with federal Medicaid matching funds, more than $40 million should have been spent by DDSN during these two years providing PDD services to children who have autism.

6. DDSN reported that they did not utilize the funds for the intended purpose because they did not have enough providers of applied behavior supports to provide the services. LAC Audit at 58.

7. After this audit was released, I led a Senate investigation of DDSN which included legislative hearings attended by Kathi Lacy inquiring about the problems reported in the audit and information provided to me by Lennie Mullis and other informants.

8. My office was flooded with phone calls about the LAC audit of DDSN from constituents and their families, employees of DDSN and former employees of that agency and many of these people reported to me and to my staff that they were fearful of retaliation by DDSN.

9. Ms. Mullis came to my office on February 5, 2008 to discuss problems with DDSN's operation of the behavior supports program and what she believed was misuse of funds.

10. Ms. Mullis told me when we met that she was fearful of retaliation by Kathi Lacy and David Rotholtz. Exhibit 1 documents the date of this meeting.

11. A few days after we met in my office, Ms. Mullis provided me with lists of questions related to the barriers to competition by private providers and the PDD program, which I had sponsored in the Senate. These questions are attached as Exhibits 2 and 3 and the e-mail attached as Exhibit 4 documents that the information was related to David Rotholtz.

12. I used these questions Ms. Mullis provided to me to prepare for the legislative hearings attended by Kathi Lacy and other DDSN officials.

13. In March of 2009, Ms. Mullis provided information to my staff about the large contract DDSN had with USC and the role of David Rotholtz through the behavior supports program. Exhibit 4 (Email dated March 23, 2009).

14. This email to my chief of staff discusses the role of Dr. Rotholtz in this contract between DDSN and USC. Id.

15. On July 1, 2009, Lennie Mullis emailed my chief of staff, Mary Riley, asking for assistance obtaining needed funding for services from DDSN for a child in Greenville County who had been injured when he was been placed at age 8 at Whitten Center in a unit with grown men. Exhibit 5. (Note that date automatically printed on the letter is the date the letter was printed as an attachment to this email, not the date it was sent).

16. On July 6, 2009, as is our regular practice, my chief of staff sent an email to Lois Park Mole and Sandra Delaney at DDSN forwarding the complaints that Lennie Mullis had provided about this parent's inability to obtain the services she needed for her child.

17. Based on my conversations with many parents, providers, employees of DDSN and former employees, there was a pervasive fear of retaliation for advocating for people who need DDSN services.

Mims 2017

FURTHER AFFIANT SAYETH NOT.

David Thomas

Sworn to and subscribed before me
this 15th day of December, 2011.

Notary Public for the State of South Carolina
My Commission Expires: 3/19/18

MARK BAIR NOTARY PUBLIC SOUTH CAROLINA

GreenvilleOnline.com

February 4, 2009

Senator: Agency retaliating against 5

Disabilities and Special Needs official says jobs outsourced based on audit

By Ben Szobody
STAFF WRITER

Five state employees who told auditors about health and safety problems in the state Department of Disabilities and Special Needs are being terminated by June in "retaliation" by the agency for their honesty, state Sen. David Thomas said.

Agency spokeswoman Lois Park Mole said it's not yet clear if the employees will be terminated, but the department is following a recommendation in December's critical audit to make the licensing of its care facilities more independent by outsourcing the job to a contractor.

The audit didn't recommend a switch to a private contractor, and George Schroeder, director of the Legislative Audit Council, said it's not the best solution.

Thomas said all five members of the agency's licensing staff were told last week their jobs would be cut, and he provided a letter signed by all five people that describes an agency meeting in which a top administrator told them the change amounts to a "reduction in force."

"The fact that the department has deviated from the specifics of the (audit) demonstrates that they are retaliating, in my opinion, against these people," Thomas said. "This is outrageous behavior."

Mole said the employees were informed of the plan to hire a contractor in an effort to be transparent, and the agency doesn't yet know what response it will get to its request for contract proposals. She said DDSN is looking for the "greatest degree of independence" when it comes to licensing but doesn't believe anything is wrong with the current arrangement.

Thomas said he's concerned by the agency's choice to go private because of past instances when he said DDSN picked contractors close to the agency that would do its bidding.

Mole said she hasn't heard those concerns from Thomas and couldn't respond Tuesday.

The audit said a former DDSN director was simultaneously employed by the agency, its local boards and an agency contractor, an arrangement that had "the appearance of impropriety," though in one instance an Ethics Commission ruling found no violations of state ethics law.

The former director told The News the services he provided were "very different" and that there was no impropriety.

Licensing employees said in a letter to Thomas, which he provided to The News, that under the new approach, DDSN would continue to determine "key indicators" and provide policy and directives to the outside contractor, effectively creating an appearance of independence while "nothing would actually be changing."

Mims 2201

The letter said an associate director told the employees that DDSN intends to hire the contractor by June 30, which would be their last day of employment.

December's audit of the department, which serves people with brain injuries and mental retardation, said DDSN reviews the quality of its adult residential facilities one-third as often as other states and didn't adequately follow up when it found expired food, missing smoke detectors and water heaters set too hot.

Contributing to the potential health and safety risks is a lack of independent licensing used by other states, the audit said, adding DDSN licenses some of its own facilities, creating potential conflicts of interest that can "impede objective reviews."

Mole has said the facilities themselves -- not the agency -- are required to follow up on quality problems. The agency said in a written response that it received "plans of correction" for 100 percent of the licensing reviews cited by the audit.

The audit said 26 residential licensing reports were reviewed and 25 should have required a follow-up.

The audit said two follow-ups were reports.

Another sample of nine reports occurring after January 2007 showed more than 100 quality deficiencies but "no documentation" that any follow-up visits took place, the audit said.

Thomas said the licensing officials would report health and safety problems, then come back three years later and find that they hadn't been fixed. He said they were "forthright" about the issues to state auditors and are now paying the price.

Auditors recommended more follow-ups as well as moving the licensing role to the state Department of Health and Environmental Control. If the job stays within DDSN, auditors said the agency should do reviews more often.

Schroeder said the problem was that the agency wasn't doing enough reviews, and that the "best thing" would be to move the licensing staff and its funding to another agency.

"We did not recommend that they fire the people that were currently" doing the reviews, Schroeder said, adding he doesn't understand how the agency will hire a contractor to do a job it wasn't doing effectively itself.

"How are they going to know what it should cost?" Schroeder said.

Mole said the decision to privatize the licensing function came out of a meeting between DDSN commissioners and Gov. Mark Sanford's staff.

"It's going as independent as you can possibly go with the highest degree of quality," Mole said.

Sanford spokesman Joel Sawyer said the licensing issue was discussed with commissioners, but not how the agency would do it. Commissioners later informed the governor's staff that they intended to privatize, Sawyer said, adding that if it isn't in line with the audit's recommendations, the governor will have the board "re-evaluate" the plan.

Mims 2202

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF SOUTH CAROLINA

GREENVILLE DI

COPY

Lennie Schlaeger Mullis, Plaintiff	)	Case No. Copy
v.	)	
	)	AFFIDA'
David Rotholtz, in his official capacity; et. al. Defendants	)	

PERSONALLY appeared before me Rob Pruitt, who after being duly sworn, deposes and says as follows:

1. I am the father and guardian of Robyn Sommer Pruitt, who has mental retardation and epilepsy and receives services from DDSN.

2. Kathi Lacy is a defendant in a lawsuit filed on behalf of my daughter in 2003 in the United States District Court for South Carolina. Exhibit 1.

3. My daughter first filed an administrative appeal when DDSN refused to provide her with services in 2002.

4. Kathi Lacy provided the DHHS hearing officer an affidavit stating that DDSN would provide my daughter with residential habilitation services and her administrative appeal was dismissed based on this affidavit in 2003. Exhibit 2.

5. Then Kathi Lacy personally retaliated against my daughter for filing the appeal by attempting to terminate her eligibility for Medicaid and she refused to provide the residential habilitation services that she had promised to provide.

6. We were forced to file the lawsuit in federal court (*Doe v. Kidd*) to keep Kathi Lacy from terminating my daughter's services.

7. In retaliation for our filing the federal lawsuit, Kathi Lacy ordered a school psychologist to secretly evaluate Sommer in 2005 to determine whether her seizures were "real" in an attempt to cause her federal lawsuit to become moot.

8. Kathi Lacy determined that my daughter does not have mental retardation, even though DDSN has billed Medicaid for services for many years under a diagnosis code of "mental retardation," she receives SSA benefits based on her condition of mental retardation and at least six physicians have diagnosed her as having mental retardation.

9. Even after my daughter underwent brain surgery to attempt to control her seizures, Kathi Lacy has continued to insist that she does not have severe epilepsy, which would entitle her to continue to receive services from DDSN.

10. Kathi Lacy secretly enlisted the assistance of Dr. David Rotholtz when she was trying to terminate my daughter's services.

11. Dr. Rotholtz showed up uninvited at my daughter's annual planning meeting and my daughter asked him to leave.

12. I had never even met Dr. Rotholtz before and had no idea how he knew about my daughter's annual planning meeting or who had invited him to attend the meeting.

13. I never authorized anyone at DDSN to release records related to my daughter to Dr. Rotholtz, who was employed by the University of South Carolina at that time.

14. I personally hand delivered the administrative appeal letter to DDSN headquarters the day after I received notice of Kathi Lacy's determination that Sommer no longer qualified for services.

15. In 2005, Kathi Lacy sent a response to me saying that DDSN was terminating Sommer's services because they did not receive my appeal.

16. Michelle Ford testified that Kathi Lacy herself ordered her to reevaluate my daughter's eligibility for services because of the lawsuit Sommer had filed against Kathi Lacy and others at DDSN. Exhibit 3.

17. Michelle Ford also testified that it was unusual to perform such a reevaluation and that these reevaluations were done only in "high profile cases."

18. Lennie Mullis began providing psychological services to my daughter in 2005 and she was listed as a witness in the federal litigation.

19. Kathi Lacy was well aware of Ms. Mullis' role in the federal litigation involving my daughter.

20. It is inconceivable that Dr. Lacy had no knowledge of the affidavits that Lennie Mullis provided in support of Sommer, that were filed with the federal Courts and the South

Carolina Supreme Court, or that she was not aware that Lennie Mullis was listed as a witness for my daughter.

21. The Fourth Circuit twice overturned the award of summary judgment to Dr. Lacy and other state actors, and in 2011 granted summary judgment to my daughter because Kathi Lacy and other defendants had failed to provide residential habilitation services to my daughter in violation of the Medicaid Act.

22. I have talked with other parents of persons who receive services from DDSN and there is a general fear of retaliation amongst parents, especially a fear of retaliation by Dr. Lacy.

23. Lennie Mullis has provided exceptional services to my daughter and she has been a strong advocate for her which facts are well known to Kathi Lacy.

24. I believe that Kathi Lacy terminated Ms. Mullis' contract in retaliation for her advocacy efforts for Sommer and other persons who receive DDSN services.

FURTHER, YOUR DEPONENT SAYETH NAUGHT.

Rob Pruitt

Sworn and subscribed before me this
14 day of December, 2011.

Notary Public for the State of South Carolina
My Commission Expires:

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

LENNIE SCHLAGER MULLINS Plaintiff vs. David Rotholz in his official capacity; et al. Defendants	Case No.: 6:10-CV-02310-TMC Affidavit of Amy Davenport

PERSONALLY appeared before me, Amy Davenport, who after being duly sworn, deposes and says as follows:

1. I am the parent of an adult child who has disabilities and receives services from DDSN.

2. My daughter was injured when a respite care provider from a list provided by the DSN Board was driving under the influence of alcohol, causing the near death of my daughter.

3. While my daughter was in intensive care, Kathi Lacy and Lois Park Mole came to the hospital to assure me that DDSN would provide sufficient respite and personal care hours to allow us to take care of my daughter at home.

4. After I filed a lawsuit against DDSN and the local DSN Board, DDSN refused to provide the hours as Kathi Lacy had promised me.

5. I have had numerous conversations with Kathi Lacy about my daughter's services and I have found her to be retaliatory and untrustworthy.

6. My DDSN funded service coordinator called me on the morning of June 11, 2010 to inform me that Lennie Mullis, my daughter's behavior support provider, had been terminated and that I would have to use a different behavior support provider.

7. Although Ms. Mullis was reinstated a week later, no one from DDSN informed me that Ms. Mullis could be restored as by daughter's behavior support provider.

8. Weeks later, I learned from Ms. Mullis that she had been reinstated as a service provider and I had to call my service coordinator to ask that Ms. Mullis be restored to provide behavior support services to my daughter.

9. As a result of Ms. Mullis's inappropriate termination, my daughter went without her receive behavior support services for over one month.

10. I have spoken with other providers who have expressed fear of retaliation if they advocate for people whose services are being illegally reduced.

11. The services that Lennie Mullis has provided to my daughter have been exceptional and have helped allow me to keep her at home instead of being institutionalized.

12. Lennie Mullis has been an advocate for my daughter and other people who have disabilities that she serves and it has been obvious to me that she has been targeted because of her advocacy efforts.

13. Other parents I have spoken with have a fear of retaliation if they advocate for their child and Kathi Lacy's name comes up frequently in conversations between parents as instigating this retaliatory conduct.

Further Affiant sayeth not.

SWORN TO BEFORE ME THIS 15th

DAY OF December, 2011.

NOTARY PUBLIC FOR SOUTH CAROLINA

MY COMMISSION EXPIRES: 8-14-2017

Exhibit 6

Required Records for Review for DDSN Authorized Nursing Services

Required Records for Review for DDSN Authorized Nursing Services

For those enrolled in the MR/RD or HASCI Waiver, Nursing Services [*both* State Plan funded (for those under 21) *and* HCB Waiver funded] are authorized by the person's Service Coordinator or Early Interventionist. In order to assure that the appropriate amount of Nursing Services are authorized and continue to be authorized, DDSN is requiring that the need for nursing services be evaluated prior to authorization and annually thereafter.

For those determined for the first time to need nursing services, the following information must be submitted to Vivian Koon, RN for review prior to issuing an authorization to the chosen provider. Records may be mailed to: PO Box 239 Clinton, SC 29325 or faxed to 864-938-3179 or scanned and sent electronically to vkoon@ddsn.sc.gov.

- Consumer Name, Date of Birth , County of Residence
- Personal Physicians assessments/progress notes for the past three (3) months
- All Specialized Physicians summaries/treatment regime for the past three (3) visits
- All Hospitalization Discharge summaries for the past twelve (12) months
- SC/EI name and contact information

For those currently receiving, the following information should be gathered prior to the annual plan date and submitted Vivian Koon, RN for review. If the review requires that adjustments be made to the authorization, those changes must be discussed with the family at the time of annual planning. The information to the send must include the following and can be mailed or sent electronically as noted above.

- Consumer Name, Date of Birth , County of Residence
- If currently receiving nursing services, nursing assessments/notes/flow charts (if applicable) for the past three (3) months
- Personal Physicians assessments/progress notes for the past three (3) months
- All Specialized Physicians summaries/treatment regime for the past three (3) visits
- All Hospitalization Discharge summaries for the past twelve (12) months
- SC/EI name and contact information.

Nursing Services

Definition: Nursing services are continuous or intermittent skilled care provided by a nurse, licensed in accordance with the State's Nurse Practice Act, in accordance with the participant's Support Plan, as deemed medically necessary by a physician. This service will be provided in the home unless deemed medically necessary by the physician and indicated in the Support Plan.

Note: State Plan Medicaid covers Nursing Services for children (under age 21). When a child is enrolled in the MR/RD Waiver, the Service Coordinator/Early Interventionist must authorize State Plan-funded Private Duty Nursing. See "Nursing Services through State Plan Medicaid for Waiver Participants under age 21" section of this chapter for more information.

The unit of service for Nursing Services through the waiver and for Private Duty Nursing through State Plan Medicaid is one hour, provided by one LPN or one RN. The unit of service for Enhanced children's Private Duty Nursing through State Plan Medicaid (LPN or RN) is 15 minutes.

Please see: Scope of Services for Nursing Services

Providers: Nursing services are provided by agencies or companies contracted with SCDHHS to provide Nursing Services.

MR/RD Waiver Nursing Services for Adults (age 21 and over)

Service Limits: MR/RD Waiver-funded Nursing Services are limited to a maximum of 56 units per week by a LPN or 42 units per week by a RN, as determined by SCDDSN assessment. A week is defined as Sunday through Saturday. If both a LPN and a RN provide services, the combined cost cannot exceed the cost of the maximum number of units provided by either a LPN or a RN alone. Unused units from one week cannot be banked (i.e. held in reserve) for use during a later week.

Please refer to the MR/RD Waiver Rate Table for unit costs.

Arranging for and Authorizing Services: A physician's order for Nursing Services (MR/RD Form 28) must be completed by a licensed physician, specifying the skill level required (RN or LPN). **Prior approval of service provision must be obtained from the SCDDSN Director of Health Services at Whitten Center, who will also determine the number of units needed. This approval can be obtained by submitting a packet as required in the "Required Records for Review for DDSN Authorized Nursing Services" at the end of this chapter. This review by the Director of Health Services is required at least annually thereafter at the time of the annual assessment/plan development. The packet should be sent to the Director of Health Services far enough in advance of the plan date (+/- 30 days) to allow for ample time for review.**

The need for the service, as well as its amount, frequency and duration must be documented by the Service Coordinator in the participant's Support Plan. Once the amount needed is determined and prior approval obtained, the Service Coordinator must enter the needed units on the Waiver Tracking System (S68-LPN or S69-RN) and obtain approval of the budget before authorizing services.

Once the physician orders the services, the Service Coordinator should provide the participant/legal guardian with a list of Medicaid-contracted Nursing Services providers and document the offering of a choice of providers. Once a provider is selected and the budget approved, the Service Coordinator should complete and send the Authorization for Nursing Services (MR/RD Form A-12).

Note: A RN can provide care if the order is written for a LPN; however, the provider can only claim the LPN rate for that participant when billing SCDHHS. A LPN **cannot** provide services when a RN is ordered by the physician.

For those participants who have private insurance, Nursing Service providers must bill the participant's private insurance carrier prior to billing SCDHHS for all nursing services provided. MR/RD Waiver Nursing Services should not be billed to SCDHHS until all other resources, including private insurance coverage, have been exhausted. The Service Coordinator/Early Interventionist must first determine if the MR/RD Waiver participant has private insurance and if the insurance policy covers nursing services. In no instance will SCDHHS pay any amount that is the responsibility of a third party resource. The MR/RD Waiver is the payer of last resort and maximum allowable limits as defined above apply.

The following guidelines are to be followed when authorizing Nursing Services:

- When private insurance covers **all** Nursing Services
    - The Service Coordinator/Early Interventionist will indicate the needed amount of Nursing Services and will indicate the private insurance carrier as the funding source in the participant's Support Plan. No authorization is necessary for the services.
- When private insurance covers **a portion** of the Nursing Services
    - The Service Coordinator/Early Interventionist will indicate the needed amount of Nursing Services that the private insurance carrier will provide and will indicate the private insurance carrier as the funding source in the participant's Support Plan.
    - For those additional hours not covered by the private insurance carrier, but deemed medically necessary, the Service Coordinator/Early Interventionist will indicate the needed amount and will indicate MR/RD Waiver as the funding source in the participant's Support Plan.
    - The Service Coordinator/Early Interventionist will issue an Authorization for Nursing Services (MR/RD Form A-12) for the amount not covered by private insurance. Providers of Nursing Services must only bill SCDHHS for that amount.
- When private insurance covers **none** of the Nursing Services or the participant does not have private insurance
    - The Service Coordinator/Early Interventionist will indicate the needed amount of Nursing Services and will indicate the MR/RD Waiver as the funding source in the participant's Support Plan. He/she will complete the Authorization for Nursing Services (MR/RD Form A-12) for the amount needed, not to exceed the service limits.

When sending the Authorization for Nursing Services (MR/RD Form A-12) to the selected Nursing provider, the Service Coordinator/Early Interventionist must attach a copy of the Physician's Order for Nursing Services (MR/RD Form 28).

The Nursing Services provider must notify the Service Coordinator within two (2) working days of any significant changes in the participant's condition or status. The Service Coordinator must respond to requests from the provider to modify the participant's Support Plan within three (3) days of receipt by notifying the

SCDDSN Director of Health Services of the change in condition/status. The Director of Health Services will determine any needed changes prior to the participant's Support Plan being revised. Once the Support Plan is updated, the new information entered on the Waiver Tracking System and approved and a new authorization sent to the provider, reflecting the new number of units and start date.

Monitoring the Services: The Service Coordinator must monitor **waiver-funded Nursing Services** for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Nursing Services:

- During the first month of service, monitoring must be conducted while the service is being provided, unless the Service Coordination Supervisor documents an exception. An exception can only be made when the service is provided in the late evening or early morning hours (between 9:00 pm and 7:00 am).
- Services must be monitored at least once during the second month of service.
- Services must be monitored at least quarterly (i.e. within 3 months of the previous monitoring) thereafter.
- Monitoring must start over as if it is the start of service any time there is a change of nursing provider.
- Monitoring must be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).
- Monitoring must be conducted by contact with the participant/family. It can be supplemented with contact with the service provider and/or review of monthly summaries of service received from the provider.
- Nursing notes completed by the nurse(s) should be reviewed during on-site visits.
- Monitoring of the participant's health status should always be completed as a component of Nursing Services monitoring.

Some questions to consider during monitoring include:

- Is the participant receiving Nursing Services as authorized?
- Does the provider show up on time and stay the scheduled length of time? If the provider does not show up to provide care to the individual, who is providing back-up care in the provider's absence?
- Does the provider show the participant courtesy and respect?
- Has the participant's health status changed since the last monitoring? If so, does the service need to continue at the level at which it has been authorized? If the individual is receiving the service for an acute condition, has the physician been consulted about the continuation of Nursing Services and the skill level required?
- Have there been any changes to the participant's specific nursing plan developed by the provider? If so, is a copy of the current nursing plan present in the participant's Service Coordination record?
- Is the participant pleased with the service being provided, or is assistance needed in obtaining a new provider?
- What is the expected duration of services at the current level?

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

Nursing Services through State Plan Medicaid for Waiver Participants under age 21

Service Limits: There is no preset service limit for children's Private Duty Nursing through State Plan Medicaid. **The amount authorized is based on assessed need.**

Arranging for and Authorizing Services: To receive Private Duty Nursing services through State Plan Medicaid, a participant must, at minimum, meet the criteria indicated on the Medical Necessity Criteria for Private Duty Nursing Care Coordination (PDN Form 01). If the participant meets these criteria, the Checklist for Medical Necessity Criteria for State Plan Private Duty Nursing Service (PDN Form 02) should be completed. A physician's order for Nursing Services (MR/RD Form 28) must be completed by a licensed physician, specifying the skill level required (RN or LPN). Additionally, **prior approval must be obtained from the SCDDSN Director of Health Services at Whitten Center, who will also determine the number of units needed. This approval can be obtained by submitting a packet as required in the "Required Records for Review for DDSN Authorized Nursing Services" at the end of this chapter. This review by the Director of Health Services is required at least annually thereafter at the time of the annual assessment/plan development. The packet should be sent to the Director of Health Services far enough in advance of the plan date (+/- 30 days) to allow for ample time for review.**

If a child (under 21 years old) is receiving ventilator care, tracheostomy care, endotracheal care, nasopharysgeal or tracheostomy suctioning, enteral feedings or parenteral feedings, the Checklist for Children's Enhanced Private Duty Nursing (MR/RD Form A-12A) should be completed and a copy included in the packet sent to the Director of Health Services so that Enhanced Private Duty Nursing (S47-LPN or S07-RN) can be approved and authorized.

The need for the service, as well as its amount, frequency and duration must be documented by the Service Coordinator in the participant's Support Plan. **The Support Plan will indicate Nursing as a separate need with State Plan Medicaid as the funding source, and the service will not be included in the waiver budget.** The Service Coordinator/Early Interventionist will only monitor State Plan Private Duty Nursing as part of routine quarterly Service Coordination monitoring.

Once the physician orders the services, the Service Coordinator should provide the participant/legal guardian with a list of Medicaid-contracted Nursing Services providers and document the offering of a choice of providers. Once a provider is selected and prior approval is obtained from the SCDDSN Director of Health Services, the Service Coordinator will complete and send the Authorization for Nursing Services (MR/RD Form A-12).

Note: A RN can provide care if the order is written for a LPN; however, the provider can only claim the LPN rate for that participant when billing SCDHHS. A LPN **cannot** provide services when a RN is ordered by the physician.

For those participants who have private insurance, Nursing Service providers must bill the participant's private insurance carrier prior to billing SCDHHS for all nursing services provided. Private Duty Nursing services should not be billed to SCDHHS until all other resources, including private insurance coverage, have been exhausted. The Service Coordinator/Early Interventionist must first determine if the MR/RD Waiver participant has private insurance and if the insurance policy covers nursing services. In no instance should SCDHHS be billed for any amount that is the responsibility of a third party resource. Medicaid is the payer of last resort.

The following guidelines are to be followed when authorizing Nursing Services:

- When private insurance covers **all** Nursing Services

- The Service Coordinator/Early Interventionist will indicate the needed amount of Nursing Services and will indicate the private insurance carrier as the funding source in the participant's Support Plan. No authorization is necessary for the services.

- When private insurance covers **a portion** of the Nursing Services

  - The Service Coordinator/Early Interventionist will indicate the needed amount of Nursing Services that the private insurance carrier will provide and will indicate the private insurance carrier as the funding source in the participant's Support Plan.
  - For those additional hours not covered by the private insurance carrier, but deemed medically necessary, the Service Coordinator/Early Interventionist will indicate the needed amount and will indicate State Plan Medicaid as the funding source in the participant's Support Plan.
  - The Service Coordinator/Early Interventionist will issue an Authorization for Nursing Services (MR/RD Form A-12) for the amount not covered by private insurance. Providers of Nursing Services must only bill SCDHHS for that amount.

- When private insurance covers **none** of the Nursing Services or the participant does not have private insurance

  - The Service Coordinator/Early Interventionist will indicate the needed amount of Nursing Services and will indicate State Plan Medicaid as the funding source in the participant's Support Plan. He/she will complete the Authorization for Nursing Services (MR/RD Form A-12) for the amount needed.

When sending the Authorization for Nursing Services (MR/RD Form A-12) to the selected Nursing provider, the Service Coordinator/Early Interventionist must attach a copy of the Physician's Order for Nursing Services (MR/RD Form 28) and a copy of the Checklist for Medical Necessity Criteria for State Plan Private Duty Nursing Service (PDN Form 02).

The Private Duty Nursing provider must notify the Service Coordinator within two (2) working days of any significant changes in the participant's condition or status. The Service Coordinator must respond to requests from the provider to modify the participant's Support Plan within three (3) working days of receipt by notifying the SCDDSN Director of Health Services of the change in condition/status. The Director of Health Services will determine any needed changes prior to the participant's Support Plan being revised. Once the Support Plan is updated, a new authorization will be sent to the provider, reflecting the new number of units and start date.

Note: If ever a child (under age 21) enrolled in the waiver needs only Nursing Services (i.e. no other waiver-funded services), then that child must be referred for State Plan Private Duty Nursing by submitting the Medicaid State Plan - Private Duty Nursing (PDN) Service Intake and Referral Information (PDN Form 001). The Service Coordinator should coordinate the transition and complete and send the Memorandum of Transition Between the MR/RD Waiver and Children's Private Duty Nursing (MR Form 18-NUR). **Disenrollment from the MR/RD Waiver must also be coordinated with DHHS PDN Services to coincide with the transition to Private Duty Nursing.**

Note: When a waiver participant who receives Private Duty Nursing through State Plan Medicaid is approaching his/her 21st birthday, the Service Coordinator/Early Interventionist must work with DHHS's PDN Services to coordinate the transition to waiver-funded Nursing Services so as to avoid a lapse in services.

Note: When a consumer who has been receiving Private Duty Nursing through State Plan Medicaid is enrolled in the MR/RD Waiver, the Service Coordinator/Early Interventionist becomes the authorizer of services.

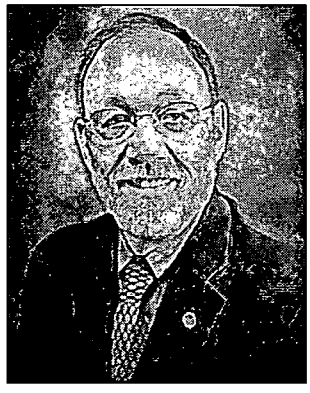
Exhibit 7

CV for Tan J. Platt, MD

Back to Main Search

Tan J. Platt, MD

Associate Professor of Clinical Family and Preventive Medicine



Contact Information
(803) 434-6113
3209 Colonial Dr.
Columbia, SC 29203

Department
Family and Preventive Medicine
Division of Family Medicine

Medical Education
Columbia University, MD, 1973

Residencies
St. Joseph's Hospital, 1974

Specialties
Family Medicine

Board Certifications
American Board of Family Medicine, 1976

Biography

Dr. Tan Platt has taught on the faculty of the University of South Carolina School of Medicine since 1986. An Associate Professor of Clinical Family and Preventive Medicine, he previously served the department in a variety of roles, including vice chairman and Family Practice Center operations director. He is currently the department's director of administration and finance.

Prior to his appointment with the School of Medicine, Dr. Platt's professional background included two years in the National Service Corp. in South Dakota and ten years in private practice in Cobleskill, New York. He currently serves as medical director of Epworth Children's Home and Babcock Center and several other community based programs that serve patients with developmental disabilities. In addition, he is an associate medical director for Companion HealthCare and medical director to the South Carolina Medicaid program. In addition he is the chief contracting officer for the Educational Trust of the School of Medicine.

After receiving a bachelor of science in biology at Trinity College, Hartford, Connecticut, Dr. Platt earned a doctor of medicine at Columbia University College of Physicians and Surgeons, New York, New York. He completed his training at Saint Joseph Hospital, Denver, Colorado.

Dr. Platt has served on numerous committees, holding roles that have included president and board chairman of the South Carolina Academy of Family Medicine, a member of the admission committee of the USC School of Medicine, and vice president and president of the School of Medicine's Educational Trust. In addition, he is one of the two delegates to the AAFP from South Carolina. In 2011, he was chosen as the South Carolina Family Physician of the year.

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Neurology
(803) 545-6050

Neuropsychiatry and Behavioral Science
(803) 434-4300

Neurosurgery
(803) 434-8323

Obstetrics and Gynecology
(803) 545-5700

Ophthalmology
(803) 434-6836

Orthopaedic Surgery and Sports Medicine
(803) 434-6812

Pediatrics
(803) 434-7950

Surgery
(803) 545-5800

University Primary Care
(803) 545-5600

Exhibit 8

News Release by SC Comptroller General
August 20, 2010

Richard Eckstrom
Comptroller General
of
South Carolina

News Release

WADE HAMPTON STATE OFFICE BUILDING, COLUMBIA SC 29201

August 20, 2010

FOR IMMEDIATE RELEASE

Contact: Jim Holly, 803-734-2588

General Fund Budget Turbulence Plagued FY10

The budget environment was uncertain throughout the fiscal year that ended June 30, 2010. Actual revenues trended down erratically for the year and they were $310.1 million less than the revenue projections used to generate the FY10 General Fund budget.

In a year of declining revenues, the state also incurred $40.2 million of unbudgeted spending through "open-ended" appropriations. Even though this spending hadn't been budgeted, it required funding. Making matters even worse, a $98.2 million operating deficit from FY09 was carried forward into FY10 with the hope that FY10 revenues would be available to pay it off.

To deal with these developments, the Budget & Control Board made $438.7 million in across-the-board cuts to agency budgets, avoiding even deeper cuts by drawing down $127.8 million from the Capital Reserve Fund to shield agency budgets. Through these and other drastic actions, the state avoided overspending and completed the year with a $71.0 million Budgetary General Fund surplus.

The General Reserve or "Rainy Day" Fund had been fully depleted in FY09 to partially offset FY09's operating deficit. To begin restoring the fund, the 2009-2010 Appropriations Act provided for a payment of $63.9 million (calculated at 1% of FY08 actual revenues) that was made July 1, 2009. In closing FY10, we restored an additional $46.9 million to the fund. The 2010-2011 Appropriations Act provided for a final payment of $55.4 million that was made July 1, 2010, thereby bringing the General Reserve Fund to FY11's full funding requirement (3% of FY 09 actual revenues of $5.5 billion).

The importance of having adequate reserve funds was made clear this year. I commend the General Assembly for submitting a proposed constitutional amendment to the voters this November to increase the Rainy Day Fund from 3% to 5% of General Fund revenues.

The current economic crisis has highlighted weaknesses in the state's efforts in forecasting and tracking revenue and in budgeting. More attention needs to be devoted to these areas so that the General Assembly will have a constant, comprehensive and reliable flow of data to make more informed decisions on short term, as well as *long range*, spending. A formal system for prioritizing all operating, as well as *capital*, expenditures needs to be developed to ensure that taxpayer dollars are spent wisely and effectively and not wasted on non-essentials.

The state can no longer postpone dealing with its obligation to fund retirement benefits for public employees. The severe funding deficit that exists needs to be dealt with immediately rather than passing it along to future generations.

These changes are needed for the state to live within its means, as prudent people and successful businesses would do in good economic times as well as the bad.

COMPTROLLER GENERAL'S OFFICE / (803) 734-2121
FAX / (803) 734-1765

State of South Carolina

BUDGETARY HIGHLIGHTS

BUDGETARY GENERAL FUND

Fiscal Year Ended June 30, 2010

Appropriations Act Budgeted Revenues for FY09-10	$ 5,552,002,165	
Actual Revenues	5,241,895,775	
Shortfall		$ (310,106,390)
Mid-Year Budget Actions of Budget and Control Board:		
Applied Capital Reserve Fund against Projected Revenue Shortfall -- June 2009	127,847,888	
Cut Agency Budgets 4.04 percent -- September 2009	200,452,112	
Cut Agency Budgets 5 percent -- December 2009	238,227,922	
		566,527,922
Closing Entries Directed by Statute or Proviso:		
To Cover "Open-Ended" Appropriations	40,244,804	
To Liquidate FY09 Operating Deficit Carried Forward to FY10	98,216,617	
To Replenish General Reserve Fund	46,959,511	
		(185,420,932)
Net Budgetary Surplus		$ 71,000,600

BUDGETARY GENERAL FUND

Changes in Budgetary Fund Balance

Fiscal Year Ended June 30, 2010

	Reserved Appropriations				
	General Reserve	Carried Forward	Capital Reserve	Unreserved/ Undesignated	Total
Revenues	$ —	$ —	$ —	$ 5,241,895,775	$ 5,241,895,775
Expenditures	—	—	—	(5,117,133,571)	(5,117,133,571)
Transfer to General Reserve per Act	63,923,944	—	—	(63,923,944)	—
Transfer to Capital Reserve per Act	—	—	127,847,888	(127,847,888)	—
Appropriations:					
Brought Forward From Last Year [a]	—	(218,728,910)	—	218,728,910	—
Carried Forward to Next Year [b]	—	63,390,442	—	(63,390,442)	—
Capital Reserve Fund Applied Against Projected Revenue Shortfall	—	—	(127,847,888)	127,847,888	—
General Reserve Fund Restoration	46,959,511	—	—	(46,959,511)	—
Net Current Year Changes	110,883,455	(155,338,468)	—	169,217,217	124,762,204
Fund Balance–July 1, 2009	—	218,728,910	—	(98,216,617)	120,512,293
Fund Balance–June 30, 2010	$ 110,883,455	$ 63,390,442	$ —	$ 71,000,600	$ 245,274,497

[a] These represent current year expenditures that did not require current year budget appropriations.

[b] These represent current year budget appropriations that will not be expended until next year.

BUDGETARY GENERAL FUND

Revenue Analysis

Fiscal Year Ended June 30, 2010

Regular sources:	Actual Revenue	Budgeted Amounts* Original	Budgeted Amounts* Final	Actual Over (Under) Original Budgeted Revenue	Actual Over (Under) Final Budgeted Revenue	Actual 2009	2010 Actual Over (Under) 2009 Actual Revenue
Individual income tax	$ 2,170,909,624	$ 2,469,023,143	$ 2,037,184,407	$ (298,113,519)	$ 133,725,217	$ 2,326,707,698	$ (155,798,074)
Retail and casual sales tax	2,190,976,127	2,192,353,185	2,137,179,935	(1,377,058)	53,796,192	2,247,876,029	(56,899,902)
Corporation income tax	109,557,160	128,926,367	114,462,730	(19,369,207)	(4,905,570)	207,174,754	(97,617,594)
Total income and sales taxes	4,471,442,911	4,790,302,695	4,288,827,072	(318,859,784)	182,615,839	4,781,758,481	(310,315,570)
Insurance tax	158,647,299	173,600,092	173,650,092	(14,952,793)	(15,002,793)	172,882,640	(14,235,341)
Beer and wine tax	99,229,717	107,385,376	107,385,376	(8,155,659)	(8,155,659)	101,356,299	(2,126,582)
Corporation license tax	73,412,950	92,132,150	90,339,862	(18,719,200)	(16,926,912)	80,987,747	(7,574,797)
Departmental revenue	63,752,920	43,108,056	43,108,056	20,644,864	20,644,864	37,485,169	26,267,751
Alcoholic liquors tax	57,463,218	57,361,772	57,361,772	101,446	101,446	57,460,842	2,376
Earned on investments	41,706,507	67,000,000	51,000,000	(25,293,493)	(9,293,493)	79,559,729	(37,853,222)
Business license (tobacco) tax	35,257,195	28,000,000	28,000,000	7,257,195	7,257,195	30,572,978	4,684,217
Documentary (deed stamp) tax	31,003,309	37,966,113	37,966,113	(6,962,804)	(6,962,804)	24,406,393	6,596,916
Admissions tax	26,164,045	27,466,616	27,466,616	(1,302,571)	(1,302,571)	27,131,738	(967,693)
Public Service Authority (excess earnings)	18,587,646	16,340,234	16,340,234	2,247,412	2,247,412	20,589,881	(2,002,235)
Bank tax	15,672,134	7,425,001	7,425,001	8,247,133	8,247,133	8,493,851	7,178,283
Workers' comp insurance tax	12,944,957	14,655,680	14,655,680	(1,710,723)	(1,710,723)	12,779,422	165,535
Motor vehicle licenses	12,362,258	15,657,903	15,627,286	(3,295,645)	(3,265,028)	15,213,183	(2,850,925)
Aircraft tax	5,356,653	5,115,477	5,115,477	241,176	241,176	6,260,566	(903,913)
Private car lines tax	3,957,024	4,034,169	4,034,169	(77,145)	(77,145)	3,733,905	223,119
Savings and Loan Association tax	3,421,963	2,002,478	2,002,478	1,419,485	1,419,485	3,815,836	(393,873)
Coin-operated device tax	1,723,124	1,517,694	1,517,694	205,430	205,430	2,134,238	(411,114)
Retailers' license tax	799,436	883,722	883,722	(84,286)	(84,286)	788,790	10,646
Estate tax	72,908	—	—	72,908	72,908	152,850	(79,942)
Motor transport fees	875	10,000	10,000	(9,125)	(9,125)	6,899	(6,024)
Total regular sources	5,132,979,049	5,491,965,230	4,972,716,700	(358,986,181)	160,262,349	5,467,571,457	(334,592,388)
Miscellaneous sources:							
Indirect cost recoveries	16,085,383	16,679,391	16,679,391	(594,008)	(594,008)	16,101,492	(16,109)
Unclaimed property fund transfers	12,000,000	12,000,000	12,000,000	—	—	12,000,000	—
Circuit and family court fines	9,724,492	10,664,363	10,664,363	(939,871)	(939,871)	10,162,045	(437,553)
Mental health fees	3,400,000	3,200,000	3,200,000	200,000	200,000	3,400,000	—
Parole and probation supervision fees	3,392,808	3,392,808	3,392,808	—	—	3,392,808	—
Debt service reimbursements	535,600	188,108	188,108	347,492	347,492	1,144,988	(609,388)
Nonrecurring revenue*	63,778,443	13,912,265	13,912,265	49,866,178	49,866,178	30,400,000	33,378,443
Total miscellaneous sources	108,916,726	60,036,935	60,036,935	48,879,791	48,879,791	76,601,333	32,315,393
Total Budgetary General Fund	$ 5,241,895,775	$ 5,552,002,165	$ 5,032,753,635	$ (310,106,390)	$ 209,142,140	$ 5,544,172,790	$ (302,276,995)

* Budgeted amounts for Nonrecurring revenue have been reduced $225,845,013 pursuant to Proviso 90.13 and General Fund Reserve transfer per the Act

Exhibit 9

April 2015 Report by OIG of USDHHS:

South Carolina Claimed Some Unallowable Room-and Board Costs Under the Intellectual and Related Disabilities Waiver for State Fiscal Year 2010

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SOUTH CAROLINA CLAIMED SOME UNALLOWABLE ROOM-AND-BOARD COSTS UNDER THE INTELLECTUAL AND RELATED DISABILITIES WAIVER FOR STATE FISCAL YEAR 2010

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

April 2015
A-04-14-04019

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

EXECUTIVE SUMMARY

The South Carolina Department of Health and Human Services claimed Federal Medicaid reimbursement of $1.6 million during State fiscal year 2010 for unallowable room-and-board costs under the Intellectual and Related Disabilities waiver program and did not reduce its Federal reimbursement by $7.9 million for an overpayment settlement.

WHY WE DID THIS REVIEW

In a previous audit of the South Carolina Department of Health and Human Services (State agency) for State fiscal years (SFYs) 2007 through 2009, we reported that the State agency claimed Medicaid reimbursement of approximately $6.7 million ($4.8 million Federal share) in direct room-and-board expenses and related administrative and general costs. Such expenses are not eligible for reimbursement. We performed this audit of SFY 2010 to determine whether the issue we identified for SFYs 2007 through 2009 continued to exist.

The objective of this review was to determine whether the State agency claimed Medicaid reimbursement for unallowable room-and-board costs under the Intellectual and Related Disabilities (IRD) waiver program operated by the South Carolina Department of Disabilities and Special Needs (the Department) for SFY 2010.

BACKGROUND

Intellectual and Related Disabilities Waiver Services

Under a Title XIX section 1915(c) waiver approved by the Centers for Medicare & Medicaid Services (CMS), the State agency operates an IRD waiver program that provides long-term care and support for individuals with intellectual or related disabilities. Payments are allowable for the cost (other than room and board) of home or community-based services that are provided under a written plan of care to individuals in need of the services. The State agency provides administrative oversight and monitoring of the IRD waiver program but contracts with the Department to provide IRD waiver services. The Department provides these IRD waiver services through contractual arrangements with a network of 39 local Disabilities and Special Needs (DSN) boards.

Reimbursement Methodology

Throughout the year, the Department makes prospective "band" payments to the local DSN boards. The local DSN boards submit monthly service reports to the Department that reflect actual services provided to clients during the month.

On the basis of monthly service reports that the DSN boards submit, the Department submits claims to the State agency for payment. The payment of these claims, subject to settlement based on the Department's annual cost reports, is the basis for the expenditure of Federal funds for IRD waiver program services. The State agency submits quarterly reports to CMS covering IRD waiver program expenditures, including any settlement payments, on the Quarterly

Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), which summarizes actual Medicaid expenses for each quarter.

CMS reimburses to the State agency the Federal share of the State agency's claimed costs. From July 1, 2009, through June 30, 2010, the State agency claimed costs for the IRD waiver program totaling $216,370,314. Under the contract between the Department and the State agency, the Department was responsible for all unallowable costs.

Cost Reporting Process

Each of the 39 local DSN boards submits to the Department annual cost reports for each of its various service areas.

Annually, the Department submits a consolidated IRD waiver program cost report to the State agency, which includes the IRD waiver program costs of all of the local DSN boards combined, as well as the administrative and general costs that are allocable to the IRD waiver program. Each year, the State agency compares the costs included on the annual consolidated IRD waiver program cost report to previous payments made to the Department for IRD waiver program services for the fiscal year and settles with the Department for the difference.

WHAT WE FOUND

The State agency claimed Medicaid reimbursement of $2,011,222 ($1,599,525 Federal share) for unallowable room-and-board costs under the IRD waiver program that the Department operated. The unallowable costs were:

- $717,329 ($570,492 Federal share) of direct room-and-board costs and
- $1,293,893 ($1,029,033 Federal share) of administrative and general costs related to room and board.

In addition, the State agency did not reduce its reimbursement on its CMS-64 for a $9,962,995 ($7,923,570 Federal share) overpayment settlement for SFY 2010, which the Department identified in July 2010.

The State agency claimed unallowable room-and-board costs because neither the State agency nor the Department had adequate controls to (1) ensure that the Department followed either applicable Federal law and guidance or its own guidance or (2) detect errors or misstatements on the local DSN boards' cost reports (e.g., prescribe a uniform format for the local DSN boards to follow when preparing the cost reports).

The State agency did not reduce its reimbursement on its CMS-64 because it did not have controls in place to ensure that it refunded the Federal share of all overpayments on its CMS-64 within the required time after it was notified of overpayments.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government $1,599,525, which is the Federal share of the room-and-board costs that the Department improperly claimed on its IRD waiver costs reports;
- ensure that it removes room-and-board-related administrative costs from the cost reports in accordance with Federal regulations;
- implement the use of a uniform cost reporting process;
- strengthen the Department's and the State agency's cost report review processes to detect errors and to ensure compliance with Federal regulations;
- report as a credit on the CMS-64 the overpayment of $9,962,995 ($7,923,570 Federal share) that the Department identified in July 2010; and
- develop and implement controls to ensure that, after being notified of an overpayment, it reports the overpayment as a credit on the CMS-64 in a timely manner.

STATE AGENCY COMMENTS

In comments on our draft report, the State agency concurred with our findings. The State agency also agreed with our recommendations and described corrective actions it has taken or plans to take to address them.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

In a previous audit of the South Carolina Department of Health and Human Services (State agency) for State fiscal years[1] (SFYs) 2007 through 2009, we reported that the State agency claimed Medicaid reimbursement of approximately $6.7 million ($4.8 million Federal share) in direct room-and-board expenses and related administrative and general costs.[2] Such expenses are not eligible for reimbursement. We performed this audit of SFY 2010 to determine whether the issue we identified for SFYs 2007 through 2009 continued to exist.

OBJECTIVE

Our objective was to determine whether the State agency claimed Medicaid reimbursement for unallowable room-and-board costs under the Intellectual and Related Disabilities (IRD) waiver program operated by the South Carolina Department of Disabilities and Special Needs (the Department) for SFY 2010.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In South Carolina, the State agency administers the Medicaid program.

Intellectual and Related Disabilities Waiver Services

Under a Title XIX section 1915(c) waiver approved by CMS, the State agency operates an IRD waiver program that provides long-term care and support for individuals with intellectual or related disabilities. Section 1915(c) allows for payment of the cost of home or community-based services that are provided under a written plan of care to individuals in need of the services. Costs that are not related to the provision of this care, as well as room-and-board costs, are not allowable under such a waiver. The State agency provides administrative oversight and monitoring of the IRD waiver program but contracts with the Department to provide IRD waiver services. The Department provides these IRD waiver services through contractual arrangements

[1] The State fiscal year begins on July 1 and ends on June 30.

[2] See report number A-04-11-04012. Also see Appendix A for a list of other related Office of Inspector General reports.

with a network of 39 local Disabilities and Special Needs (DSN) boards. These local DSN boards are divided into four regions: Piedmont, Pee Dee, Coastal, and Midlands.

Reimbursement Methodology

Throughout the year, the Department makes prospective "band"[3] payments to the local DSN boards. The band payments are advance payments for IRD waiver services based on the number of clients within each band at a particular local DSN board. The local DSN boards submit monthly service reports to the Department that reflect actual services provided to clients during the month. There is no provision for the Department to reimburse a local DSN board's costs that exceed its band payments. However, if a local DSN board spends less than 98 percent of its band payments in a contract period, it must refund the excess payments to the Department.

On the basis of the monthly service reports from the local DSN boards, the Department submits claims to the State agency for payment. The payment of these claims, subject to settlement based on the Department's annual cost reports,[4] is the basis for the expenditure of Federal funds for IRD waiver program services. The State agency submits quarterly reports covering IRD waiver program expenditures, including any settlement payments, on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), which summarizes actual Medicaid expenses for each quarter. CMS uses information on the CMS-64 to reimburse States for the Federal share of Medicaid expenditures.

CMS reimburses to the State agency the Federal share of the State agency's claimed costs, using the Federal medical assistance percentage (FMAP). South Carolina's FMAP for the period was approximately 79.53 percent.[5] Under the contract between the Department and the State agency, the Department was responsible for the cost of any unallowable services provided under the IRD waiver.

Cost Reporting Process

Each of the 39 local DSN boards submits to the Department annual cost reports for each of its various service areas. These cost reports include both direct costs for the various service areas and administrative and general costs that each local DSN board allocates.

Annually, the Department submits a consolidated IRD waiver program cost report to the State agency. It includes the IRD waiver program costs of all of the local DSN boards combined, as well as the Department central and regional offices' administrative and general costs that are

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[3] The band payment system is a budgeting system that assigns nine different funding levels, known as bands, to service users on the basis of their needs. The amount of funding assigned to each band depends on the level of residential care and intensity of services that the clients in each band are expected to need.

[4] The State agency compares the Department's actual costs incurred to previous band payments that the State agency has paid to the Department. This comparison results in a settlement payment due to or from the State agency.

[5] This percentage is a weighted average of FMAPs during our audit period. See Appendix B for details of our methodology.

allocable to the IRD waiver program. Each year, the State agency compares the costs included on the annual consolidated IRD waiver program cost report to previous payments made to the Department for IRD waiver program services for the fiscal year and settles with the Department for the difference.

HOW WE CONDUCTED THIS REVIEW

Our audit covered the period July 1, 2009, through June 30, 2010, which was SFY 2010. For this period, the State agency claimed costs for the IRD waiver program totaling $216,370,314. We calculated the direct room-and-board costs that the local DSN boards claimed on their cost reports. Additionally, we calculated the portion of administrative and general costs attributable to room and board.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix B for the details of our scope and methodology and Appendix C for applicable Federal and State requirements.

FINDINGS

The State agency claimed Medicaid reimbursement of $2,011,222 ($1,599,525 Federal share) for unallowable room-and-board costs under the IRD waiver program that the Department operated. The unallowable costs were:

- $717,329 ($570,492 Federal share) of direct room-and-board costs and
- $1,293,893 ($1,029,033 Federal share) of administrative and general costs related to room and board.

In addition, the State agency did not reduce its reimbursement on its CMS-64 for a $9,962,995 ($7,923,570 Federal share) overpayment settlement for SFY 2010.

The State agency claimed unallowable room-and-board costs because neither the State agency nor the Department had adequate controls to (1) ensure that the Department followed either applicable Federal law and guidance or its own guidance or (2) detect errors or misstatements on the local DSN boards' cost reports.

The State agency did not reduce its reimbursement on its CMS-64 because it did not have controls in place to ensure that it refunded the Federal share of all overpayments on its CMS-64 within the required time after it was notified of overpayments.

THE STATE AGENCY CLAIMED MEDICAID REIMBURSEMENT FOR DIRECT ROOM-AND-BOARD COSTS

Under a Title XIX section 1915(c) waiver, payments are allowable for the cost of home or community-based services that are provided under a written plan of care to individuals in need of services. However, costs that are not related to the provision of this care, as well as room-and-board costs, are not allowable (Social Security Act (the Act), § 1915 (c)(1)).

The State agency claimed Medicaid reimbursement totaling $717,329 ($570,492 Federal share) for unallowable direct room-and-board costs that were incurred at the local DSN board level.

Some local DSN boards included maintenance costs related to residential service programs (a direct room-and-board cost) in a pool of costs to be allocated to the various residential locations rather than directly assigning those costs to the specific residential program locations. Generally, the local DSN boards properly made adjustments to remove these costs from the cost reports. However, 13 of the 39 local DSN boards did not remove the allocated maintenance costs. As a result, the Department improperly claimed for reimbursement $717,329 ($570,492 Federal share) for direct room-and-board costs. (See Appendix D for a list of direct room-and-board costs claimed by the 13 local DSN boards.)

THE STATE AGENCY CLAIMED MEDICAID REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL ROOM-AND-BOARD COSTS

Under a Title XIX section 1915(c) waiver, payments are allowable for the cost of home or community-based services that are provided under a written plan of care to individuals in need of services. However, costs that are not related to the provision of this care or to room-and-board costs are not allowable (the Act, § 1915(c)(1)).

Federal regulations (42 CFR § 441.310(a)(2)) state that Federal financial participation (FFP) "for home and community-based services is not available for the cost of room and board except when (1) provided as part of respite care services in a facility approved by the State that is not a private residence; (2) a portion of rent and food is attributable to an unrelated personal caregiver who resides in the same household with a waiver recipient; or (3) meals are provided as part of a program of adult day health services as long as the meals do not constitute a full nutritional regimen."

The *State Medicaid Manual* (CMS Pub. 45) states that room includes "related administrative services" (§ 4442.3 B.12). A Department guidance document, *Calculation of Room and Board for Non-ICF/ID Programs,* which was directed to all local DSN boards and contractors that provide residential services, referenced that section of the *State Medicaid Manual* to provide instructions for removal of room-and-board costs from allowable costs.

The State agency claimed Medicaid reimbursement totaling $1,293,893 ($1,029,033 Federal share) for unallowable administrative and general costs related to room and board that the local DSN boards had allocated to residential service programs. Of the $10,721,832 in administrative and general costs that the local DSN boards allocated to the residential service programs,

$1,293,893, or 12.07 percent, was related to room and board and therefore not allowable for reimbursement. (See Appendix E for our estimate of indirect room-and-board costs that each local DSN board claimed.)

Most local DSN boards removed the unallowable direct room-and-board costs from allowable costs but did not remove unallowable indirect costs associated with the direct room-and-board costs. To determine the unallowable indirect costs for each local DSN board residential service program, we divided the total direct room-and-board costs by the total direct costs and multiplied the result by the administrative and general costs that the local DSN board allocated to the residential service program.

THE STATE AGENCY DID NOT INCLUDE AN OVERPAYMENT SETTLEMENT AS A CREDIT ON ITS CMS-64

The State has 1 year from the date of discovery to recover or attempt to recover overpayments made by a State to a person or other entity (the Act, §1903(d)(2)(C) and 42 CFR § 433.316(a)). Regardless of whether recovery was made, the State must make an adjustment to its Federal payments at the end of the 1-year period.

Other than fraud and abuse situations, an overpayment is considered discovered on the earliest of (1) the date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery or (2) the date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency (42 CFR § 433.316(c)(2)).

The State agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its CMS-64 submitted for the quarter in which the 1-year period following discovery ends. The State must report a credit on the CMS-64 whether or not the State has recovered the overpayment from the provider (42 CFR § 433.320(a)).

The State agency did not reduce its reimbursement on its CMS-64 for a $9,962,995 ($7,923,570 Federal share) overpayment settlement that the Department reported for SFY 2010. The Department identified this estimated overpayment in a July 9, 2010, letter to the State agency. In South Carolina, the Department is the provider of IRD waiver services, and, therefore, July 9, 2010, meets the CFR § 433.316(c)(2) definition as "the date on which a provider initially acknowledges a specific overpaid amount in writing to the State Medicaid agency."

The 1-year period following discovery of the overpayment ended on July 9, 2011. Thus, the State agency was obligated to report the overpayment as a credit on its CMS-64 no later than for the quarter ended September 30, 2011.

INADEQUATE CONTROLS

The State agency claimed unallowable room-and-board costs because neither the State agency nor the Department had adequate controls to (1) ensure that the Department followed applicable

Federal law and guidance or the Department's own guidance or (2) detect errors or misstatements on the local DSN board cost reports. Specifically:

- The Department did not follow the Federal guidance in the *State Medicaid Manual* that it cited in its instructions to residential providers regarding the calculation of room-and-board costs.

- The Department did not prescribe a uniform format for the local DSN boards to follow when preparing the cost reports. Because each local DSN board prepared its own cost report in its own format, it was difficult for the Department to identify when direct room-and-board costs were included in a pool of costs to be allocated by a local DSN board. While most local DSN boards removed direct room-and-board costs, neither the State agency's nor the Department's controls were sufficient to prevent room-and-board costs from being claimed for reimbursement.

In its comments on our previous audit report, the State agency indicated that, beginning July 1, 2012, it would ensure that room-and-board-related administrative and general costs were removed from the cost reports and begin using uniform cost reports. It also indicated that the Department would strengthen its cost report review process to detect errors or misstatements on the local boards' cost reports and that the State agency would also strengthen its cost report review process. However, because these proposed changes were not in effect until after our audit period, we did not test to determine whether the State agency and the Department had properly implemented them.

The State agency did not reduce its reimbursement on its CMS-64 because it did not have controls in place to ensure that it refunded the Federal share of all overpayments on its CMS-64 within the required time after it was notified of overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $1,599,525, which is the Federal share of the room-and-board costs that the Department improperly claimed on its IRD waiver costs reports;

- ensure that it removes room-and-board-related administrative costs from the cost reports in accordance with Federal regulations;

- implement the use of a uniform cost reporting process;

- strengthen the Department's and the State agency's cost report review processes to detect errors and to ensure compliance with Federal regulations;

- report as a credit on the CMS-64 the overpayment of $9,962,995 ($7,923,570 Federal share) that the Department identified in July 2010; and

- develop and implement controls to ensure, after being notified of an overpayment, it reports the overpayment as a credit on the CMS-64 in a timely manner.

STATE AGENCY COMMENTS

In comments on our draft report, the State agency concurred with our findings. The State agency also agreed with our recommendations and described corrective actions it has taken or plans to take to address them.

The State agency's comments are included in their entirety as Appendix F.

Exhibit 10

July 30, 2010, Memo from Beverly Buscemi, State Director of SC DDSN

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy
Thomas P. Waring
Associate State Director
Administration

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

MEMORANDUM

TO: Commission Members, DDSN Staff, Providers and Advocates

FROM: Beverly A. H. Buscemi, Ph.D.
State Director

RE: Federal Office Inspection General (OIG) Investigation

DATE: July 30, 2010

Last year United States Senator Chuck Grassley's office received a formal complaint alleging misuse/management of Medicaid funds by DDSN. Senator Grassley is the Ranking Member of the United States Senate Committee on Finance.

The complaint was referred to the Office of Inspector General (OIG) of the United States Department of Health and Human Services. Investigators and auditors held an OIG entrance conference with DDSN staff on November 17, 2009. The investigators and auditors stated the four primary areas of the audit: 1) treatment of vacant days, 2) treatment of census days, 3) accounting of room and board cost, and 4) Medicaid allowance of property purchases. The investigation concentrated on DDSN's 2008 Medicaid Cost Report for the Mental Retardation/Related Disabilities Home and Community Based Waiver.

Through November and the first of week of December 2009, the OIG investigators reviewed financial documentation and cost allocation methodologies at SCDDSN Central Office. In December through March of 2010, they conducted field audits at the Newberry Disabilities and Special Needs Board and the Babcock Center. The field audits consisted of reviewing methodologies used in cost allocation plans and individual transactions for Medicaid compliance.

During most of April and May, OIG investigators conducted their audit efforts at Central Office testing individual transactions and verifying the allocation methodologies used in Medicaid cost reports.

The OIG auditors held an exit conference with me and other DDSN staff on June 3, 2010. The investigators and auditors reported no findings or any improprieties. The OIG process is to issue a written report only when there are findings. Since their investigation yielded no findings against DDSN at any level – administrative, civil or criminal – there will not be a written report.

I have provided information and verbal updates about this investigation at numerous Commission meetings. This memo is to communicate to everyone what happened and the results. This investigation/audit was in-depth, detailed and rigorous. Thanks and appreciation is extended to our staff at DDSN and the staff at Babcock Center and the Newberry Disabilities and Special Needs Board for their fine work and the many hours they spent with the federal investigators and auditors.

We feel very positive that this investigation/audit validates DDSN processes, methodologies, and actions taken to carry out our mission of providing quality services to South Carolinians with disabilities.

Exhibit 11

News Release by SC Comptroller General for FYE June 30, 2011

State of South Carolina
Office of Comptroller General

1200 Senate Street
305 Wade Hampton Office Building
Columbia, South Carolina 29201

Telephone: (803) 734-2121
Fax: (803) 734-2064
E-Mail: cgoffice@cg.sc.gov

RICHARD ECKSTROM, CPA
COMPTROLLER GENERAL

JAMES M. HOLLY
CHIEF OF STAFF

News Release

State ends fiscal year with $123 million surplus, but volatility remains

The state ended the fiscal year with an unobligated surplus of $122.7 million. While that's certainly good news, there's far more reason for caution than for celebration.

All signs point to continued economic and financial volatility – signs such as stock market turmoil, high and unstable gas prices, unsustainable debt, and low economic growth. And this month, we were once again reminded of the daunting challenges we face when the state unemployment rate climbed to 10.9 percent.

Again, although the unobligated surplus is a positive development, going forward it'd be unwise to take anything less than a frugal approach to spending. We must recommit to the state's historically conservative budgeting practices.

I'd recommend two courses of action: first, continue to find ways to cut non-essential state spending as a means of conserving resources for even tighter financial times ahead; and secondly, continue to replenish the state's reserve accounts which provide "cushion" when times get tough.

Finally, let me take this opportunity to once again sound the alarm that the "unfunded liability" in the State Retirement System is worsening by the day. This unfunded liability is now at $14 billion and growing -- meaning serious reforms are in order to shore up the pension fund. To fail to do so would jeopardize our state's financial health, its credit rating and the retirement benefits of its public employees who are depending upon them.

State of South Carolina

BUDGETARY HIGHLIGHTS

BUDGETARY GENERAL FUND

Fiscal Year Ended June 30, 2011

FACTORS THAT PRODUCED THE FISCAL YEAR SURPLUS:

Actual Revenues Over Estimates Used in Appropriations Act	$	511,824,361
"Opened-Ended" Appropriations		(228,125,838)
Governor's Vetoes Sustained by the General Assembly		9,464,259
Fiscal Year 2011 Unappropriated Balance in Capital Reserve Fund		3,200,000
Agency's Appropriations that Lasped at Year-End		177,293
Available for Distribution		**296,540,075**

DISTRIBUTION OF SURPLUS

Supplementally Appropriated (not available until after September 1, 2011)		(173,803,544)
Available for Transfer to Contingency Reserve Fund, as of July 1, 2011	**$**	**122,736,531**

BUDGETARY GENERAL FUND

Changes in Budgetary Fund Balance

Fiscal Year Ended June 30, 2011

	Reserved					
	General Reserve	Appropriations Carried Forward	Capital Reserve	Contingency Reserve [d]	Unreserved/ Undesignated [e]	Total
Revenues	$ —	$ —	$ —	$ —	$ 5,633,230,594	$ 5,633,230,594
Expenditures	—	—	—	—	(5,167,237,705)	(5,167,237,705)
Transfer to General Reserve per Appropriations Act	55,441,728	—	—	—	(55,441,728)	—
Transfer to Capital Reserve per Appropriations Act	—	—	110,883,455	—	(110,883,455)	—
Transfer to Contingency Reserve per Appropriations Act	—	—	—	71,000,600	(71,000,600)	—
Unappropriated Balance in Capital Reserve Fund	—	—	(3,200,000)	—	3,200,000	—
Appropriations:						
Brought Forward From Last Year [a]	—	(64,283,271)	—	—	64,283,271	—
Carried Forward to Next Year [b]	—	70,610,902	—	—	(70,610,902)	—
Net Current Year Changes	55,441,728	6,327,631	107,683,455	71,000,600	225,539,475	465,992,889
Fund Balance-July 1, 2010, as adjusted [c]	110,883,455	64,283,271	—	—	71,000,600	246,167,326
Fund Balance–June 30, 2011	$ 166,325,183	$ 70,610,902	$ 107,683,455	$ 71,000,600	$ 296,540,075	$ 712,160,215

[a] These represent current year expenditures that did not require current year budget appropriations.

[b] These represent current year budget appropriations that will not be expended until next year.

[c] The July 1, 2010 fund balance, as previously reported, was adjusted by $892,829 to reflect additional appropriations carried forward into fiscal year 2011.

[d] The Contingency Reserve Fund established by proviso receives unobligated surplus from the prior fiscal year.

[e] The fiscal year 2011 unreserved/undesignated includes $173,803,544 supplemental appropriations which are available for spending after September 1, 2011, leaving $122,736,531 to be transferred to the Contingency Reserve Fund on July 1, 2011.

BUDGETARY GENERAL FUND

Revenue Analysis

Fiscal Year Ended June 30, 2011

Regular sources:	Actual Revenue	Budgeted Amounts [a] Original	Budgeted Amounts [a] Final	Actual Over (Under) Original Budgeted Revenue	Actual Over (Under) Final Budgeted Revenue	Actual 2010	2011 Actual Over (Under) 2010 Actual Revenue
Individual income tax	$ 2,396,091,331	$ 2,046,313,876	$ 2,278,669,542	$ 349,777,455	$ 117,421,789	$ 2,170,909,624	$ 225,181,707
Retail and casual sales tax	2,244,705,634	2,137,179,935	2,228,520,769	107,525,699	16,184,865	2,190,976,127	53,729,507
Corporation income tax	182,647,544	119,995,775	199,031,184	62,651,769	(16,383,640)	109,557,160	73,090,384
Total income and sales taxes	4,823,444,509	4,303,489,586	4,706,221,495	519,954,923	117,223,014	4,471,442,911	352,001,598
Admissions tax	26,888,957	27,466,616	27,472,246	(577,659)	(583,289)	26,164,045	724,912
Aircraft tax	3,813,496	5,115,477	5,495,926	(1,301,981)	(1,682,430)	5,356,653	(1,543,157)
Alcoholic liquors tax	59,144,434	57,361,772	58,037,850	1,782,662	1,106,584	57,463,218	1,681,216
Bank tax	24,451,371	7,425,001	16,142,298	17,026,370	8,309,073	15,672,134	8,779,237
Beer and wine tax	101,449,246	107,385,376	101,710,460	(5,936,130)	(261,214)	99,229,717	2,219,529
Business license (tobacco) tax	24,692,298	28,000,000	28,866,756	(3,307,702)	(4,174,458)	35,257,195	(10,564,897)
Coin-operated device tax	1,558,977	1,517,694	2,240,061	41,283	(681,084)	1,723,124	(164,147)
Corporation license tax	88,714,000	90,339,862	78,828,317	(1,625,862)	9,885,683	73,412,950	15,301,050
Departmental revenue	42,023,112	40,065,056	41,215,056	1,958,056	808,056	63,752,920	(21,729,808)
Documentary (deed stamp) tax	28,589,612	37,966,113	31,549,841	(9,376,501)	(2,960,229)	31,003,309	(2,413,697)
Earned on investments	33,433,568	46,000,000	34,000,000	(12,566,432)	(566,432)	41,706,507	(8,272,939)
Estate tax	8,220	—	—	8,220	8,220	72,908	(64,688)
Insurance tax	186,965,779	173,600,092	185,408,178	13,365,687	1,557,601	158,647,299	28,318,480
Motor transport fees	—	10,000	3,500	(10,000)	(3,500)	875	(875)
Motor vehicle licenses	15,359,562	15,627,286	12,609,503	(267,724)	2,750,059	12,362,258	2,997,304
Private car lines tax	3,925,705	4,034,169	4,111,348	(108,464)	(185,643)	3,957,024	(31,319)
Public Service Authority (excess earnings)	18,734,362	16,340,234	19,865,522	2,394,128	(1,131,160)	18,587,646	146,716
Retailers' license tax	876,579	883,722	811,428	(7,143)	65,151	799,436	77,143
Savings and Loan Association tax	1,707,370	2,002,478	3,524,622	(295,108)	(1,817,252)	3,421,963	(1,714,593)
Workers' comp insurance tax	11,423,977	14,655,680	13,139,131	(3,231,703)	(1,715,154)	12,944,957	(1,520,980)
Total regular sources	5,497,205,134	4,979,286,214	5,371,253,538	517,918,920	125,951,596	5,132,979,049	364,226,085
Miscellaneous sources:							
Circuit and family court fines	9,564,970	10,664,363	9,821,737	(1,099,393)	(256,767)	9,724,492	(159,522)
Debt service reimbursements	562,398	188,108	188,108	374,290	374,290	535,600	26,798
Indirect cost recoveries	11,161,935	16,731,391	11,061,222	(5,569,456)	100,713	16,085,383	(4,923,448)
Mental health fees	3,400,000	3,200,000	3,400,000	200,000	—	3,400,000	—
Nonrecurring revenue [a]	92,943,349	92,943,349	92,943,349	—	—	63,778,443	29,164,906
Parole and probation supervision fees	3,392,808	3,392,808	3,392,808	—	—	3,392,808	—
Unclaimed property fund transfers	15,000,000	15,000,000	15,000,000	—	—	12,000,000	3,000,000
Total miscellaneous sources	136,025,460	142,120,019	135,807,224	(6,094,559)	218,236	108,916,726	27,108,734
Total Budgetary General Fund	$ 5,633,230,594	$ 5,121,406,233	$ 5,507,060,762	$ 511,824,361	$ 126,169,832	$ 5,241,895,775	$ 391,334,819

[a] ***Budgeted amounts for nonrecurring revenue have been reduced $49,107,658 by Proviso 90.21 of the FY10-1 Appropriation Act.***

BUDGETARY GENERAL FUND

Appropriations and Expenditures

Fiscal Year Ended June 30, 2011

Expenditures by Function	Appropriations Per Act [a]	Adjusted Final Appropriations	Disposition of Adjusted Final Appropriations: Expenditures	Appropriations Carried Forward to 2012	Lapsed
Education	$ 1,831,503,698	$ 1,871,220,211	$ 1,860,631,189	$ 10,589,022	$ —
Health and Human Services	726,880,269	877,638,949	877,539,039	—	99,910
Higher Education	603,631,188	625,588,399	624,316,357	1,272,042	—
Aid to Local Government	307,194,075	310,807,913	310,706,280	101,633	—
Corrections	295,164,468	296,393,732	296,206,771	186,961	—
Debt Service	210,236,963	212,781,637	207,790,685	4,990,952	—
Mental Health	137,889,163	138,932,752	138,920,345	12,407	—
Disabilities and Special Needs	128,950,404	133,790,008	132,268,942	1,521,066	—
Social Services	118,783,374	120,377,234	120,116,541	260,693	—
Juvenile Justice	88,994,616	89,772,879	88,336,572	1,436,307	—
Health and Environmental Control	81,953,599	88,446,531	81,720,988	6,725,543	—
Public Safety	65,880,728	67,585,212	66,309,466	1,275,746	—
Budget and Control Board	84,124,678	47,291,123	35,246,095	12,045,028	—
Revenue	40,933,851	41,241,782	40,256,580	985,202	—
Judicial Department	37,443,155	37,640,564	37,623,160	17,404	—
Governor's Office	32,819,136	33,843,914	32,231,886	1,612,028	—
Parks, Recreation and Tourism	18,564,305	23,336,710	22,107,264	1,229,446	—
Probation, Parole, and Pardon	18,774,954	19,569,580	17,403,485	2,166,095	—
House of Representatives	17,615,280	19,204,379	13,403,832	5,800,547	—
Natural Resources	14,730,347	15,063,313	14,971,488	91,825	—
Senate	12,330,194	14,689,903	10,652,638	4,037,265	—
Commerce	3,904,915	14,646,164	9,621,448	5,024,716	—
School for the Deaf and Blind	11,369,841	11,465,473	11,214,541	250,932	—
Forestry Commission	9,776,307	9,878,453	9,878,453	—	—
Educational Television Commission	9,556,490	9,667,576	9,648,994	18,582	—
Vocational Rehabilitation	8,939,247	9,023,949	9,023,949	—	—
Prosecution Coordination Commission	8,691,363	8,769,544	8,609,371	160,173	—
Commission on Indigent Defense	8,451,178	8,495,363	8,487,396	7,967	—
State Library	8,284,263	8,293,628	8,293,585	43	—
Alcohol and Other Drug Abuse Services	6,535,617	6,540,829	6,540,829	—	—
Adjutant General	4,458,056	6,442,568	4,827,543	1,615,025	—
Legislative Support Agencies	5,190,065	5,611,911	5,357,242	254,669	—
Lieutenant Governor	4,503,893	4,615,215	4,014,915	600,300	—
Transportation	57,270	4,504,131	582,574	3,921,557	—
Attorney General	3,700,380	3,869,515	3,742,505	127,010	—
Election Commission	1,244,432	3,454,975	2,972,860	482,115	—
John de la Howe School	2,867,984	3,290,239	3,085,906	204,333	—
Agriculture	3,080,506	3,104,823	3,104,823	—	—
Museum Commission	2,783,588	2,834,253	2,827,234	7,019	—
Wil Lou Gray Opportunity School	2,520,649	2,777,116	2,461,874	315,242	—
State Treasurer	1,596,170	2,675,470	2,675,329	141	—
Archives and History	2,445,764	2,368,927	2,346,970	21,957	—
Commission for Blind	2,212,368	2,328,691	2,127,003	201,688	—
Comptroller General	2,101,105	2,188,062	2,156,041	32,021	—
Arts Commission	2,040,382	2,052,444	2,047,347	5,097	—
Aeronautics	566,264	2,012,315	1,121,669	890,646	—
Insurance	1,954,538	1,977,504	1,977,504	—	—
Workers' Compensation Commission	1,919,955	1,941,794	1,941,794	—	—
Administrative Law Court	1,539,294	1,588,204	1,568,318	19,886	—
Labor, Licensing and Regulation	1,348,776	1,370,521	1,363,861	6,660	—
Legislative Audit Council	847,421	894,264	881,626	12,638	—
Human Affairs Commission	1,226,488	658,536	652,961	5,575	—
Law Enforcement Training Council	631,824	635,726	495,161	63,182	77,383
Consumer Affairs	1,299,921	628,607	628,607	—	—
Secretary of State	618,262	623,371	623,371	—	—
Employment and Workforce	429,716	444,837	444,837	—	—
Commission for Minority Affairs	395,514	398,631	398,631	—	—
Sea Grant Consortium	360,134	364,654	363,558	1,096	—
State Ethics Commission	254,955	257,618	256,694	924	—
Procurement Review Panel	85,368	113,274	110,778	2,496	—
Total	**$ 5,004,188,708**	**$ 5,238,025,900**	**$ 5,167,237,705**	**70,610,902**	**$ 177,293**

[a] Appropriations Per the FY10-11 Appropriation Act column do not include $110,883,455 set aside for the Capital Reserve Fund.

BUDGETARY GENERAL FUND

Appropriations Carried Forward to FY11–12

Fiscal Year Ended June 30, 2011

	Total Carried Forward	Special Carry-Forwards[a]	General Carry-Forwards[b]	General Carryforward as % of Final Adjusted Appropriation
Law Enforcement Training Council	$ 63,182	$ —	$ 63,182	$ 9.94%
Commission for Blind	201,688	—	201,688	8.66%
Wil Lou Gray Opportunity School	315,242	192,552	122,690	4.42%
John de la Howe School	204,333	69,568	134,765	4.10%
Budget and Control Board	12,045,028	10,700,423	1,344,605	2.84%
Revenue	985,202	—	985,202	2.39%
Procurement Review Panel	2,496	—	2,496	2.20%
School for Deaf and Blind	250,932	—	250,932	2.19%
Lieutenant Governor	600,300	514,333	85,967	1.86%
Prosecution Coordination Commission	160,173	—	160,173	1.83%
Juvenile Justice	1,436,307	104,031	1,332,276	1.48%
Comptroller General	32,021	—	32,021	1.46%
Probation, Parole and Pardon	2,166,095	1,903,226	262,869	1.34%
Health and Environmental Control	6,725,543	5,579,625	1,145,918	1.30%
Administrative Law Court	19,886	—	19,886	1.25%
Disabilities and Special Needs	1,521,066	—	1,521,066	1.14%
Election Commission	482,115	448,164	33,951	.98%
Human Affairs Commission	5,575	—	5,575	.85%
Adjutant General	1,615,025	1,574,255	40,770	.63%
Governor's Office	1,612,028	1,445,953	166,075	.49%
Labor, Licensing and Regulation	6,660	—	6,660	.49%
State Ethics Commission	924	—	924	.36%
Parks, Recreation and Tourism	1,229,446	1,152,636	76,810	.33%
Sea Grant Consortium	1,096	—	1,096	.30%
Education	10,589,022	5,753,243	4,835,779	.26%
Arts Commission	5,097	—	5,097	.25%
Museum Commission	7,019	—	7,019	.25%
Social Services	260,693	—	260,693	.22%
Educational Television Commission	18,582	—	18,582	.19%
Public Safety	1,275,746	1,168,993	106,753	.16%
Commission on Indigent Defense	7,967	—	7,967	.09%
Corrections	186,961	—	186,961	.06%
Aid to Local Governments	101,633	—	101,633	.03%
Higher Education	1,272,042	1,087,182	184,860	.03%
Aeronautics	890,646	890,318	328	.02%
Natural Resources	91,825	89,957	1,868	.01%
Mental Health	12,407	—	12,407	.01%
State Treasurer	141	—	141	.01%
Archives and History	21,957	21,894	63	—
State Library	43	—	43	—
House of Representatives	5,800,547	5,800,547	—	—
Commerce	5,024,716	5,024,716	—	—
Debt Service	4,990,952	4,990,952	—	—
Senate	4,037,265	4,037,265	—	—
Transportation	3,921,557	3,921,557	—	—
Legislative Support Agencies	254,669	254,669	—	—
Attorney General	127,010	127,010	—	—
Judicial Department	17,404	17,404	—	—
Legislative Audit Council	12,638	12,638	—	—
Total	$ 70,610,902	$ 56,883,111	$ 13,727,791	.26%

[a] *Provisos contained within Part 1B of the FY10-11 Appropriations Act allow certain agencies to carry forward specific appropriation balances to FY11-12 for expenditure.*

[b] *Proviso 89.27 of the FY10-11 Appropriations Act allows agencies to carry forward to FY11-12 up to ten percent of original appropriations less any appropriation reductions.*

BUDGETARY GENERAL FUND

Open-Ended Appropriations

Fiscal Year Ended June 30, 2011

Agency Name	Description	Amount
Department of Health and Human Services.....	Agency Budgetary Deficit	$ 222,452,086
Adjutant General.....	State Active Duty Pay for Emergency Services	90,113
Budget and Control Board–Employee Benefits.....	Workers' Compensation Insurance	40,428
Technical and Comprehensive Education Board...	Proviso 18.1 - CATT Program	2,006,670
Aid to Subdivisions–State Treasurer.....	Aid to Counties - Mini Bottle Hold-Harmless	1,254,020
Aid to Subdivisions–State Treasurer.....	Aid to Fire Districts - Formula Funding Shortfall	2,282,521
Total Open-Ended Appropriations [a]		**$ 228,125,838**

[a] *"Open-ended" appropriations* result from Legislative commitments to fully fund certain budgetary items without providing sufficient specific appropriations to fully fund them or to cover an agency's budgetary deficit if approved by the Budget and Control Board. In these instances, the State uses budgetary surplus at year end to fund appropriation shortfalls.

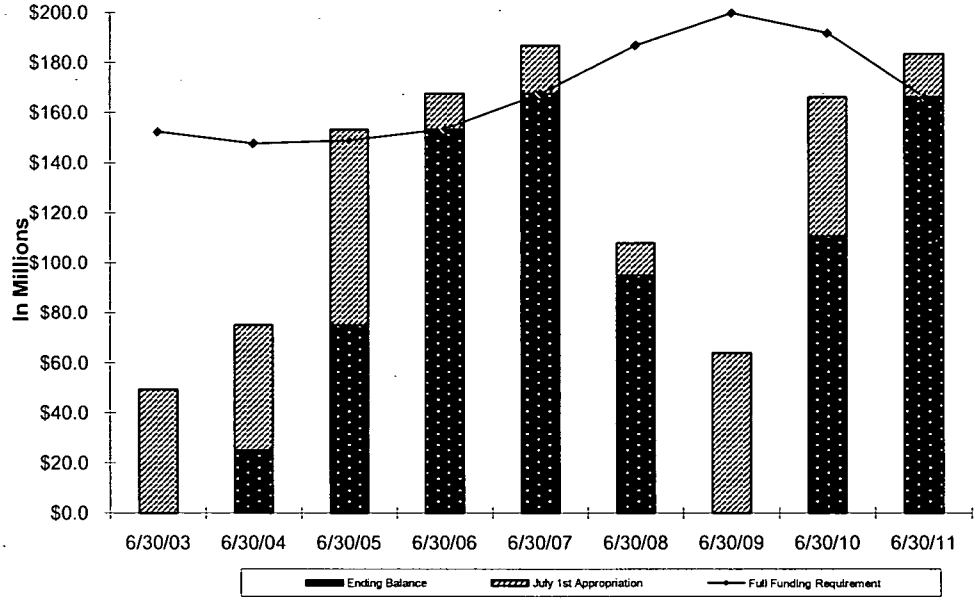
General Reserve

BUDGETARY GENERAL FUND

Fiscal Years Ended June 30

Year	Beginning Balance	Net Additions (Reductions)	Ending Balance	Full Funding Requirement	Over (Under) Funded	July 1st Appropriation[a]
2003	$ —	$ —	$ —	$ 152,409,712	$ (152,409,712)	$ 49,299,599
2004	—	25,154,528	25,154,528	147,707,970	(122,553,442)	50,000,000
2005	25,154,528	50,000,000	75,154,528	149,034,038	(73,879,510)	78,333,866
2006	75,154,528	78,333,866	153,488,394	153,488,394	—	14,243,425
2007	153,488,394	14,243,425	167,731,819	167,731,819	—	19,048,978
2008	167,731,819	(72,609,202)	95,122,617	186,780,797	(91,658,180)	12,974,290
2009	95,122,617	(95,122,617)	—	199,755,087	(199,755,087)	63,923,944
2010	—	110,883,455	110,883,455	191,771,831	(80,888,376)	55,441,728
2011	110,883,455	55,441,728	166,325,183	166,325,183	—	17,141,169

[a] Ending balances in table above do not reflect payments made on July 1 of any succeeding year as a result of appropriations to General Reserve Fund. The graph below shows balances in General Reserve Fund including these July 1 appropriations (cross-checked portion of bars). Beginning July 1, 2011, the full funding requirement for the General Reserve Fund increased from 3% in annual increments of one-half percent until the fund reaches 5%. The graph reflects the first annual increment amounting to $17.1 million in the 6/30/11 bar below.



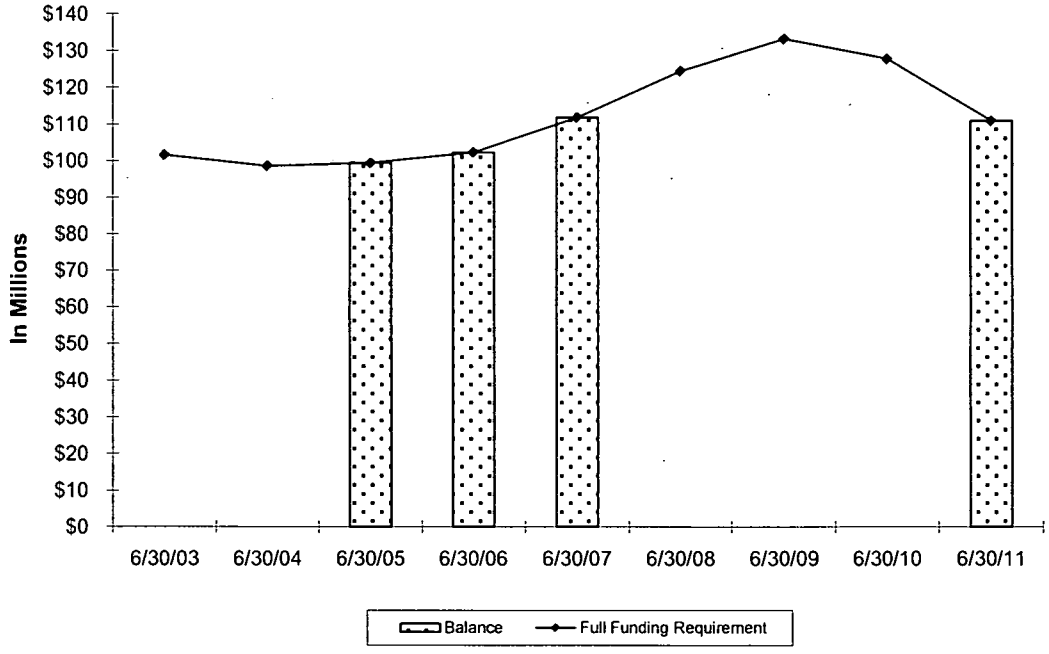
Capital Reserve

BUDGETARY GENERAL FUND

Fiscal Years Ended June 30

Year	Beginning Balance	Appropriation	Amount Applied Against Revenue Shortfall	Used for Supplemental Appropriations	Transferred to Unreserved/ Undesignated	Ending Balance	Full Funding Requirement
2003	$ —	$ 101,606,475	$ (101,606,475)	$ —	$ —	$ —	$ 101,606,475
2004	—	98,599,197	(98,599,197)	—	—	—	98,599,197
2005	—	99,356,026	—	—	—	99,356,026	99,356,026
2006	99,356,026	102,325,596	—	(99,356,026)	—	102,325,596	102,325,596
2007	102,325,596	111,821,213	—	(102,325,596)	—	111,821,213	111,821,213
2008	111,821,213	124,520,532	(124,520,532)	(111,821,213)	—	—	124,520,532
2009	—	133,170,058	(133,170,058)	—	—	—	133,170,058
2010	—	127,847,888	(127,847,888)	—	—	—	127,847,888
2011	—	110,883,455	—	—	(3,200,000)	107,683,455	110,883,445 [a]

[a] $107,683,455 was appropriated on July 1, 2011, and the remaining balance of $3,200,000 was transferred to the unreserved/undesignated fund.



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SC SUPREME COURT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Appellate Case No. 2014-002513

Richard Stogsdill,.....Petitioner,

v.

South Carolina Department of Health and Human Services.....Respondent.

CERTIFICATE OF SERVICE

I, John N. Harrison, certify that I sent by US Mail the *Reply to Respondent's Return to Motion to Vacate Order and to Supplement the Record* to Richard G. Hepfer, Esq., Office of General Counsel, South Department of Health and Human Services, PO Box 8206, Columbia, SC 29202-8206 on February 22, 2016.

John N. Harrison
Law Office of Patricia Logan Harrison
611 Holly St.
Columbia, SC 29205
803-256-2017