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THE STATE OF SOUTH CAROLINA
In the Supreme Court S.C. Supreme Court

Richard Stogsdill,.....Petitioner,

v.

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

Appellate Case No. 2014-002513
Lower Court Case No. 10-ALJ-08-0774-AP

RECORD ON APPEAL

Volume 1-A

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250. Karen is currently receiving services in a hospital which could have been avoided had her mother been provided with supports at home.
251. Karen is at immediate risk of institutionalization if waiver services are not provided.
- Susan E.
252. Susan is a twenty-five year old woman who has profound mental retardation, cerebral palsy, lupus, immune deficiency, seizures, severe osteoporosis and hydrocephalia. She is nonverbal, is unable to walk, incontinent of bowel and bladder and is legally blind. Susan's IQ is 14. Appendix B at pages 13-14.
253. Susan is totally dependent upon others for every activity of daily living.
254. Susan attended school until she was twenty-one. She received physical therapy and occupational therapy at school, but these services have not been provided since she left school.
255. Susan's parents, who are 65 and 62 years old, provide care for her twenty-four hours a day, seven days a week. She cannot be left alone, for even a brief time. Last year, Susan's father suffered a heart attack and spent more than a month in the hospital.
256. Susan's sister-in-law was paid approximately \$70 per day to provide respite services through the MR/RD Medicaid waiver, but SCDDSN terminated these services.
257. SCDDSN has informed Susan's parents that one of them must remain in the home at all times when respite services are provided through the MR/RD Medicaid waiver because the respite caregiver cannot administer her medications or her tube feeding. This effectively eliminates Susan's ability to access respite services.
258. Susan's plan of care calls for 2,160 hours a year of LPN services, however, there is a shortage of nurses in Horry County and nursing services have not been available due to

the low reimbursement rate for these services paid by Medicaid. Although the MR/RD Medicaid waiver amendments submitted to CMS in 2009 increase the reimbursement rate for institutional respite services by more than 70%, the rate for nursing services has not been increased. According to SCDDSN, there are no residential providers in Horry County that can meet Susan's needs.

259. When Susan is not able to find appropriated providers of services contained in her plan, the local DSN Board is allowed to retain her unexpended "band" funding.
260. Due to her conditions, Susan must be sedated in order to examine and clean her teeth and has been on a waiting list each year at Palmetto Health because no dentists in her area provide dental services for persons who have mental retardation and require sedation. She is required to travel more than two hours to obtain dental services.
261. Despite SCDDSN's knowledge of the lack of availability of dental services for persons like Susan, the waiver amendments submitted to CMS reduced the reimbursement rate paid to dentists by approximately 10%.
262. The MR/RD Medicaid waiver program provides Susan with diapers, wipes and nutritional supplements, however Defendants have told her that she would be limited to two cases of nutritional supplements January 1, 2010.
263. Susan has been using 2 ½ cases of Ensure a month because she is very limited in what she can eat. Many foods cause her to bleed. Her neurologist ordered Susan to drink 2 cans of ensure a day. When she began this therapy, Susan gained from 40 pounds to a healthy weight of 135 pounds.
264. If Susan is forced to move to an institution funded by Medicaid, all of her nutritional needs and diapers would be funded by Medicaid, at a significantly greater expense to

taxpayers than the cost of providing these medically necessary items at home.

265. Susan is at imminent risk of institutionalization due to the health of her parents and the inability to access home-based services which are needed to keep her safely at home.

Edward M.

266. Edward is a thirty-five year old individual who has severe mental and physical disabilities, including profound mental retardation and cerebral palsy. Appendix I at pages 4 to 186. These conditions have existed from birth and are lifelong. He is toxic to water and has only one kidney. Edward has pica, an eating disorder characterized by an appetite for non-nutritive substances (e.g., soil, paper, insects, soap, mucus, etc.). This is a serious condition which requires constant supervision to avoid life-threatening consequences of eating hazardous substances which can cause choking or bowel obstructions. Edward is nonverbal and expresses pain of discomfort by making crying sounds.
267. Edward lives with this aging mother, who cleans houses for a living. When his mother does not have someone to supervise Edward, she cannot work.
268. Edward currently receives eight hours a day of respite services at a cost of \$70 per day.
269. SCDDSN has informed Edward's guardian that effective January 1, 2010, he can only receive 68 hours a month of home-based respite services, but he can receive unlimited daily respite in an ICF/MR at a cost of \$270 per day.
270. On January 1, 2010, SCDDSN will increase the reimbursement rate for ICF/MR respite services from \$157 per day to \$270 per day.
271. Between 1999 and 2005, Edward lived in an ICF/MR, but he was repeatedly injured there.

272. When Edward lived at Clusters ICF/MR, an institution operated by the Babcock Center and supervised and funded by SCDDSN, he experienced frequent “unexplained” injuries and judicial records document that he was actually beaten by an employee.⁷ After this assault, Edward’s mother attempted to remove Edward from the facility. In response to this effort, SCDDSN successfully secured an order from the Probate Court having Edward involuntarily committed to the custody of SCDDSN.
273. According to the GAL appointed by the Probate Court, she was provided inaccurate and misleading information in order to cause her to recommend that Edward be involuntarily admitted to the custody of SCDDSN. Appendix I at pages 152 to 154.
274. After this assault, Edward’s plan of care was changed to provide one-on-one supervision in the institution. However, despite his plan of care requiring one-on-one supervision, Edward was beaten across his face and body with a belt. Appendix I at page 216. The cost of Edward’s services in the Babcock Center ICF/MR exceeded more than \$100,000.00 a year.
275. Without notice to Edward’s mother or his physician, his “one-on-one” supervision was terminated when he was moved by the Babcock Center to a different ICF/MR after his mother had requested placement at UCP.
276. Edward experienced “unexplained” injury at this Babcock Center ICF/MR in May of 2005, just seven months after his roommate choked to death in the facility. Appendix F at page 74. The injury required six stitches to his genital area. Appendix I at page 45. At the

⁷ Even though the assault was witnessed by two other employees, Edward’s mother was not informed of the beating. A warrant was not issued until a year after the assault, when the employee pled guilty to simple assault. Appendix I at page 21 to 24.

time of this injury, DHEC had issued a letter to parents of the residents of that facility informing them that the facility was being decertified. Appendix I at 86. However, even though parents had been given notice of the decertification and informed of the right to move their child out of the facility SCDDSN objected to Edward's release from the ICF/MR.

277. General Counsel for SCDDSN, James Hill, appeared at the Probate Court objecting to his mother being appointed as Edward's guardian and he filed objections with the Court on behalf of SCDDSN. Appendix I at 111.
278. Despite SCDDSN's efforts to oppose Edward's mother being appointed as his guardian, she was appointed by the Richland County Probate Court in 2005 and was finally able to secure his release from the facility where he had been injured and his roommate had died.
279. Edward has lived at home with no serious injury or illness since 2005. When Edward moved home from the facility, despite SCDDSN decreasing his funding from more than \$65,000 (from approximately \$100,000 until his mother asked to move him to UCP in 2003) to Band B, which is currently only \$12,360 a year.
280. The waiver amendments that take place on January 1, 2010 terminate Edward's ability to receive daily respite in his home or the home of his respite caregiver (which cost \$70 per day), but SCDDSN will provide unlimited institutional respite to Edward at a cost of \$270 per day.
281. On January 1, 2010, Edward's home-based respite services will be reduced from eight hours a day to 17 hours a week (68 hours per month).

282. Unless this Court grants an injunction, either Edward be forced into institutional services or his mother will not be able to continue her job as a domestic worker. As a single parent, Edward's mother is not financially able to retire.

283. Edward's mother is fearful of his safety if he returns to an institution, because of the many injuries he received while living in two ICF/MR facilities and the repeated findings by P&A, state agencies and the federal government substantiating abuse and neglect in SCDDSN facilities.

284. Edward is at risk of immediate institutionalization if this Court does not grant an injunction.

Richard S.

285. Richard is 22 years old. He weighs 130 pounds. Richard has severe cerebral palsy but he has normal intelligence. Appendix B at pages 6-7.

286. Richard has the same interests as non-disabled young adults.

287. Richard lives independently in an apartment adjacent to his parents' home and both parents work outside of the home. Richard did not graduate from high school because his physical disability is so severe that his therapies took many hours during the school day as did his recovery from many surgeries. Richard requires total assistance for any/all daily needs/functions. He requires assistance in bathing, toileting, dressing and preparing food.

288. It takes two people to safely lift Richard out of the bed in the morning and to return him to bed in the evening because of his size and spasticity.

289. When Richard was in school, most of his friends were non-disabled peers. Although he enjoys attending special needs athletic events, Richard prefers to spend his time in the

community with persons who do not have disabilities.

290. Richard would like to have a job, but he does not want to work on contracts at the workshop, where he would be required to spend most of the day sitting around a table in a metal building with other disabled persons.
291. When the local DSN Board that receives Richard's capitated waiver funds reduced his hours of care, Richard filed an appeal with SCDHHS. Richard learned for the first time during this appeal that Adult Companion Services were available to him and should have been offered by his SCDDSN services coordinator as an option. Richard's service coordinator never informed him that he was entitled to receive Adult Companion Services under the MR/RD Medicaid waiver. Since his appeal, Richard has been receiving Adult Companion Services, but these services will be terminated on January 1, 2010.
292. However, SCDDSN will pay for him to attend the congregate workshop operated by the DSN Board.
293. At the time of his hearing at SCDHHS, Richard had been attending a program operated by the South Carolina Department of Vocational Rehabilitation, but his parents had to leave their jobs during the middle of the day to assist Richard with toileting. The South Carolina Department of Vocational Rehabilitation determined that they could not meet Richard's needs due to the severity of his disability and he no longer attends that program.
294. Richard's physician has determined that he additional hours of Personal Care services and Adult Companion Services.
295. The hearing officer ordered SCDHHS to reassess the number of Personal Care hours

Richard needs taking into account the recommendations of Richard's treating physician.

296. The costs of the services Richard needs to remain safely in his own home are less than the cost of services which would be required if Richard were moved to an institution. CMS has approved, and Defendants bill Medicaid for "one-on-one services" provided to persons who live in group homes funded by the MR/RD Medicaid waiver. SCDDSN receives more than \$150,000.00 per year for some of these individuals who receive one-on-one services in more restrictive settings, but this level of supervision is not provided to those individuals who choose to remain in their homes.

297. The recent changes to the MR/RD Medicaid waiver, which were approved by CMS based on claims of budget reductions, without regard to the stimulus funds sitting in the rainy day account, approved caps which will prevent people like Richard from remaining in their homes.

298. The following chart shows the services contained in Richard's plan of care now, the services his physician has determined that he needs each week and the services he will receive effective January 1, 2010:

	Ordered by Treating Physician	2009 Plan of Care	Effective Jan. 1, 2010
Adult Companion		15	None
Personal Care II	112	53	28
Personal Care I			6
Respite (hourly)	46	46	17
Respite (daily) 1	1		0
Total hours/week	158	114	51
Respite (daily) 1 (at home)	1 (at home)	Unlimited (only in ICF/MR)	

299. Effective January 1, 2010, Richard can only receive daily respite if he is admitted to an ICF/MR. Hourly respite at home is limited to 68 hours a month.
300. SCDDSN determined that Richard does not meet its definition of "severely disabled," which would allow him to receive 240 hours of respite services each month.
301. Providing the services Richard needs at home would not fundamentally alter the State's waiver program.
302. Richard is at imminent risk of institutionalization if he does not receive the services prescribed by his physician.

Peter B.

303. Peter B. is a forty-three year old person who has moderate mental retardation, hydrocephalus and diabetes. Affidavit of Carolyn Brown. Appendix B at pages 8 to 10. When he was a teenager, Peter moved from the home of his mother to an institution (ICF/MR) funded and supervised by SCDDSN. Peter later moved out of the institution and into a supervised apartment setting where he pays for room and board, but his support services are funded by the MR/RD Medicaid Waiver.
304. When Peter moved from the ICF/MR, he experienced a serious loss of weight and developed anxiety and other psychological problems which required treatment and his physical health deteriorated. Peter began receiving 12 hours a week of companion services more than 14 years ago. His mental and physical health improved when these services were being provided and the progression of his diabetes has been delayed because of these services. Appendix B at pages 8-10.
305. SCDHHS bills Medicaid and pays SCDDSN more than double the cost of Peter's

Medicaid services. These payments are made by SCDHHS to SCDDSN under Peter's name and social security number, but more than half of these funds are spent for other purposes than providing services for Peter. SCDHHS pays SCDDSN more than \$150.00 a day for Peter's "residential habilitation," but SCDDSN pays the provider less than one half of this amount.

306. Peter's guardian filed a complaint with the U.S. Department of Health and Human Services Office for Civil Rights which resulted in Peter's provider having to repay him more than \$7,000. This was for reimbursement for transportation costs Peter had paid out of pocket when the provider was receiving funds from Medicaid to cover those costs. Soon after the last payment on this debt was made to Peter, the agency terminated the 12 hours a week of companion services Peter had received since 1992. Peter filed an appeal and the agencies agreed that these 12 hours a week would be provided during the appeal.
307. However, in June of 2009, the agencies terminated these services during the appeal after Carolyn Brown was elected as President of Voices for the Voiceless, a large state-wide grassroots organization advocating against reductions in SCDDSN services.
308. Peter's physicians have determined these twelve hours a week of adult companion services are medically necessary. Appendix I at 189 to 190.
309. His physicians and psychological services provider have determined that Peter would be at risk of a decline in his independence and psychological health, as well as physical decline, due to his condition of diabetes, if these companion services are not provided.
Id.
310. SCDDSN and SCDHHS terminated these services, without medical justification, or even input from any physician or psychologist, based on a change made by employees of

SCDDSN to an agency manual. Appendix I at 187 to 188.

311. This SCDDSN Manual amendment, which affects hundreds, if not thousands of individuals would otherwise be eligible for these services, was made without the approval of the Commissioners of SCDDSN. Appendix I at pages 187 and 188. This change in the SCDDSN manual was intended to force waiver participants into congregate workshops operated by the SCDDSN Boards. SCDDSN acknowledges that it would pay for Peter to attend a segregated, congregate workshop, at a significantly higher cost to the State.
312. The SCDDSN manual conflicts with federal regulations and the Olmstead Act, which require SCDHHS and SCDDSN to provide services in the least restrictive setting. It is undisputed that SCDDSN would pay for Peter to attend the workshop operated by the Charles Lea Center, but he does not want to attend that large congregate workshop, where he would be segregated from non-disabled persons.
313. Peter was receiving twelve hours a week of companion services, under appeal, on July 1, 2008 after his guardian became president of a large advocacy organization opposing the reduction of waiver services. Since these services were terminated, Peter has become anxious and is not getting the exercise his doctors have determined that he needs to prevent the progression of his diabetes. Appendix B at pages 8 to 10.
314. Peter is at risk of having to move to a more restrictive placement if the services which were being provided on July 1, 2008 are not restored.

Ann J.

315. Ann formerly resided in a large regional center operated by SCDDSN. She later moved to a supervised apartment setting and attended the same SCDDSN funded workshop that Karen attended. Ann was assaulted at two different Babcock Center workshops, requiring

emergency room treatment on both occasions. Afterwards, like Karen, Ann became afraid to return to the workshop. Ann's psychological services providers have determined that Ann needs adult companion services, which are an approved services under the MR/RD Medicaid waiver program.

316. Although SCDDSN will pay for Ann to attend a segregated congregate workshop, SCDDSN has refused to allow Ann to choose to receive less expensive adult companion services. For a year, Ann received no day services, but she was required to spend most of the day riding in the van transporting other residents of her apartment complex to and from the workshops they attend. Ann subsisted primarily on frozen dinners she could cook herself. For more than two years, Ann attempted to move out of her placement at the Babcock Center, but she encountered barriers when she tried to move.
317. After Ann's health deteriorated at the Babcock Center, Ann's guardian was finally able to move her out and into a group home operated by UCP during 2009. Still, SCDDSN would not allow Ann to choose to receive adult companion services instead of attending a day program, despite determinations by her psychologist and counselor that Ann needs these companion services. SCDDSN would pay for Ann to attend a congregate workshop.

Corrie D.

318. Corrie moved to a home in Columbia operated by the Babcock Center and began working at a job where she would package medical supplies in 2000.
319. Corrie has an excellent work history at her job.
320. The Babcock Center was forced to "downsize" in 2005 after its rate of abuse and neglect exceeded four times the statewide average and the management of Corrie's home was transferred to the Burton Center.

321. The group home burned and Corrie got out with the clothes on her back, but the Burton Center did not pay her for the property she lost.
322. Corrie was very unhappy at the Burton Center and wanted to move.
323. Corrie's guardian agreed to allow her to move to a supervised apartment setting supervised by UCP, but SCDDSN cut Corrie's funding by more than ½ if she moved to an apartment. (In either location, Corrie pays her own room and board.)
324. The group home operated by the Burton Center was very loud and not well maintained.
325. While Corrie was living at the group home operated by the Burton Center, and while her guardian was attempting to move her to UCP, most of Corrie's teeth were pulled without notice to her guardian. Corrie has required extensive reconstructive surgery and she was unable to eat solid food for months because of the lack of proper dental hygiene and the unauthorized removal of her teeth.
326. Finally, Corrie's guardian was successful in moving her to a home in Columbia operated by UCP.
327. Corrie would like to move from the group home operated by UCP to an apartment supervised by UCP, but SCDDSN will cut her funding in half if she moves from the group home to a less restrictive setting, which will not pay for the supervision she needs.
328. Despite having a "money follows the person" policy, SCDDSN will not allow Corrie to move her funds to a different setting.
329. In fact, SCDDSN sent UCP a letter advising them that Corrie should be moved to home operated by the Berkeley County DSN Board.
330. This was done without regard for the fact that Corrie has worked with the same employer in Columbia for many years and she enjoys her job and does not want to move.

331. Corrie is being forced to live in a more restrictive setting due to SCDDSN's refusal to provide the funds needed for the supports Corrie would need if she moved to an apartment, which would cost less than the cost of the group home where she now lives.
- Robyn P.
332. Robyn P. receives a monthly disability benefit because the Social Security Administration determined when she was eighteen years old that she has a primary diagnosis of mental retardation. Appendix B at pages 15-17. Robyn has been diagnosed by at least seven treating physicians as having mental retardation, in addition to two licensed psychologists. Robyn is planning to have brain surgery in early 2010, which has been recommended by her treating neurologist and neuropsychologist to attempt to control her seizures.
333. These seizures have been documented by three different in-patient EEG studies, one at Duke and two more recently at the Medical College of Georgia. Appendix I at pages 193 to 204. Robyn's seizure disorder results from brain injury at birth. MRI studies document severe injury to sixty percent of the right hemisphere of her brain.
334. Robyn also has cerebral palsy, which causes her to limp and limits her use of her left hand and leg.
335. When Robyn was in school, the school psychologists never determined whether she has mental retardation, but identified her as having a "learning disability" because they did not have classes in her school for persons diagnosed as having "mental retardation."
336. After Robyn appealed the denial of services by SCDDSN, in 2003, SCDDSN determined that Robyn qualified to receive MR/RD Medicaid waiver services because of her seizure disorder and condition of cerebral palsy. In 2003 Robyn filed a lawsuit naming the

director of SCDDSN, Stanley Butkus, and Associate Director, Kathy Lacy as defendants alleging that SCDHHS and SCDDSN had violated the Medicaid Act by failing to provide Residential Habilitation services with reasonable promptness, as required by 42 U.S.C. 1396a(a)(8). This lawsuit is still pending in the United States District Court.

337. After this lawsuit was filed, SCDDSN offered to allow Robyn to move to a home operated by the Newberry DSN Board, however, they would not allow her to move from Newberry to a vacant bed either in her home community (operated by UCP) or in Charleston.
338. SCDDSN continued to refuse to provide "Residential Habilitation" services to Robyn and would only provide temporary "Respite" services at Newberry.
339. Each time beds operated by UCP came open in the community, SCDDSN would deny Robyn's request to move to a home operated by UCP.
340. SCDDSN convinced the federal judge to dismiss Robyn's case, advising the court that she had been determined to be eligible for services and those services were being provided. The district judge granted summary judgment, which was reversed by the Fourth Circuit.
341. While Robyn's appeal was pending in Richmond, without notice to or the consent of Robyn's guardian, a SCDDSN school psychologist was sent by the Deputy Director of SCDDSN to assess Robyn to determine whether Robyn's seizures were "real."
342. The director of the Newberry DSN Board informed this school psychologist that Robyn had only experienced seven seizures. This was not true. His staff had recorded many more seizures. Appendix at page 214.
343. After this information was provided by the director to cause Robyn to be determined not

to qualify for the MR/RD Medicaid waiver, SCDDSN paid the Newberry DSN Board more than \$330,000 for "vacant beds" in one year.

344. Based on an assessment by the school psychologist contracted by SCDDSN, the DSN CAT determined that Robyn's seizures were not epileptic and that she was faking seizures. The CAT determined that Robyn no longer met level of care requirements for the MR/RD Medicaid waiver because she does not have severe epilepsy. This decision, that Robyn's seizure disorder was not severe and that she does not have mental retardation, was made based on the "professional judgment" of the CAT team.
345. Robyn's neurologist, her psychiatrist nor any of her treating physicians were consulted before the CAT determined she was ineligible for SCDDSN services.
346. Robyn appealed the decision to terminate her services in a three day "fair hearing" before a SCDHHS hearing officer.
347. During the appeal, the hearing officer determined that Robyn's health and safety were being jeopardized at Newberry and he ordered SCDDSN to move her.
348. A bed was open at UCP in Robyn's home community, but SCDDSN would not allow her to move to that group home.
349. Instead, SCDDSN gave the Aiken DSN Board funds to purchase a home and Robyn was moved to Aiken.
350. The decision of the SCDDSN hearing officer is now on appeal to the South Carolina Court of Appeals.
351. Robyn spent more than a month in the hospital because her neurologist could not control her seizures.
352. Robyn's treating physicians diagnosed her as having mental retardation during her

teenage years. However, the SCDHHS hearing officer determined that she does not have mental retardation because the school psychologist did not identify Robyn as having mental retardation before age eighteen, and instead identified her as having learning disabilities.

353. According to SCDDSN CAT, Robyn does not qualify under the "Related Disability" criteria because she is "faking" seizures, although the epileptic nature of her seizures have been repeatedly documented in repeated inpatient EEG studies.
354. Robyn's treating neurologist at the Medical College of Georgia has recommended brain surgery to try to control her epileptic seizures based on two separate inpatient EEG assessments, each involving three days of evaluation. Robyn has been receiving "respite" services, which are by definition "short term" services, for more than six years now. The SCDDSN Consumer Assessment Team ("CAT") determined, based on its "professional judgment," that Robyn P. does not have mental retardation or a related disability and her that her seizures are not "real." No member of the CAT was a licensed psychologist nor had any member of the team which determined that she no longer met eligibility requirements ever examined her in person. Robyn P. appealed the decision to terminate her MR/RD Medicaid waiver services to SCDHHS in 2005.
355. Since that time, Robyn spent more than a month in the hospital because of her seizure disorder and she has undergone two additional inpatient hospital stays to confirm the diagnosis of "intractable epilepsy" and the severity of her seizures.
356. SCDDSN continues to litigate Robyn's eligibility for the MR/RD Medicaid waiver, claiming that her seizures are volitional.
357. When SCDHHS submitted the waiver amendments to CMS in September of 2009, they

of Appeals and Robyn's lawsuit to determine whether SCDDSN provided services with "reasonable promptness" is pending before the South Carolina Federal District Court.

Robyn is at risk of having her MR/RD Medicaid waiver services terminated if the more restrictive eligibility standards, giving the CAT team authority to make eligibility determinations based on "professional judgment" and eliminating physicians as persons who can diagnose mental retardation, epilepsy and cerebral palsy.

362. Robyn P. requests an injunction requiring SCDDSN and SCDHHS to comply with the requirements of the ARRA, and specifically not to impose more restrictive eligibility requirements than those used in the SSI program and in effect on July 1, 2008.

363. For more than six years Robyn has received "respite" services in a group home (CTH II). The waiver amendments which take effect on January 1, 2010 only allow daily respite to be provided in a more restrictive setting, an ICF/MR. If an injunction is not granted, Robyn will be forced to move to an ICF/MR to receive respite services.

DISCUSSION

364. SCDDSN received more than \$34 million in stimulus funds during SFY 2009, but \$31 million of those funds were paid to a rainy day account established by Proviso 90.13, the Health Care Annualization and Maintenance of Effort Fund, instead of being used to maintain jobs and services. The chart at Appendix H at page 147 documents the reductions and the increased funding SCDDSN has received since October of 2008. This chart was prepared by SCDDSN and presented at the December 17, 2009 Commission Meeting.

365. During SFY 2010, SCDDSN will receive more than \$40 million in federal stimulus funds, but more than \$22 million of these funds will be paid to the Health Care

Annualization and Maintenance of Effort Fund. Appendix H at page 145.

366. At the start of SFY 2010, SCDDSN was holding more than \$7.8 million in an "excess debt service" fund. Nearly \$6 million from this fund was used to purchase and/or renovate buildings, to pay for a computer system and provide a personal contract awarded to the former director of SCDHHS. Appendix D at pages 7 and 8.
367. SCDDSN actually will receive more funding in SFY 2010 than in SFY 2008.
368. Although the numbers provided by SCDDSN have not been consistent, SCDDSN has reduced or eliminated services to thousands of persons and thousands of jobs have been or will be eliminated due to "budget reductions."
369. SCDDSN has continued to spend millions of dollars purchasing and renovating large buildings to be used as congregate workshops instead of using these funds to provide services. Appendix D at pages 5 to 8.
370. The expenditure of \$2.6 million approved by the South Carolina Budget and Control Board to purchase three buildings in Horry, Richland and Beaufort Counties was never approved by the SCDDSN Commissioners. In response to Senator Leatherman's inquiry about his Board's support of the expenditures, Dr. Laurent advised him that "there was a unanimous vote on this matter." Appendix D at page 5.
371. By using these funds to purchase real estate for local DSN Boards, SCDDSN has continued to establish barriers to private providers who compete with SCDDSN to provide services instead of encouraging competition and choice. The LAC audit recommended that SCDDSN increase the number of private providers of services and the actions taken by SCDDSN have the opposite effect.
372. Unless federal funds were used to purchase or improve the three buildings approved by

the South Carolina Budget and Control Board at a cost of \$2.8 million (which would have been a violation of federal law), SCDDSN lost more than \$11 million in matching federal funds because those funds were used to purchase real estate instead of providing Medicaid services. Many jobs were lost due to this decision.

373. The facts are undisputed that SCDDSN has drastically reduced the number of persons receiving MR/RD and HASCI Medicaid waiver services and has reduced the duration, scope and amount of services which were provided on July 1, 2008 in violation of the ARRA.
374. These reductions were based solely on claims of budget reductions at a time when millions of dollars were available, both in the stimulus fund rainy day account and the "excess service debt fund" to maintain these services.
375. Not only have Defendants violated ARRA by not maintaining services, thousands of jobs have been and will be lost because SCDDSN has not maintained MR/RD and HASCI Medicaid waiver services.
376. Services and eligibility have been reduced based on an arbitrary decision to reduce the cost of the MR/RD and HASCI Medicaid waiver programs, without individual assessments of the needs of waiver participants in violation of the Americans with Disabilities Act and *Olmstead*.
377. SCDDSN has failed to consider the treatment decisions of responsible treating physicians in determining eligibility for waiver programs and treatment needs for participants, as required by *Olmstead*.
378. Maintaining services in effect on July 1, 2008, and any services determined by treating physicians to be medically necessary since that time, would not result in a fundamental

alteration in the way the State provides services. Funds are available to provide these services and the State has a duty to protect the health and welfare of all waiver participants.

379. During SFY 2009 and SFY 2010, SCDDSN terminated or reduced waiver services based on pretextual reasons, especially the services of those participants who did not choose to attend congregate workshops.
380. Recently, courts in other states have prohibited States from reducing home-based services based on claims of the State that budget reductions require reductions in services.
381. On December 14, 2009, a federal judge in Eastern North Carolina granted a temporary restraining order in response to a complaint filed on December 11, 2009 by disabled persons asking the court to prohibit the State from reducing services Plaintiffs need to remain in their homes. Just three days after the complaint was filed, that court determined that the State should be enjoined from reducing services due to alleged violations of the Americans with Disabilities Act. *Marlo M. v. Lanier Casler*, No. 5:09-CV-535-BO, December 14, 2009. Appendix H at 150.
382. In *Crabtree v. Goetz*, a court in Tennessee prohibited the State from reducing Medicaid services where reductions were likely to force waiver participants into nursing homes or to suffer other serious harms. N 3:08-0930 (M.D. Tenn.), 2008 WL 5330306, Dec. 19, 2008.
383. The United States Department of Justice has recently filed amicus briefs in three separate cases in Connecticut, Virginia and New York to enforce the rights of persons who have disabilities to live in the least restrictive setting, as required by the *Olmstead* decision.

Appendix H at page 154. In Connecticut, the Department of Justice opposed a motion to dismiss a lawsuit challenging the State's lack of community resources, which require persons with disabilities to be housed in large, private nursing homes. In New York, the Department of Justice filed a brief in support of plaintiffs objecting to services being provided in "large congregate homes." In Virginia, the Department of Justice filed an amicus opposing the dismissal of a lawsuit objecting to the State spending millions of dollars building new, large segregated facilities for persons who have intellectual disabilities.

384. Waiver participants in SC in this case were not individually notified of the denial, reduction, suspension or terminated of their SCDDSN services until December of 2009 and some were notified that caregivers who have worked with them for many years will lose their jobs.
385. Participants were not provided with written notice of their right to appeal these denials, reductions, suspensions and terminations of services.
386. Exclusions and inflexible caps are causing Plaintiffs to lose vital home-based services. Without these services, Plaintiffs will be forced into more restricted, segregated settings.
387. Pursuant to the ARRA, the Defendants had a duty to maintain Medicaid services which were in effect on July 1, 2008.
388. Using federal stimulus funds to provide the services requested in this Complaint is a ministerial act.
389. Plaintiffs have a right to receive waiver services with reasonable promptness based on needs as determined by responsible treating physicians. *Olmstead, supra* and *Doe v. Kidd, supra*.
390. Plaintiffs have no other remedy than to petition this Court for a writ of mandamus.
391. Plaintiffs request that this Court maintain the status quo, with services not to be reduced from the level provided on July 1, 2008 without a determination by the participant's treating physician that the services are not needed.
392. Plaintiffs request an injunction prohibiting Defendants from paying funds for the purchase of real estate to be used for congregate segregated services.
393. Plaintiffs request an order directing that any funds distributed pursuant to the request of Dr. Laurent to the South Carolina Budget and Control Board for any capital projects not specifically authorized by the SCDDSN Commissioners in the capital plan approved in April of 2009 be immediately returned to SCDDSN.

FIRST CLAIM FOR RELIEF

(American Recovery and Reinvestment Act ("ARRA"))

394. Plaintiffs adopt and restate the allegations set forth in the paragraphs above.
395. The ARRA requires the State to maintain services at the level funded on July 1, 2008

- and prohibits the State from placing funds in a rainy day or reserve account.
396. Congress' intent in the ARRA was to maintain jobs and to stimulate the economy by promptly spending federal stimulus funds paid to South Carolina.
397. Plaintiffs are intended beneficiaries of the ARRA.
398. The interests of the Plaintiffs are not too vague or amorphous to be beyond the competence of this Court to enforce.
399. The statute provides a binding obligation upon the state.
400. A justifiable controversy exists between the parties as to (1) whether the Defendants have correctly interpreted Proviso 90.13 to require that federal stimulus funds paid to SCDDSN be transferred to a rainy day account instead of using those funds to maintain MR/RD and HASCI Medicaid waiver services.
401. This justiciable controversy is now ripe and Plaintiffs have standing to raise the issues set forth herein.
402. Plaintiffs seek a writ of mandamus, or alternatively a declaratory judgment, prohibiting the SCDDSN Commission from transferring any funds attributable to federal stimulus funds to the Health Care Annualization and Maintenance of Effort Fund and requiring the agency to use those funds to maintain and restore MR/RD and HASCI waiver services.
403. Plaintiffs request an order requiring that stimulus funds received by SCDDSN be used to provide Medicaid waiver services, as has been determined by the Plaintiff's treating physician to be needed to prevent regression and to maintain and improve the functional level of waiver participants.
404. Plaintiffs request that this Court order SCDDSN to apply reasonable standards, based on needs which are identified by the treating physician, and that these services be provided with reasonable promptness.
405. Pursuant to Rule 57, SCRAP, Plaintiffs further request a speedy determination of the matters contained within this complaint due to the time-sensitive nature of the dispute.
406. Plaintiffs request legal fees and costs which shall be determined to be reasonable by the Court.

SECOND CAUSE OF ACTION

(Supremacy Clause of the United States Constitution)

407. Plaintiffs adopt and restate the allegations set forth in the paragraphs above.
408. The ARRA contains an unambiguous prohibition against transferring any funds attributable to federal stimulus funds, directly or indirectly, to a reserve or rainy day account. ARRA, Section 5001(f)(3).
409. The ARRA prohibits Defendants from applying eligibility standards, methodologies, or procedures which are more restrictive than the eligibility standards, methodologies and procedures in effect on July 1, 2008. The purposes of the ARRA are as follows:
- (1) To provide fiscal relief to States in a period of economic downturn.
 - (1) To protect and maintain State Medicaid programs during a period of economic downturn including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements. (Emphasis added.)

410. Defendants have violated the ARRA and the intent of Congress by transferring funds attributable to federal stimulus funds to a rainy day account and have applied eligibility standards, methodologies and procedures which are more restrictive than those in effect on July 1, 2008, in violation of the Supremacy Clause of the United States Constitution.
411. In so doing, Plaintiffs have lost services or are threatened with the loss of eligibility or services in violation of their constitutional rights. 42 U.S.C.1983.
412. Plaintiffs request an order requiring the return of funds attributable to the ARRA to SCDDSN from the Health Care Annualization and Maintenance of Effort Fund and an order prohibiting SCDDSN from transferring additional funds to that rainy day account.
413. Plaintiffs request an order requiring SCDDSN to spend those funds providing direct services in the least restrictive setting chosen by waiver participants, requiring that these services be provided with reasonable promptness as set forth in the First Cause of Action.
414. Plaintiffs request payment of legal fees and costs, as determined by this Court to be reasonable.

THIRD CAUSE OF ACTION

(Americans with Disabilities Act)

415. Plaintiffs adopt and restate the allegations set forth above in this complaint.
416. Title II of the Americans with Disabilities Act ("ADA") provides that "no qualified individual with a disability shall, by reason of the disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity or be subject to discrimination by such entity." 42 U.S.C. § 12132.
417. A "public entity" is defined as any State or local government or other instrumentality of

a State or local government. See 42 U.S.C. 12131(1)(A)&(C).

418. Regulations implementing Title II of the ADA require that a public entity administer its services, programs and activities in “the most integrated setting appropriate” to the needs of qualified individuals with disabilities. 28 C.F.R § 35.130(d).

419. Regulations implementing Title II provide that:

“A public entity may not, directly through contractual or other arrangements, utilize criteria or other methods of administration (1) that have the effect of subjecting qualified

420. Plaintiffs request preliminary and permanent injunctions enjoining Defendants and all persons who may be in active concert and participation with them from reducing services which are needed for the Plaintiffs to remain or move to the least restrictive setting below the level provided in July of 2009, except where the participant’s treating physician determines that these services are not needed.

421. Plaintiffs request that SCDDSN and SCDHHS be required to make reasonable modifications in the programs operated by SCDDSN so as to provide services in the least restrictive, most integrated setting chosen by the waiver participants.

422. Plaintiffs request payment of legal fees and expenses.

FOURTH CAUSE OF ACTION

(Section 504 of the Rehabilitation Act)

423. Plaintiffs adopt and restate the allegations set forth above.

424. Plaintiffs are “qualified person[s] with disabilities” within the meaning of Section 504, because they have physical and/or mental impairments that substantially limit one or more major life activities, and they meet the essential eligibility requirements for long term care under the MR/RD Waiver and HASCI Medicaid Waiver programs.

425. Defendants' denial of Medicaid funding for the in-home health services that Plaintiffs require to avoid segregation in an institution and remain in the integrated home settings that are appropriate to their needs constitutes unlawful discrimination in violation of Section 504 of the Rehabilitation Act, 29 U.S.C. §794(a), and its implementing regulation, 28 C.F.R. §41.51(d).
426. Defendants have also utilized criteria and methods of administration that subject Plaintiffs to discrimination on the basis of disability, including risk of unnecessary institutionalization, by (1) failing to assess properly the services and supports that would enable Plaintiffs to remain in the community, (2) failing to ensure that Plaintiffs have access to Medicaid-covered services that will meet their needs in the community, and (3) compelling health care providers to reduce recommended levels of in home nursing and community based services, thereby violating Section 504 and its implementing regulations.

FIFTH CAUSE OF ACTION

(Civil Rights Act, 42 U.S.C. §§ 1983, 1985 and 1988)

(Against Individual Defendants Sanford, Forkner, Floyd, Harrell, Waring and Goodell)

427. Plaintiffs adopt and restate the allegations set forth in the paragraphs above.
428. Individual Defendants Sanford, Forkner, Floyd, Harrell, Waring and Goodell have acted in concert to deny Plaintiffs federal benefits to which they are entitled under the Medicaid Act, the Americans with Disabilities Act and the ARRA as set forth in this Complaint.
429. These acts violate 42 U.S.C. §§ 1983 and 1985 and violate the civil rights of the Plaintiffs.
430. Defendants have reduced services and terminated eligibility in violation of the Civil

Rights of the Plaintiffs.

431. Services have been reduced, terminated or withheld in the least restrictive setting, in an effort to increase the attendance at congregate workshops operated by SCDDSN, where waiver participants are segregated from non-disabled persons and are, in some cases, subjected to workplace violence that would not be tolerated outside of these settings.
432. The civil rights of the Plaintiffs have been violated by the Defendants actions restricting the right of choice under 42 U.S.C. 1396a(a)(23) and right to receive services in the least restrictive setting with reasonable promptness (42 U.S.C. 1396a(a)(8)).
433. Defendants have established and applied eligibility standards which are more restrictive than allowed by federal law to reduce services and rolls for the MR/RD and HASCI Medicaid waiver programs in violation of the rights of the Plaintiffs.
434. Plaintiffs pray for attorney fees and costs as shall be determined by this Court to be reasonable.

PRAYER FOR RELIEF

Plaintiffs request a writ of mandamus or a declaratory judgment determining that SCDDSN was "obligated" to use the increased FMAP funds to maintain Medicaid services. In the alternative, Plaintiffs request an order directing these funds to be retained by and returned to the South Carolina Department of Disabilities and Special Needs because payment to the Health Care Annualization and Maintenance of Effort Fund violates the Supremacy Clause of the United States Constitution for the reasons set forth herein. Plaintiffs request that this Court issue an order directing Defendants to restore all eligibility and services that were provided on July 1, 2008 and other services determined by participant's treating physician to be medically necessary. Plaintiff's request the relief requested in this complaint and such other relief as shall be

determined by this Court to be just and equitable. Plaintiffs request payment of legal fees and costs of this action.

Dated: December 23, 2009

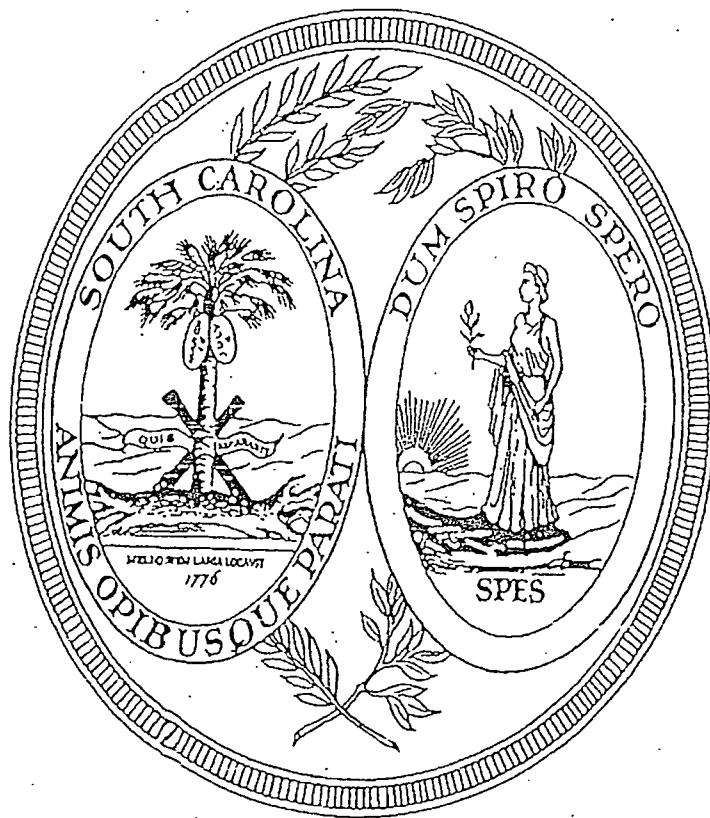
Respectfully submitted,

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South Carolina Department of Health and Human Services
Director's Internal Audit Report

A REVIEW OF THE MR/RD WAIVER AS OPERATED BY
THE DEPARTMENT OF DISABILITIES AND
SPECIAL NEEDS

Performed by the Division of Audits

February 28, 2006

EXECUTIVE SUMMARY

The Division of Audits in the SC Department of Health and Human Services (DHHS) has conducted a limited scope audit of the Medicaid Mental Retardation/Related Disabilities (MR/RD) Waiver program. Through this waiver program, individuals with mental retardation and related disabilities receive a broad range of services to assist them to live in the community instead of an institution. This program is a joint effort of DHHS and the SC Department of Disabilities and Special Needs (DDSN). DHHS provides administrative oversight and monitoring to ensure compliance with Medicaid requirements and the health, welfare and safety of the waiver beneficiaries. DDSN has the primary responsibility for the daily operation of the program.

DHHS has both a contract and a memorandum of agreement with DDSN for the management of the MR/RD waiver program. Waiver services are provided by a network of Disabilities and Special Needs (DSN) Boards and private providers. In federal fiscal year 2003, total MR/RD waiver expenditures were \$157,878,607 before cost settlement, with 69.7% federal Medicaid funds and 30.3% state and other funds provided by DDSN.

We reviewed the management and cost of the MR/RD waiver program in order to determine whether Medicaid funds are spent effectively, efficiently and in compliance with contractual, state, and federal Medicaid requirements, and also to determine whether there is an effective system of oversight to ensure clients are properly served. Concerns about DDSN allocation and expenditures of Medicaid funds, as well as issues that surfaced in FY 2003 during a review of a major DDSN provider, The Babcock Center, Inc., were the impetus for this review. While this audit focused on DDSN and DHHS management of the MR/RD waiver program, we tested certain program and financial aspects in-depth at two major providers: The Disabilities Board of Charleston County (Charleston) and The Babcock Center, Inc. (Babcock).

Overall, we identified several areas where both DDSN and DHHS need to improve the oversight of the MR/RD waiver program. Findings are listed below.

Quality Assurance, Sanctions, and Inspections

Three major programs review home and community-based waivers and other services provided to DDSN clients to ensure that quality of care and program standards are met: (1) First Health Services of South Carolina, Inc., reviews all DDSN home and community based programs, using national benchmarks and quality indicators, in order to determine client outcomes, consumer satisfaction, and adherence to policies and procedures; (2) the DDSN State Licensing Division inspects DSN Board programs and residential facilities; and (3) the University of South Carolina, under contract with DHHS, has conducted on-site quality reviews of DSN Boards for compliance to waiver program standards. We noted several issues and impediments to the effectiveness of these programs.

- According to DDSN management staff, the goal of the First Health reviews has been quality improvement, not necessarily compliance with Medicaid requirements. Because many of the standards used to determine service quality (quality indicators) are unique to DDSN, and were developed without input by DHHS, the First Health quality assurance system does not fully meet the needs of DHHS for waiver oversight.
- Some of the key quality indicators reviewed by First Health are also required Medicaid components. For example, all waiver clients are required to have a current single plan (plan of care) and level of care determination in place before waiver services can be billed to Medicaid. Failure to meet these standards results in an unallowable Medicaid payment, which must be refunded to DHHS.
- We found, however, the amount of sanctions applied to the DSN boards, and the money DDSN has refunded to DHHS for non-compliance with its standards, does not accurately reflect actual Medicaid costs and is not a full repayment.
- For example, for fiscal years 2003 and 2004, we determined that Medicaid payments to DDSN totaled \$796,530 for MR/RD waiver services provided to clients during the time their single plans or level of care determinations were either missing or invalid. Of this amount, we could verify only \$191,576 in refunds that DDSN made to DHHS as the result of sanctions identified by First Health reviews. DDSN should pay back the federal share for these unallowable Medicaid payments or \$422,077.
- Statistics reported by First Health show a steady improvement in DSN boards' adherence to quality indicators from FY 2003 to FY 2005. However, there are 265 quality indicators, and non-compliance with key indicators such as having a valid plan of care can be diluted by 100% compliance with less important indicators.

DDSN has the responsibility for licensure and certification of the residential and day program facilities for waiver consumers. DDSN has closed or de-certified a small number of community residential facilities in response to serious licensing and certification violations found during annual licensing reviews. DDSN recently added more staff to this process in order to conduct a follow-up review when there is a significant deficiency related to health, safety, or management of funds.

DHHS does not receive DDSN state licensing inspection reports of waiver facilities and programs, even if serious deficiencies reflecting abuse or neglect of waiver consumers are discovered.

DDSN licensing inspections found a number of deficiencies at Babcock, including homes that were unsanitary and in need of repair and maintenance; a lack of background checks on caregivers; and multiple medication errors. In response to this and other problems, DDSN has required Babcock Center to downsize by 50%.

Waiver Funding System

DDSN uses a band payment system to provide the DSN Boards with funds in advance in order to operate the waiver and other programs. For clients with special needs, DDSN also provides outlier funding. We concluded that the current method for funding the waiver program is similar to average, per diem payments made for other types of Medicaid services, although it is difficult to compare band payments with actual Medicaid reimbursements for services.

- We found that while some types of residential facilities were less expensive for the boards to operate, and thus the boards had revenues in excess of costs for these homes, this did not seem to be influencing where clients were placed.
- Average costs for a small number of individuals in the MR/RD waiver program exceeded the average cost of care for an ICF/MR. However, we found no indications that the waiver program does not meet required financial conditions.
- DDSN has improved its process to ensure that all residential outliers are re-justified in writing, and that the consumers' medical and/or behavioral conditions show the continued need for outlier funding.
- We reviewed a sample of MR/RD clients who were or had been receiving outlier funding. Although we found minor discrepancies in the clinical records, we concluded that the continued need for outlier funding was sufficiently documented.

Cost Reports And Administrative Expenditures

We reviewed regional cost reports, audited financial statements, and other documentation for FY 2003 to determine whether MR/RD waiver costs are properly settled in compliance with Medicaid reimbursement methodologies and whether appropriate fiscal oversight of the waiver is provided. These cost reports also are critical since they are the basis for cost settlements made by DHHS to DDSN, and for setting future rates for Medicaid reimbursement for waiver services. We concluded that there is a lack of fiscal oversight of the MR/RD waiver program by both DHHS and DDSN.

- DDSN's administrative costs are not separated from the direct service costs but rather are included in total waiver costs that become the Medicaid rate paid for waiver services. For the two boards reviewed, waiver allocated costs and central office administration amounted to approximately 14%-17% of direct service costs.
- In 2003 the DSN boards, including Charleston and Babcock, had costs higher than the band payments received from DDSN plus other revenues, but their accumulated fund balances provided a cushion. During the same year, total cost for waiver services was lower than the Medicaid funds reimbursed to DDSN, and therefore DDSN has made an interim settlement to DHHS of \$2,150,000. There is a wide variance in actual DSN Board costs for waiver services.

- We identified some unallowable room and board-related expenditures in the waiver cost reports: \$182,450 for Babcock CTH II homes and \$54,446 for Charleston CTH II homes.
- There have been no reimbursement audits performed on the regional cost reports compiled by DDSN, and DHHS staff in the Division of Ancillary Reimbursements are not reviewing audited financial statements or DDSN reconciliation schedules that support costs reported in the waiver reports. There are no written audit procedures to guide the waiver report desk review process.

Chapter 1: INTRODUCTION

Background

The Division of Audits in the SC Department of Health and Human Services (DHHS) has conducted a limited scope audit of the Medicaid Mental Retardation/Related Disabilities (MR/RD) Waiver program. Through this waiver program, individuals with mental retardation and related disabilities receive a broad range of services to assist them to live in the community instead of an institution. This program is a joint effort of DHHS and the SC Department of Disabilities and Special Needs (DDSN). DHHS provides administrative oversight and monitoring to ensure compliance with Medicaid requirements and the health, welfare and safety of the waiver beneficiaries. DDSN has the primary responsibility for the daily operation of the program.

In federal fiscal year (FFY) 2003, 4,654 Medicaid-eligible clients with mental retardation and related disabilities received home and community-based services in South Carolina. Total MR/RD waiver expenditures before any cost settlement for FFY 2003 were \$157,878,607 — 69.7% federal Medicaid funds and 30.3% state matching funds. DDSN provides the matching funds from its state appropriation and other sources.

The MR/RD waiver program offers an array of services to Medicaid-eligible clients as an alternative to institutional care in an intermediate care facility for the mentally retarded (ICF/MR). These services include:

- Personal care services,
- Habilitation services designed to help individuals live in the community and achieve and maintain their maximum functioning level,
- Environmental modifications, such as ramps and widening of doorways,
- Respite care,
- Specialized medical equipment, supplies and technology,
- Adult companion services,
- Adult day health services,
- Nursing services,
- Private vehicle modifications, and
- Behavioral and psychological services.

In addition, waiver recipients receive extended state plan Medicaid services such as two extra prescription drugs each month; physical, speech, and occupational therapy; and adult dental and vision services.

Through a contract with DHHS for the *Purchase and Provision of Home and Community-Based Mental Retardation/Related Disability Waiver Services*, DDSN provides home and community-based services to Medicaid-eligible clients. In addition, a *Memorandum of Agreement between DHHS and DDSN for the Provision of Home and*

Community-Based Waiver Services establishes how the two agencies will coordinate program activities and conditions for reimbursement. Under the SC Code of Laws Section 44-20-240, DDSN was created with the authority over all of the state's services and programs for the treatment and training of persons with mental retardation and related disabilities. DDSN uses a network of 39 county Disabilities and Special Needs (DSN) Boards, plus other service organizations, which provide waiver services directly to clients or which sub-contract with private providers. County DSN Boards are authorized to plan for, administer, or provide services to people with mental retardation and related disabilities. (SC Code of Laws Section 44-20-375 [C]). For example, the Babcock Center, Inc., is considered a local DSN Board and serves a four county area.

The "entry point" for potential waiver recipients is the local DSN Board, which screens applicants and then links them with a service coordinator. The service coordinator determines eligibility for services, assesses the client's care needs, and creates a written plan of care, called the "single plan". Medicaid will pay only for those waiver services that are specified in this plan. The DSN Boards provide most (94% for FY 2003) of the services funded through the waiver as well as service coordination, although the consumer is required to be given a choice of providers whenever possible.

Audit Objectives and Scope

We have reviewed the management and costs of the MR/RD waiver program in order to determine whether Medicaid funds are spent effectively and efficiently and in compliance with applicable contractual, state, and federal Medicaid requirements, and also to determine whether there is an effective system of oversight to ensure funds are spent on client needs. Concerns about DDSN's allocation and expenditures of Medicaid funds, as well as issues that surfaced in FY 2003 during a limited-scope review of a major DDSN provider, The Babcock Center, Inc., were the impetus for this review. Our specific audit objectives are as follows:

- Determine whether quality assurance activities conducted by both DDSN and DHHS effectively ensure clients are properly served, and whether results of quality assurance activities are reported and deficiencies are appropriately addressed.
- Determine whether the capitated or "band" payment system implemented by DDSN ensures that adequate funding is provided to meet clients' needs.
- Determine whether additional or "outlier" funding is provided to clients whose single plans justify the need for extra services, and whether this funding is actually spent on these clients.
- Determine whether waiver program costs are properly settled in compliance with Medicaid reimbursement methodologies, and whether safeguards are in place to ensure that only allowable costs are born by the Medicaid program.

- Determine whether both DDSN and DHHS provide appropriate fiscal oversight of the MR/RD waiver.

We reviewed costs and services only for DDSN clients who are MR/RD waiver recipients, and did not review any intermediate care facilities for the mentally retarded (ICF/MR). Even though the level of care provided and clients' needs may be similar to that in a community-based setting, ICF/MRs are institutions and therefore different licensing and certification requirements apply. We did not review the Head and Spinal Cord Injury Waiver (HASCI) or other Medicaid services provided by DDSN, such as early intervention and service coordination. We also did not review some components of the waiver program, including level of care, plan of care, and freedom of choice, as these are reviewed by DHHS and DDSN through their quality assurance programs. The time period of our review ranged from FY 2002 through FY 2004. Appendix A contains definitions for terms and the legal authority.

In general, we identified several areas where both DDSN and DHHS need to improve oversight of the MR/RD waiver program. The following pages detail multiple findings and recommendations involving quality assurance, payment of sanctions, serious licensing discrepancies at residential facilities, unallowable waiver costs, and a lack of financial audits.

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Chapter 2: REVIEW OF QUALITY ASSURANCE EFFORTS

Background

One of our audit objectives was to verify that quality assurance efforts put forth by the SC Department of Disabilities and Special Needs (DDSN) and the SC Department of Health and Human Services (DHHS) are substantial and effective in ensuring that the requirements of the MR/RD waiver are being met. A second objective was to determine whether findings noted during the QA reviews are properly reported, corrective action plans are developed and implemented, and appropriate follow-up is conducted to ensure problems have been satisfactorily addressed. Both DHHS and DDSN are responsible for monitoring care provided to Medicaid MR/RD waiver clients.

There are three major programs that review home and community-based waivers and other services provided to DDSN clients to ensure they meet applicable quality of care and programmatic standards:

- First Health Services of South Carolina, Inc. (First Health), is under a five-year contract with DDSN to conduct a quality assurance review program in accordance with a request for proposal awarded in December 2001. First Health reviews all Disabilities and Special Needs Boards (DSN Boards) and qualified providers annually, and issues a report of findings to DDSN and the DSN Board reviewed. In addition, First Health is required by its contract to conduct consumer interviews, follow-up reviews, and special circumstance reviews. First Health reviews include DDSN home and community-based services and are not just limited to MR/RD waiver services or Medicaid clients.
- The DHHS Division of Waiver Management is contracting with the University of South Carolina to conduct on-site QA reviews of the 39 DSN Boards on a scheduled basis. Currently the division is restructuring its QA process to incorporate enhanced CMS quality oversight requirements for waiver programs.
- The DDSN State Licensing Division inspects all DSN Boards and qualified providers on an annual basis, as DDSN is responsible for the licensing and/or certification of home and community based facilities. The SC Department of Health and Environmental Control licenses "institutional" facilities such as intermediate care facilities for the mentally retarded (ICF/MR), and community residential care facilities.

Issues Involving First Health's QA Reviews

We have reviewed the quality assurance system administered by DDSN through its external contractor, First Health Services, and have determined that its effectiveness in ensuring compliance with Medicaid requirements could be improved. We reviewed the

First Health QA process in general as well as the outcomes of First Health reviews for multiple DSN Boards, and calculated the amount owed to Medicaid based on First Health findings of serious service deficiencies. We also reviewed specific First Health reports for the Disabilities Board of Charleston County and the Babcock Center, Inc.

According to DDSN management staff, the goal of the First Health reviews has been quality improvement, not necessarily compliance with Medicaid requirements, although compliance and quality improvement are obviously related. However, DDSN views the First Health QA process as its "own" system, and in fact DHHS has operated a separate monitoring process for waiver services through a contract with USC. We also found that the sanctions imposed as a result of DSN Boards' failure to comply with First Health's quality indicators do not result in a complete and accurate repayment to Medicaid for funds spent inappropriately.

Even though DDSN developed the First Health process to meet its own quality assurance goals, the costs for the First Health contract are allocated to the Medicaid services DDSN claims for reimbursement. About 70% of the costs for First Health are reimbursed by federal Medicaid funds. The five-year cost for the First Health contract is \$4,481,934. Therefore, both DHHS and DDSN should coordinate quality assurance reviews to make sure this process meets the goals and needs of both agencies.

FOCUS OF FIRST HEALTH REVIEWS

In the waiver submitted to CMS for approval, DHHS certifies that it "...will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this document...Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that services furnished are consistent with the identified needs of individuals."

The First Health quality assurance system, as it has been developed and implemented by DDSN, does not fully meet the needs of DHHS for waiver oversight, for the following reasons:

- While core standards (quality indicators) for the waiver program and the First Health QA process are essentially the same, many of the quality indicators reviewed by First Health are unique to DDSN.
- First Health goes well beyond assessing compliance with program requirements because it also is geared toward measuring personal outcomes and consumer satisfaction and providing an assessment of consumer services. First Health reviews a sample of DDSN clients, not all of whom are Medicaid clients, and also reviews other services that are not part of the MR/RD waiver, including service coordination, early intervention, and head and spinal cord injury (HASCI) waiver services.

- Sanctions resulting from First Health reviews are not necessarily linked to Medicaid non-compliance, have been capped by DDSN, and have not been reported timely to DHHS.

First Health Standards

The quality indicators used to assess the MR/RD waiver and other DDSN programs were developed by DDSN in conjunction with First Health. DHHS had no input into the assessment standards, although we found no evidence that such input was either required or requested by DHHS. The First Health QA system utilizes National Core Indicators. These indicators or benchmarks are the result of collaboration among state agencies participating in the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute, with the goal of developing a systematic approach to performance and outcome measurement. Through this collaboration, participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out data collection strategies, and share results.

First Health is required to attempt to interview approximately five percent of DDSN's consumers annually, as well as conduct provider surveys and satisfaction surveys. (Not all consumers consent to the interview.) The QA process utilizes quality review tools that incorporate the National Core Indicators to compare outcomes with nationally recognized benchmarks. The focus of the First Health QA reviews is not just the waiver program and Medicaid clients, but all DDSN community-based programs and clients. These review tools cover several areas:

- Administrative quality indicators – administrative and fiscal areas, based on DDSN policies.
- General agency quality indicators – the single plan, service operation, and waiver funded services.
- Early intervention quality indicators – referral intake, individualized family service plan, family training, service notes, other documentation, waiver funded services, and BabyNet services.

As of March 2005, there were 265 quality indicators – 44 administrative, 112 general agency, and 109 early intervention. Some of the key quality indicators reviewed by First Health are also required Medicaid components. For example, all waiver clients are required to have a current single plan (plan of care) and level of care determination in place before waiver services can be billed to Medicaid. These indicators are reviewed both by First Health and DHHS's own reviewers for compliance. However, many of the First Health standards go beyond minimum requirements in order to assess service quality and outcomes. At the same time, other components of MR/RD waiver services might not be reviewed and reported by First Health.

The Code of Federal Regulations states, "In order for an agency to qualify as the Medicaid agency—The agency must not delegate, to other than its own officials, authority to—Exercise administrative discretion in the administration or supervision of the plan, or issue policies, rules, and regulations on program matters." [42 CFR 431.10 (e) (1)] Under the Memorandum of Agreement, "SCDHHS is the final authority and shall make all final decisions regarding all matters related to the administration of the MR/RD and HASCI waivers." Therefore, DHHS should have final approval on the quality indicators used by DDSN and First Health to evaluate Medicaid services.

SANCTIONS FOR NON-COMPLIANCE WITH STANDARDS

DDSN sanctions the DSN Boards that fail to meet critical First Health quality indicators. If the DSN Boards and other providers fail to meet certain quality indicators, then they must repay DDSN the funds they received for services that did not meet the standard (sanctions). According to DDSN executive staff, they initiated a process of sanctioning the DSN Boards in order to improve compliance with the quality indicators considered by DDSN to be a priority. First Health QA reports identify these quality indicators. Examples of sanctionable quality indicators include the single plan was not reformulated or completed annually, or the intake process was not completed within required time frames. Because DHHS has paid DDSN for the services provided to Medicaid clients, once DDSN levies a sanction on a DSN board, it should refund the federal Medicaid share to DHHS.

However, we found that DDSN did not base these sanctions on the amount Medicaid should have been refunded for unallowable payments made for MR/RD waiver services. The money DDSN has refunded to DHHS for non-compliance with its standards does not accurately reflect actual Medicaid costs and is not a full repayment, for the following reasons.

First, DDSN bases the amount of the board sanctions on the "band payment" sent to the board prior to service delivery. DDSN uses the following calculation to determine the repayment amount for each sanctionable indicator:

- Full formula: $1/365^{\text{th}}$ of the payment (either the band payment or the payment for the individual service) for each day the file was out of compliance.
- Capped formula: Full formula limited to 30 days maximum. Additionally, cites related to training goals are calculated at one-half of $1/365^{\text{th}}$.

As discussed in Chapter 3, the band payment is not the same as the amount Medicaid reimbursed DDSN for the MR/RD waiver or other services. Since band payments are funds that DDSN advances to DSN Boards based on average, expected costs, the amount Medicaid reimbursed DDSN for a service could be more or less than the amount the board was given to provide it.

Second, not all the "sanctionable indicators" found in the First Health reviews are Medicaid discrepancies or improper payments. For example, DDSN might apply a sanction to a board for failing to provide new training goals to a client once he or she has

mastered the goals. This is not necessarily a discrepancy that DHHS Medicaid reviewers would sanction for, although it does indicate low quality of services.

Finally, DDSN caps the amount it would sanction a board to 30 days in order to shield the boards from large repayments. For example, if a consumer in the MR/RD waiver program lacked a valid plan of care for 150 days, DDSN would base the sanction on 30 days worth of band payments, rather than the waiver services actually paid during the 150 days.

We determined the amount DDSN should have refunded DHHS for Medicaid payments for instances when a DSN board was in clear violation of MR/RD waiver requirements. This determination was based on information provided by DDSN regarding the First Health sanctions applied to all the DSN Boards reviewed for two fiscal years, 2003 and 2004. We determined the amount of Medicaid reimbursement for those clients, where First Health found that:

- The single plan (plan of care) or family service plan was out of date or there was no plan;
- The services were not adequately documented on the plan; and
- The level of care determination was out-of-date or not made in a timely fashion.

The reason we focused on these three discrepancies is that these conditions *must* be met before DDSN can claim federal Medicaid reimbursement for the services rendered, and both First Health and DHHS review for compliance to these standards. In the waiver agreement, DHHS certifies that "FFP (federal financial participation) will not be claimed for waiver services furnished prior to the development of the plan of care (single plan). FFP will not be claimed for waiver services which are not included in the individual written plan of care." Furthermore, the waiver agreement specifies that:

The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is every 12 months.

In a similar fashion, DDSN is required to ensure that a level of care (LOC) determination is performed and up-dated annually to ensure the individual is still eligible for services. Therefore, having a valid plan of care and meeting LOC eligibility requirements are key components of the waiver program, and failure to meet these requirements results in an unallowable Medicaid payment which should be refunded.

We used information from the First Health reviews for FY 2003 and FY 2004 to identify 71 clients receiving services under the MR/RD waiver program, and the amount that, according to DDSN, they sanctioned the DSN Boards for the discrepancies in the services to waiver clients. We then used Medicaid claims reports to determine what was actually

paid to DDSN for the dates of service when the waiver clients did not have a valid single plan or LOC determination. Table 1 shows the difference between these two amounts.

Table 1: Unallowable Medicaid Payments for MR/RD Waiver Services

Fiscal Year	Total Medicaid Paid to DDSN	Sanctions Amount	Difference
FY 02-03	\$336,186	\$44,012	\$292,174
FY 03-04	\$460,344	\$44,308	\$416,036
TOTAL	\$796,530	\$88,320	\$708,210

Source: First Health reports for Contractual Compliance Review; DHHS SURS reports.
 Notes: (1) Total Medicaid reimbursement for MR/RD waiver services furnished to Medicaid eligible clients during only those dates when the single plan or level of care determination was missing, invalid, or not timely.
 (2) Amount DDSN has required the DSN Boards to pay back for these discrepancies and clients.

This does not take into account billing discrepancies or other overpayments which should be refunded to Medicaid, but which cannot be clearly distinguished in the reports furnished by First Health. Therefore, the sanctions assessed as a result of the First Health reviews are not an accurate reflection of the Medicaid funds that have been spent inappropriately by the DSN Boards.

The DHHS contract with DDSN for waiver services states, "SCDDSN...agrees that it shall be solely responsible for any costs that are not in accordance with the Medicaid State Plan, SCDHHS policies, Medicaid regulations and the terms of the waiver". The contract also states, "SCDDSN shall be solely responsible for the performance of any subcontractors". Therefore, DDSN is responsible for repaying DHHS the federal portion of unallowable costs, minus what it has already returned as a result of the First Health findings.

Tracking Sanctions a Problem

We then reviewed the amount of funds DDSN reports it paid back to DHHS for these discrepancies. DDSN reports that it has sanctioned the DSN Boards a total of \$606,135 for sanctionable discrepancies identified by First Health reviews during fiscal years 2003-2004, and has subsequently refunded the Medicaid share of \$423,987 to DHHS. Again, these sanctions were based on payments made by DDSN to the boards, and not on actual Medicaid payments to DDSN, and also covered all services, not just MR/RD waiver. In addition, we found it impossible to tie refunds to Medicaid with corresponding First Health sanctions because of the way this information is reported by DDSN.

Once sanctions against a DSN Board are determined, DDSN is responsible for informing DHHS of the Medicaid share so these funds can be taken out of the Medicaid payment to DDSN. DDSN writes a memorandum to appropriate DHHS program staff stating,

“DDSN has identified Medicaid reimbursement claims, where billing errors have occurred. Accordingly, we are requesting the Department of Health and Human Services to adjust future remittance advices for DDSN to refund these funds to the Medicaid program.” DHHS staff are supposed to reduce the reimbursement to DDSN by posting the sanctioned amounts as a “gross debit adjustment” to the Medicaid Management Information System (MMIS).

The letters from DDSN do not indicate whether debit adjustments are the result of sanctions from First Health QA reviews nor do they specify what discrepancies were found and the DSN Boards involved. For example, in February 2005, DHHS staff received a debit adjustment request from DDSN in the total amount of \$278,630.77 for MR/RD and HASCI waiver recipients. DDSN did not provide supporting documentation to show that part of this debit request was the accumulated result of several First Health reviews of multiple DSN Boards that had occurred over the prior two years.

The debit adjustments reported by DDSN also include adjustments based on reasons other than First Health reviews. The funds repaid by DDSN appear to be a mixture of First Health sanctions and corrections for various billing errors, and we could not tie the debit request letters from DDSN back to the First Health sanction reports. Also, because of the process used to calculate and refund the Medicaid share of sanctions imposed from First Health reviews, it is possible that DDSN has repaid to DHHS funds that were not considered overpayments from a Medicaid standpoint.

However, the most we could verify that was actually paid back to DHHS, resulting from sanctions assessed to the DSN Boards because of discrepancies identified by First Health in reviews for FYs 2003 and 2004 and involving only MR/RD waiver clients, was \$191,576. This would include all First Health sanctions applied for any reason to the DSN Boards, not just those involving the timeliness of the single plan and level of care determinations. Therefore, allowing DDSN the \$191,576 in debit adjustments we could trace, DDSN is responsible for \$422,077 – the federal share of remaining unallowable Medicaid payments, as shown in Table 2.

Table 2: Required Pay Back for DDSN, FY 2003 and 2004 Combined

Total Medicaid Reimbursement for MR/RD Waiver Services (1)	DDSN Debit Adjustments for MR/RD Waiver Services (2)	Difference	Combined FFR Rate (3)	Amount DDSN Pay Back
\$796,530	\$191,576	\$604,954	69.77%	\$422,077

Notes:

- (1) Total Medicaid reimbursement for MR/RD waiver services furnished to Medicaid eligible clients during only those dates when the single plan or level of care determination was missing, invalid, or not timely, based on First Health reviews for FY 2003 and FY 2004.
- (2) Debit Adjustments made to DDSN Medicaid reimbursement for MR/RD Waiver Services that could be traced to First Health sanctions applied for any MR/RD waiver services reviewed during FYs 2003 and 2004.
- (3) Average of the federal composite match rate of 69.69% applied in FY 02-03, and 69.85% applied in FY 03-04.

REVISIONS NEEDED IN QA PROCESS

Because the First Health reviews were not designed as a Medicaid compliance tool, DHHS has developed its own process of external reviews of clients' records. This process is currently being revised. Therefore, we find that the timing is right to re-design both processes in order to have a more unified and consistent approach to quality assurance that meets the goals of both agencies.

In order to conduct more focused waiver reviews, the Division of Waiver Management within DHHS has contracted since July 1, 2002, with the University of South Carolina, Centers for Disability Resources (USC) for quality assurance record reviews for the HASCI (Head and Spinal Cord Injury) and MR/RD waivers. The USC reviewer, in conjunction with DHHS program staff, has reviewed approximately 24 DSN Boards. DHHS recouped the federal portion of \$99,417.89 from these reviews in FY 2004 and identified approximately \$353,000 in potential recoupments in FY 2005. (DDSN has appealed part of this recoupment.) Most of the findings discovered during these QA reviews were related to level of care re-evaluations, timely plan of care re-evaluations, and incorrect billing to Medicaid for residential or day habilitation services. The results of these findings have led DHHS program staff to require DDSN to issue policy memorandums and hold special training sessions for DSN Board staff regarding identified findings.

In effect, the waiver program was being reviewed under two different programs that were developed separately and used different review tools and samples, although both reviews contained similar elements. The federal Centers for Medicare and Medicaid Services (CMS) conducted a review of South Carolina's MR/RD waiver. The CMS draft report, dated February 2004, was generally positive about waiver quality assurance. However, CMS offered two recommendations in its report relating to quality assurance. The first recommendation encouraged DHHS and DDSN to coordinate and collaborate on findings noted from their respective QA systems. CMS also recommended that DDSN "...develop a detailed reporting system of their QA activities and statistical sampling to be reported to DHHS and discussed at the quarterly meetings".

As noted, DHHS is currently revising its own QA process in order to better delineate its quality management oversight responsibilities for the two home and community based waivers operated by DDSN, and has retained the services of a CMS national quality contractor to strengthen its oversight of the waiver. This contractor has recommended that DHHS and DDSN identify any gaps in DDSN's quality management system for producing and using evidence for oversight purposes. According to this contractor, "It is only once DHHS has a firm understanding of DDSN's QM system and its ability to produce and use evidence (and to share this evidence with DHHS) that DHHS will be in a position to determine strategies appropriate to its oversight role." The contractor also recommended that DHHS request "DDSN produce evidence based on a representative sample of waiver participants" and that "DDSN increase case management contacts with participants". The contractor will also be reviewing First Health findings for accuracy and appropriateness, and according to DHHS program staff, they plan to incorporate

licensing and certification reports of community-based programs and critical incidents reports for MR/RD waiver clients into this review as well. According to DDSN, they also have obtained a contractor to evaluate the validity and reliability of its statewide quality assurance/quality improvement program.

DDSN and DHHS also had differing systems for assessing financial sanctions on DSN Boards for deficiencies identified under the two review systems, although many of the standards reviewed were similar. If DDSN wishes to continue using sanctions in order to enforce quality standards, the funds returned to DHHS should be in line with what Medicaid paid for the services. This will require staff from both agencies to jointly develop a reporting process that clearly shows the First Health findings, the resulting Medicaid discrepancy, and the amount of the improper payment that should be recouped (based on Medicaid reimbursement and not band payments). DDSN should provide supporting documentation to link the amount that Medicaid should be reimbursed with the applicable First Health sanctions. Also, as part of this process both agencies should explore the feasibility of using the "void and replace" claim-specific adjustment process, instead of using gross-level adjustments as it is currently done. This may help ensure that First Health findings are tracked in a timely manner, and that Medicaid funds are recouped shortly after the discrepancies are identified by First Health. Ultimately, it is DHHS' responsibility to oversee and monitor the quality assurance and sanction process.

Recommendations

1. The Department of Health and Human Services and the Department of Disabilities and Special Needs should revise the quality assurance process as it is currently being conducted by First Health to meet the goals and needs of both agencies. This should include all the Medicaid-funded services reviewed for quality assurance by DDSN. The quality assurance standards and QA review process should incorporate both quality indicators as well as Medicaid requirements. DHHS should have final approval on the quality indicators used to evaluate Medicaid services.
2. The Department of Health and Human Services should amend the Memorandum of Agreement with the Department of Disabilities and Special Needs to include provisions for the two agencies to jointly develop a quality assurance, Medicaid monitoring system.
3. The Department of Health and Human Services and the Department of Disabilities and Special Needs should jointly develop a reporting process that clearly shows the First Health findings, the resulting Medicaid discrepancy, the program and specific service, and the amount of the improper Medicaid payment that should be recouped. Once this process has been developed, DHHS should consider requiring DDSN to make adjustments directly to the specific claims involved.
4. The Department of Disabilities and Special Needs should refund \$422,077 to the Department of Health and Human Services as the federal share of funds

inappropriately spent by DSN Boards for fiscal years 2003 and 2004 for services provided when the client did not have a valid plan of care or level of care determination.

5. Department of Health and Human Services in conjunction with DDSN should develop a schedule of potential Medicaid recoupments for fiscal year 2005 (based on the process developed in response to recommendation #3), so that Medicaid recoupments can be linked with the applicable First Health findings. Since this information would involve services in addition to the MR/RD waiver, it should then be provided to the applicable DHHS division — Division of Preventive and Ancillary Health Services, Division of Family Services, and/or the Division of CLTC Waiver Management, in order to make adjustments on MMIS.

REPORTING BY FIRST HEALTH

Statistics reported by First Health show a steady improvement in DSN Boards' adherence to quality indicators. We reviewed the FY 2004 QA reports provided by First Health as well as aggregate data for three years. First Health provides DDSN with quarterly and annual reports for all the DSN Boards and qualified providers reviewed, based on the state fiscal year of July 1 through June 30. DHHS also receives copies of these reports.

First Health is required to review a 5% sample of records at each DSN Board annually, as well as to conduct follow-up reviews within 120 days after the annual review. First Health examines all services for each client selected for review, regardless of whether the client is a MR/RD waiver participant. In FY 2004, for example, First Health sampled records for 1,421 DDSN consumers (1,095 clients receiving MR/RD waiver and other DDSN services; 83 HASCI waiver clients, and 243 clients receiving early intervention services). Table 3 reflects average scores for the administrative, general agency and early intervention indicators for FY 2003 through 2005 for the Babcock Center, Inc., and Charleston DSN Boards, as well as statewide averages for those years.

Table 3: Average Scores by Indicator

Provider	Indicator	FY 2003	FY 2004	FY 2005
Babcock Center	Administrative	87.3%	81.4%	83.3%
	General Agency	77.3%	84.2%	90.5%
Charleston	Administrative	90.9%	93.2%	86.0%
	General Agency	86.5%	94.9%	97.6%
	Early Intervention	90.1%	95.3%	98.7%
Statewide Average	Administrative	92.1%	94.7%	93.9%
	General Agency	86.6%	90.9%	91.2%
	Early Intervention	87.8%	91.3%	94.1%

Source: CCR Tracking Comparison of First Health Reviews, DDSN.
 Notes: While this audit focused on MR/RD waiver services, First Health reviews do not segregate this information; so findings relating to other services have been included.

Selected indicators where DSN Boards, on average, had less than 80% compliance for FY 2004 are shown in Table 4; performance on these indicators improved in 2005, as shown. "Sanctionable" indicators, as previously described, are situations where non-compliance results in recoupment of funds from the DSN Board. The following indicators would apply to both waiver and non-waiver services.

Table 4: Selected Indicators with less than 80% Compliance for FY 2004

Indicator	FY 2004	FY 2005
SANCTIONABLE Board/Provider follows DDSN procedures regarding the reporting and responding to critical incidents as outlined in DDSN policy.	46.2%	29.0%
SANCTIONABLE Service reporting to DDSN is appropriate, adequate, and does not reflect under or over reporting.	35.0%	26.9%
The Consumer/Legal Guardian received a copy of the Single Plan and facilitated Single Plan (when appropriate).	31.4%	12.0%
SANCTIONABLE Progress is made towards meeting identified needs and implementing supports, or revisions are made when satisfactory progress is not indicated.	25.8%	14.9%
SANCTIONABLE Services are monitored as often as needed, but at least quarterly, to assure they are implemented as prescribed.	25.5%	17.0%
SANCTIONABLE The nature, frequency, and intensity of service coordination activity is adequate to identify and address service needs and personal goals.	23.8%	14.9%
SANCTIONABLE The intake process is completed within the required time frames (for new consumers only).	22.5%	15.2%
All Consumers records contain the Behavior Support Plan, if applicable.	21.6%	15.6%

Source: First Health Annual Reports for FY 2004 and FY 2005.

While these statistics do show an improvement in quality of services provided by the DSN Boards based on First Health indicators, this information should be reviewed in conjunction with the DDSN certification and licensing process that is described in the following pages. For example, although Babcock Center showed a better than 80% compliance with administrative and general standards in 2004, DDSN's licensing reports tell a somewhat different story. Furthermore, with so many indicators (265) non-compliance with key indicators such as having a valid plan of care can be diluted by 100% compliance with less important indicators. For example, one quality indicator states that if a consumer is disenrolled from the MR/RD waiver, a Notice of Disenrollment form must be completed within two days. The DSN Boards achieved 100% compliance with this indicator in 2005. DDSN and DHHS staff should review all available information on the performance of DSN Boards in order to determine if the First Health quality assurance process is helping improve waiver service quality and achieve better compliance with program standards. As previously noted, DHHS is already planning to incorporate this in its revision of the QA process.

Issues Involving DDSN State Licensing Surveys

We reviewed the process used by DDSN to license and/or certify residential and day program facilities for MR/RD waiver clients. Under a Memorandum of Agreement with the SC Department of Social Services (DSS), DDSN is granted the authority to license community training homes for children. Since 1982, a proviso initiated by DHEC has granted DDSN the authority to certify community training homes for adults. (DHEC is mandated to license institutional facilities such as ICF/MRs and CRCFs.) DDSN's own state legislation grants it the authority to license day facilities, such as work activity centers or child development centers, for both children and adults.

The DDSN State Licensing division annually reviews community residential facilities for one-third of all adult consumers, all facilities for children, and all day programs. DDSN has developed its own licensing standards, which are approved by DHEC or by DSS if they pertain to children. The standards cover a wide range of requirements, including fire, health and safety, storage and administration of medicine, consumer programs, accountability for consumer funds, reporting of critical incidents, and staff certification. The surveyors physically inspect the facilities selected for review and examine client files as well as personnel records for current staff at the facilities, although personnel records for terminated employees are not reviewed. At the conclusion of the review, DDSN licensing division issues a report to the executive director of the DSN Board, with a plan of correction due one month after the report is issued. The DDSN licensing coordinators review corrective action plans to ensure findings are appropriately addressed.

Reviews conducted by the DDSN licensing division are completely separate from reviews conducted by First Health. Although First Health and DDSN licensing may review records for the same client, First Health's review focuses on reviewing all services that the client receives. DDSN licensing selects the residence or facility that will be inspected and also reviews records for all consumers in that facility.

We reviewed DDSN's policies and procedures for licensure and certification of home and community-based facilities for waiver clients, as well as the license and certification reports for Babcock Center, Inc., and The Charleston DSN board in order to determine how standards for health, safety, and programs for waiver clients are upheld. In general, we concluded that the licensing inspections carried out by the DDSN State Licensing Division were thorough and appropriate. However, DDSN should improve the way it reports and acts upon serious deficiencies identified by the survey teams.

LICENSING REPORTS NOT SHARED WITH DHHS

DHHS has not been receiving DDSN inspection reports of residential facilities and day programs serving waiver recipients, even if serious deficiencies that could harm waiver consumers are discovered. Although annual state licensing reports are normally provided to the executive directors of the DSN Boards, they are not provided to DHHS and

generally not provided to the DSN Boards of Directors. As far as we could determine, DHHS program staff had not ever received DDSN licensing reports for facilities that house MR/RD waiver clients.

While a large majority of the waiver funding is used for residential and day habilitation services and programs, DHHS has no authority over residential facilities themselves, and the room and board charged to consumers who live in the community residential facilities are not allowable Medicaid expenses.

However, the MR/RD waiver agreement requires DHHS to assure "...that necessary standards have been taken to protect the health and welfare of persons receiving services under this waiver", including assurances "...that the standards of any State licensure or certification requirements are met". The Code of Federal Regulations also requires, under 42 CFR 441.302, that the Medicaid agency must provide satisfactory assurance that "...the standards of any State licensure or certification requirements are met for services or for individuals furnishing the services under the waiver; and ...assurance that all facilities covered by section 1616 of the Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities."

According to DHHS waiver program staff, because the waiver funding does not cover room and board, as long as a facility or program maintained its license, the waiver requirements would be satisfied. However, it is difficult for DHHS to provide the required assurances to CMS when agency staff do not receive the licensing reports and have no information regarding how the standards are enforced by DDSN. In contrast with the requirements for ICF/MR, which call for an independent licensing and certification reviews by DHEC, we must rely on DDSN to enforce its own standards for health and safety of consumers in the MR/RD waiver program. Therefore, DDSN needs to communicate serious deficiencies identified by its State Licensing Division to DHHS, and demonstrate what it has done to enforce these standards, so that DHHS can fulfill its responsibility of ensuring the health and safety of waiver clients and that providers are meeting waiver standards.

PENALTIES INFREQUENTLY ASSESSED FOR LICENSING VIOLATIONS

Only a small number of community residential facilities have been closed by DDSN as a result of serious licensing and certification violations found during annual licensing reviews. If a deficiency noted during a DDSN licensing review is so serious that it reflects neglect or abuse of a client, DDSN has the ability to require the provider to take immediate corrective action. According to DDSN, this means the inspectors will not leave a facility or residence until the problem is corrected. For example, a DDSN inspection of a Babcock residence in 2004 found sharp knives unsecured in a kitchen drawer. A lock was replaced on the drawer before the surveyors finished their inspection and exited the building.

We could not identify any provision in its enabling legislation that would allow or require DDSN to penalize DSN Boards for failure to meet minimum licensing standards for residential facilities. Section 44-20-770 of the SC Code of Laws requires DDSN to deny, suspend, or revoke a license for a day facility on any of the following grounds:

- (1) Failure to establish or maintain proper standards of care and service as prescribed by the department;
- (2) Conduct or practices detrimental to the health or safety of residents or employees of the day program. This item does not apply to healing practices authorized by law;
- (3) Violation of provisions of this article or regulations promulgated under it.

The standard DDSN contract with the DSN Boards also provides that in the event a provider loses its license from DHEC or DDSN to operate any of the facilities funded through the contract, that particular facility's participation in the contract will be terminated as of the date of decertification or loss of licensure.

In addition, DDSN's internal policy states that, if a re-visit to either a residential or day facility cited for discrepancies determines that the plan of correction has not been implemented, depending on the seriousness and duration of the violation, DDSN may administer the following sanctions:

- Issuing a provisional license with a shorter expiration date;
- Reducing the capacity of the program;
- Suspending or reducing financial payments; and
- Denying, suspending, or revoking the facility's license or certificate.

DDSN does not keep a database to show how often it has applied any of the above sanctions to DSN Boards or other providers for serious licensing or certification discrepancies. During the course of this audit, DDSN furnished us with documentation showing that since December 2001, five residential facilities at four different DSN Boards have either been closed or lost licensure/certification as a result of facility inspections, necessitating the re-location of a total of nine MR/RD waiver clients.

Also, until recently, DDSN had only three state licensing coordinators (surveyors) to perform inspections. Due to the small staff size, these surveyors were unable to conduct follow-up reviews and only performed annual reviews, but they did determine whether deficiencies noted in a prior review had been corrected. In August 2005, DDSN hired a fourth staff person to conduct follow-up inspections, re-directed three additional staff to perform license and certification inspections on a part-time basis, and developed a draft protocol. The protocol provides that DDSN may conduct a follow-up review when there is a significant deficiency related to health, safety, or management of funds or when there are a significant number of repeat deficiencies from the prior year(s). However, the protocol does not specify at what point, if a DSN board fails to improve conditions at its residential or day facilities, DDSN would begin applying the penalties according to its policy.

Chapter 3: WAIVER FUNDING SYSTEM

One of our audit objectives was to review the method used to fund services for Medicaid-eligible clients in the Mental Retardation - Related Disabilities (MR/RD) waiver program. We have reviewed the capitated or "band" payment system implemented by DDSN as well as the system for providing extra funds for waiver clients with special needs ("outlier funding"). We did not find that band payments contravened any Federal regulations, and do not have any recommendations for dramatically altering this system.

Overall, we concluded that the current method for funding the waiver program is similar to average per diem payments made for other types of Medicaid services, and as such may be an effective method of channeling funds to direct care providers. However, we noted several areas of concern, including:

- The difficulty in comparing band payments with actual Medicaid reimbursement;
- Band payments for low-cost clients subsidize the care for high-cost clients;
- Minor discrepancies in the documentation for outlier funding.

We also noted that DDSN has improved its process to ensure that all residential outliers are re-justified in writing. We also found that while some types of residential facilities were less expensive for the boards to operate, and thus the boards had revenues in excess of costs for these homes, this did not seem to be influencing where clients were placed.

The Band Payment System

DDSN contracts with a network of DSN Boards to provide or arrange for an array of services to clients, most of who are eligible for Medicaid funding. The band payments from DDSN to the DSN Boards comprise an advance payment system for both ICF/MR services as well as for home and community-based services. At the beginning of each month, DDSN advances funding to each DSN Board based on the number of clients within each "band" at that particular board. There are five different bands and statewide rates. (See Table 6, p.26) The rate depends on the level of residential care and intensity of services that the clients in each band are expected to need.

The DSN Board provides the services required by the clients' individual plan of care ("single plan") and then sends service provision logs to the DDSN central office by the 5th day of the following month. DDSN processes the expenditures and mails the Medicaid-reimbursable portion to DHHS for payment. The Medicaid reimbursement for waiver services is based on average, statewide interim rates that are later settled to actual costs. Multiple services are bundled into a single rate, and there are individual rates for the residential program, adult day program, respite care, and personal care. DDSN is paid the same rate for each waiver client depending on the individual service and number of units provided. In other words, DDSN is *not* reimbursed the same amount it had forwarded to the DSN Boards but rather is reimbursed based on individual service rates.

Table 6: Statewide Band Rates, 2003

Category	Description	Identifiers	Statewide Rate
At Home - Day Supports	Individuals who live at home and only receive day habilitation support	A	\$7,715
At Home - Enhanced Support	Individuals who live at home and receive day habilitation and enhanced waiver services	B	\$12,544
Residential Low Needs	Individuals in supervised living arrangements who do not need intensive supervision	C	\$19,434
Residential Low - To -Moderate Needs	Individuals in community residential care facilities and CTH II homes who need more care	D	\$45,076
Residential High Needs	Individuals also in CRCF and CTH II homes, as well as ICF/MRs, who need intensive services	E	\$65,567

Source: Request for Proposal, Services to Consumers with Mental Retardation, Related Disabilities or Autism and Services Specialized for Consumers with Traumatic Brain Injury, Spinal Cord Injury, or Similar Disability for SCDDSN. See Appendix A for a more detailed description of these programs.

DDSN is required to furnish the state share out of its own state general fund appropriations and other sources of funds eligible for matching purposes. DHHS reimburses DDSN for the federal share (approximately 70%) of Medicaid costs incurred.

Not all the costs covered by the band payments are Medicaid-reimbursable. DDSN uses the band system regardless of whether the client and/or the service are Medicaid-eligible. Some clients are private-pay, and not all services provided by the DSN Boards can be covered by Medicaid.

The band payment is expected to cover all waiver program costs for clients, even though some waiver services, such as dental care and additional prescription drugs, are not provided by the DSN Board but by private providers who bill Medicaid directly. Each month, DDSN receives a tape from DHHS with information on the amount of services for waiver recipients billed directly to DHHS; DDSN then subtracts this amount from each DSN Board's next band payment.

Since the bands are *average* payments, there can be a variation of client needs within each band. For example, one client in Band C may not need \$19,434 worth of services and another client may need more. The board does not have to spend the band amount "generated" by a client on that client. Once the total budget is determined, DDSN allows the boards to spend the band funding within all of the programs, as long as individual client needs are met. Finally, some clients have costs so far above the average that DSN allows extra funding, called "outlier" funding, for these clients. This is discussed further on pages 29-30.

COMPARING BAND PAYMENTS TO MEDICAID REIMBURSEMENT

In our review of the band payments, we concluded that there are no Medicaid compliance issues involved because the band payment is not a Medicaid payment from DHHS to the DSN Boards. Medicaid funds are not an issue until DDSN bills DHHS and is reimbursed for Medicaid waiver services. However, the band payment system does make it almost impossible to connect allocated funds (the band payment) with actual expenditures for an individual client's care and Medicaid reimbursement for that cost. The following table for two waiver recipients compares their band and outlier payments and actual expenditures for their care with the Medicaid reimbursement recorded for them in FY 2003.

Table 7: Comparison of Band Payments with Costs and Reimbursements

	Band & Outlier Payments	Client Fees	Total Board Expenditures	Medicaid Allowable Costs	Medicaid Reimbursement
Client # 1	\$102,109	\$4,800	\$114,733	\$109,150	\$77,912
Client # 2	\$162,975	\$4,800	\$170,837	\$158,921	\$88,265

Source: "Band & Outlier Payments," plus the "Client Fees" were the revenues the DSN Board received for those clients in FY 2003; "Total Board Expenditures" includes room and board, which are not allowable Medicaid costs for reimbursement. "Medicaid Allowable Costs" are the costs remaining after room and board are subtracted. Both "Total Costs" and "Medicaid Allowable Costs" are based on the FY 2003 audited financial statement of the DSN Board that serves these individuals as well as DDSN waiver cost schedules. The "Medicaid Reimbursement" is based on the claims for FY 2003 adjudicated by the DHHS Medicaid Management Information System.

This table illustrates the fact that neither the Medicaid reimbursement nor the band payments are a reliable indicator of what is actually spent to care for an individual receiving MR/RD waiver services. According to DDSN, the DSN Boards are not able to track costs for each individual client. While the audited financial statements of the DSN Boards provide specific cost data, for most waiver clients this is only at the individual residential or program level. For example, both the Disabilities Board of Charleston County and Babcock Center, Inc.'s, audited financial statements contained a schedule of revenues and expenses for each CTH II and CRCF managed by the boards. Most of these residential facilities have three or four beds. We could review the individual costs for the two clients shown in Table 6 above because they lived in single-bed CTH IIs.

We conducted a limited test to ensure that, for clients in the residential bands, there were charges to Medicaid for MR/RD waiver services. DDSN also reviews a monthly report that shows the clients' residential placements and makes sure this is in line with the band payment levels as shown on Table 6.

BANDS NOT A DISINCENTIVE TO LEVEL OF PLACEMENTS

We also sought to determine whether the band payment system provided any disincentives to placing clients in the most appropriate residential facility. Again, we tested these issues with only two boards, Charleston and Babcock. The audited financial statements for each board show a statement of revenues and expenditures broken out by each residential facility. Revenues are primarily the band payments received from DDSN plus client fees; expenditures are all costs, not just Medicaid allowable costs. With Charleston, the majority of the CTH II homes (which house the largest share of clients), the four ICF/MR facilities managed by the board, and one of the two community residential care facilities had expenditures greater than the revenues in FY 2003. The supervised living residences (SLP I), which are also for those clients with the lowest level of need, had revenues exceeding expenditures by a total of \$293,512. With Babcock, the CTH II homes also experienced net losses as well as its SLP II homes in FY 2003. Babcock had excess revenue with its SLP I homes, CRCF, and CTH I homes.

One could conclude, therefore, that under a capitated funding system the DSN Boards made a "profit" from the clients in the SLP I homes. However, as noted, the DSN Boards are allowed to spend their revenues where needed, and the band payment associated with a particular client does not have to be spent on that client – a client can cost more or less than his or her band. For both Babcock and Charleston, the majority of the consumers were in CTH II homes, not in supervised living arrangements. Therefore, while the boards' expenses were less for the SLP I homes, this did not seem to be driving where clients were placed.

The imbalance between revenues and expenditures may also mean that DDSN should adjust the band payments to better reflect actual costs for the different levels of residential facilities. It also indicates that the band payments received for low cost clients are subsidizing the high cost clients. According to DDSN, it is seeking additional state funding in order to re-base the band payments so that actual cost of care can be covered.

Recommendation

12. The Department of Disabilities and Special Needs should review the adequacy of band payments compared to local Disabilities and Special Needs Boards' expenditures and adjust the band payments to better reflect actual costs for the different levels of residential facilities.

HIGH COST OF SOME WAIVER CLIENTS

The costs to care for a limited number of consumers in MR/RD waiver program are high, but we found no indications that the waiver program does not meet required financial conditions. In the waiver agreement with the federal Centers for Medicare and Medicaid Services, DHHS provides three financial assurances about waiver costs:

- The average per capita expenditures under the waiver will not exceed 100 percent of the average per capital expenditures for institutional care (ICF/MR).
- Actual total expenditures will not exceed the cost of institutional care.
- The state will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care in an ICF/MR.

DHHS provides an annual report to CMS showing all MR/RD waiver and other Medicaid expenditures-versus the ICF/MR costs. For federal fiscal year 2003, DHHS reported that the average cost for a waiver recipient was \$42,263 versus \$75,042 for an individual in an ICF/MR. This cost includes waiver services as well as the cost of other Medicaid services, such as inpatient hospital.

However, some individuals in the waiver program exceeded the average cost of care in an ICF/MR. For example, the Medicaid reimbursement for the two individuals in Table 7 was \$88,265 and \$77,912. This understates the actual cost of their individual care because, as noted, the Medicaid reimbursement is based on an average rate for all waiver recipients in residential care plus any individual services directly billed to Medicaid. The allowable Medicaid cost for these individuals was actually \$158,921 and \$109,150, respectively. In addition, annual costs for waiver individuals do not include subsequent cost settlements to DDSN.

However, we found no evidence that serving these consumers in an institutional setting as opposed to a home and community-based setting would have been more cost-effective. The two consumers reviewed were high-cost because of enhanced staffing needs, and the cost to serve these individuals would be high regardless of where they were placed.

Even as some clients in the MR/RD waiver are very expensive to serve, there is a waiting list for waiver services. As of August 2005, there is a regular waiting list of 750 for the MR/RD waiver program plus a "critical" waiting list of another 20 individuals. According to DHHS program staff, consumers on the critical list are waiting on average one to two months, while consumers on the non-critical list may remain there indefinitely.

Review of Outlier Payments

In cases where a consumer's circumstances and needs are substantially higher than average, a DSN Board may receive additional funding from DDSN equal to the difference in the consumer's approved budget and the consumer's band amount. This additional funding is referred to as "outlier funding". The main triggers for outlier funding are the need for intensive nursing care for medically-fragile individuals, many of whom live at home, or for one-on-one staffing for individuals with severe medical, behavioral, and/or other problems. DDSN has established outlier thresholds where the costs for caring for a client must exceed a certain dollar amount before the DSN Board is

eligible to request outlier funding from DDSN. Effective July 1, 2004, these thresholds are \$85,718 for consumers residing in a residential facility and \$28,560 for consumers living at home.

As of July 2004, a total of 8,239 DDSN clients were funded through the band payment system; 259 or 3% were "outlier" cases that required the increased funding. The two boards reviewed in detail - Charleston and Babcock - received the following band and outlier payments in FY 2003:

Table 8: Outlier Payments for Two DSN Boards, FY 2003

Board	Clients in Bands	Outlier Cases	Band Payments	Outlier Payments	Total Payments
Charleston	526	22	\$12,066,409	\$822,709	\$24,504
Babcock	1,134	76	\$36,695,279	\$2,786,726	\$34,817

Source: DDSN final totals as of November 2005. These figures include the waiver program and ICF/MR beds, and both Medicaid and non-Medicaid clients.

RE-JUSTIFICATION OF OUTLIER FUNDING

Prior to the *Limited Scope Review of Babcock Center, Inc.*, DDSN verbally obtained confirmation from waiver providers that consumers receiving outlier funding continued to have medical and/or behavioral conditions that would justify on-going need for outlier funding. DDSN assumed that providers would notify the agency whenever a consumer's needs changed and outlier funding would no longer be necessary. Due to the significant dollar amounts of outlier funding, we recommended in the *Limited Scope Review* that providers justify in writing to DDSN each year, waiver consumers continued medical and/or behavioral need for greater services.

In response, DDSN established a new policy requiring DSN Boards to re-justify in writing each consumer's medical and/or behavioral condition to show their continued need for outlier funding. The policy also requires that the DSN Board's executive director submit a signed "Certification Statement". DDSN set April 15, 2004, as the due date for providers to submit initial re-justification documentation to the agency, and also required all residential outliers to be re-justified in writing each year within 30 days following the annual plan date noted on DDSN's Service Tracking System. Failure by the DSN Board to submit re-justification within this time period would result in the discontinuance of outlier funding. Outlier funding for nursing services was not required to be re-justified, as this is adjusted quarterly by DDSN based on the level of services delivered.

The following schedule summarizes the results of the initial re-justification for Charleston and Babcock:

Table 9: Results from Initial Re-Justification

Description	# of Consumers	
	Charleston	Babcock
Continued outlier funding approved	3	25
New outlier funding approved	1	0
Paperwork not submitted to continue outlier funding	0	18
Outlier funding approved through 6/30/04, then funding transferred to another consumer	2	0
Outlier funding approved through 6/30/04, and not transferred to another consumer	0	4
Totals	6	47

Source: DDSN Schedule, Residential Outliers by DSN Board, as of April 9, 2004. Does not include nursing outliers.

USE OF OUTLIER FUNDING BY DSN BOARDS

We reviewed a sample of MR/RD waiver clients at Charleston and Babcock to determine whether the recipient's file adequately documents the need for enhanced services requiring outlier funding, and in general to verify compliance with other waiver requirements. Although the overall purpose of this audit is to review the MR/RD waiver as operated by DDSN, we conducted site visits to review MR/RD waiver client records in order to identify any problems with outlier funding that may necessitate further review.

Using outlier re-justification schedules prepared by DDSN, we selected eight waiver recipients at each DSN Board — including at least one recipient for each of the following criteria: continued outlier funding was not requested by the DSN Board; outlier funding was requested to be discontinued as of July 1, 2004, by the DSN Board; or continued outlier funding was requested by the DSN Board. We also selected several Medicaid recipients who received nursing outliers at these two DSN Boards. Using these criteria, the following sample was developed:

Table 10: Medicaid Recipients Reviewed

Criteria	# of Consumers Reviewed	
	Charleston	Babcock
Nursing outlier	5	2
Continued outlier requested	2	2
Outlier not requested	1	2
Discontinue outlier 7/1/04	0	2
Total Consumers Reviewed	8	8

*Note: Charleston did not have any consumers that met this criterion.

Although we found some minor discrepancies, we do not believe systematic problems with justification for outlier funding were identified that would necessitate further review. In general, our review found that documentation was sufficient and complete at both boards for the consumers where continuation of the residential outlier funding was

requested. However, for two consumers at each DSN Board, where residential outlier funding was provided for the consumers to have one-on-one and/or enhanced staffing, accountability (monitoring) was not consistently documented, progress notes were not consistently completed for each shift, dates were incorrectly shown, and some required activities were not provided. The boards are supposed to maintain sufficient documentation showing that appropriate monitoring was provided to these clients. Also, the DDSN policy implemented in April 2004 for use of outlier funding requires that "Services provided to residential outliers must be properly documented and accounted for." Specific findings for each board are as follows:

Charleston Review Results

- A reasonable and justifiable explanation was provided for the consumer where outlier funding was not requested.
- Fifteen Single Plans were in effect during the audit scope (FY 2004). Of the 15 single plans reviewed, eight (53%) had various minor errors, including questions not being answered, services not being properly or consistently shown throughout the plan, and changes to the plan not being initialed and dated. One major deficiency noted was that Charleston was unable to produce a signed signature page for one single plan documenting the individuals attending the planning meeting.
- The most significant deficiency found concerned one consumer whose behavior was not being formally reviewed and assessed, due to lack of resources in the Charleston area relating to behavior support and because this client chose not to work with a certified staff member at the Disabilities Board of Charleston County.

Babcock Review Results

- Review of consumers where outlier funding was not requested or where outlier funding was requested to discontinue July 1, 2004, clearly showed that Babcock had in the past failed to notify DDSN when consumers' needs changed or they were moved to other facilities. This occurred prior to the re-justification policy implemented by DDSN.
- The Richland/Lexington DSN Board (Rich/Lex) provides service coordination for MR/RD waiver clients served by Babcock. Eleven single plans were in effect during the audit scope for the six consumers selected for review that were not nursing outliers. Of the 11 single plans, 100% had various errors that showed a lack of communication and coordination between Babcock and Rich/Lex. Specifically, we found that Babcock did not have all pages of one plan; another single plan was not updated for changes in the client's medication; and two consumers' plan were not updated for changes in their accountability levels.

- Two consumers' files did not adequately document whether they received the medical and/or dental treatment identified in their single plans and when, and under what conditions, one-on-one staffing should be provided.

Because Babcock employees are involved in the consumers' day-to-day lives and are familiar with medical, physical, and other changes, it is important that Babcock keep Richland/Lexington DSN Board apprised of changes made as a result of called team meetings, medical appointments, etc.

Recommendations

13. The Department of Disabilities and Special Needs should work with the Richland/Lexington Disabilities and Special Needs Board and the Babcock Center, Inc., on developing better communication and coordination of care for consumers served by both boards.
14. Both the Babcock Center, Inc., and the Disabilities Board of Charleston County should ensure that they are following policy promulgated by the Department of Disabilities and Special Needs regarding proper documentation of one-to-one staffing and uses of residential outlier funding in consumer's single plans.

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Chapter 4: COST REPORTS AND ADMINISTRATIVE EXPENDITURES

Included in our audit objectives was to determine whether MR/RD waiver program costs are properly settled in compliance with Medicaid reimbursement methodologies, whether there are program safeguards to ensure that only allowable costs are born by the Medicaid program, and whether appropriate fiscal oversight of the waiver is provided. In this section we review the process used by DDSN and the DSN Boards to report costs attributable to the Medicaid MR/RD waiver and institutional care. These cost reports are critical in that they are the basis for cost settlements made by DHHS to DDSN, and also are the basis for setting future rates for Medicaid reimbursement for waiver services. Our review of the audited financial statements, cost reports, and reconciliations for FY 2003 identified some questions and concerns about the waiver program, including:

- Some unallowable costs are included in the cost reports which are used to establish rates and cost settlements;
- The wide variance in waiver program costs between DSN Boards; and
- There is a lack of fiscal oversight of the MR/RD waiver program on the part of both DHHS and DDSN.

We also determined the percentage of administrative and program operating costs compared to direct service costs for the MR/RD waiver.

The Cost Reporting Process

DHHS contracts with DDSN as the provider of Medicaid waiver services. The contract requires DDSN to submit cost reports that support the expenditures incurred, which will be used to settle interim reimbursement rates to actual costs. Two types of cost reports are used: regional cost reports and Medicaid MR/RD waiver specific cost reports.

There are four regional cost reports (Midlands, Piedmont, Coastal, and Pee Dee) that correspond with the four Medicaid provider identification numbers for the MR/RD waiver services. The regional cost reports include all DDSN program costs, not just Medicaid costs. In addition to expenditures for the waiver program, the regional cost reports also include other DDSN programs as well as ICF/MR costs for those facilities reimbursed through the DSN Boards. (The ICF/MR facilities, which contract directly with DHHS to provide institutional care, file individual cost reports with DHHS.)

The regional cost reports are also used as a mechanism to allocate DDSN's administrative costs for the central state office in Columbia, plus overhead and other general costs, to the four regions. The reports use a step-down methodology to allocate these costs to the various programs within each region. The various components of the waiver program are rolled into one "cost center" for the regional cost reports.

For the Medicaid MR/RD waiver specific cost reports, the DSN Boards compile waiver expenditures by type of program and facility (SLP I, SLP II, CTH I, etc.) at the end of each state fiscal year. DDSN also requires that each board submit an independent audit of its financial statements, as well as a reconciliation of the waiver cost reports to the audited financial statements. Costs attributable to Medicaid recipients are calculated based on the percent of Medicaid recipient attendance in the various programs.

The total waiver cost for each region is then reported in a combined report to DHHS. Staff in the DHHS Division of Ancillary Reimbursements perform a desk review of this report, which becomes that basis for rates paid for MR/RD waiver services. These rates are then used to calculate a final payment to DDSN. If the federal share of actual expenditures reported in the waiver cost reports exceeds what DDSN has received in monthly Medicaid reimbursements from DHHS, then DDSN receives an additional payment or cost settlement from DHHS. If costs are less, DDSN owes DHHS. The cost settlement completes the funding cycle begun by the band payment that DDSN forwards to the boards (see page 25).

COSTS OF WAIVER ADMINISTRATION

Use of Funds for Direct Care

One concern has been whether DSN Boards spent the majority of the band payments on client care. For waiver services plus ICF-MR facilities DDSN requires local boards to spend 98% of their revenues on client services. Funds remaining after the 98% are spent can be used for a two-month reserve for times when the band payments do not cover all of a board's costs. At the end of each year DDSN requires a reconciliation from the boards to show that 98% of revenues, based on the audited financial statements, were spent. If the boards spend less than 98%, they must refund the difference to DDSN.

The total costs for the boards' programs, with the exception of depreciation on buildings and assets, are included in the 98% calculation. This includes all salary and operating costs associated with direct client care and the DSN Boards' overhead and administration. (Allocated costs for central state office functions are not included in the 98% calculation.) Because of the method used by DDSN to account for program costs, administration and overhead are rolled up in the client cost. Therefore, while the boards are required to spend 98% of their revenues on client services, the boards' administrative costs are considered part of client service for this calculation and thus become part of the Medicaid waiver rate.

The audited financial statements are the main sources of information about how the DSN Boards spend their revenues, which include band payments and other sources of funds. As far as we could determine, there is not a waiver requirement for a Medicaid-specific audit.

Administrative Costs

We tried to determine what percent of waiver costs claimed for reimbursement in FY 2003 were administrative costs, including both administration by DSN Boards and by DDSN central state office. Administrative costs for the waiver program include DSN Board-level costs (such as for program supervisors, financial staff and the executive director) and central state office costs of DDSN itself. As noted above, allowable central state office costs are allocated based on a "step-down" in the four regional cost reports, and the waiver program gets its share based on total waiver expenditures versus the rest of the programs for DDSN clients. DDSN central state office administrative and other costs allocated to the MR/RD waiver program were \$10,087,085 in FY 2003, or 6.88% of the \$146,580,911 total waiver costs reported for the four regions. According to DDSN financial officials, slightly less than half of this amount, \$4,971,589, are program costs directly tied to operating the waiver program. For example, this figure would include the annual cost for the First Health quality assurance contract.

The following table illustrates the administrative costs reported for the MR/RD waiver program for FY 2003 for Babcock and Charleston, with a pro-rated share of DDSN's central office administration and other overhead costs from the regional cost reports.

Table 11: Administrative Costs for Charleston and Babcock's Waiver Programs

Expenditures	Charleston	Babcock
Board Waiver Cost	\$7,947,236	\$21,255,513
DSN Board Level Administration	\$759,403	\$1,595,336
Percent of Total Waiver Cost	9.6%	7.5%
Allocated Central State Office and Waiver Operational Costs	\$578,607	\$1,350,448
Percent of Total Waiver Cost	7.3%	6.4%
Total Administration & Allocated Costs	\$1,338,010	\$2,945,784
Percent of Total	16.8%	13.9%

Source: 2003 Audited Financial Statements and 2003 Coastal and Midlands Regional Cost Reports.

These waiver administrative expenses do not include the costs for the management functions performed by DHHS. We estimated this could add up to one percent. Therefore, waiver operating and central office overhead costs which look relatively minor from the regional cost reports could actually be close to 15% - 18% of direct service expenditures when administrative and allocated costs are added together.

As noted, DDSN's administrative costs illustrated in Table 11 are not separated from the direct service costs, but rather are included in total waiver costs that become the Medicaid rate paid for waiver services. Therefore, these costs are reimbursed with federal Medicaid funds on a 70-30 ratio that is used for direct Medicaid services. DDSN and the DSN Boards are an "organized health care delivery system" (OHCDs), and therefore all waiver allowable costs are eligible for the 70% federal Medicaid funds.

ADEQUACY OF FUNDING

One concern was whether the DSN Boards received adequate funding from DDSN in order to provide for client needs. The past three cost reporting cycles where a settlement has been finalized (FY 2000 through FY 2002) have resulted in a cost settlement to DDSN. This means that expenditures as shown in the cost reports were higher than what the Medicaid rate covered, so DHHS made another payment of federal Medicaid funds to DDSN for the difference. DDSN retained these funds; they were not passed on to the DSN Boards because DDSN had already advanced them funding through the band and outlier payments.

According to DHHS staff in the Division of Ancillary Reimbursements, the waiver rate was increased after several years of cost settlements to DDSN in order to more accurately reflect costs and thus avoid large cost settlements every year. However, for FY 2003; DDSN received more federal Medicaid revenues than allowable waiver cost. DDSN has already made an interim cost settlement of \$2,150,000 to DHHS, although the final amount is still under review.

When either DDSN or a DSN Board spends less than revenues, both must refund the excess – the board to DDSN, and DDSN to DHHS. If DDSN reports allowable waiver costs higher than the Medicaid reimbursement, then DHHS provides additional federal Medicaid funds toward the difference. However, if a DSN Board spends more than its band payment and other revenues, as did Charleston and Babcock in FY 2003, there is no cost settlement to the board. The boards are expected to cover any losses with their reserves. These reserves consist of unexpended band payments (up to 2% per year) plus other revenues.

DDSN does not automatically pass on increased waiver rates in the form of higher band payments to the DSN Boards. It should be noted that at the end of fiscal years 2004 and 2005, the band payments were increased to reflect insurance rates and state employees' pay increases mandated by the General Assembly. However, these band increases were not reflective of any general increases in the DSN Boards' costs.

Both boards that we reviewed had total expenditures greater than total revenues in FY 2003, as indicated in Table 12. (However, these operating losses also include depreciation of capital assets reported as an expense.) Also, both Babcock and Charleston had fund balances remaining, although in FY 2004 Babcock Center again experienced financial deterioration with a decrease in net assets of \$4,340,739. The external auditors also found weaknesses in internal controls that were reported in a management letter to the Babcock Board of Directors.

On a statewide basis, according to information provided by DDSN, total deficit experienced by the DSN Boards amounted to \$6,041,463 – this included all sources of funding and all program expenditures. Again, accounting for depreciation is part of the reason for the boards' deficits and not necessarily inadequate band payments. The accumulated fund balances for all boards amounted to \$16.9 million.

Table 12: Changes in Net Assets for FY 2003: Charleston and Babcock

	Charleston	Babcock
Total Program Revenues	\$16,409,525	\$41,247,224
Total Expenditures	16,525,599	43,269,434
Other Gain (Loss)	(14,152)	777,037
Changes in Net Assets	\$(130,227)	\$(1,245,172)
Remaining Fund Balance	\$529,127	\$3,265,041

Source: DDSN and the DSN Boards Audited Financial Reports, 2003. Includes all programs, not just the MR/RD waiver.

Variance in Waiver Residential Costs

There is a wide variation in the cost to provide Medicaid waiver services between the individual DSN Boards. The waiver cost reports submitted to DHHS provide a basis for determining the "unit" (per diem) cost for the different services. The largest cost is for residential services. This includes Medicaid allowable costs for the community training homes, the community residential care facilities, and the supervised living program II, as well as for enhanced waiver services such as physical, occupational, and speech therapy and psychological services. The variance in residential costs is illustrated below for boards in the Midlands (Babcock) and Coastal (Charleston) regions, with the highest and lowest board within both regions.

Table 13: Variance in Unit Costs for Residential Waiver Services, FY 2003

	Lowest Board	Babcock	Charleston	Lowest Board	Highest Board
Per Diem Cost	\$144.49	\$140.83	\$133.87	\$96.20	\$185.54
Variance		-2.5%	-7.4%	-33.4%	28.4%

Source: Home and Community Based Waiver Statement of Reimbursable Cost.

In conclusion, in 2003 the DSN Boards in general had costs higher than the band payments received from DDSN plus other revenues, but their accumulated fund balances provided a cushion. During the same year, total cost for waiver services was lower than the Medicaid funds reimbursed to DDSN, and DDSN was required to refund this excess to DHHS. Therefore, based on financial reports for FY 2003, we found no evidence that the band payments were inadequate that year, although some boards may have more difficult financial circumstances than others.

UNALLOWABLE EXPENDITURES

We also sought to identify what controls are in place to ensure that only actual waiver program costs, that are allowable and related to client care, are attributed the Medicaid program. Federal law does not allow the Medicaid program to pay for all costs incurred by DDSN clients in the waiver program. We reviewed audited financial statements for

both Babcock and Charleston in order to test, in a limited fashion, the appropriateness of costs claimed for reimbursement under the waiver program.

Unallowable expenditures for room and board are deducted from the waiver cost reports since Medicaid cannot pay for these kinds of expenditures; they are supposed to be paid by client fees. This would include costs for rent, repairs and maintenance, telephone, utilities, basic groceries, depreciation and insurance. However, we determined that some housing-related costs, including household and maintenance supplies, exterminating, and trash removal, are included in the waiver cost reports submitted for Medicaid reimbursement. The following table shows the FY 2003 expenditures reported by Charleston and Babcock in these categories for the CTH II homes managed by the boards.

Table 14: Housing-Related Costs Included in Waiver Rate

	Babcock CTH II Homes	Charleston CTH II Homes
Exterminating	\$28,005	\$8,505
Trash removal	11,138	Not specified
Household Supplies	99,393	35,922
Maintenance Supplies	43,914	10,019
TOTAL	\$182,450	\$54,446

Source: Audited financial statements for The Babcock Center, Inc, and the Disabilities Board of Charleston County, for FY 2003

Federal guidance on what should be included as room and board is not detailed. However, DDSN recently provided guidance to the DSN Boards which identifies specific room and board costs that should be included in client fees, including the cost categories of exterminating, trash removal, and maintenance and household supplies. In addition, DHHS waiver program staff told us that they did not intend for the waiver program to include these kinds of costs within its services. Although these costs would have been included in the 2003 waiver cost report, their inclusion did not have a material effect on the statewide waiver rates.

Recommendations

15. The Department of Health and Human Services Division of CLTC Waiver Management, in conjunction with Division of Ancillary Reimbursements, should review all costs currently charged to the MR/RD waiver program and determine which costs are appropriate and allowable. This review should incorporate DDSN waiver cost reports and schedules.
16. The Department of Disabilities and Special Needs should ensure that all room and board-related costs are deducted from waiver cost reports beginning with cost reports for FY 2005.

Audits And Fiscal Oversight

We concluded that there is a lack of fiscal oversight of the MR/RD waiver program on the part of both DHHS and DDSN, although DDSN staff conduct fiscal reviews of the DSN Boards in the process of compiling the Medicaid waiver cost reports. But DHHS performs only limited reviews of these reports, and DDSN's four regional cost reports are not subjected to any type of external audit.

REGIONAL COST REPORTS NOT AUDITED

As previously described, DDSN compiles four regional cost reports annually in order to report expenditures for the MR/RD waiver as well as other DDSN programs and services. These cost reports include all expenditures for the DDSN network of providers except for those ICF/MR and other programs that bill directly to DHHS. These statements establish the direct service costs, as well as the allocated costs for central administration and overhead, for reimbursement by Medicaid. Information from the regional cost reports is used in the MR/RD waiver specific cost reports, which in turn establish waiver per diem rates and cost settlements.

As far as we could determine, there have been no reimbursement audits performed on the regional cost reports in recent years. This holds true for costs for the ICF/MR facilities in addition to the MR/RD waiver program. While the State Auditor's Office (SAO) conducts agreed-upon procedures of DDSN, as it does for state agencies in general, the SAO does not audit DDSN's cost reports. For FY 2003, the four regional cost reports together accounted for \$340,492,717 in costs for DDSN programs.

DHHS has a contract with the State Auditor's Office to regularly audit nursing home cost reports at least once every four years. However, no such provision exists for audits of DDSN expenditures.

As a result, there has been no external oversight of DDSN's spending to provide assurances that:

- All costs attributed to the waiver program are allowable and appropriate;
- Medicaid and other federal financial criteria are followed;
- The State Medicaid Plan and contracts between DHHS and DDSN are followed;
- Rates for reimbursement are reflective of costs;
- The central administrative and other DDSN costs are appropriate, Medicaid-reimbursable, and allocated to direct service lines on a statistically valid basis.

The Code of Federal Regulations requires that: "The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials." (42 CFR 447.202) DHHS could fulfill this obligation by requiring DDSN to obtain periodic external audits of the regional cost reports.

WAIVER SPECIFIC COST REPORT NOT AUDITED

The waiver specific costs of the DSN Boards are not routinely subjected to an in-depth audit, although they are subjected to a desk audit review process by staff at DDSN and DHHS. In addition, the waiver cost reports can be tied to the DSN Boards' audited financial statements. The Medicaid allowable costs are derived from the audited financial statements via a reconciliation process, and DDSN then aggregates these costs and reports them to DHHS in order to develop average rates for various waiver services. We tested the reliability of the waiver costs reported for two DSN Boards (Charleston and Babcock) by tracing waiver costs reported to DHHS back to the audited financial statements and DDSN reconciliation. While there were some minor exceptions, in general the audited financial statements supported the waiver costs claimed by the DSN Boards.

However, we found that DHHS staff in the Division of Ancillary Reimbursements are not reviewing the DSN Boards' audited financial statements as part of the waiver report desk review process. DHHS staff perform some limited audit steps on the waiver cost reports. For example, they review the math accuracies of the step-down allocations and also verify the days of service reported by DDSN with the reimbursements recorded in the Medicaid Management Information System. DHHS staff do not have any written desk audit procedures to guide this review. In addition, DHHS does not review DDSN reconciliation schedules that support costs reported in the waiver reports.

The external financial statements could provide some assurances that waiver costs are appropriate. For example, DDSN promulgates a provider audit policy that the DSN Boards are to follow for their audited financial statements. Among other things, this policy requires that the external auditors perform the following audit procedures:

- Reconcile adjusted allowable cost for Medicaid programs in the provider's (DSN Board) cost report to total program cost in the audit report;
- Review the cost allocation plans submitted by the DSN Boards;
- Gain an understanding of the controls over consumers' personal funds managed by DSN Board staff;
- Select a representative sample of the Medicaid billable services and determine that documentation is on file to support billings and ensure that supervisory staff are monitoring provision of services; and
- As part of expenditure test work, include a sample of financial transactions made by or on behalf of the executive director and top administrative staff of the DSN Board.

If the boards' external auditors are following this policy, it would help provide assurances that Medicaid funds for the waiver program are being spent appropriately. However, without reviewing the workpapers of the boards' external auditors, it is difficult to tell if they followed these procedures because reporting is done on an exception basis. Also, in our review of the audited financial statements for Babcock Center for fiscal years 2003

and 2004, we could not find a reconciliation of allowable Medicaid costs to total program costs. (Charleston's financial report did provide the reconciliation.)

The Code of Federal Regulations also requires that "the agency will assure financial accountability for funds expended for home and community-based services [and] provide for an independent audit of its waiver program..." (42 CFR 441.302) Because the waiver cost reports are not reviewed in-depth, DHHS lacks the assurance that the waiver reimbursement rates are based on reliable cost information and that the waiver program is paying only for allowable costs.

We also identified a need for periodic on-site audits of the waiver adult day rehabilitation and other programs at DSN Boards in order to verify client attendance as recorded on the service provision logs. Currently, this is not regularly audited although the DDSN internal auditor or its First Health quality assurance provider may sometimes review service logs. The Medicaid per diem rates reimbursed to DDSN are contingent upon allowable Medicaid costs divided by the number of patient days or units of service provided, so this factor is a critical component of the cost.

Recommendations

17. The Department of Health and Human Services should require the Department of Disabilities and Special Needs to obtain an external audit of the four regional cost reports on a periodic basis.
18. The Department of Health and Human Services staff in the Division of Ancillary Reimbursement should develop written desk audit procedures for the review of the Medicaid MR/RD Waiver cost reports. As part of these audit procedures, the division should ensure that the audited financial statements of a sample of DSN Boards and other supporting documentation are reviewed, including results of the required audit procedures and tests of Medicaid billable costs.
19. The Department of Health and Human Services should require DDSN to provide on-site audits of service provision logs maintained by local boards and programs.

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Appendix A: DEFINITIONS AND LEGAL AUTHORITY

Assessment: A method of determining a consumer's current long term care needs through the use of a comprehensive standard instrument.

Babcock Center, Incorporated (Babcock or Babcock Center): A private, non-profit organization founded in 1970 serving people with mental retardation, autism, head and spinal cord injury, and related lifelong disabilities. In order to receive services from the Babcock Center, individuals must be determined eligible for services from the SC Department of Disabilities and Special Needs. Babcock Center provides Medicaid services either under a subcontract with the SC Department of Disabilities and Special Needs or directly through a contract with SC Department of Health and Human Services.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services. CMS administers the Medicare program, Medicaid program, and State Children's Health Insurance Program.

Client Funds (also known as personal needs allowance/consumer funds): Funds received or retained by a resident for personal expenses and sometimes deposited and held in an account administered by a facility for the convenience of the individual.

Community Residential Care Facility (CRCF): A facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal care for a period of time in excess of 24 hours for two or more persons, 18 years old or older, not related to the licensee within the third degree of consanguinity. Included in this definition is any facility (other than a hospital), which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities. These facilities may be referred to as "assisted living" provided they meet the above definition of a community residential care facility.

Community Training Home I (CTH I): A residential placement similar to foster care in that a private citizen's home which is licensed and where the caregiver is a contract agency employee. Up to three individuals live in the home and receive personalized care, supervision and training.

Community Training Home II (CTH II): A home owned or rented by the agency where up to four individuals live. A caregiver may also live in the home or staffing may be provided in shifts. This model differs from the Community Training Home I placement because, if the caregiver changes, residents will not have to move.

Cost Report: The report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicaid program.

Disabilities Board of Charleston County (Charleston): The Board was established as provided in Act 1127 of 1974 of the State of South Carolina, as amended to develop, provide and improve community services for mentally retarded persons and others with

Appendix A: DEFINITIONS AND LEGAL AUTHORITY

disabilities and special needs, including autism, head and spinal cord injuries and any other disability not covered by any other

state agency. The Board is qualified to receive funding through its various contacts with the SC Department of Disabilities and Special Needs. The Board also receives funding for its programs from Charleston County, fees charged to individuals served, and various other sources.

Disabilities and Special Needs Board (DSN Board): A local Board which has been established pursuant to S.C. Code Ann. §44-21-810 *et seq.*, the members of which are appointed by the Governor or through the County Council authority and which provides, under contract with the SC Department of Disabilities and Special Needs and SC Department of Health and Human Services, comprehensive community services to eligible residents of a geographic service area designated by DDSN.

Federal Financial Participation (FFP): Any funds, either title or grant, from the Federal government.

Head and Spinal Cord Injury (HASCI) Waiver: A 1915 (c) Medicaid waiver that addresses the long term needs of persons with Head and/or Spinal Cord Injuries.

Home and Community-Based Waiver: A special Medicaid program operated under Section 1915 (c) which allows the provision of a special package of approved services to a defined target population with long term care needs.

Intermediate Care Facility for the Mentally Retarded (ICF/MR): A health related facility which meets the requirement for state licensure to provide care to persons with mental retardation who do not need care in a hospital or skilled nursing facility.

Memorandum of Agreement (MOA): A legal document that binds two or more parties outlining their scope of responsibilities one to the other.

Mental Retardation and Related Disabilities (MR/RD) Waiver: A 1915 (c) waiver which provides a broad range of special home and community-based services to Medicaid eligible individuals with mental retardation or related disabilities to help them live in the community rather than an institution.

Recoupment: Funds previously paid to a provider of Medicaid services or sub-grantee of the state's Medicaid program in error or determined, by post-payment review, to have been improperly paid and returned to the department or withheld from payments owed to the provider or sub-grantee.

Sanction: A penalty imposed for failure to meet standards or improperly billing Medicaid.

Appendix A: DEFINITIONS AND LEGAL AUTHORITY

Service Coordinator: A professional who assists Medicaid clients in accessing appropriate and available services. Also known as a case manager.

Single Plan: A document which provides a comprehensive review of a consumer's problems and strengths. Goals are set based on the consumer's identified needs, and interventions are specified to meet those needs. Also referred to as a plan of care.

Service Tracking System (STS): The Service Tracking System is DDSN's system for tracking information about the individuals applying for and receiving services. STS collects intake, eligibility, waiting list, service assignment, and service delivery data for billing and reporting purposes. The STS is primarily maintained by the staff assigned to coordinate services for individuals requesting/receiving services from DDSN.

SC Department of Disabilities and Special Needs (DDSN): The State agency that plans, develops, coordinates and funds services for South Carolinians with the severe, lifelong disabilities of mental retardation and related disabilities, autism, traumatic brain injury, spinal cord injury and similar disabilities.

SC Department of Health and Environmental Control (DHEC): The State health agency. Section 1864(a) of the Social Security Act directs the Secretary of Health and Human Services to use the help of State health agencies when determining if health care institutions meet provider certification to receive Medicaid reimbursement. 42 CFR part 488 sets forth that the State health agency performs surveys to support its certifications.

SC Department of Health and Human Services (DHHS): The State Medicaid agency as specified in 42 U.S.C. §1396 *et. seq.* and S.C. Code Ann. §44-6-10 *et. seq.* to administer the Medicaid Program in South Carolina.

SC Department of Social Services (DSS): The State agency authorized by the Omnibus Adult Protection Act of the South Carolina Code of Laws, to investigate all reports of abuse, neglect and financial exploitation of children and adults living in the community (non-institutionalized) and provide services. Services are provided to meet the adults' basic needs and to ensure their safety.

Supervised Living Program I (SLP I): The least restrictive residential placement which still provides staff oversight. Individuals live in apartments, duplexes or other housing and receive staff support and intervention based on personal need.

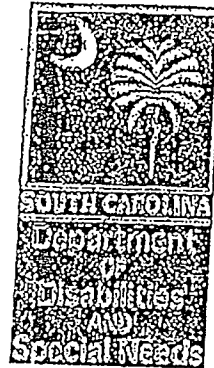
Supervised Living Program II (SLP II): Similar to the Supervised Living Program I, except residents need more supervision. Staff are on-site or available within three minutes (they usually live in another section of a duplex or apartment).

Title XIX: The Title of the Social Security Act dealing with Medicaid. Codified at Title 42 of the United States Code, Chapter 7, subchapter XIX (42 U.S.C. §1396 *et seq.*)

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Appendix B: Response from Department of Disabilities and Special Needs

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Ronald G. Dozier
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DDSN's Response to the Recommendations

DDSN is appreciative of the manner in which this audit was conducted and the willingness of DHHS staff to take the time and effort to understand the complexities and difficulties inherent in providing care for individuals with disabilities and their families. DDSN is also pleased that for the most part, we are meeting the State Medicaid agency's expectations. Importantly, the audit identifies a number of areas of improvement where the two agencies can collaborate.

1. DDSN will work with DHHS staff to revise the quality assurance process so as to satisfy the goals and needs of both agencies. DDSN recognizes that DHHS, as the Medicaid agency within the state, has final authority over all Medicaid expenditures and requirements.
2. DDSN will work with DHHS on a joint quality assurance and monitoring system for Medicaid services provided by DDSN.
3. Staff at DDSN will be designated to work with DHHS staff on developing a reporting process related to First Health findings and Medicaid recoupments.
4. A refund of \$422,077 will be made for FY 2003 and FY 2004 before the end of the current fiscal year.

5. DDSN staff will coordinate with appropriate DHHS division staff on potential Medicaid recoupments for FY 2005 related to First Health findings.
6. DDSN will coordinate with DHHS staff to implement the recommendations.
7. Starting with next year's review cycle, a timeline will be added for correction of serious deficiencies involving the health and safety of clients.
8. By the start of next fiscal year, DDSN will collect and share data concerning correction of serious licensing and certification violations and any sanctions that were applied with DHHS staff.
9. Starting with next year's review cycle, DDSN will ensure that copies of the annual licensing reports will be shared with the board members.
10. As DDSN continues to track its mandated reduction in program capacity of Babcock Center, Inc., the agency will update the status to DHHS staff.
11. DDSN will refund the Medicaid share of MR/RD waiver services provided when the licensing and certification inspections find that these services were not identified as a need or appropriately delivered as authorized in the consumers' single plans.
12. As noted in this audit, and as DDSN previously recognized, there is a need to adjust the band payments and the agency has requested additional funding as part DDSN's budget request for next fiscal year. DDSN intends to realign the rates next fiscal year if at all possible.
13. DDSN will coordinate with the Richland/Lexington County Disabilities and Special Needs Board and the Babcock Center, Inc., concerning better communication and coordination of care for consumers served by both boards.
14. By March 31, 2006, DDSN will review with both Babcock Center, Inc., and the Disabilities Board of Charleston County the policy concerning proper documentation of one-to-one staffing and uses of residential outlier funding in consumer's plans.
15. DDSN staff will work with DHHS staff on any cost reviews.
16. DDSN has already excluded any room and board-related costs from the waiver cost reports being prepared for FY 2005.
17. DDSN will obtain an external audit of the regional cost reports on a periodic basis as determined by DHHS.

18. DDSN staff will work with DHHS staff on any reviews.
19. Beginning next fiscal year, DDSN will provide for onsite audits of service provision logs maintained by local boards and programs.

**PROTECTION AND
ADVOCACY FOR
PEOPLE WITH
DISABILITIES, INC.**

October 27, 2005

The Protection & Advocacy System for South Carolina

Dear Elected Officials and Citizens of South Carolina:

South Carolina cannot wait to improve the protection of its most vulnerable citizens: persons with disabilities who reside in facilities across the state. The enclosed report, *Unequal Justice for South Carolinians with Disabilities: Abuse and Neglect Investigations*, clearly shows the need for an independent system within criminal justice to investigate ongoing abuse, neglect, and exploitation.

For many years, investigations of abuse, neglect, and exploitation have been entrusted to state agencies, particularly the Department of Disabilities and Special Needs, and organizations with whom they contract. These entities are failing to protect the individuals with disabilities whom they are charged to serve. As you will learn from the report, we cannot continue to excuse the current system by saying that incidents of abuse, neglect, and exploitation are infrequent or trivial or that incidents are being adequately investigated. This is clearly not the case.

This report includes one homicide, two deaths from choking¹, physical injuries with excruciating pain, and other shocking examples of abuse and neglect. The injured individuals include people who are non-verbal and unable to tell their own stories. This report sets out some of the stories from a sample population. Based on the cases we have reviewed, we believe that procedures for preventing and investigating the abuse and neglect of individuals with disabilities are totally inadequate. The State's "out of sight, out of mind" inadequate response must end now.

A major problem identified by this report is that agencies investigate themselves, with little external oversight. Law enforcement is rarely contacted. Agencies use their own standards rather than following the state's comprehensive Omnibus Adult Protection Act, which was designed to protect vulnerable adults. Investigators in provider agencies and local law enforcement lack expertise in the abuse and neglect of people with disabilities. While the process for investigating abuse and neglect of vulnerable adults is often described as a system, in fact there is no system at all.

Protection and Advocacy for People with Disabilities, Inc. (P&A) calls on the Governor, Lieutenant Governor, and members of the General Assembly to move this issue to the top of the agenda for action this year. P&A also asks the media to assure that this disgrace is in the public

¹ The choking death mentioned in the September 13, 2005 Wall Street Journal is not included in this report.

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eye until addressed. Investigation of abuse and neglect can no longer be left to be handled by the service providers themselves.

Since we completed the review, a member of the press contacted me about an August 2005 death of a middle-aged person residing in a group home. The staff on duty documented that during the shift ending at 11:30 p.m. the resident was making "gurgling" (sic) sounds in his chest. Rather than contacting medical personnel, the resident was simply placed on fifteen minute checks. On the following shift, another staff person found the resident unresponsive and contacted administrators before contacting medical personnel. It appears that there was an additional delay of approximately an hour before 911 was called. When paramedics arrived they determined that the resident was dead; a coroner's report is pending.

Some of South Carolina's most vulnerable citizens are needlessly suffering, even dying. They will continue to do so until South Carolina has the will, backed by the funds, to protect persons with disabilities by demanding an effective, independent investigation system to address these often criminal activities. Those least able to speak for themselves deserve no less.

P&A knows that elected officials, family members, the media, and other concerned citizens care about the very vulnerable people who reside in group homes, residential facilities, and long-term care institutions. The data in this report offers the necessary information to begin making desperately needed changes. We are ready to assist in this process and await the opportunity to explore the next steps with all interested parties.

Thank you for your immediate attention to this unequal justice for South Carolinians with disabilities.

Very truly yours,



Gloria M. Prevost
Executive Director

THE STATE OF SOUTH CAROLINA
In the Supreme Court

RECEIVED

JUL 13 2015

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS SC Supreme Court

Appellate Case No. 2014-002513

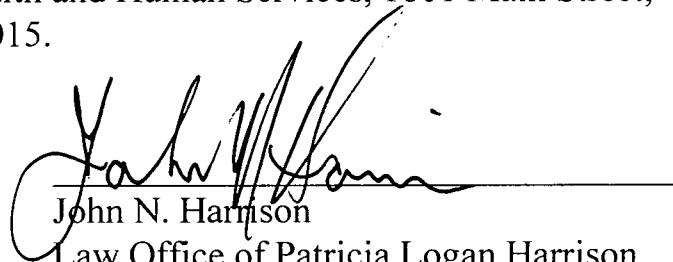
Richard Stogsdill,.....Petitioner,

v.

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

CERTIFICATE OF SERVICE

I, John N. Harrison, certify that I hand-delivered the *Record on Appeal*, pages 405 - 485, in the above case to Richard G. Hepfer, Esq., Office of General Counsel, South Department of Health and Human Services, 1801 Main Street, Columbia, SC 29201 on July 13, 2015.



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