

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE COURT OF COMMON PLEAS
Honorable G. Thomas Cooper, Jr.
Circuit Court Case No.: 2007-CP-40-03365

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SC Court of Appeals

Appellant Case No. 2014-001373

Estate of Edward James Mims,
Laura M. Cole, Personal Representative.....Appellant,

v.

The South Carolina Department of Disabilities
and Spécial Needs, Kathi Lacy and Stan Butkus, ...Respondents.

Volume VII

RECORD ON APPEAL

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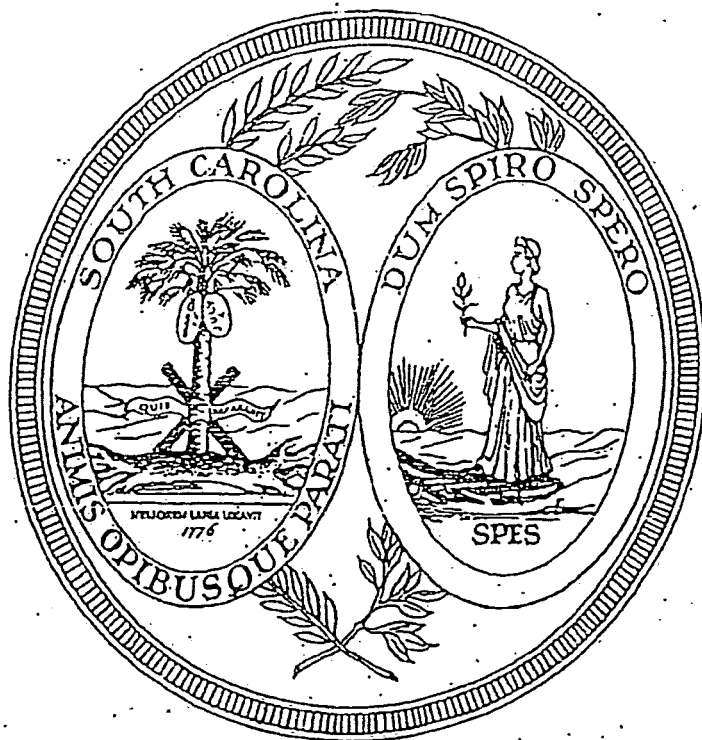
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South Carolina Department of Health and Human Services
Director's Internal Audit Report

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

Mims0360

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.

Mims0361

- 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.

Mims0363

A Review of the MR/RD Waiver as Operated by the Department of Disabilities and Special Needs

- 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.

Mims0364

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*

Mims0365

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

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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

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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

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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 Reimbursement for MR/RD Waiver Services	Amount Paid to DDSN for MR/RD Waiver Services	Unallowable Amount
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,

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"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 (2)	Unallowable Amount (3)	Combined Amount
\$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

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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

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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.

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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 Compliance	FY 2005 Compliance
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.

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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

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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.

As described in the following pages, DDSN licensing inspections found that Babcock Center facilities had serious deficiencies that remained uncorrected for several years. We reviewed licensing and certification reports for only Babcock and Charleston DSN Boards, so we cannot conclude as to how widespread MR/RD waiver facility problems are. However, Babcock is the largest provider of MR/RD waiver services in the DDSN network.

The DHHS contract with DDSN for waiver services states that, "SCDDSN represents and warrants that all home and community-based mental retardation/related disability waiver services...meet applicable standards specified by Title XIX of the Social Security Act, federal regulations promulgated pursuant thereto, the laws of the State of South Carolina, any regulations promulgated thereto, and the South Carolina State Plan for Medical Assistance and the terms of the waiver". Therefore, it is incumbent upon DDSN to ensure that residential and day facilities with serious problems are closely monitored and closed if they fail to improve within reasonable time frames.

CONCERNS ABOUT BABCOCK IDENTIFIED BY DDSN STATE LICENSING

We reviewed DDSN's 2004 annual licensing survey reports for the day and residential programs at the Babcock Center, Inc., and also reviewed license reports for the previous two years (2002 and 2003), as well as a recently finished 2005 report, to note any trends and improvements. We have serious concerns with the following:

- The number of deficiencies cited by the DDSN State Licensing Division.
- Deficiencies found in multiple residential facilities, many of which were repeat issues from prior licensing surveys.
- Babcock did not adequately address or correct all the findings in its first corrective action plan.

It should be noted that Babcock is not the only DSN provider with licensing deficiencies. However, according to an internal DDSN report, Babcock has "significantly higher rates of abuse, neglect, and exploitation among people served in residences (like group homes) than similar programs across the state. There has been a substantial increase in both reports and substantiated incidents of abuse, neglect, and exploitation. In FY 2003 the rate of substantiated incidents of abuse was almost double the statewide average per 100 residential consumers and in FY 2004 it was four times the statewide average."

Findings from 2004 Residential Licensing/Certification Survey

DDSN's State Licensing Division reviewed a sample of 73 of Babcock's residential habilitation programs on September 1, 2004, through October 6, 2004 (8 CTH I, 25 CTH II, 8 SLP I and 32 SLP II). The results of the DDSN review of Babcock's residential surveys were provided to Babcock's Executive Director on December 13, 2004. Most of

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the deficiencies were repeat findings from the 2003 review, and many were found in multiple facilities. A total of 409 residential deficiencies were cited by DDSN licensing and are categorized as follows:

Table 5: Licensing Deficiencies by Deficiency and Facility Type

Deficiency Category	Admin/Personnel	Behavior Supports	Consumer Care	Consumer Funds	Consumer Programming	Home & Safety	Totals /% of Total
Admin/Personnel	4	0	0	0	0	0	4 (1%)
Behavior Supports	0	4	41	1	13	59 (15%)	
Consumer Care	1	5	49	0	34	89 (22%)	
Consumer Funds	0	10	45	1	19	75 (18%)	
Consumer Programming	0	14	96	11	23	144 (35%)	
Home & Safety	0	1	32	1	4	38 (9%)	
Totals /% of Total	5/(1%)	34/(8%)	263/(64%)	14/(4%)	93/(23%)	409/(100%)	

Source: Babcock's Annual Residential Licensing Survey Report dated December 13, 2004.

Some significant deficiencies noted by the surveyors included:

- Consents for psychotropic medication were falsified for one consumer, and training data was falsified for another client.
- Babcock did not report one critical incident, as required by DDSN Policy 533-02-PD, "Sexual Assault, and Incident Procedure Follow-up".
- Some homes were unsanitary "...to the point of being uninhabitable..." and in need of repairs and maintenance. Kitchens and bathrooms were "very dirty" with broken appliances, water damage, and rotten cabinets.
- Caregivers in all CTH IIs and SLPs failed to have DSS' Child Abuse and Neglect Central Registry checks performed. Medication technician training had not occurred for 29 of 33 employees sampled.
- For many consumers, training goals and objectives assigned were not functional, based on a true need, and based on assessments. Some consumers continued to work on specific objectives after criteria for the objective had been met. (Repeat findings)
- Physical and dental exams were not completed annually or as ordered. (Repeat findings) Several consumers were classified as morbidly obese and had significant weight gains during the past year.
- Medications were not being kept under proper conditions. Medications at one SLP II were found to be unsecured without staff present. Consumers were not receiving medications as prescribed. The surveyors noted approximately five pages of medication errors.

Babcock's first corrective action plan in January 2005 did not address some deficiencies found by DDSN surveyors, including the falsification of multiple documents and the medication errors. Some deficiencies, such as issues involving consumers' personal funds, were not addressed at all. DDSN licensing coordinators refused to approve the first corrective action and required Babcock to submit a second corrective action plan, which addressed all the deficiencies but one (which Babcock disagreed with). This was finally addressed by the third corrective action plan.

Also, many of the deficiencies were corrected during the DDSN surveyors' visit or shortly thereafter, and the residential facility with the dirty living conditions cited above was closed January 2005. Babcock Center and DDSN also agreed to reduce Babcock's licensed bed capacity, for both institutional and community-based facilities, by 25% beginning March 2004. Babcock began closing one 48-bed ICF/MR facility in December 2003 after licensing inspections by the federal Centers for Medicare and Medicaid found immediate jeopardy; the remaining beds in this ICF/MR were closed by October 2004.

In December 2004, because of complaints from consumer advocates and families as well as findings of continuing problems by various audits and licensing/certification inspections, DDSN required Babcock through its contract to downsize by another 25%. According to DDSN, the reduction should be completed by June 30, 2006. As of December 2005, Babcock residential capacity had been reduced overall by 30%, based on information provided by DDSN. To date, most of this reduction has been in ICFs/MR. For community residential facilities for MR/RD waiver clients, reduction in capacity was only 15.6%. The reduction was accomplished by closing some facilities altogether, transferring "slots" to other DSN Boards, or moving consumers to other facilities.

In addition, the recently completed 2005 survey of Babcock's residential facilities found an overall reduction of discrepancies from 409 to 226, with improvements in the physical condition of many houses and apartments and fewer medication errors. However, the 2005 review still found many problems in how caregivers managed and accounted for consumer funds. This has been a recurring violation in all four years of inspection reports we reviewed.

Results of Day Program Survey

DDSN licensing conducted a separate review of nine Babcock work activity centers (day programs) on September 1, 2004, through September 30, 2004. The licensing review of Babcock's day programs also noted deficiencies, including:

- Background checks of the DSS Child and Abuse Neglect Central Registry had not been done for any of the personnel whose records were reviewed (a total of 21 records were reviewed). Required abuse checks for three records (14% reviewed) cited from a previous 2003 survey were also still not completed.
- An employee at one of the day programs (hired in 1988) was convicted in 1993 of Criminal Domestic Violence and an Unlawful Weapons charge. At the time of

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the conviction it appears that she was employed at one of the residential programs as a caregiver.

- Multiple findings related to the development and documentation of the consumers' single plans. For example, one consumer's single plan did not identify day program services as a need, and therefore these were not authorized. (As noted on page 9, all waiver clients must have a valid single plan that authorizes services before DHHS can claim federal Medicaid funds for the waiver services.)

In a February 2005 letter, DDSN notified Babcock that their corrective action plan for the day programs had been reviewed and accepted, even though the issue relating to the employee had not been fully addressed. Babcock subsequently submitted a *Request for Waiver* from the licensing standard to DDSN for this employee, which DDSN approved on April 27, 2005. Babcock justified the continued employment of this individual on the basis that the convictions were misdemeanors that had occurred 11 years ago; the employee only had four disciplinary actions since 1988, and she has met or exceeded her annual performance expectations. Babcock also stated in its corrective action that it subsequently obtained the required background checks and also obtained an addendum to the consumer's single plan reflecting a need for the day program. Therefore, DDSN took no other action.

Recommendations

6. The Department of Health and Human Services should amend its contract with the Department of Disabilities and Special Needs to address issues involving licensure and certification of MR/RD waiver residential and day program facilities, to include the following provisions:
 - The two agencies should jointly establish the severity levels at which a deficiency would jeopardize the continuing licensure of the provider's facility. This could be patterned after the system used by DHEC in finding "immediate jeopardy" in ICFs/MR and the "class violation" system used for community residential care facilities (CRCF).
 - DDSN should notify DHHS whenever serious deficiencies in residential and day facilities are found by their state licensing division.
 - Once a serious deficiency has been identified, the two agencies should jointly establish a process by which DDSN could invoke a series of actions if the provider fails to immediately correct the serious deficiency, up to and including withholding band payments from the DSN board, revoking the licensure or certification of the facility in question, and terminating all waiver services contingent upon a valid license or certificate.

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A Review of the MR/RD Waiver as Operated by the Department of Disabilities and Special Needs

7. The Department of Disabilities and Special Needs should add to its draft protocol a timeline by which a DSN board would be required to correct serious deficiencies involving the health and safety of clients.
8. The Department of Disabilities and Special Needs should establish a database showing whether serious licensing and certification violations have been corrected and whether any sanctions were applied to DSN Boards as a result of failure to correct them, and report this information to DHHS.
9. The Department of Disabilities and Special Needs should provide copies of annual DDSN licensing reports to each Disabilities and Special Needs Board member so they will be informed of deficiencies noted by the DDSN surveyors.
10. The Department of Disabilities and Special Needs should continue tracking the reduction in program capacity of Babcock Center, Inc., and report these results to DHHS.
11. The Department of Health and Human Services should require the Department of Disabilities and Special Needs to 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.

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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.

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Table 6: Statewide Band Rates, 2003

Category	Description	Identifier	State 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.

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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 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.

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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:

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- 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

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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	Inpatient		Outpatient		Total
	Number	Outlier	Number	Outlier	
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:

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Table 9: Results from Initial Re-Justification

Category	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	Total 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

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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.

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- 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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A Review of the MR/RD Waiver as Operated by the Department of Disabilities and Special Needs

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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.

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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

	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" (OHCHS), and therefore all waiver allowable costs are eligible for the 70% federal Medicaid funds.

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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.

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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

	Charleston Highest Board	Babcock	Charleston Lowest Board	Midlands Lowest Board	Midlands 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

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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.

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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.

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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

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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

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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.

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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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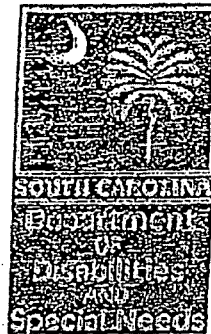
A. Review of the MR/RD Waiver as Operated by the Department of Disabilities and Special Needs

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Appendix B: Response from Department of Disabilities and Special Needs

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Ronald G. Doster
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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.

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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.

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A Review of the MR/RD Waiver as Operated by the Department of Disabilities and Special Needs

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.

The following is a copy of the final report of the study conducted by the University of South Carolina Center for Health Services and Policy Research on the Licensing Functions of Residential and Day Habilitation Services conducted by the Department of Disabilities and Special Needs (DDSN). The Department of Health and Human Services (DHHS) and DDSN have prepared a response, which has been included at the end of the report.

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Mims0417

**An Independent Study of the
Quality Management Functions for the MR/RD
Home and Community Based Services Waiver Program**

**Produced by:
Center for Health Services and Policy Research
at
Arnold School of Public Health
University of South Carolina
November 8, 2007**

Mims0418

Introduction by the South Carolina Department of Health and Human Services

The South Carolina Department of Health and Human Services (DHHS) commissioned this study by the University of South Carolina's (USC) Center for Health Services and Policy Research in 2006. The Scope of Work for this study is found in Attachment 1. The original intent of this study and objectives from this scope are as follows:

- *To review the state legislative history related to regulations and DDSN's responsibility for the licensing and oversight of residential and day facilities and services for adults and children so as to determine agency authority and responsibility.*
- *To review a sample of comparable states with residential and day home and community-based waiver services to determine how their current legislation, standards and oversight processes compare; including best practices, and appropriate license sanctions for non-compliance;*
- *Determine if current state regulations and procedures are appropriate or need improvement, and identify legislation and policy changes needed;*
- *Interview DDSN State Office, and licensing and certification staff to review the current licensing process and proposed sanctioning process;*
- *Determine appropriate information and reports needed by the Department of Health and Human Services (DHHS), to meet federal oversight responsibilities and waiver assurances.*
- *Based on a survey of comparable states, investigate the advantages of having separate 1915(c) waivers for persons in residential setting and community settings.*

The overall objective was to obtain information from an independent source that would help us improve oversight of the Medicaid services provided to DDSN clients. Since the research for this report was conducted, however, both DDSN and DHHS have made significant changes and improvements to the licensing, oversight, and quality management functions. Information on these changes has been added as attachments to this report by DHHS and DDSN. Therefore, the recommendations of the USC Center for Health Services and Policy Research should be viewed within the context of these changes.

DHHS is reviewing the recommendations of this report and will determine the most effective and valid process to follow. DHHS will continue to work with DDSN to further enhance the role that both agencies play in the oversight and management of programs for the developmentally disabled.

Acknowledgments

This report was prepared by the Center for Health Services and Policy Research, University of South Carolina Arnold School of Public Health, for the South Carolina Department of Health and Human Services (DHHS) under Contract No. A7 1542 A. The authors of the report are Pamela S. Gillam, M.P.A. and Erik Simensen, M.S.W. with contributions from research intern, Beth LaPine. David E. Murday, Ph.D., served as advisor. This report is based on data collected between October 2006 and August 2007 and does not reflect systems changes occurring subsequent to data collection.

Disclaimer

This report was prepared by the Center for Health Services and Policy Research, University of South Carolina Arnold School of Public Health, for DHHS under Contract No. A7 1542 A. The content of this report does not necessarily reflect the views, opinions, or policies of DHHS.

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Executive Summary

In South Carolina, the Department of Health & Human Services (DHHS) is the single state agency responsible for administering the federal Medicaid program. Having sole responsibility for administering the state Medicaid program also means that DHHS has administrative responsibility for all Medicaid Home & Community Based Services (HCBS) waiver programs. While DHHS has retained line authority for operating some HCBS waivers, the Department of Disabilities & Special Needs (DDSN) is the operating agency for the Mental Retardation/Related Disabilities (MR/RD) HCBS waiver.

In 2006, an audit conducted by the DHHS Division of Audits identified several areas where both DHHS and DDSN need to improve oversight of the MR/RD HCBS waiver. DHHS contracted with the University of South Carolina, Arnold School of Public Health's Center for Health Services and Policy Research to conduct an independent study of the licensing, certification, and quality management processes for the MR/RD HCBS waiver.

Based on information collected from the literature, documentation and materials reviews, state comparison analysis, interviews, focus groups, and site visits, there are several issues that raise concerns about South Carolina's processes for assuring the health, welfare and safety of the individuals in the HCBS waiver. South Carolina's health and safety regulations are comparable to other states' regulations and there are quality management processes in place to oversee the Medicaid MR/RD HCBS waiver program. However, these quality management processes must be strengthened to ensure consumers' safety and well being.

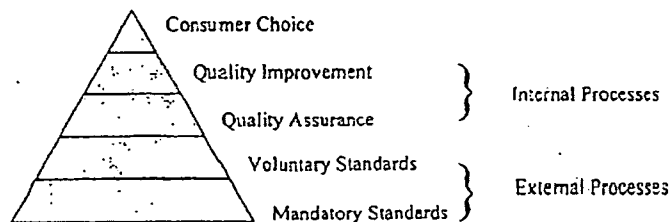
I. Introduction

The Code of Federal Regulations, under 42 CFR 441.302, specifies certain assurances in which the single state Medicaid agency must fulfill in order to receive home and community based services waivers (HCBS). The Medicaid agency must assure "that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include:

- Adequate standards for all types of providers that provide services under the waiver;
- Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
- Assurance that all facilities covered by section 1616(e) 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."

In 2006, an audit of the Mental Retardation/Related Disabilities (MR/RD) HCBS waiver conducted by the South Carolina Department of Health and Human Services (DHHS) Division of Audits identified areas where oversight of the MR/RD waiver needed to improve. Thus, DHHS contracted with the University of South Carolina, Arnold School of Public Health's Center for Health Services and Policy Research (USC) to conduct an independent study of the licensing, certification, and quality management processes for the MR/RD HCBS waiver. The study examined the effectiveness of these processes through an exploratory method comprised of legislative history, related literature, state comparisons, regulation reviews, and structured interviews. This report, therefore, is organized along these major areas:

A. Quality Management Framework



A quality management framework is the means by which a system ensures that quality is maintained and improved, and appropriate service standards are achieved. A quality framework must be designed to meet the challenges posed by external as well as internal scrutiny.

Mandatory Standards. States are responsible for protecting the public's health and safety. Through state licensure (and sometimes additional certification), states set minimum

performance standards and expectations. Enforcement processes are established for identifying, investigating, and sanctioning violations of the minimum standards and expectations.

Voluntary Standards. Purchasers (e.g., Medicare, Medicaid, insurance companies) and private professional accreditation organizations may set higher performance standards and expectations. To qualify for reimbursement from a purchaser or for professional recognition, a system may voluntarily comply with these higher standards and receive the private organization or purchaser's "seal of approval." Sometimes states may require a provider to be accredited as well as licensed.

Quality Assurance. Often required by external quality management processes, a system will establish a quality assurance program to identify and fix problem areas where the system does not consistently meet the minimum licensing or higher accreditation performance standards and expectations.

Quality Improvement. Increasingly expected by external quality management processes, a system may establish a quality improvement program that is less focused on finding and fixing defects and more focused on improving performance to exceed minimum standards and expectations.

Consumer Choice. Recognizing that even high quality service providers cannot be all things to all people, systems can allow customers freedom to choose the provider that meets their personal preferences. Different customers place different value on convenience (business hours, location), cost, efficiency, staff attitude/responsiveness, etc.

B. Scope of Work

The specific objectives of this study are:

- To review the state legislative history related to regulations and the South Carolina Department of Disability and Special Needs' (DDSN) responsibility for the licensing and oversight of residential and day facilities and services for adults and children so as to determine agency authority and responsibility.
- To review a sample of comparable states with residential and day home and community-based waiver services to determine how their current legislation, standards and oversight processes compare; including best practices, and appropriate license sanctions for non-compliance.
- Determine if current state regulations and procedures are appropriate or need improvement, and identify legislation and policy changes needed.
- Interview DDSN State Office, and licensing and certification staff to review the current licensing process and proposed sanctioning process.
- Determine appropriate information and reports needed by DHHS, to meet federal oversight responsibilities and waiver assurances.
- Based on a survey of comparable states, investigate the advantages of having separate HCBS waivers for persons in residential setting and community settings.

C. Research Methodology

Several data collection methods were used to gather information to provide an in-depth overview of the licensing functions and quality assurance and improvement processes used by states to ensure the health and welfare of consumers receiving services through MR/RD HCBS waivers. Data collection methods include:

- State comparison analysis;
- Key informant interviews;
- Focus groups;
- Review of literature;
- Review of state licensing regulations, standards and processes; and,
- Observation of licensing process.

It is important to note that the use of qualitative methods in research such as key informant interviews and focus group has its strengths and limitations. Personal interviews and focus groups are sometimes preferable to other forms of data collection because they offer respondents an opportunity to explain what and how they think and feel about a topic. Although qualitative research methods cannot estimate how many other people share those thoughts or feelings, they do provide deeper insights about a topic in the participants' own words.

Information was gathered from seven (7) state organizations that are responsible for implementing state MR/RD HCBS waivers. States were chosen based on feedback provided from DHHS and from reviews of state websites and national organization websites. Websites of the states who participated in the study were reviewed to identify licensing regulations, standards, and processes and quality assurance and improvement activities. States that agreed to participate in the study were California, Colorado, Georgia, Kentucky, North Carolina, Pennsylvania and Tennessee. Phone interviews were conducted with all of the states with the exception of North Carolina and Pennsylvania who chose to complete the survey documents and return via email.

Key informant interviews were conducted with public and private providers, DDSN staff (in the departments of licensing and quality improvement/assurance), DHHS staff, state advocacy groups, and staff from two national organizations, the Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). Interview questions asked of public and private providers and advocacy groups were focused on the general components cited in South Carolina licensing regulations. Questions asked of DDSN licensing staff were focused around licensing standards and the licensing process which they use. Interviews with other DDSN staff and with national organizations were based on their perceptions about best practices used in the state and across the country with regard to licensing standards and processes and quality assurance and improvement activities.

Two (2) focus groups were conducted with advocates, consumers, and family members of consumers. One focus group was held in Columbia and one in Charleston. Focus group questions were developed around the general components cited in South Carolina licensing regulations.

A review of the literature was conducted to get a sense of the information available about approaches used by states to ensure the health and welfare of consumers served by MR/RO HCBS waivers. Reports, PowerPoint presentations, and national models were identified.

USC researchers attended three (3) licensing site visits. Two visits were initial visits; the third visit was an annual review. The licensing processes for the visits were observed to get a sense of what the process entails and how standards are implemented.

II. Implementation of the HCBS Waivers in South Carolina

Each state has a single agency that is responsible for administering the Federal Medicaid program. Having sole responsibility for administering the state Medicaid program also means the agency has administrative responsibility for waiver and demonstration projects authorized by the United States Department of Health and Human Services Center for Medicare and Medicaid Services (CMS). These programs include various waiver programs authorized under Section 1915(c) of the Social Security Act for Home and Community Based Services (HCBS).

Through HCBS Waivers, states may design their waivers to offer a variety of services to consumers with no limit to the number of services that can be provided. Waiver programs may be designed to provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) and non-medical services (i.e. respite, case management, and environmental modifications). In addition, line of authority for waiver operation may be designated to a unit within the state Medicaid agency or a state agency separate from the state Medicaid agency. Regardless of the designated line of authority, the state Medicaid agency is ultimately responsible and, by statute, continues to exercise administrative discretion in the management and direction of the waiver and issues policies, rules and regulations related to the waiver.

A. Organizational Structure

In South Carolina, DHHS is the single state agency responsible for administering the federal Medicaid program. Having sole responsibility for administering the state Medicaid program also means DHHS has administrative responsibility for all HCBS waiver programs. While DHHS has retained line authority for operating some HCBS waivers, DDSN is the operating agency for the MR/RD HCBS waiver.

In the state's MR/RD HCBS waiver program designed under the section of the federal code, most waiver services are controlled by DDSN. DDSN contracts with the state's organized disability service delivery system comprised of 39 local Disabilities and Special Needs (DSN) Boards. DSN boards are quasi-governmental entities found at the county level. They provide, coordinate, and purchase services for South Carolinians with severe, lifelong disabilities including mental retardation and related disabilities; autism; traumatic brain injury; spinal cord injury and similar disabilities. In addition to the DSN boards, there are a few private providers who contract with the DSN boards to provide and coordinate services to DDSN clients.

B. Licensing Process

In 1967, state law transferred the responsibilities and authority to take care of children with developmental disabilities from the SC Department of Mental Health to DDSN. State law passed in 1974 gave DDSN the authority to license or certify residential and day facilities and services for adults and children with developmental disabilities. South Carolina Code of Laws Section 44-20-710 authorizes DDSN to license day facilities for children and/or adults. These facilities include Residential or Day Camp; Child Development Center; Adult Activity Center;

Work Activity Center; and Sheltered Workshop. South Carolina Code of Laws 44-7-260 authorizes DDSN to sponsor, certify, or license community based housing like Community Training Homes (CTH). Since 1985, DDSN has maintained a Memorandum of Agreement (MOA) with the SC Department of Social Services (DSS), which grants DDSN authority to license Community Training Homes for children. The MOA is in accordance with provisions of South Carolina Code of Laws 44-20-1000. DDSN standards meet Child Foster Care Regulation 114-550 for homes licensed as a CTH I, or Child Group Home Regulation 114-590 for homes licensed as a CTH II, as approved annually by DSS.

Prior to state budget cuts, DDSN operated four regional administrative offices that each housed between four and six licensing staff. At that time, site visits were conducted by regional staff on a quarterly basis and licenses were renewed annually. DDSN reorganized after the budget cuts closing the regional administrative offices and centralizing licensing at DDSN's state office. The licensing division reports to the Director for the Division of Quality Management, who in turn reports to the Associate Director of Policy who reports to the State Director of DDSN. Executive management that is responsible for the oversight of the service delivery system is also responsible for oversight of the licensing division.

Currently, the State's licensing division has only four staff members responsible for licensing and regulating residential habilitation and day treatment programs. One staff member is responsible for initial and annual licensing of adult day programs; one is responsible for initial and follow up to initial licensing of adult residential programs. Two staff members are responsible for the annual licensing of adult residential programs.

The licensing and certification activities are designed to assess the health and safety factors associated with facility operations. State law requires programs to maintain these credentials and establishes standards covering the qualifications of staff, staff ratios, fire safety, medication management, consumer health and safety and the like. In general, activities associated with these reviews involve staff from DDSN, the Department of Health and Environmental Control (DHEC), Department of Social Services (DSS), and the State Fire Marshall's office. DDSN conducts annual licensing visits to providers. All child residential homes under each provider are visited on an annual basis. Unless trends are noticed during licensing reviews of adult residential homes, only one third of those provider's homes will be reviewed per year.

C. Quality Assurance and Improvement Activities

As part of its operational responsibilities, DDSN uses a quality management process that combines risk management and quality assurance. Risk management includes practices that are designed to monitor and prevent events that have negative impacts on consumer experiences. Quality assurance includes practices that are designed to assess and improve elements that have positive impacts on consumer experiences, i.e. licensing/certification activities, contractual compliance oversight, personal outcomes measurement monitoring, consumer/family satisfaction screening, and quality enhancement activities.

DDSN contracts with an independent contractor to monitor providers by reviewing a sample of consumer records on an annual basis. At the time of this study, DDSN contracted with First Health, a Quality Improvement Organization designated by CMS. First Health conducts three nationally recognized assessment surveys with consumers and their families. The information collected from the surveys is used to ensure providers are meeting the minimum standards for quality assurance.

In addition to the independent contractor reviews, DDSN has partnered with the Council on Quality and Leadership (CQL) to develop a quality management process referred to as the Quality Enhancement Process (QEP). The process involves a four-day provider visit by state DDSN staff to conduct a review of provider performance using multiple consumer outcome measures. The process identifies the strengths and weaknesses in a provider's service program and uses the findings to develop and/or build upon existing quality enhancement plans. The process is built upon a technical assistance and learning approach to quality enhancement. Provider reviews are voluntary and have been conducted at more than two-thirds of the local board sites. It is anticipated that by the end of state fiscal year 2008 the remaining board sites will be reviewed and that private providers will be offered comparable service.

Additional formal quality assurance and quality improvement activities include satisfaction surveys. Each provider is required to conduct their own annual satisfaction surveys to their consumers and their families. Providers are to use the findings from the surveys to identify areas for improvement. The agency's Risk management program, established by a directive in 2001 which was revised this year, calls for a state level Risk Management committee and provider level committees. The state committee is in the process of forming and will utilize data to make informed decisions to protect the health and safety of consumers. At the provider level, three elements must be in place. A provider must employ a risk manager, a risk management program must be in place and a risk management committee must be established. The provider level committee will be responsible for providing data and other information to the state level committee.

III. Multi-State Comparison Analysis

The purpose of this section is to synthesize the similarities and differences within various states' licensing processes, and quality assurance and quality improvement systems. Interviews were conducted with seven other states—California, Colorado, Georgia, Kentucky, North Carolina, Pennsylvania, and Tennessee. Interviews were conducted with the staff of state divisions or agencies responsible for serving the developmentally disabled population and for administering the states' MR/RD HCBS waivers. A supplemental review was also conducted of materials and information provided by the state interviewees, from the state agencies' websites, and from national organizations' websites such as NASDDDS and the HSRI. Individual state summaries are available in Appendix A. The interviews and material highlight the critical elements of interest to DHHS. The interviews focused on four areas—Organizational Structure, Licensing Process, Process for Detecting and Addressing Complaints/Problems, and Quality Assurance/Improvement Infrastructure.

A. Organizational Structure

To provide some background on the states' organizational structures for administering and operating MR/RD HCBS waivers, state waiver applications were reviewed. In the HCBS waiver application, there are three options for specifying waiver operation:

- The waiver is operated by the state Medicaid agency and the line of authority is within the Medical Assistance Unit, the division responsible for the Medicaid program.
- The waiver is operated by the state Medicaid agency and the line of authority for its implementation is within a separate division or unit from the Medical Assistance Unit (Pennsylvania, North Carolina).
- The waiver is operated by a separate agency of the state that is not a division or unit of the state Medicaid agency (California, Colorado, Georgia, Kentucky, Tennessee and South Carolina).

In addition to reviewing MR/RD HCBS waiver applications, interviews were conducted to understand how the organizations with line authority to operate the HCBS waivers are organized. A majority of the agencies responsible for operating HCBS waivers contract with local entities to administer the waiver program. Local entities range from being private, not for profit corporations to quasi-governmental or governmental area authorities. Colorado's Community-Centered Boards and California's regional centers are private, not for profit organizations; North Carolina's Local Management Entities (LME) and Pennsylvania's Administrative Entities (AE) are county programs or area authorities.

States vary widely in which entities administer the functions of service coordination and provision. Service provision and coordination are not functions of the agencies operating HCBS waivers in Georgia and Tennessee; instead, they are contracted out to private and not for profit organizations. Service coordination and provider agencies contract directly with the state offices in Tennessee and Georgia; both states have regional offices that oversee service coordination and provision. As part of the state's Mental Health Care Reform, North Carolina's LMEs are

moving away from service coordination and provision and into management and oversight of provider agencies that perform those two functions. Service coordination and provision are functions that the other states' entities perform and/or purchase from private or not for profit organizations.

B. Licensing Process

Several similarities were identified among the states' licensing processes. With the exception of Pennsylvania, the initial licensing process is conducted by a unit or agency other than the one responsible for waiver operation. For example, in Colorado, the agency responsible for the licensing of group homes of 4 to 8 residents served under the HCBS waiver is the Department of Public Health and Environment; in Kentucky, the Office of the Inspector General is responsible for the initial licensing of group home and adult day health care providers to ensure they meet state regulatory requirements. Each state's licensing function is written into statute and is typically focused on health and safety standards. Tables are provided in Appendix B comparing South Carolina and the other participating states adult day program and residential habilitation standards.

Licensing by these external entities is conducted on an annual basis. For most of the states, a two-step licensing and certification process is required for providers. The initial licensing process is required to be completed prior to initiating the second step, a certification process established by the agencies responsible for serving consumers with developmental disabilities. The certification process may look at health and safety standards but is primarily focused on ensuring providers meet required programmatic standards.

To highlight one state's certification process, Kentucky's Department of Mental Retardation (DMR) requires providers to attend a two-day training for an overview of the program and its requirements. Both days include competency-based testing. Visits by DMR's provider development specialist and by the regional center's area administrator are conducted for a pre-service review. Certification standards are based on the CMS's HCBS Quality Framework and outcomes developed by the CQL. Approximately thirty (30) field staff review certified providers at least once per year and monitor individual and organizational outcomes.

C. Quality Assurance/Quality Improvement Infrastructure

Each state utilizes several mechanisms for quality assurance and quality improvement. Looking across the states, a number of comparable practices are being used.

Web-based data collection and reporting systems. A majority of the states have internal web-based data collection and reporting systems. The information collected and reported varies from state to state; however, one common element is critical incident data. Other data collected include service utilization data, consumer demographics/characteristics, consumer outcomes and satisfaction information, and consumer case management information. States have established committees to review the data on a regular basis (for some states, on a monthly basis) and use it to identify case trends to develop quality improvement activities. Colorado's state Medicaid

agency developed Benefits Utilization System, a case management and critical incident reporting system in which the Division of Developmental Disabilities enters plans of care, individual service plans, and client service notes. Pennsylvania utilizes the Home and Community Services Information System to monitor its local AE's performance. In addition to critical incident data, the HCSIS includes service reviews, complaint investigation data, and incident and risk management data. North Carolina makes available on its website quarterly and annual reports of the LME's performance. Reports include performance requirements and best practice standards. LMEs are scored based on meeting the two criteria. Kentucky and Tennessee have web-based provider profiles that score providers based on specific criteria including organizational and consumer outcomes.

Unannounced visits. Three of the states conduct unannounced visits. In California, regional center staff is required to visit providers at least once per quarter. Policy requires that two visits per year must be unannounced. In addition to their regularly scheduled inspections, North Carolina's Department of Mental Health and Developmental Disabilities and Pennsylvania's Office of Developmental Programs conduct unannounced visits.

Scoring systems. A majority of the states have developed a scoring system that is utilized for various purposes. Kentucky, Tennessee, and Pennsylvania develop scores for providers based on multiple criteria. North Carolina uses a "confidence rating" for each of its providers to determine the frequency at which providers will be monitored. A standardized evaluation tool is used to collect data such as compliance with reporting requirements, critical incidents, complaints, and review findings from other state agencies as related to service provision requirements and compliance.

Provider staff training. A number of the states' agencies that provide services to the developmentally disabled have a training division that provides required training to provider management and provider staff. Kentucky's DMR requires a two-day core training course for providers serving HCBS waiver recipients. The training includes topics such as person-centered planning, positive behavior supports and building community inclusion. Moreover, the agency offers trainings such as crisis prevention and intervention and rights and advocacy. North Carolina's Division of Mental Health/Developmental Disabilities/Substance Abuse Services' training division partners with entities such as the state's Area Health Education Centers and the University of North Carolina's School of Social Work to create a learning community that provides various trainings to providers.

Standardized, regular reviews. In addition to annual licensure/certification, many states conduct comprehensive programmatic reviews of their local entities and providers to measure performance. The data collected from these reviews typically are reported in the states' web-based reporting systems. Pennsylvania's utilizes the Office of Mental Retardation Monitoring of Counties (OMOC) and the Independent Monitoring for Quality (IM4Q) to measure AE performance and consumer outcomes. Regional staff conduct retrospective individual service plan reviews on a random sample (a maximum of five percent) of client service plans per provider. Furthermore, individual site assessments are conducted, including visits with waiver participants. IM4Q is an independent review of quality of life issues for people with

developmental disabilities; like OMOC, it is conducted statewide and on an annual basis. Approximately 6,000 consumers and their families are interviewed. In Tennessee, annual quality assurance surveys are collected. Regional surveyors sample at least ten percent (10%) of the consumers served by a provider and the data collected reflect the ten domains of the HCBS Quality Framework. Data are collected and reported to the Regional Quality Management Committee, an area committee under state authority. The committee meets monthly and reviews the findings. If a provider is deficient in multiple domains, the committee can mandate technical assistance and/or a moratorium on serving additional consumers. In California, regional centers conduct annual programmatic reviews of service providers. At the state level, the Department of Disability Services conducts comprehensive reviews every three years of its regional centers. Data collected over the three years from various entities including the risk management contractor, licensing divisions, and the regional centers are used to monitor regional center performance. Colorado also conducts reviews of its Community Centered Boards every three years to ensure they are meeting waiver and program quality requirements.

State Medicaid Agency Quality Assurance Activities. For many of the states, the state Medicaid agencies regularly conduct quality assurance reviews to ensure programmatic and waiver requirements are being met by the agencies providing services to the developmentally disabled. The state Medicaid agencies in Tennessee, Kentucky and North Carolina conduct reviews of providers. TennCare pulls a sample of 15 to 20 providers per region and conducts an independent review. In North Carolina, the Division of Medical Assistance pulls a random sample of waiver cases on a monthly basis. Plans of care are reviewed to ensure that services and supports are appropriate to the needs of the consumer and to assure that quality outcomes are met. Moreover, this unit and the agency responsible for implementing the waiver jointly conduct Medicaid Compliance audits. These audits are shifting in focus from Medicaid billing compliance to quality and treatment issues. Kentucky's Department of Medicaid Services conducts "look behind" reviews and regularly talks to consumers and their families. In addition, it requires monthly reports from the agency serving the developmentally disabled.

D. Components of Interagency Agreements

Four of the states provided copies of the agreements between the state Medicaid agencies and the agencies or divisions responsible for operating the MR/RD HCBS waiver. Those states were Colorado, Georgia, Kentucky and Tennessee. The agreements were reviewed to identify similarities and differences compared to the memorandum of agreement (MOA) between DHHS and DDSN. See Appendix C for a comparison of state interagency agreement elements.

Scope of Services: There are multiple components to the interagency agreements that delineate the scope of services.

Communication In each of the agreements reviewed, the roles and responsibilities of each party are clearly defined, including the sharing of data and information among the parties involved. An additional requirement in the DHHS/DDSN MOA that is not found in the other states' agreements is a direct requirement for monthly meeting between the two departments.

Service Coordination With regard to service coordination, which includes freedom of choice and level of care determination, Kentucky and Tennessee establish a set of guidelines for service delivery in their agreements. Colorado and Georgia do not address service coordination specifically, but focus upon quality assurance as it relates to service delivery.

Freedom of Choice Kentucky and Tennessee include freedom of choice requirements in their agreements. Like SC, these states require that consumers be aware of the choice of providers and services, and acknowledge this through a freedom of choice waiver.

Level of Care The DHHS/DDS agreement assigns DDSN with the responsibility for making level of care determination for the three waiver programs and also for ICF-MR. These determinations must meet both the DHHS and CMS guidelines and a sample of the cases will be reviewed by DHHS.

Level of care determination is addressed in the Georgia, Kentucky and Tennessee agreements. Tennessee's agreement requires DMRS to review the ICF-MR level of care determination on an annual basis. In Georgia, the assignment of responsibility for level of care determination is found in supplemental documents specific to each waiver.

Quality Assurance Management All of the states reviewed address quality assurance in their respective agreements, though some are more detailed than others. The DHHS/DDS MOA requires DDSN to put measures and procedures in place to assure state and federal regulatory compliance through quality contractor indicators. These measures include compliance with health and safety standards, consumer surveys, and records reviews, as well as corrective action procedures to rectify deficiencies. All of the states reviewed have delegated these quality assurance management measures to the department responsible for administering the waiver programs.

The Tennessee and Kentucky agreements include comprehensive, detailed quality assurance measures. Tennessee's agreement, for example, offers specific and detailed guidelines for monitoring service delivery as well as health and welfare standards.

The main body of Georgia's interagency agreement requires the submission of reports by the agency operating the waiver to the Medicaid agency, such as consumer complaints, but these reports are done outside of a quality assurance management framework. The framework for quality management is found in supplemental documents that focus on the specific waiver programs. These responsibilities and deliverables are extensive, and unlike the SC agreement, Georgia's supplemental documents provide specific objectives and the data required to measure progress toward those objectives.

Colorado's quality assurance management guidelines are referenced in the agreement but are located in a supplemental document. The guidelines are found within a contract between its Medicaid agency and the agency operating the waiver and the Community Centered Boards and include the same components of the DHHS/DDS agreement, but are more comprehensive.

Medicaid Management Information Systems The Colorado, Kentucky, and Tennessee agreements require that the Medicaid Management Information System (MMIS) be used for data collection and sharing among the agencies.

Certification of Residential Homes for Waiver Participants While Colorado, Kentucky and Tennessee have language related to certification, there are distinct differences between these states and South Carolina's MOA. The DHHS/DDSN MOA describes a class violation system in which deficiencies are identified and categorized based on the degree of the deficiency discovered during the review process. The class violation system utilizes as a means of addressing and preventing future incidences of deficiencies. Although, Colorado, Kentucky and Tennessee's agreements do not include a class violation system similar to South Carolina's, their agreements do include similar requirements for corrective action, timelines, and data collection. Georgia's agreement is the only one that does not contain guidelines for the certification of residential homes.

Fiscal Administration. In addition to components related to scope of services, there are also elements related to fiscal administration.

Administrative Costs for Attendant Care Services Georgia and Tennessee address the issue of costs associated with the administration of the waiver programs and include in their contracts additional requirements. In contrast, Colorado and Kentucky do not directly address these administrative costs. For example, the Kentucky contract describes other cost and payment procedures such as reimbursement and plan costs, but does not address payment for administrative costs for the waiver programs.

Reimbursement Methodology The reimbursement methodology outlined in the DHHS/DDSN agreement pertains directly to the Pervasive Developmental Disorder (PDD) waiver; the 2004 MOA addresses the reimbursement methodology for the MR/RD and HASCI waivers. The methodologies outlined are brief; they do not include the detailed payment schedule process and funds allocation requirements that are found in other states' reimbursement methodologies. While the DHHS/DDSN agreement outlines the relationship between the agencies for the payment and reimbursement of services, the agreement does not offer a description of how each party will fulfill their contractual obligation.

The Colorado agreement indicates the amount of state funds allocated for the waiver programs and the process for submitting payments; however, the agreement does not discuss the waiver services costs associated with the program. Georgia addresses all of the fiscal administration requirements with a detailed explanation of the actual procedures for reimbursement.

Elements Unique to Other States' Agreements. There are a number of components included in the other states' agreements that are not found in the DHHS/DDSN MOA.

Statutory Compliance (i.e. HIPAA, Civil Rights Act, Americans with Disabilities Act)
Compliance with federal and state laws and statutes is a basic element of all of the contracts

reviewed. The DHHS/DDSN agreement does not refer to any statutes or laws or any other supplemental materials that specify compliance.

Confidentiality Requirements All of the states' agreements that were reviewed include confidentiality requirements as part of their contractual agreement. SC does address confidentiality requirements in other official documents such as the DHHS Medicaid Provider Manual.

Staffing Requirements The Georgia agreement requires that staff responsible for the implementation of the contract must be qualified and competent, and its Medicaid agency reserves the right to remove unfit persons from their positions.

Inspection of Work In Georgia and Kentucky, the Medicaid agency reserves the right to monitor, inspect or evaluate the department operating the waiver program and its subcontractors. This serves as a monitoring mechanism to ensure compliance with the contract.

Termination of Agreement, Notices, Assignment Most of the agreements reviewed present the roles and responsibilities of each party in contractual language which includes provisions for terminating the contract, i.e. termination for cause or convenience, as well as requirements that changes to the terms of the contract must be in writing and submitted to both parties. These contractual elements clearly define the obligations of both parties and procedures for altering contracts.

E. Multi-State Comparison Summary

Table 1 provides a snapshot of each state's structure, licensing process and quality assurance and improvement activities. The information offers insight into how other states provide services to the developmentally disabled and what mechanisms they have in place to ensure the health, safety and welfare of this population. This information will be used with the qualitative information presented in the next sections to consider issues about South Carolina's efforts to assure the health, safety and welfare of the developmentally disabled in the state.

Table 1. Summary of State Interviews

	South Carolina	California	Colorado	Georgia	Kentucky	North Carolina	Ohio	Tennessee
State Medicaid Agency	Department of Health and Human Services	Department of Health Services	Department of Healthcare Policy and Financing	Dept of Human Resources, Department of Community Health	Cabinet for Health and Family Services, Department for Medicaid Services	Department of Health and Human Services, Division of Medicaid Assistance	Department of Public Welfare, Office of Medical Assistance	Department of Finance and Administration, TennCare
HCBS Waiver Line of Authority Option	Agency Separate from Medicaid Agency	Agency Separate from Medicaid Agency	Agency Separate from Medicaid Agency	Agency Separate from Medicaid Agency	Agency Separate from Medicaid Agency	Within Medicaid Agency, Separate Division	Within Medicaid Agency, Separate Division	Agency Separate from Medicaid Agency
Division/Agency responsible for operating HCBS waiver	Department of Disabilities and Special Needs	Department of Disability Services	Department of Human Services, Division of Developmental Services	Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases	Cabinet for Health and Family Services, Division of Mental Retardation	North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	Department of Public Welfare, Office of Developmental Programs	Department of Finance and Administration, Division of Mental Retardation Services
Licensing Authority for HCBS waiver services	Department of Disabilities and Special Needs	Department of Social Services-Residential and Day programs	Department of Public Health and Environment	Department of Human Resources, Office of Regulatory Services	Cabinet for Health and Family Services, Office of the Inspector General	North Carolina Department of Health and Human Services, Division of Health Service Regulations	Department of Public Welfare, Office of Developmental Programs	Department of Finance and Administration, Department of Mental Health and Developmental Disabilities

	South Carolina	California	Colorado	Georgia	Kentucky	South Carolina	Tennessee	Tennessee
Dollar flow	Federal dollars flow to state Medicaid agency; State dollars appropriated to DDSN; most day and residential providers bill DDSN	Federal dollars flow to state Medicaid agency; state dollars appropriated to DDS; DDS regional centers bill DHS for federal match	Federal and state match dollars flow through state Medicaid agency; Providers have 3 options to bill for reimbursement	Federal match flows through state Medicaid agency; state match flows through MHDDAD; providers bill directly to Medicaid	Federal and state match dollars flow through state Medicaid agency; Providers bill third party agent	Federal match flows through state Medicaid agency; providers bill directly to Medicaid agency	Federal and state match flows to state Medicaid Agency	Federal dollars flow through state Medicaid agency; state match dollars are allocated in the DMRS budget but as a component of the state Medicaid agency's budget
Service Coordination and Provision Separated?	No	Yes	No	Yes	No	Moving in that direction	No	Yes
Licensing Frequency	Annually, all children homes; Annually, Every 3 years, adult homes of providers	Annually, all providers	Annually, all providers; alternating years with DPHE licensing and DDD certification	Annually, all providers	Annually, all providers	Annually, all providers	Annually, all providers	Annually; all providers
Licensing Process	Single step process, initial and annual licensing by DDSN	Two-step process- initial and annual licensing by DSS; vendorization process by DDS	Two-step process- joint licensure by DPHE and DDD; license/certify in alternating years	Two-step process- initial and annual licensing by ORS; certification process by MHDDAD	Two-step process- initial and annual licensing by OIG; certification process by DMR	Two-step process- must receive endorsement from Local Management Entities who contract with DMHDDSAS; once endorsed, initial and annual licensing by DHSR	Two-step process- must qualify with Administrative Entity; initial and annual licensing by ODP	Two-step in first year- initial licensing by DMHDD and certification by DMRS; annual certification by DMRS in subsequent years

IV. South Carolina Perspective.

In this section, major themes are highlighted from interviews and focus groups with key stakeholders of the state's service delivery system for the developmentally disabled. Key stakeholders include advocacy groups, consumers, family members of consumers, advocates, DDSN staff, DHHS staff and service providers. Questions were developed around the key components of DDSN licensing standards. Although not all of the stakeholders were able to speak directly to the standards, they did speak to issues and concerns related to the standards.

A. Summary of Interviews with Key Informants, Consumers and Advocates

Facility Cleanliness and Maintenance. Issues raised included keeping appliances in working order, locked up cleaning supplies, fresh food, and sanitary bathrooms. Participants also reported that some homes lack basic necessities such as soap, and pointed to the presence of pests such as lice, cockroaches and ants as hazards to client safety and welfare. Insufficient hand washing by staff was also mentioned. Participants believed that more frequent monitoring of facilities would encourage staff and administrators to do more to ensure that the homes were better maintained and free of hazards, thus improving the quality of life for clients.

Staff Training. Participants expressed concern about cases of abuse and neglect, which they feel are attributable to a lack of monitoring of staff and to insufficient training. This was especially true in cases where patients require special services, such as with patients that exhibit behavioral problems or who require adaptive or assistive technologies for basic needs such as eating and breathing. In addition, concerns about basic care practices, such as lifting patients in bed or on the floor, were also raised.

Problems with food preparation were reported in both focus groups, showing that some staff do not or cannot adhere to the food preparation guidelines for clients. This may be due to a deficiency in staff training, or to staff not being effectively monitored.

Consumers and families feel that staff are unable or unwilling to interact with the clients, and, as a result, the needs of the clients are ignored or misunderstood. Consumers and families would like to see staff training that would give staff more guidance in understanding clients' needs and provide opportunities to improve the relationship between consumers and staff.

Participants feel that the clients would be best served if the training programs were consistent for all staff across the state. Currently, staff training is limited to the training received from private providers or county DSN boards. While basic standards are in place, the content of the training process varies across the state.

The failure to pay for staff training impedes the recruitment of new staff. According to participants, larger providers are in a better financial position to compensate staff for training, which places smaller providers at a competitive disadvantage because they may not be able to afford the expense of paid training.

Background Checks. Participants described a number of incidents that were associated with insufficient background checks that did not detect violations that could endanger clients. Moreover, participants felt that providers are so desperate to obtain staff, potentially dangerous violations are being overlooked, and in doing so, putting the client's safety at risk.

Lack of Accountability & Monitoring. Participants see a lack of accountability as a pervasive problem in all levels of the system that could be addressed with increased quality assurance and monitoring measures. More frequent visits from staff supervisors, DDSN staff, and state level staff would give consumers and family members the peace of mind that client health and safety are being protected. The increased monitoring would also serve as a deterrent to some of the incidents associated with client funds and implementation of individual service plans.

Client safety was a major concern attributed to the lack of monitoring and accountability. Increased investigation of reports of abuse, as well as other client safety concerns, would go a long way in preventing the occurrence of abuse and neglect. Consumers and family members were also troubled that the process for reporting and investigating abuse and neglect does not appear to be aimed at prevention or ensuring client safety.

Staff to Client Ratios Are Insufficient. Participants believe that the actual staff-to-client ratios are insufficient. In some situations, they believe this to be an administrative decision to under-staff facilities to minimize costs, whereas others felt that the insufficient staff ratios are a result of providers not fully understanding and appreciating the needs of the clients. Consumers and family members feel that, because of the level of care for many of the clients in residential facilities, there should be enough trained staff on duty to maintain client safety, but also to allow more engagement with the clients, such as activities, which would improve the client's well-being.

ISPs and BSPs Not Implemented/Followed. A common concern for many consumers and families related to the development and adherence to clients' individual service plans (ISP) and/or behavioral support plans (BSP). Consumers and family members see some of the goals as unrealistic and unattainable, whether because of the client's level of functioning or due to the reluctance of staff to appropriately implement aspects of the plan. Additionally, if the staff is unwilling or unable to adhere to the plan, consumers and families feel there is no recourse.

Consumers and family members seemed to sympathize with staff, noting that they understood that caring for disabled clients is emotionally and physically draining. However, they also assert that the client's caregivers are hired to implement the ISPs of the clients and should be held accountable if they do not adhere to the plan's goals and objectives.

While staff might document that an aspect of the client's ISP or BSP was followed, there is no assurance that the task was completed as required, or if it was completed correctly or in a timely fashion. Because the regulations look only for the documentation of adherence to the client's ISP or BSP, implementation of the plan is dependent on the willingness and effectiveness of staff to follow the plan.

Consumer and Family Rights Are Not Protected. Advocates, consumers and family members do not feel that their rights as parents and advocates are protected. Consumers and family members find it difficult to obtain accurate and timely information from providers and staff. Because they lack sufficient information about the services that are available for clients and the process by which they are attained and rendered, consumers and family members are confused.

Some communication problems are due to confidentiality regulations and because many have waived their rights as guardians. Consequently, families feel helpless in ensuring the safety of their family member and that the goals for the client are implemented and achieved. While family members appreciate the need to protect the clients, they feel as though their role as family members should allow them to remain informed about their relative's progress.

Lack of Choice in Providers. Some of the strongest sentiments heard in the focus groups concentrated on the lack of choice in providers. Consumers and families agreed that lack of choice is in large part due to the complexity in the process for private providers to obtain licensure or certification. They see this as a systematic problem that discourages potential providers from attempting to enroll. The process is difficult and expensive, and there is little support from the DSN boards. The lack of choice forces consumers and families to select substandard service that risks the health and safety of the client or to forego services altogether.

Health Services and Medication. Consumers and families discussed concerns that the client's medical needs were not being met due to a number of reasons, including instances where non-medical staff were making medical decisions, medical assessments were not being completed, and medical plans were not being followed. Therefore, consumers and family members felt that more training and monitoring is necessary to ensure client health is maintained.

Documentation and Records. The focus group participants also mentioned concerns that forms and paperwork are not being accurately and thoroughly completed.

B. Interviews with DDSN, DHHS and Providers

Role of Licensing and Certification. Questions were raised about the purpose, procedures and processes associated with licensing and certification. First, there were questions raised about the independence of the process. For example, why have licensing and certification staff report to the same management staff responsible for programmatic aspects of service delivery? How does this affect appeals? Second, there was confusion regarding the procedures employed during the review process. For example, why site visits are conducted during daytime hours (while consumers were off-site)? Is the on-going consultation provided by site visit staff during a review actually consistent with their assigned duties?

Standards and Directives. Two issues were raised that addressed the service standards and agency directives governing program design, delivery and oversight. First, there were concerns about public access to the pertinent information. Agency staff and enrolled providers reportedly have access to information through a secured website that is not readily available to providers, consumers and advocates. Currently, DDSN's web site grants public access to 39 of 149 of the documents by which agency operations are governed.

Second, interview participants questioned whether a comprehensive review of the current standards and evaluation of the "expanding" collection of related agency directives might ultimately prove useful for all parties. The services for day habilitation programs associated with the MR/RD HCBS waiver are governed by 3 DHHS Standards, 7 DDSN Standards, and 27 DDSN Agency Directives. Residential habilitation programs are subject to review based on 2 DHHS Standards, 5 DDSN Standards, and 34 DDSN Agency Directives. These standards and directives do not include regulations identified in state and federal legislation, DHEC standards, DSS standards, nor do they include the standards governing inspections by heating ventilation and air conditioning professionals, Fire Marshalls, etc.

Consumer Choice. Participants expressed concern about the comprehensive role of local DSN Boards and the limitations that role places on private provider enrollment and related reimbursement options.

The current system discourages provider enrollment in a variety of ways. First, the application procedures for operating a single site of service are the same as those in place for large provider entities that intend to operate multiple sites, placing onerous administrative demands on small providers. Small providers are forced to become subcontracted providers of the local DSN boards, reducing flexibility in hiring practices and variability of competition in the market. Second, providers with an interest in delivering services in an area that crosses DSN Board area boundaries are required to complete separate sets of administrative documents. Third, local DSN Boards manage provider reimbursement, deliver services and act as case manager/care coordinator; the service opportunities available to private providers are limited.

Staffing. Concerns related to staffing are divided into three areas: recruitment and retention of qualified staff; training of new hires; and, supervision of existing staff. First, the low wages paid for service workers in the field result in an array of problems, most notably staff turn over. DSN Boards can offer wages comparable to jobs available at a local fast food restaurant, while the day-to-day demands upon a caregiver of an individual with a disability are significantly higher. Second, the training required to adequately prepare a staff person for work with individuals with disabilities is significant, and is much less than the on-going training required for improving a staff person's skills. Financial and personnel resources may not be available to deliver the numerous training sessions that staff turnover may necessitate. Third, the interview participants acknowledged the struggles their organizations face in finding and retaining qualified supervisory staff. This may result in marginally qualified (but available) staff being promoted to supervisory roles; lack of mentoring for new hires and overall substandard service delivery. Compounding the problem, providers with staff that deliver services within multiple residential locations may have infrequent opportunities to observe those staff, further limiting the provider's ability to assure quality of care.

Other Reviews. The array of reviews, audits and investigations currently conducted have a significant impact on facility and program productivity. One area reported that outside reviewers were on-site conducting activities in excess of 200 days during the prior fiscal year. Granted, all involved recognize the importance of independent oversight, but interview information suggests

that the processes and procedures for these activities need to be coordinated to reduce duplication and significantly improve reporting.

Program Comparisons. Participants expressed interest in establishing a system by which programs, providers and facilities can be compared and the information made publicly available for use by consumers, advocates and case managers.

Communication and Information. Interview participants expressed an interest in receiving what one respondent referred to as "functional reports," i.e. consolidated reporting, consistency across review activities, and information conveyed to an audience with authority to effect necessary change. The inconsistent availability of standards, directives, reports and related information make transparency impossible. Interview respondents suggested that all participants, from consumers to providers, would benefit from an improved understanding of the entire service system.

V. National Perspective

Interviews were conducted with national level stakeholders to identify promising and best practices states are using for quality management.

Licensing & Certification. The requirement that a provider be licensed or certified for provision of services is a historical remnant of the hospital-based systems that existed prior to the de-institutionalization initiatives, sparked in the early 1960s by the Community Mental Health Act of 1963 and furthered in 1999 by the Supreme Courts decision in *L.C. & E.W. v. Olmstead*. The continued use of these procedures has some minor facility-based structural value, but is only a small aspect of what should constitute current day quality management initiatives. The functional definitions of licensing and certification are state-based and typically associated with an established set of service standards. Licensing typically refers to health and safety elements of core residential services and site-based services. Certification tends to be used for similar purposes with "less hard core services" such as supported living, independent living, respite and employment training. CMS has defined the types of programs and services that are reimbursable with an approved waiver application, but states remain responsible for establishing the structural features and regulatory requirements that govern delivery, i.e. services, standards, frequencies, reviews, supports and oversight mechanisms. Organizations like the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute have worked with CMS to produce and promote best practice guidelines, but have not yet produced best practice standards. This leaves states with discretion on how to manage HCBS waivers.

Best and Promising Practices. The existing best practice guidelines promoted by CMS are a component of the HCBS Quality Framework (see Figure 1, HCBS Quality Framework). These identify licensing and certification as a "Discovery" component of a much larger system for continuous quality improvement (see Figure 2, Continuous Quality Improvement).

The national experts reported that states are in various stages of implementing these guidelines. Those that are further along tend to have been expediting their efforts as a result of federal audit findings. Model states include Massachusetts, Tennessee, Colorado, Delaware and Connecticut. Most states have maintained a role for licensing and certification, but have streamlined and simplified the related regulations to cover the structural aspects of facilities in which services are provided. The oversight of service delivery has begun moving away from the traditional site-by-site review systems and toward organizational improvement monitoring similar to those associated with accreditation offered by the Commission on Accreditation of Residential Facilities. For example, Connecticut has redesigned the service delivery system to include 24 components of quality oversight that include: Incident Reporting; Abuse and Neglect Reporting; Employee Registry; Criminal History Review and Verification; Motor Vehicle License and Record Review; Work's Comp and Liability Insurance; Training Requirements; Organizational Self-Assessments; Continuous Improvement Plan; Corrective Response System; Integrated Data; Provider Profiles; Quality Individual Plan of Care; Case Manager and Supervisor Plan Oversight; Program Review Committees; Human Rights Review Committees; Medication Administration Regulations; Mortality Reviews; Quality Visits; Contract Administration and Monitoring; Licensing; National Core Indicator Surveys; Complaints and Prior Approval Review System;

Figure 1: HCBS Quality Framework

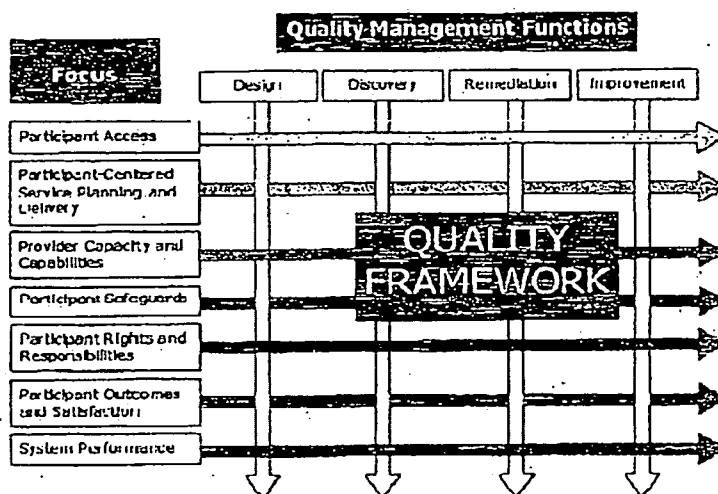
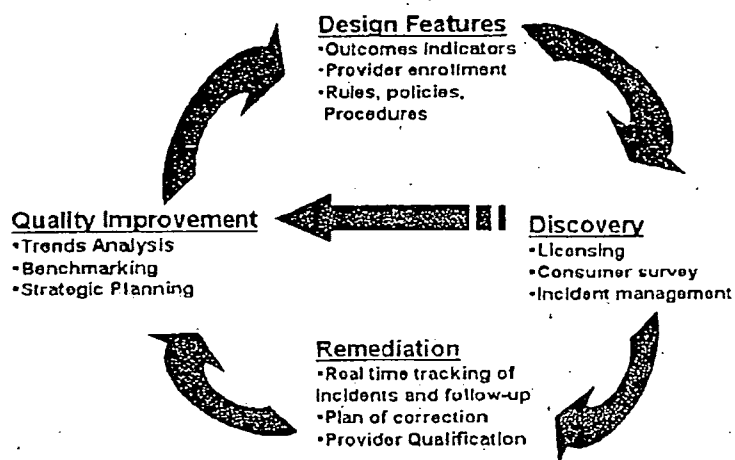


Figure 2: Continuous Quality Improvement



and, Financial Audits. They have also designed a computer-based system to compile the data captured across those processes for integrated reporting.

Organizational Structure. Organizationally, the national stakeholders acknowledged the role typically served by existing state licensing and certification systems, cautioning that they tend to be systemically "arcane and vestigial -- hard to change". If a state system has progressed towards a regulatory structure that provides a license or certification contingent primarily upon the structural features of a facility, then procedural responsibility for conducting those visits should be housed external to the service delivery structure. If, however, licensing and certification serve both a structural and a programmatic role, external oversight could prove problematic if the assigned entity lacks the expertise necessary to audit services specifically designed for individuals with developmental disabilities. Regardless of model, national stakeholders maintained that licensing and certification systems must be empowered to issue, revoke, and monitor services with sufficient autonomy and control over all associated tasks. It is recommended that the process require good standards, good reviewers, independence and related authority.

Case Management (also called Service Coordination). Nationwide, waiver related case management activities present a set of complications similar to those identified with the organizational placement of licensing and certification systems. National experts suggest that case management systems need to be at an arm's length from service providers. Examples of promising case management systems in operation can be found in states like Kansas, Connecticut, Nevada, Minnesota and California. In each of these systems, case management services are delivered by an entity that is operationally separate from the service providers. In California, for example, oversight is provided by the state waiver authority, and both case management and service delivery are outsourced separately to private providers. In other states, the waiver authority provides case management and all service delivery is outsourced to private providers. The separation of these functions creates necessary "fire walls" that prevent conflicts of interest, facilitate functional outcomes and serves as an independent oversight mechanism.

Separate Waivers. The national experts also recommend that states consider following the growing trend of separate waivers for categories of services, instead of the traditional approach where comprehensive waivers are proposed for a select population of consumers. States have begun to recognize the value added by separating waivers by categories (e.g., residential-based and community-based; supported living and supported employment). By design, being able to waive "state wideeness", comparability of services, and income/resource rules, allows states to reduce overall financial exposure. Operating an all-inclusive waiver limits a state's ability to restrict eligibility and availability. A consumer who is determined eligible for a particular waiver program is therefore eligible for all service components offered. Separate waivers for residential- and community-based services (or otherwise delineated), allow a state to define a consumer group, a geographical area, or a resource allocation strategy and provide the legal constraints necessary to offer services efficiently and effectively. These constraints enable a system to more aptly manage competition among providers and ultimately determine service quality. Georgia and Colorado have separate HCBS waivers. The primary advantage the interviewees noted was a financial one.

VI. Considerations for an Effective Quality Management System

Based on the center's expertise in quality improvement and the findings from the multi-state comparison, below is a list of critical elements that are considered the basic foundation for an effective quality management system.

Inclusion of All Stakeholders in Quality Improvement Process. A key component to an effective quality improvement process is engaging stakeholders or "customers" and understanding their needs and requirements to drive performance outcomes. Effective quality improvement processes implement mechanisms to gather customer perspectives and use that information to identify performance outcomes. Quality improvement processes fall short of effectiveness when customer perspectives are gathered but not used to develop performance outcomes. DHHS's customers for the HCBS waiver include HCBS waiver participants, the legislature, CMS and DDSN.

Identification of Performance Indicators and Data Measures. As mentioned above, performance outcomes and their indicators are identified from gathering customer perspectives. Data measures are established based on performance indicators. An effective quality management system for DHHS would be one in which indicators are developed based on the perspectives of DHHS's customers and data measures are identified and data are collected to measure performance. A number of the states reviewed collect data on performance indicators developed by CQL and NASDDDS; indicators measured go beyond typical indicators such as utilization reviews, medication errors, critical incident and mortality reporting. Indicators also collected include client outcomes, human rights, and staff training.

Continuous Collection and Review of Data Measures. Data are collected on a regular basis which is typically defined as a minimum of monthly. Data are summarized and reported to designated groups who meet regularly to discuss the data, trends, and develop solutions to address identified problems. These groups, typically in the form of committees, are made up not only of management level staff but also direct line staff and other stakeholders.

Integrated, Accessible Database for Data Analysis and Reporting. An effective quality management system uses a database that houses data for all identified performance measures and is accessed regularly by designated staff and others to collect, summarize, analyze and report data. Colorado's state Medicaid agency has developed a database that is accessible to providers and to the agency responsible for operating the MR/RD HCBS waiver to enter and review data collected to measure performance.

Institutionalization of Quality Improvement Mindset. It is critical that persons or groups engaged in quality improvement understand what that term means and how to do it effectively. Below is a table from an article by Nicholas Castle et al that describes the differences between quality assurance and quality improvement (Health Care Management Review: June 1997).

Table 2. Differences between Quality Assurance and Quality Improvement

Quality Assurance	Quality Improvement
Used by specific staff	Used by all management
Involves only specific staff	Involves all staff (often as teams)
Studies individuals	Studies processes
Asks how processes are different from the norm	Asks how processes can be improved
Comparison to a preformed standard	Comparison to an objective
Often limited to clinical activities	Used in clinical and nonclinical activities
Output: judgmental reports	Output: flow charts
Output used by managers	Output used by teams

Although DHHS has quality assurance mechanisms in place, those processes and the agency's quality improvement processes could be enhanced by orienting staff and stakeholders to quality improvement models in order to change mindset and restructure its current quality management activities to improve results.

VII. Study Findings

Based on information collected from the literature, documentation and materials reviews, state comparison analysis, interviews, focus groups, and site visits, there are several issues that raise concerns about South Carolina's processes for assuring the health, welfare and safety of the individuals in the HCBS waiver. Although other issues were raised, the ones highlighted in this report relate to the scope of the study.

A. Licensing Process for Providers

Comparable licensing standards. South Carolina's licensing standards were compared to the licensing standards of those states studied. See Appendix B for to review the comparison. Overall, South Carolina's standards are comparable; there were no significant discrepancies among the states' standards.

No external licensing process. South Carolina has a single licensing process that is performed within DDSN. All of the other states studied have two-step licensing and certification processes. The licensing process is external to the agency that serves individuals with developmental disabilities, and it focuses on health and safety regulations. The certification process is an internal process within the division or agency responsible for serving the developmentally disabled population, and while it has health and safety requirements, its focus is primarily on programmatic requirements. At DDSN, the words "licensing" and "certification" represent the same, single-step internal process.

No separation between management of licensing functions and management of service delivery functions. At DDSN, the licensure of providers is not only internal to the agency, but also is supervised by the same management responsible for oversight of local DSN boards and private organizations who provide and/or coordinate services. The lack of separation raises questions about the independence of the licensing process. On occasion, deficiencies cited in licensing visits that would have required corrective action by the providers have been overturned by executive management. The concern is, if providers "bark loud enough," they can get licensing report findings changed.

Insufficient resources dedicated to licensing function. There are only four staff in the division responsible for initial licensing and licensure renewal. Only one third of adult residential group homes per provider are licensed per year. Unless there are recurring problems that arise in the homes being licensed, no licensing visits for those homes will occur for three years. Of the other states studied, all provider agencies and their provider homes are licensed and/or certified on an annual basis.

Lack of standardized licensing protocol. There is no single, standardized licensing inspection document that is used across the division. Each staff person has his or her own tool that he or she uses when inspecting a provider. Moreover, without standard protocols, prior experiences influence how staff conducts provider inspections. Thus, provider licensing reports may vary due to staff differences. In other states, standardized licensing and certification tools are used by staff when inspecting provider agencies. In addition, in these states licensing and inspection

information collected was synthesized and used to identify case trends. The information collected in DDSN's licensing process is not systematically consolidated to identify case trends. If case trends are identified, it is through informal discussion among licensing staff.

B. Quality Assurance/Quality Improvement Activities

The other states studied use multiple mechanisms to ensure that the programs and services are systematically being reviewed for quality improvement and assurance. In addition, the mechanisms in place are instituted by multiple divisions or agencies responsible for the health, welfare and safety for the developmentally disabled. The information collected and used for quality assurance and improvement is not only shared internally but also across organizational boundaries and with the general public.

National Movement towards Outcomes. States are shifting the focus of their quality management strategies to consumer outcomes. Most of the states studied are using CMS's HCBS Quality Framework and NASDDDS's National Core Indicators as measures for their quality management systems. In addition, there are states, including South Carolina, using measures developed by the Council on Quality and Leadership.

Lack of standardized AND accessible data collection and reporting system. Most of the state agencies responsible for offering services to the developmentally disabled had systematic data collection and reporting systems in place to monitor their services and programs. It is clear what information is collected, how often it is collected and reported, who is responsible for collecting, reporting, and reviewing the information, and how the information is utilized to make informed decisions. While data are collected by DDSN, systematic procedures for collecting, sharing / reporting, and using these data are not clear.

Need for stronger quality assurance and quality improvement processes. Other states supplement their licensing and certification processes through ongoing quality assurance and quality improvement processes. Most of the states' operating agencies have regional as well as state staff to conduct quality assurance surveys or reviews to collect data on the performance of providers. Most of the states' Medicaid agencies regularly collect information for their own quality assurance reviews and some also participate in quality assurance and improvement activities that are implemented by the divisions or agencies responsible for serving the states' developmentally disabled populations.

DHHS is responsible for the implementation of the HCBS waiver and ensuring the health, welfare and safety of the individuals served by it. DHHS currently has one full-time quality assurance position designated to conduct "look-behind" reviews and, as of July 2007 has entered into a contract with Qualis Health, a private, nonprofit organization based in Seattle, to conduct utilization reviews. Based on our comparisons with other states, the limited resources allocated to perform the agency's quality assurance activities must be strengthened to ensure that HCBS waiver requirements are met.

DDSN has two major activities for quality assurance and improvement—First Health Reviews and the QEP. The First Health reviews are used for quality assurance purposes to ensure that

providers are meeting the minimum standards or requirements. QEP is a promising model for quality improvement; however, the process is in its infancy and currently is not required of participants to participate. At this time, DDSN does not share QEP data with DHHS and DHHS does not play a formal role in DDSN's quality management processes. In addition, DHHS does not collect this type of data on its own to use for quality management purposes.

Lack of Access to Information. Quality assurance and quality improvement information is not easily accessible by individuals and entities external to DDSN. In the states studied, reviews, audits, findings and related data elements are shared across organizations on a regular basis. In two of the states surveyed, the agencies involved share access to the same web-based data reporting system. In comparison, our review suggests and DHHS audits indicate, additional quality assurance and quality improvement information is needed by DHHS to ensure that HCBS waiver requirements are met. These data can be collected and shared by DDSN or collected directly by DHHS.

No separation of service provision and coordination functions. Although service coordination is not a quality assurance or quality improvement activity, the separation of the two functions allows for multiple "pairs of eyes" to monitor quality. Most states studied have separated the two functions or are moving in that direction; in South Carolina, responsibility for the two functions are not separated.

VIII. Recommendations

A. General Recommendation

- State law should be changed to remove the licensing function from DDSN. DDSN should develop a certification process that focuses on quality and outcomes. An external licensing process would allow for an outside check on provider performance in meeting statutory requirements focused on health and safety.

B. Recommendations for DHHS

- In collaboration with DDSN, the agency should enhance its quality assurance and quality improvement processes to ensure that providers who serve individuals in the MR/RD HCBS waiver are meeting waiver requirements.
- The agency should enhance its current quality management process to ensure that DDSN, as operating agency, is meeting HCBS waiver requirements. Based on the principles outlined in Section VI, key changes would include:
 - Create a subcommittee of stakeholders (e.g. DHHS and DDSN staff, licensing agency staff, advocates, waiver recipients) who will regularly meet (at least quarterly) to review data, identify case trends and make decisions on how to act upon case trends.
 - Through the subcommittee, systematically identify the types of quality management data needed. Potential guides include the CMS framework, the NASDDDS's National Core indicators, and the types of data collected by other states (see Sections III, IV, and VI).
 - DHHS should have access to individual level service data to: increase quality management/oversight; monitor the multiple (and sometimes conflicting) roles of DDSN; improve rate setting mechanisms; respond to consumer inquiries with enhanced specificity; and, increase overall accountability.
 - Through the subcommittee, decide how the needed quality management data are to be collected, shared, and used.
 - Allocate additional resources for the agency's quality management activities to ensure that HCBS waiver requirements are met.

C. Recommendations for DDSN

- If licensing remains at DDSN:
 - Its line of authority should be separated from the division responsible for service delivery. Currently, it appears that there are no checks and balances in place.
 - Adequate resources should be allocated to enhance the licensing function. The number of licensing staff should be increased in order to ensure that all adult residential group homes are licensed on an annual basis.
 - Licensing tools and procedures should be standardized. All staff should be trained to use a single standardized evaluation tool in order to increase inter-rater reliability and consistency across licensing inspections.

- The agency should develop a formal, standardized system for data collection and reporting.
- Resources should be allocated to this system so data can be collected and reported on a more frequent basis.
- Participation in the agency's quality improvement process should be required for all providers, including private providers.
- Information on quality of services should be shared with external entities such as DHHS and the general public on a regular basis. Agency standards and directives should be readily available to the public.
- Require the separation of service provision and coordination. The North Carolina mental health care system reform is an interesting model in which its local management entities are shifting from service provision and coordination to the purchasers and supervisors of entities that provide those functions. In North Carolina, no provider can perform both functions.

IX. Appendices

Appendix A

California (CA)

Organizational Structure. California's state Medicaid agency is the Department of Health Services (DHS). It provides oversight to the Department of Disability Services (DDS) who is responsible for providing services to the developmentally disabled and is responsible for the implementation of the HCBS waiver. DDS contracts with twenty-one (21) private, not for profit corporations which are responsible under state law for operating regional centers to implement programs and services for individuals with developmental disabilities including coordinating, providing, arranging or purchasing

The Department of Social Services (DSS) is responsible for the initial licensing of entities interested in providing services to consumers served under the HCBS waiver. This licensing process is health and safety-focused. A provider must obtain a license from DSS before they can begin the "vendorization" process DDS requires of potential providers before they serve HCBS waiver consumers. The vendorization process includes programmatic standards in addition to health and safety standards.

The survey respondent expressed the advantages and disadvantages of having two separate licensing standards required by two separate agencies. A disadvantage is that there are two separate licensing regulations that sometimes conflict. DSS implements Title XVII regulations; DDS implements Title XXII regulations. This conflict comes in to play when serving severe, behaviorally challenged and medically-fragile consumers. The advantage is that this set up favors the consumer—there are two agencies ensuring adequate care. If there is a problem in the home, DSS is able to take more concrete action than DDS in addressing the problem.

Licensing Process. The time it takes to obtain a license from DSS is approximately three (3) to six (6) months. Once a potential provider obtains a license from DSS, it begins the vendorization process by applying through a regional center. The vendorization process can take up to three (3) months. A key component of the process is a detailed proposal of the services a provider plans to provide. Reimbursement rate negotiation (For residential programs, there is a 11-step rate system; for day programs, they receive the state average rate) is also part of this process. Licensing standards meet HCBS waiver requirements. There is a pilot being conducted by the Bay Area regional center using the National Core Indicator framework developed by the NASDDDS.

Process for Detecting and Addressing Complaints/Problems. There is a memorandum of understanding that delineates how DDS and DSS will work together to address problems/complaints. Title XVII regulations provide a formal process for handling complaints and problems. There are many ways to detect problems or receive and investigate complaints:

- Regional centers are required to visit each provider at least once per quarter. Policy requires that two of the visits per year must be unannounced.

- There is an electronic incident reporting database that allows for timely reporting of information.
- A triennial review is conducted by DDS with each provider. The review is comprehensive and examines all the information collected over the three years from various entities including the risk management contractor, licensing divisions, and the regional centers.

Quality Assurance/Quality Improvement Infrastructure. Beyond annual licensing, there are several other components to DDS's quality management system to ensure the health and welfare of its consumers. The regional centers utilize multiple ways for monitoring the quality of service provision. A facility liaison employed by the regional center conducts an annual programmatic review of providers. In addition, service coordinators employed by the regional centers conduct regular visits with consumers. Thus, service providers have multiple coordinators in and out of their facilities who "keep an eye on" them.

A risk management contractor regularly collects data for the regional centers. This information is reported and used to identify case trends. Each regional center has a Risk Management board that reviews the information collected and makes decisions for quality improvement. On an annual basis, a risk management report is published and presented to the legislature. This process has evolved over the past six years.

Another mechanism used to ensure the quality of service provision is a comprehensive review that each regional center is responsible for conducting every three years on each provider. An area board who is under state authority conducts the review. A significant component of the review is interviews with the consumers and their families. A stipend is paid to employees or volunteers to conduct these interviews.

DDS's state office conducts a review to monitor the implementation of the waiver. Depending on the size of the regional center, a sample of 50-120 providers is reviewed. Interviews with consumers are conducted and services provided are monitored. The state Medicaid agency is invited to participate in the on-site reviews of regional centers to review service providers.

Colorado (CO)

Organizational Structure. Colorado's state Medicaid agency is the Department of Healthcare Policy and Financing (HCPF). By statute, the Department of Human Services (DHS) is responsible for the implementation of Medicaid waivers. Its Division of Developmental Disabilities (DDD) oversees the implementation of three Home and Community Based Services (HCBS) waivers for persons with developmental disabilities.

The Department of Public Health and Environment (DPHE) and DDD are responsible for the licensing of group home providers who provide residential services consumers living in home with 4-8 residents funded under the HCBS waiver (Colorado statute 27-10-5). This licensing process is defined by statute and is site-specific—all health care facilities are required to be licensed. Residential homes serving three or fewer persons are legally exempt from licensing requirements. Licenses for facilities for the developmentally disabled are renewed biennially based upon on-site surveys of programmatic requirements by DHS/DDD and

environmental/health requirements by DPHE in alternating years. A certification process is conducted by DHS and is not site-specific; it ensures programmatic, health and environmental requirements of the HCBS waiver are met by service agencies providing residential services in home serving 3 or fewer consumers. DDD also completes certification processes for day program services, targeted case management service providers and agencies providing support services to adults and children.

The survey respondent stated that because mandates are broad, the licensing structure has not impeded regulatory efforts. A licensing agreement exists describing how DHS, DPHE and HCPF will work together; their relationship is described as "good"—the system is moving towards automation and a tremendous amount of information is shared across organizations.

Licensing Process. To become a qualified provider to serve HCBS consumers, applicants must go through a two-pronged process. First, a provider applies for a license through DPHE. It takes approximately six weeks to two months to obtain a license from DPHE. Once this license is obtained, the provider applies for certification. Within ninety (90) days, the provider obtains certification from DHS.

There are three ways in which a provider can contract to provide services to consumers. It can contract directly with the state Medicaid agency; with a Community-Centered Board (CCB) through participation in an Organized Health Care Delivery System (OHCDS); or, with DHS. CCBs are private, not for profit organizations responsible for administering programs and services at the regional level. In addition, there are three ways in which the provider can bill for reimbursement. It can bill the CCB directly per the OHCDS, it can bill directly, or it can go to a third party business billing agent.

Process for Detecting and Addressing Complaints/Problems. Several mechanisms are in place for detecting and addressing complaints or problems. DDD's quality management system is one venue and discussed in the next section. There is a formal critical incident reporting system. In addition, there is protocol in place for consumers and their families to make complaints. Complaints can be made through the CCB or through DHS. In addition every CCB has trained and approved investigators to conduct investigations on filed complaints. The state has the Adult At-Risk Act that specifically defines what must be investigated by adult protection units in local county departments of social services and local law enforcement.

Quality Assurance/Quality Improvement Infrastructure. Several mechanisms are in place at the state and local levels to ensure the health and welfare of consumers. At DDD's state office, there are the Program and Finance sections that review information collected. The Program section has nine (9) staff that conduct on-site, programmatic-focused surveys of the providers. In addition, they review data collected on incidents, complaints reported to DDD and follow-up to serious incident/sentinel events. In addition, there are several internal reports that are developed from data that is collected on a regular basis. Data collected and reviewed include consumer satisfaction data, complaint logs, and quality improvement survey outcomes.

Certification staff look at core indicator outcomes for group homes every year, for supported living programs every 2 years, for day programs every 3 years; will look at program quality,

detailed standards. Case management agencies (CCB) are surveyed every three years. Survey schedules are shortened if critical incident report surveys, complaint logs or survey outcome data base indicate the agency is having difficulty meeting waiver and program quality requirements. For each survey of residential, day program and support services surveys, a 20% stratified sample of consumers is used. For CCB/Case management surveys, a 10% sample up to 50 consumers is used. Group homes samples always included two persons as the minimum sample size.

DHS and HCPF meet on a monthly basis to review data collected. In addition, the entities share access to their databases. For example, HCPF developed the Benefits Utilization System (BUS), a case management system for waiver programs to use. Individual service plans are available on BUS. Written notes on client are entered into the system. In addition, a web-based critical incident reporting system is used in which CCBs report information. DDD utilizes both systems. Quarterly quality management reports and an annual report are submitted to HCPF that includes findings on information collected around quality improvement indicators.

Currently, DDD is developing a statewide Quality Advisory Committee. This Committee will review data and discovery processes, client outcomes and be responsible for ensuring waiver program deliverables are met.

Georgia (GA)

Organizational Structure. Georgia's Department of Human Resources is the operating agency for the implementation of the state's MR/DD 1915(c) waiver. The state's Medicaid agency is the Department of Community Health (DCH) who is responsible for overseeing the implementation of the state's 1915(c) waivers. DCH contracts with the Department of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) to operate the 1915(c) waivers. The Office of Regulatory Services (ORS) is legally authorized to license providers who offer services to consumers who are developmentally disabled. These licenses pertain to residential and child care services, private home care and community living arrangements. Licensing does not apply to day programs for the developmentally disabled. DCH, MHDDAD, and ORS all fall under the auspices of the Department of Human Resources.

Licensing Process. ORS handles all initial licensing and is responsible for reviewing providers every year for annual license renewal. Additionally, an accreditation process is conducted by MHDDAD's certification unit. If a provider's budget is greater than \$250,000, it must be accredited by a national organization such as Joint Commission on Accreditation of Healthcare Organizations or Council on Accreditation and Residential Facilities. If a provider receives less than \$250,000, the agency is certified by MHDDAD. Upon initial application, ORS issues a provisional license and then the application must go through MHDDAD for approval to provide services to the agency's consumers. Once the provider receives approval from MHDDAD, the agency forwards approval to DCH to begin the process of obtaining a Medicaid provider number. It takes approximately eighteen (18) months for the division's accreditation process.

Survey respondents addressed the advantages and disadvantages of the state's licensing process. One advantage is that the licensing regulations for Community Living were written by

MHDDAD specifically for the population served. In addition, survey respondents state that the relationship is good between MHDDAD and ORS. A disadvantage is that there are two different sets of regulations which, at times, conflict with one another.

Process for Detecting and Addressing Complaints/Problems. Several means exist for MHDDAD to detect and address problems. One is through service monitoring. MHDDAD contracts with four (4) support coordination agencies in the state. Coordinators from these agencies visit providers regularly to see consumers. In addition, the MHDDAD division has a formal deficiency rating system that classifies problems, delineates the mechanism for corrective action, and the timeline for problem resolution.

Quality Assurance/Quality Improvement Infrastructure. MHDDAD is in the midst of restructuring the organization. As part of the restructuring, the agency is creating a more formal quality assurance/quality improvement infrastructure. The agency is hiring one quality manager per region. Quality measurement processes were developed around the Centers for Medicare and Medicaid Services Home and Community Based Services Quality Framework and the National Core Indicators framework. The state will engage thirty (30) to forty (40) community councils that assist and guide in the development of quality measurement standards and implementation.

MHDDAD contracts with an independent organization to extract approximately 1,000 consumer records for review. Data are collected around quality improvement indicators and are used to identify case trends.

Kentucky (KY)

Organizational Structure. The state Medicaid agency in Kentucky is the Department for Medicaid Services (DMS). The Division of Mental Retardation (DMR) is responsible for the implementation of the 1915(c) waiver. The Office of the Inspector General (OIG) is responsible for licensing providers who serve consumers served under the 1915(c) waiver. All three entities fall under the umbrella of the Cabinet for Health and Family Services. There are 144 certified service providers in the state, including the fourteen (14) regional Community Mental Health/Mental Retardation centers, which are quasi-governmental agencies.

Licensing Process. In order to be licensed by OIG to serve consumers in the Home and Community Based Services (HCBS) waiver program, potential providers must obtain certification from DMR, as well as enroll as a Medicaid provider. The certification process focuses on health and safety and programmatic areas. The process of DMR certification is extensive. Potential providers must attend two days of training for an extensive overview of the program and its requirements. Both days of training include competency-based tests. Providers develop policies and procedures to meet requirements set by DMR. A visit is made by DMR's provider development specialist and area administrator for a pre-service review. Certification standards are linked to the Center for Medicare and Medicaid Services HCBS Quality Framework and outcomes developed by the Council for Quality Leadership (CQL). It takes an average of seven (7) months to become certified. For Group Home and Adult Day Health Care providers, the Office of the Inspector General also conducts an initial inspection that is focused on health and safety standards to determine whether providers meet state regulatory

requirements. The breadth of the DMR certification process was purposely designed to help agencies be appropriately prepared for service delivery prior to certification. Approximately thirty (30) field staff review certified providers at least once per year and monitor individual and organizational outcomes.

Process for Detecting and Addressing Complaints/Problems. DMR has several processes in place to detect problems and investigate complaints. Systematic data collection is used to identify case trends and issues. Data collected include medication errors, mortality reviews, and other indicators recommended by the CQL. There is a formal incident reporting process in place for the providers to use. All incident reports are reviewed and if needed, additional follow up by DMR field staff is assigned. In addition, DMR has two investigators who are assigned to conduct formal investigations when circumstances require additional information.

Quality Assurance/Quality Improvement Infrastructure. Currently, DMR systematically enters information in formal databases around risk management and provider development. A quality assurance workgroup exists that has three teams: a Program Development team, a Training team and a Risk Management team. This workgroup provides oversight for all mental retardation and related disabilities programs under the auspices of DMR. With stakeholder engagement, the agency is in the process of developing a web-based provider profile to illustrate how well it is doing in providing services to consumers. Information provided includes how long the provider has been certified, if it is under moratorium or accepting referrals, and how well the provider has achieved organizational and individual outcomes. The Division is enhancing its program by moving toward web-based documentation.

The state Medicaid agency conducts look-behind reviews. DMS provides oversight to DMR efforts, regularly talks to consumers and their families. DMR submits monthly reports to DMS that include information such as the number of clients on the waiting list and the number already served by the program.

North Carolina (NC)

Organizational Structure. North Carolina's Department of Health and Human Services (DHHS) is the state's agency responsible for ensuring the "health, safety and well-being" of all North Carolinians. The agency is divided into thirty (30) divisions and office that fall under four broad service areas—health, human services, administrative and support functions. The Division of Medicaid Assistance (DMA) is the agency's division responsible for the state's Medicaid program. The agency's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDASAS) is responsible for ensuring service provision to, among other populations, the developmentally disabled and is responsible for administering the state's Home and Community Based Services (HCBS) waiver.

In 2001, North Carolina's General Assembly enacted comprehensive mental health care system reform at the state and local levels. As a part of this reform, the area authorities and county programs that were responsible for service provision and coordination became Local Management entities (LME). Their relationship with DHHS shifted into a more business-like relationship; governance of the programs moved from the signing of memoranda of understanding to performance contracts. These contracts established a clear understanding of

respective responsibilities and performance requirements to meet program outcomes and reflected the new management functions of LMEs. LMEs are moving out of service provision and coordination and are now responsible for the oversight of provider agencies who will contract with the LMEs to provide these functions. Provider agencies are not able to offer both service provision and coordination.

Under statute, the Division of Health Service Regulations (DHSR) is responsible for licensing MHDDSAS provider agencies that provide residential and day services. This division also has responsibility to deny, suspend, amend or revoke a license in any case in which the Secretary of DHHS finds a substantial failure to comply with licensure rules.

Licensing Process. DHSR performs initial and annual inspections of licensed residential and day programs. However, providers must have an endorsement from an LME before they can be enrolled to receive reimbursement for providing Medicaid services. The endorsement process was established to ensure that provider agencies meet state and federal requirements that are consistent with the DMHDDSAS reform plan. The DHSR licensing process focuses on the health and safety of individuals. Licensure rules are linked to state statutes and assess the physical plant, equipment, and personnel. DMHSSAS is responsible for insuring providers meet licensure rules linked to programmatic areas related to service delivery. DHSR is required to inspect provider facilities a minimum of once per year; however, facilities are subject to the division's inspection at any time. DHSR coordinates inspections and investigations with DMHDDSAS and the LMEs.

Process for Detecting and Addressing Complaints/Problems. LMEs act as the first point of access for detecting and addressing complaints and problems. The LME is required by statute, rule and the performance contract to develop a formal protocol to monitor licensed provider agencies. The protocol must address the processes for 1) receiving, reviewing and responding to critical incidents, 2) receiving and responding to complaints, 3) monitoring provider agencies, and 4) implementing quality improvement activities as related to identified trends based on critical incident and complaint reporting. The frequency at which providers are monitored is based on a confidence rating. This rating is calculated by the use of a standardized evaluation tool that is used statewide. The rating is based on information collected by the LME including critical incident reporting, complaints, compliance with reporting requirements, and review findings conducted by other state agencies related to compliance with service provision requirements.

LMEs submit a monthly report of monitoring activities to the DMHDDSAS Quality management team. This team along with the division's Accountability Team and LME Team review the report. If there are concerns with the LME's ability to provide oversight to providers, then the division has the ability to require technical assistance from the division to the LME.

Quality Assurance/Quality Improvement Infrastructure. As part of the state MHDDSAS plan, an outcome-based quality management system was developed to measure system performance. Data are collected on a regular basis and correspond to the HCBS Quality Framework domains. The framework's domains are linked to the goals of the state DMHDDSAS plan. Several tools are used to measure various elements including service utilization, consumer

demographics/characteristics, critical incident reporting, consumer outcomes/satisfaction information and consumer assessments. The information collected is reported on a regular basis. Quarterly and annual reports are available on the division's website.

As part of its quality management protocol, DMA's Behavioral unit conducts quality assurance reviews on a monthly basis. A random sample of waiver cases is pulled and plans of care are reviewed. The purpose of these reviews are to ensure that services and supports are appropriate to the needs of the consumer and to assure that defined quality outcomes are met. In addition, this unit and DMHDDSAS's Accountability Team routinely conduct Medicaid Compliance audits of the provider agencies. Historically, these audits were to ensure that waiver requirements were followed for services in which providers billed to Medicaid and were paid. A shift is occurring to focus on quality and treatment issues.

Pennsylvania (PA)

Organizational Structure. Pennsylvania's Department of Public Welfare (DPW) is the Commonwealth's Medicaid agency. The Office of Medical Assistance (OMA) is responsible for administering the Medicaid program. The Office of Developmental Programs (ODP) is responsible for serving the developmentally disabled population and for the administration and implementation of the Commonwealth's Home and Community-Based Services waivers. OMA and ODP fall under the auspices of DPW. By statute, ODP is responsible for the licensing of providers who serve the developmentally disabled. ODP's central office is responsible for the development and distribution of policies and regulations as related to the waiver programs. ODP has operating agreements with Administrative Entities. An Administrative Entity (AE) is a county Mental Health/Mental Retardation program or a non-governmental entity who directly contracts with the ODP; both entities are delegated by ODP the administrative and operational functions of waiver implementation. Only one AE is a non-governmental administrative entity. An AE is the primary point of access for consumers to enroll in supports and service programs offered under the waiver programs. AEs provide and purchase services for its consumers.

Licensing Process. There are four ODP regional offices that provide direct oversight of AE's. Licensing staff are located in these regional offices. Inspectors are responsible for conducting initial and annual inspections of provider agencies. The focus of these inspections is on health and safety standards. In addition to obtaining a license, a provider agency must also meet waiver provider qualification criteria. An AE qualifies the provider which allows the provider to then enter into a Medical Assistance Provider Agreement with ODP (Medicaid enrollment process to deliver services to consumer under the Home and Community Based Services waiver program). A full inspection takes approximately one (1) to two (2) weeks to complete. The certificate process takes an additional two (2) weeks.

Process for Detecting and Addressing Complaints/Problems. As part of the licensing process, ODP uses a weighted scoring system to assess a provider's compliance with regulations. Depending on the types and numbers of violations, the provider can receive a provisional or non-renewal determination at the time of inspection. Providers develop a corrective action plan around the cited regulatory violations and make corrections before a regular certificate will be

authorized. A provider is allotted up to four consecutive provisional licenses for failure to correct non-compliance areas before the Commonwealth recommends closing the facility.

In addition to the licensing process, there are other venues ODP provides to ensure the health, safety and welfare of its consumers. An 888- consumer hotline is available for reporting incidents and for consumers and their families to use to report concerns and issues. In addition, ODP has the Home and Community Services Information System (HCSIS), a web-based reporting system to report incidents. When an incident is reported via the hotline or HCSIS, a response is followed up by the appropriate regional office or by one of the bureaus within ODP. In addition to regularly scheduled inspections, ODP conducts unannounced visits.

Quality Assurance/Quality Improvement Infrastructure. The Commonwealth's Quality Management system includes several mechanisms for quality assurance and improvement. ODP monitors AE performance through ODP Monitoring of Counties (OMOC), service reviews, complaint investigation, incident management and risk management. Regional staff conduct annual OMOC reviews of each AE. OMOC conducts retrospective individual service plan reviews. A random sample of a maximum of five percent of individual service plans is pulled. In addition, individual site assessments are conducted in which visits are made to waiver participants. Information is collected in these reviews to examine AE performance, compliance with policies and regulations, and to ensure corrective action of any areas of noncompliance. Information collected is entered into the HCSIS. A score is given based on the results of the OMOC review. AE's develop a corrective action plan based on the review which is then sent to ODP to review to ensure it adequately addresses the review findings.

Each regional office has a Risk Management Committee that meets monthly to review regional trend data including incident reports, certified investigations, licensing issues and death reports.

ODP collects additional data through the Independent Monitoring for Quality (IM4Q) process, a method implemented statewide to independently review quality of life issues for people with developmental disabilities. IM4Q monitors consumer satisfaction and outcomes. IM4Q indicators are based on the National Association of State Developmental Disabilities Directors' National Core Indicators; the indicators are organized around areas of individual satisfaction, dignity and respect, choice and control, and inclusion and physical setting. A representative sample of waiver participants is pulled and interviews are conducted. There are thirty three (33) IM4Q programs in the Commonwealth and there are approximately seven hundred (700) surveyors across the state, primarily people with disabilities and their families. Approximately 6,000 consumers and their families are interviewed on an annual basis.

Tennessee (TN)

Organizational Structure. Tennessee's State Department of Finance and Administration is the umbrella agency over the organizations responsible for implementing the state's Medicaid waivers. TennCare is the state's Medicaid agency. The Division of Mental Retardation Services (DMRS) is responsible for serving persons with mental retardation and for implementing the 1915(c) waiver. The Department of Mental Health and Developmental Disabilities (DMHDD) is the department responsible for licensing providers who serve waiver consumers. Originally the DMRS was a part of the Department of Mental Health and Mental Retardation. However, due to

significant problems in the late 1990's with the implementation of the waiver programs that led to subsequent lawsuits and a CMS moratorium on service expansion, organizational restructuring occurred separating it into two separate departments. DMRS responsibilities include waiver program and operations, quality assurance and incident investigation. DMRS has three (3) regional offices where quality management staff are located. The agency contracts with private, not-for-profit or for-profit providers that offer service provision and coordination. These two functions are kept separate.

Licensing Process. According to Tennessee Code Annotated, Statute TCA 33-22-401, DMHDD is responsible for licensing every provider that provides services to more than one person. This department provides initial licensing; its standards are health- and safety- focused. DMRS is responsible for ongoing oversight. Potential providers must first obtain a license from DMHDD before they can execute contracts with the DMRS. It takes approximately thirty (30) to forty-five (45) days for a provider to obtain a license from DMHDD. DMRS then examines a detailed proposal that includes services the provider plans to provide, staff and management qualifications, and background checks. In the first ninety (90) to one hundred and twenty (120) days, DMRS visits the provider and conducts a quality assurance "consultative survey." This provides an initial picture of how the new provider is operating and whether additional technical assistance is needed before the provider is allowed to expand. Quality Assurance surveys are conducted by DMRS annually with all providers. DMHDD can use the survey results after the first year to renew provider licenses in lieu of conducting programmatic site visits for licensure. In addition, DMHDD conducts unannounced reviews to all day and residential providers.

The survey respondent stated one advantage to the current structure is that the quality assurance standards implemented by DMRS hold a higher degree of credibility which allows for bypassing of DMHDD licensure. Since the two divisions originally existed as one, the relationships between the two are strong.

Process for Detecting and Addressing Complaints/Problems. There are several means DMRS uses to detect and address problems. An annual quality assurance survey is conducted to ensure waiver requirements are being met. A comprehensive incident management system and complaint resolution system are in place to report problems. An investigative arm is established to handle abuse and neglect cases. In addition, internal audits are conducted. TennCare can also receive and investigate complaints.

Quality Assurance/Quality Improvement (QA/QI) Infrastructure. In 2002, the Center for Medicare and Medicaid Services (CMS) funded ongoing technical assistance to the state provided by Human Services Research Institute and helped Tennessee develop a comprehensive QA/QI system. Technical assistance was provided for over two (2) years. As a result of using CMS's Home and Community Based Services (HCBS) Quality Framework, elements from over twenty (20) existing survey tools were pulled into quality measurement tool that measures performance in ten (10) domains including access and eligibility, health and security, rights, and choice.

A Regional Quality Management committee exists in each DMRS regional office. This function is located at the regional level but is under state authority. A Regional Director of Quality

Assurance oversees the collection of data through annual quality assurance surveys of providers. A sample of at least ten percent (10%) of the consumers served by a provider (at least 4 persons, no more than 15 persons) is pulled prior to the provider's annual quality assurance survey. The provider is informed of the people in the sample when the surveyors arrive on site for the survey. The sample is referred to as the core sample" for each provider; all of the persons in the core sample receive a full, comprehensive review as to their service provision. If negative trends are detected during the survey, an additional number of persons are pulled for a focused review on the area in question.

The data are collected by forty (40) surveyors. Data collected reflect the ten (10) domains of the HCBS Quality Framework. The information is collected and reported to the regional committees. The committees meet on a monthly basis, review the data and make determinations of what needs to happen to resolve any problems. This includes the development of a quality improvement plan that relates back to the provider's system. If a provider is deficient in multiple domains, the committee can mandate technical assistance and/or a moratorium on serving additional consumers. Starting in 2007, a provider "report card" is available to view on the agency's website based on the annual surveys.

TennCare also pulls a sample of providers, approximately fifteen (15) to twenty (20) per region, and conducts its own review.

Appendix B

Multi-State Comparison of Licensing and Certification Standards

The purpose of the comparison tables is to evaluate consistencies and variations between South Carolina's adult day health and adult residential habilitation program standards and those to six of the seven other states who participated in the study (California, Colorado, Georgia, North Carolina, Pennsylvania, Tennessee). In doing so, South Carolina could identify areas that parallel, exceed or fall short of the standards of those other states, and use these findings to make changes to the current licensing and certification standards.

The framework used to develop the comparison tables was a report prepared by June Rowe, entitled *Analysis of Five State's Licensing/Certification Processes and Requirements*,¹ which focused upon licensing and certification standards related to person-centered outcomes. For this project, the methodology was to take the licensing and certification provisions within the South Carolina Residential Habilitation Standards and the South Carolina Facility-Based Adult Day Standards, and categorize them in a table format. The information collected was then evaluated qualitatively, looking at the language, content, and provisions contained in the standards for the other states.

Key:

√	standards are comparable to South Carolina standards
-	standards are in place, but are less
+	standards exceed South Carolina standards
(Blank)	standards are not established or unavailable

Missing Information:

In researching each state, there were instances in which sufficient information was unavailable to thoroughly complete the table. Colorado's Volume of Developmental Disability Services did not include information pertaining to staff and personnel requirements. For this reason, the items in the table related to staff and personnel, including staff qualifications, staff to client ratios, and criminal background checks, were left blank. The information for Georgia's standards for residential facilities could not be located; thus, Georgia was excluded from the residential facilities standards comparison table.

¹ Rowe, June, "Analysis of Five State's Licensing/Certification Processes and Requirements," Human Services Research Institute, October 17, 2002

Residential Habilitation Standards Comparison Table

	South Carolina	California	Colorado	North Carolina	Pennsylvania	Tennessee
Inspections						
Fire Safety	√	-	√	√	√	-
Electrical	√	-	-	-	-	-
HVAC	√	-	-	-	-	-
Water Supply	√	√	-	√	√	√
Home Environment						
Assistive Technology & Home Modification	√	√	√	√	√	√
First Aid Kit	√	√	√	√	√	√
Sanitary, Free from Hazards	√	√	√	√	√	√
Minimum Bedroom Size	100 sq ft	-	80 sq ft	100 sq ft	80 sq ft	-
Maximum Water Temperature	120°	120°		116°	120°	
Emergency Preparedness						
Disaster Preparedness Plan	√	+	√	√	√	-
Fire Drills	√		√		+	
Consumer Rights & Protection						
Client Rights	√	√	√	√	√	√
Abuse & Neglect	√	-	-	√	-	√
Incident Reporting	√	√	√	√	√	√
Confidentiality	√	√	√	√	-	√
Client Records	√	√	√	√	√	√
Human Rights Committee	√		√	√		

	South Carolina	California	Colorado	South Carolina	Pennsylvania	Florida
Accountability of Consumer Funds & Property						
Financial Plan	w/in 30 days of admission				√	
Receipts & Records	√	√	-	√	√	√
Accountability	√	√	-	-	√	√
Personnel & Household Members						
Minimum Ratio						
CTH I	1:2	1:3			1:6	
CTH II	1:4	1:3			1:6	
SLP I	1:20	1:3				
SLP II	1:20	1:3				
CRCF	1:8	1:3				1:10
Qualifications		+		√	√	√
Background Check	√	+		-	√	√
Training	√	+		√	+	√
Residential Habilitation						
Functional Assessment	√	√	√	-	√	√
Residential Plan/ISP	√	√	√	-	√	-
Skills Training	√				√	-
Documentation	√	√	√	-	√	√
Implementation	√		√	-	√	√
Review & Changes	√	√	√	-	√	-
Behavior Services & Supports						
Behavior Support Plan	√		√	√	√	√
Restraints	√		√	√	√	√
Documentation	√		√	√	√	√

	South Carolina	California	Colorado	Georgia	North Carolina	Pennsylvania	Tennessee
Health Services							
Medical Assessments	✓	+	-			✓	✓
Medication Storage	✓	+	✓	+		✓	✓
Medication Administration	✓	+	✓	+		✓	✓
Bed Capacity							
Reservation and Census Reporting							
Bed Capacity	✓	✓	✓	✓			
Daily Census Report							
Meals							
Diet	✓	+				✓	+
Food Storage	✓	+				✓	+
Consumer Outcomes							
Home Reviews	✓	✓	✓			✓	
Quality of Life	✓						

Adult Day Program Health Standards Comparison Table

	South Carolina	California	Colorado	Georgia	North Carolina	Pennsylvania	Tennessee
Personnel							
Qualifications	✓	+		+	+	+	-
Background Checks	✓	+			-	✓	✓
Customer/Staff Ratios - Supervision of Consumers							
Minimum Ratio	10:1	8:1		8:1	10:1	10:1	20:2
Supervision	✓	✓		✓	✓	✓	✓
Customer Protection							
Client Rights	✓	✓	✓	✓	✓	✓	✓
Advocacy	✓		✓		✓	-	✓
Abuse & Neglect	✓	✓	✓		✓	-	✓
Facility							

	South Carolina	California	Colorado	Georgia	Illinois	Mississippi	Pennsylvania	Tennessee
Minimum Indoor Space	50 sq ft				100 sq ft	60 sq ft	-	
Sanitation	√	√	√	√	√	√	√	√
Fire Safety Inspection	Annual	-	√		√	√		
Fire drills	√		√	+		√		
Electrical System Inspections	√	-	-		-	-	-	-
Heating & Cooling Inspection	Annual	-	-	-	-	-	-	-
Grounds - free of hazards	√	√	√	√	√	√	√	√
Disaster Preparedness Plan	√	+		√	√	√	-	-
Safety Equipment		√	√			√	+	+
Transportation								
Inspections	√	√	√	+				√
Safety equipment	√	-	√	+				√
Health Services								
Assessments	√	+	-	√				-
Emergency Medical Plan	√		√	√		+		√
Medication Storage	√	+	√	√	+			√
Medication Administration	√	+	√	√	+			√
Evaluations/Planning								
Plan Development	√	√	√	-	-	√		
Accountability & Timeline	√	√	√	-	√	√		√
Implementation	√	√	√	-	-	√		√
Reporting & Documentation	√	√	√	-	√	√		√
Review & Changes	√	√	√	-	√	√		
Records								
Confidentiality	√	√	√		-	-		√
Minimum Records Requirements		+	√	√	√	√		√
Records Management		√	√	√	-	-		√

Appendix C

Interagency Agreement Comparison Table

The following table categorizes and compares the essential elements of the South Carolina Department of Health and Human Services' Memorandum of Agreement with the South Carolina Department of Disabilities and Special Needs for the delivery of MR/RD HCBS Waiver services with similar interagency agreements used by other state Medicaid authorities with their state providers of MR/RD HCBS Waiver services. A checkmark (✓) indicates where comparable intention and language exist between documents.

	South Carolina	Colorado	Georgia	Kentucky	Tennessee
Agreement					
Contract Terms	✓	✓	✓	✓	✓
Purpose					
Purpose of MOA/MOU/Contract	✓	✓	✓	✓	✓
Department Roles & Responsibilities	✓	✓	✓	✓	✓
Scope of Services					
Communication	✓	✓	✓	✓	✓
Coordination	✓			✓	✓
Freedom of Choice	✓			✓	✓
Level of Care	✓		✓	✓	✓
Quality Assurance Management	✓	✓	✓	✓	✓
Indicators ¹	✓	✓	✓	✓	✓
Waiver Record Reviews	✓	✓	✓	✓	✓
Quality Contractor ²	✓	✓	✓	✓	✓
Outlier Funding	✓				
Reports	✓	✓	✓	✓	✓
Medicaid Management Information Systems	✓	✓		✓	✓
Cert. of Residential Homes for Waiver Participants	✓	✓		✓	✓
Class Violations System	✓				
Corrective Action	✓	✓		✓	✓
Timelines	✓	✓		✓	✓
Data	✓	✓		✓	✓
Fiscal Administration					
Administrative Costs ³	✓		✓		✓
Reimbursement Methodology ⁴	✓	✓	✓	✓	✓
State Plan Costs ⁵	✓	✓	✓	✓	✓
Waiver Services Costs ⁶	✓		✓	✓	
Payment of State Match Funds	✓	✓	✓	✓	✓
Terms & Conditions					

	South Carolina	Colorado	Georgia	Kentucky	Tennessee
Subcontracts	✓			✓	✓
Modifications or Corrections to Agreement	✓	✓	✓	✓	✓
Elements Found in other Agreements, but not SC					
Statutory Compliance (i.e. HIPAA, Civil Rights Act, Americans with Disabilities Act, etc)		✓	✓	✓	✓
Confidentiality Requirements		✓	✓	✓	✓
Staffing Requirements			✓	✓	
Inspection of Work			✓	✓	
Termination of Agreement		✓		✓	✓
Notices		✓	✓	✓	
Assignment		✓	✓	✓	

¹Indicators: The SC DHHS/DDSN MOA requires DDSN to put measures and procedures in place to assure state and federal regulatory compliance through quality contractor indicators. For this study, quality contractor indicators was interpreted to include quality assurance measurements such as surveys, records reviews and other measures.

²Quality Contractor: SCDDSN will conduct field reviews aside from and in addition to those conducted by its Quality Contractor.

³Administrative Costs (for Attendant Care Services): the SC DHHS/DDSN MOA refers to the administrative costs for the administration of the MR/DD and HASCI waivers; for this study, the administrative costs were broadened to include costs for administration of all waiver programs.

⁴Reimbursement Methodology: the SC DHHS/DDSN MOA discusses the reimbursement methodology specifically for the PDD waiver. For this study, the methodology was broadened to waiver programs in general.

⁵State Plan Costs: the SC DHHS/DDSN MOA discusses the state plan costs specifically for the PDD waiver. For this study, the state plan costs were broadened to waiver programs in general.

⁶Waiver Services Costs: the SC DHHS/DDSN MOA discusses the reimbursement methodology specifically for the PDD waiver. For this study, the methodology was broadened to waiver programs in general.

Medicaid Home and Community-Based Waiver
Scope of Work
For
A Study of DDSN Licensing Functions

South Carolina Department of Health and Human Services (SCDHHS) is contracting with the Center for Health Services and Policy Research at the University of South Carolina (USC) Arnold School of Public Health to conduct an independent study of the SC Department of Disabilities and Special Needs (DDSN) licensing functions of residential and day services, and to make recommendations for improving the current licensing, reporting and oversight process to ensure the health and welfare of Medicaid waiver participants.

Scope of Work

The specific objectives are:

- To review the state legislative history related to regulations and DDSN's responsibility for the licensing and oversight of residential and day facilities and services for adults and children so as to determine agency authority and responsibility.
- To review a sample of comparable states with residential and day home and community-based waiver services to determine how their current legislation, standards and oversight processes compare; including best practices, and appropriate license sanctions for non-compliance;
- Determine if current state regulations and procedures are appropriate or need improvement, and identify legislation and policy changes needed;
- Interview DDSN State Office, and licensing and certification staff to review the current licensing process and proposed sanctioning process;
- Determine appropriate information and reports needed by the Department of Health and Human Services (DHHS), to meet federal oversight responsibilities and waiver assurances.
- Based on a survey of comparable states, investigate the advantages of having separate 1915(c) waivers for persons in residential setting and community settings.

USC will conduct a literature review of current licensing and sanctioning practices of community-based waiver services to identify best practices and to identify the advantages and disadvantages of separate 1915(c) waivers for persons in residential settings and community settings. A search will be conducted to determine CMS guidelines and standards around licensing and sanctioning practices. In addition, a focused review will examine South Carolina legislative history as it relates to licensing and oversight processes of residential and day facilities and, more specifically, identifying agency authority and responsibility.

A comparison will be made between South Carolina and other states' legislation, licensing and sanction practices. Six (6) states will be identified for the comparison:

- ❖ Three (3) states that are utilizing best practices in licensing and sanctioning.
- ❖ One (1) state that uses a similar process to South Carolina.
- ❖ Two (2) states whose current processes have caused significant problems in meeting federal guidelines.

Attachment 1a

Mims0472

Information will be requested from and interviews will be scheduled with each state to gather in-depth information around their current licensing and oversight standards; state legislation; sanctioning practices; information provision, review and reporting processes; and staffing ratios. For those states in the study that have separate 1915(c) waivers, additional questions will be asked of its advantages and disadvantages. Findings will be compared to determine if current South Carolina regulations are appropriate or need improvement.

A series of interviews and observations will be conducted to review current DDSN licensing and sanctioning processes and to gather feedback from stakeholders on their opinions and expectations around licensing and oversight standards. Interviews will be conducted with the following:

- ❖ Five (5) DDSN-licensed facility staff.
- ❖ Three (3) DDSN licensing and certification staff.
- ❖ Two (2) local DSN board members.
- ❖ Five (5) advocates from various advocacy groups.

Three (3) on-site visits will be made to community based residences and day programs of waiver beneficiaries that are in the process of being licensed by DDSN.

In addition to interviewing comparable states about their current processes for identifying and collecting appropriate data and facility review and reporting processes, interviews will be conducted with DHHS staff and CMS/Medstat to gather their feedback on current processes and federal standards.

Based on the findings from the interviews with comparable states, DDSN staff and local board members, advocacy group members, DHHS staff and CMS/Medstat staff, recommendations will be made around the following:

- Improvement in current licensing and oversight standards, policy and processes.
- Data to be incorporated into the Centers for Medicare and Medicaid Services (CMS) Quality Management System, in accordance with Medicaid waiver requirements.

Finally, USC will design and recommend a quality assurance and quality improvement process for oversight of the licensing functions that will include the:

- Determination of an appropriate sample size of waiver recipients;
- Development of a review instrument;
- Appropriate reviewer qualifications; and
- Appropriate service staffing ratios.

USC deliverables:

- A monthly meeting with DHHS staff to report on progress.
- A draft report within 8 months of contract acceptance.
- An oral presentation of findings in draft report
- A final report within 30 days of presentation.

DHHS deliverables:

- Provision of reports for USC review

Attachment 1a continued

Mims0473

Medicaid Home and Community-Based Services Waiver
Revised Scope of Work for Two-Month Extension
To
A Study of DDSN Licensing Functions

South Carolina Department of Health and Human Services (DHHS) has a contract (A 7 1542 A) with the Center for Health Services and Policy Research at the University of South Carolina (USC) Arnold School of Public Health to conduct an independent study of the SC Department of Disabilities and Special Needs (DDSN) licensing functions of residential and day services, and to make recommendations for improving the current licensing, reporting and oversight process to ensure the health and welfare of Medicaid waiver participants.

This amendment is to add an additional activity to the original scope of work and to extend the completion date by two months, to August 31, 2007.

Scope of Work

USC will gather and review the contracts, memorandum of agreements or memorandum of understandings (between the Medicaid agency and the agency operating the HCBS waiver) from the seven states that have participated in the DDSN Study of Licensing Functions. USC will examine language used, identify common and unique elements, and develop a comparison table.

USC deliverables:

- A monthly meeting with DHHS staff to report on progress.
- An oral presentation of findings in draft report at end of two month extension.
- A final report within 30 days of presentation.

DHHS deliverables:

- Provision of reports for USC review

Attachment 1b

Mims0474

**SC Department Of Health And Human Services
Response to the study conducted by the
USC Center for Health Services and Policy Research on
The Licensing Functions of Residential and Day Habilitation Services**

The following comments are in response to the study conducted by the USC Center for Health Services and Policy Research on behalf of the SC Department of Health and Human Services (DHHS). The agency's interest in the licensure issue is based upon the prerequisite of a license for the provision of residential and day waiver services to ensure the health and welfare of Medicaid waiver consumers. The primary focus of this study was to provide DHHS with an independent analysis of the licensing functions of residential and day habilitation services conducted by the SC Department of Disabilities and Special Needs (DDSN).

Recommendations of the study involved two major categories: the appropriateness of the licensing functions performed by DDSN in addition to quality management oversight of DDSN by DHHS. The study recommended that DHHS enhance its quality management oversight in several areas, and State law should be changed to remove the licensing function from DDSN.

Over the last several years, the Centers for Medicaid and Medicare Services (CMS) have strengthened quality requirements for home and community-based (HCB) waiver programs. CMS determines if the State has an adequate quality system in place to meet the health and welfare assurances of waiver consumers. As the state Medicaid agency, DHHS has administrative authority of the HCB waivers operated by DDSN. In 2006, the State submitted and CMS approved a revised quality management plan detailing the quality framework currently applied to all DDSN operated waivers. In 2007, DHHS submitted to CMS a compliance report for the Head and Spinal Cord Injury waiver. In the CMS evaluation of the evidentiary-based information they indicated, "The State's system to assure health and welfare is adequate and effective, and the State demonstrates ongoing, systematic oversight of health and welfare."

Appreciating that quality management is an ongoing process, the State has implemented several efforts to enhance quality practices in 2008. Thomson-Medstat, the CMS contractor for technical assistance to States, will be returning to South Carolina to consult with DHHS on CMS Quality Management (QM) waiver processes. In 2005, the State engaged Thomson-Medstat to assist in the development of a more comprehensive, revised QM plan. A second visit is being confirmed with Thomson's lead consultant, Beth Jackson, for February to discuss and incorporate the new 2008 CMS quality initiatives into the current QM plan. In conjunction with the CMS initiatives, the State is planning to add a second full time position devoted to quality activities. Additionally, Winthrop University and Qualis, a national Quality Improvement Organization (QIO), have been contracted to conduct statewide independent reviews of waiver assurances. Winthrop will focus on waiver participant plans of care, and Qualis will review and validate the level of care determinations conducted by DDSN to ensure Medicaid criteria have been appropriately applied. These measures will further enhance QM oversight of the DDSN operated waivers to ensure the State can continue to substantially meet oversight requirements.

Attachment 2

Mims0475

Stanley J. Butkus, Ph.D.
 State Director
 Robert W. Barfield
 Deputy State Director
 Administration
 David A. Goodell
 Associate State Director
 Operations
 Kathil K. Lacy, Ph.D.
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 Mary Katherine Bagnall, MSW, CMC
 John Powell

February 11, 2008

Ms. Emma Forkner
 SC Department of Health and Human Services
 PO Box 8206
 Columbia, SC 29202-8206

Dear Ms. Forkner:

Please find attached DDSN's feedback and serious concerns regarding the USC Center for Health Services and Policy Research's report.

My intent is for this to aid our discussion of this study at our meeting Wednesday morning.

Sincerely,

Stanley J. Butkus, Ph.D.
 State Director

/sb

Attachment

C: Felicity Myers, Ph.D.
 Sam Waldrep

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DISTRICT II

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 Salceby Center - Phone: 843/332-4104

Mims0476

SC Department of Disabilities and Special Needs

DDSN's Response to "A Review of the Licensing & Oversight Processes Related to the MR/RD Home and Community Based Services Waiver Program" produced by the Center for Health Services and Policy Research at the USC Arnold School of Public Health.

Executive Summary

The purpose of the report as suggested by the introduction is to assess whether necessary safeguards have been taken to protect the health and welfare of recipients receiving Home and Community Based (HCB) waiver services. Our analysis of the report found significant problems. The report does not describe the specifics of the research methodology. The information used to carry out the research in numerous instances is inaccurate, incomplete, misunderstood, or omitted altogether. The report contains no evidence, quantitative reliable qualitative data, or facts to support the findings or recommendations.

Most important the report fails to demonstrate any link between recommendations made and how health and welfare for persons receiving services in the HCB waiver could be strengthened or improved. It is not appropriate to take any action based on the evidence and conclusions provided by this report. Some of the egregious examples of problems with the report include:

- > Excluding a discussion of the quality management activities of DDSN's privatized Quality Improvement Organization (QIO) that is in its seventh year of operation.
- > Incorrectly concluding that DDSN is just forming a Risk Management Committee when it has been actively operating for six years.
- > Omitting that many other studies, reviews and reports conclude, including reviews conducted in 2004 and 2006 by CMS, that DDSN and DHHS are meeting all requirements for participation in the waiver

program including assuring the health, safety and welfare of their consumers.

- > Recommending that DDSN use the CMS quality framework when it has already been in use for seven years as part of DDSN's QIO contract and further, omitting that DDSN competed and won a CMS \$500,000 grant to study how DDSN quality assurance activities match up with the CMS Quality Framework.
- > Recommending the National Core Indicators (NCI) as something South Carolina should consider doing when DDSN has been participating and utilizing NCI for six years.
- > Assuming at DDSN that licensing and operations are overseen by the same person when they are not.
- > Not interviewing DDSN supervisory or management personnel to identify or confirm essential features of agency quality assurance functions and activities, risk management activities or roles and lines of authority of staff.
- > Omitting the licensing role of the ongoing nationwide RFP for soliciting new providers.
- > Drawing conclusions from other states' websites without understanding their context and failing to include the criteria used for comparing states.
- > Failing to recognize that one-half of the states reviewed have service coordination and service provision similar to South Carolina.
- > Failing to include methodological details for the conduct of the focus groups, the selection process, group composition, the analysis of data from the groups, measures used to support full participation of cognitively impaired individuals and validity checks, precluding the reader from evaluating the quality of the methods used.

A Review of the Most Important Errors and Omissions

Section I Introduction

B. Scope of Work Objectives

Although the report claims to have the objective of comparing a sample of other states' standards and oversight processes for residential and day home and community based waiver services (HCBWS), the report completely omitted the work performed by the Quality Improvement Organizations (QIOs), First Health, Inc. and Delmarva Foundation, both certified by CMS. The report only mentions that the QIOs are used for QA purposes but fails to include that DDSN purchases a significant part of its quality assurance activities from CMS-certified QIOs for many of its services including both residential and day HCBWS.

Furthermore, to our best knowledge, no interviews with DDSN's mental retardation director or her staff responsible for policy and procedural aspects of the MR/RD HCBWS were conducted, no interviews with the DDSN contract compliance director responsible for day to day operations of the QIO contract was conducted, and no interviews with employees of the QIO were conducted. In addition, there was no review of any data collected or analyzed on the work of the QIO, including the NCI face-to-face interviews conducted by the QIO.

Although the report includes other QA activities of the other states, it contains none of the other QA activities employed by DDSN, yet the report makes across the board comparisons.

C. Research Methodology

The report claims to have gathered "information to provide an in-depth overview of the licensing functions and quality assurance and improvement processes used by states to ensure the health and safety of consumers receiving services through the MR/RD HCBS waivers", yet no data was collected by the authors on these **bolded**

processes at DDSN. Therefore the research methodology is compromised and flawed. In addition, no evidence was produced to back up statements made by staff (e.g., "If a provider barks loud enough, executive management will change the reports"). The statements were accepted as being factual and the authors to our understanding did not request information or clarification from appropriate staff. Oversight and supervision mean draft reports are sometimes legitimately corrected, with or without provider input. In the last paragraph of this section, it states, "key informant interviews were conducted with DDSN staff (in the departments of licensing and quality improvement/assurance); again, to our knowledge, no DDSN staff responsible for quality assurance activities were interviewed nor any staff responsible for the MR/RD HCBS waivers.

Section II Implementation of the HCBS Waivers in South Carolina

A. Organizational Structure

The report states on page 9, "In addition to the DSN Boards, there are a few private providers who contract with the DSN Boards..." This is incorrect in two ways. First, the fact is that there are 21 private providers and 39 DSN Boards. Further all of the private providers of residential and day HCBWS contract directly with DDSN, not the DSN Boards.

B. Licensing Process

(1) On page 10 – The report states that "DDSN operated four regional administrative offices that each housed between four and six licensing staff." This is incorrect. The fact is these staff conducted both quality assurance (QA) and licensing functions, not solely licensing. The QA functions previously managed by these regional administrative offices were contracted out to a QIO. The QA portion was the largest function which required the majority of costs and staff positions.

The report misses the point of DDSN's reorganization in these areas: it was to create better, independent, more consistent quality assurance across the state as opposed to across a region. The reader is led to believe the reorganization was in response to budget cuts. This is

incorrect as the fact is that resources were not reduced but shifted to privatization at the same dollar amount.

(2) On page 10 it states, "Executive management that is responsible for the oversight of the service delivery system is also responsible for oversight of the licensing division." This is incorrect. Oversight of the licensing division is under the Associate State Director for Policy and oversight of the service delivery system is under the Associate State Director for Operations. These are two different people to intentionally separate the oversight of the two different areas.

(3) On page 10 – the report states that the State's licensing division has only four staff members responsible for licensing and regulating residential habilitation. This is inaccurate. DDSN has shifted many of the oversight and regulating functions related to residential and day services to the QIO in the reorganization mentioned above. Moreover, the report claims to have collected data through August 2007 – if so, the report should have included statements about the unannounced visits performed by the QIO Delmarva in a random sample of residential programs at each provider's programs on an annual basis. Shifting functions to the QIO was part of the earlier reorganization.

(4) On page 10 – the statement that "only one-third of each provider's homes will be reviewed per year" is misleading. The fact is that DDSN reviews every residential provider every year using a 33 percent sample that is both representative and generalizable to that provider's residential population. This review is akin to other states' certification visits. Providers are expected, and the licensing reports reflect, that corrections across all settings are required. In addition, follow up reviews take place in other settings than the homes in the annual sample to ensure that corrections are made across settings and not just the houses reviewed in the large 33 % sample. The authors state on page 26 that national experts reported, "The oversight of service delivery has begun moving away from the traditional site-by-site review systems and toward organizational improvement monitoring." DDSN's processes do just this.

C. Quality Assurance and Improvement Activities.

(1) Pages 10 & 11 of the report should have included exactly what the QIO does for DDSN; the omission of this substantial activity questions the validity of the report and any findings. Although First Health is mentioned as a QIO none of their processes were reviewed and reported on. On top of page 11, the report inaccurately states, "The information collected from the surveys is used to ensure providers are meeting the minimum standards for quality assurance." This is incorrect. The survey results do not assure QA but reflect the outcomes of care as perceived by consumers and family members based on actual customer feedback. The QIO does ensure that standards are met, period; there is no range from minimum to maximum.

(2) This section fails to mention the other QA activities performed by DDSN. This includes the Department's extensive abuse, neglect and exploitation system, critical incident system, and mortality reporting system including an extensive database. It also omits the fact that two (2) full time staff at DDSN are devoted entirely to consumer and family concerns, and omits the contract DDSN has with the USC Center for Disability Resources to support consumer advocacy groups across the state. The report also omits the 5% review of service coordination and early intervention plans conducted by DDSN staff on an annual basis which includes a review of day and residential services authorized.

(3) Another omission and mis-statement is found on page 11: "The process involves a four-day provider visit by state DDSN staff." Not recognized is the fact that consumers, family members, The Council on Quality and Leadership staff, and provider staff from other agencies participate with DDSN staff on these visits.

(4) Another error in this section on page 11 inaccurately states that "The state (risk management) committee is in the process of forming..." This is incorrect. The committee has been meeting and acting on risk issues for 6 years as evidenced by minutes of each meeting.

(5) The authors fail to understand and report that DDSN's quality management system, including licensing and certification, is not a

single component in and of itself but a comprehensive system with many, multi-tiered and intentionally redundant components.

Section III Multi-State Comparison Analysis

General Comment- Comparisons to South Carolina's systems were noted only under the elements of Certification and Reimbursement Methodology, meaning in 8 of the other elements the authors did not differentiate the similarities or differences between South Carolina and the states. The authors apparently never examined the actual result of differences between states. Seven comparative states are reported to be used in this study yet the authors never point out or mention any benefits or otherwise to the other state's systems.

A. Organizational Structure

While no statement of comparisons or differences was made by the authors, the fact is that several of the states mirrored South Carolina's structure. For example, one half of the states have the same structure related to service coordination and service provision. The authors offer no results in this section to determine if a state organized differently is doing better or worse than the states that are organized similarly to DDSN. As a matter of fact, several of the states used have recently had serious CMS review/audit issues. This is opposite of CMS's reviews of South Carolina's waivers.

B. Licensing Process

Again, comparisons are not made correctly. DDSN uses the terms licensing and certification interchangeably. DDSN has a provider certification process (i.e., RFP) which sounds like the other states' "certification" process (i.e., page 13, "certification... is primarily focused on ensuring providers meet required programmatic standards"). The authors never mention or evaluated the RFP DDSN has on the MMO website soliciting new providers. There is an extensive process for approving new providers. Kentucky is highlighted under this section: "Visits (there is no description of what a visit entails) are made by the DMR provider development specialist and by the regional center's area administrator are conducted for a pre-service review." This may be akin to DDSN's RFP approval process for new providers

and is combined with a DDSN pre-licensing review process which is omitted in the report. During DDSN's review process the State Fire Marshall also inspects the homes in addition to external, private HVAC and electrical inspectors. Once consumers move into a newly licensed home, DDSN licensing conducts a complete inspection of the home (i.e., annual licensing review). This is also omitted from the report.

D. Components of Interagency Agreements

The report incorrectly compares the MOA between DHHS and DDSN to some of the other states. In South Carolina, the MOA is more global in scope and the specific requirements are detailed in the contracts between the two agencies for each service provided. For example, service coordination requirements, reimbursement methodology, and statutory compliance are all addressed in the contracts for service delivery. The authors, to our understanding, did not request information or clarification from staff as to how or where these items were spelled out.

E. Multi-state Comparison Summary

Table 1 contains many errors and omissions. The main error is the authors' attempt to compare DDSN's "single-step" process to other states' two-step processes for licensing. The authors failed to recognize DDSN's process including quality assurance activities which appear to be very similar to Pennsylvania's two-step process, California's vendorization process, and North Carolina's endorsement process as a two-step process like the others.

Section IV South Carolina Perspective

General Comments: (1) The questions used for the interviews and focus groups are not included with the study and should be appended to the report. In addition, the report states that the questions used for the interviews and focus groups were developed around the key components of DDSN licensing standards. This means that other relevant pieces of DDSN's QA system for the MR/RD HCBS waiver were omitted. The composition and methodology of selecting participants should be included. Also very important is that DDSN received a \$500,000 grant from The Centers for Medicare and Medicaid Services (CMS) to validate DDSN's quality

assurance system. The majority of work was contracted out via a DDSN-produced RFP to the National Association of State Directors of Developmental Disabilities (NASDDDS). The NASDDDS, with partners from the University of Minnesota and the University of South Carolina conducted a scientifically sound research and evaluation study on the licensing and QIO aspects of DDSN's quality management system. Their study took over 3 years to conduct and is a much different product than this study.

(2) Because of the serious methodology issues, the findings of this study cannot be considered valid until further exploration occurs.

(3) Other quantitative and qualitative studies such as USC's consumer feedback report done by outside entities show remarkable differences to this report's anecdotal information. Combined with the methodological flaws, the validity of the feedback is questionable.

B. Interviews with DDSN, DHHS, and Providers

As noted before, the authors did not follow-up with appropriate staff.

Roles of Licensing and Certification: One example used to challenge DDSN's organization structure was a question: "why have licensing and certification staff report to the same management staff responsible for programmatic aspects of service delivery?" The manager for licensing is one person and the manager for policy and procedures of MR/RD HCBS waiver is another. Neither report to the other, they both report to the Associate Director for Policy who is not over service delivery and operations.

Consumer Choice: This includes some incorrect statements. Only two of the services are subcontracted from the DDSN Boards. The largest, most expensive services are contracted directly with DDSN just like the boards. DDSN monitors the subcontracting agreements for the only two services to assure equity and fairness. There is no real impact on hiring or competitive practices.

Staffing: South Carolina is the only State that requires that provider direct care employees have pay equity with the DDSN direct care employees. The Legislature appropriated funding for this many years ago. The starting wage is \$9.28 per hour plus fringe. This is not the

starting pay for fast food workers. The RFP for Qualified Providers requires the same pay to assure that the employees are capable of learning and carrying out duties assigned. The wages are higher and the turnover rate is lower than the long-term care industry in the State.

Section VI Considerations for an Effective Quality Management System

This section includes elements of an effective QM system but the report fails to address whether South Carolina's (DDSN) system includes such features. DDSN has data to support that each element featured is indeed part of DDSN's QM system. Further, DDSN participates with other states in tracking core indicators across states and across years.

Section VII Study Findings

As has been cited through-out the DDSN response to the report, there are numerous errors and omissions in the report. The design of the study is not scientific, there are significant methodological questions and errors, and results are not evaluated nor reported. Therefore, the resulting findings are not trustworthy or useful.

A. Licensing Process for Providers

No external licensing process.

The report failed to include DHEC's role in the licensure of CRCFs; DDSN does not license these settings, but DHEC does. CRCFs provide residential habilitation services just like the CTH and SLP programs that are licensed by DDSN. Nearly 230 people are served in CRCFs operated by DSN Boards across the state. It would have been important for the study to differentiate between the two licensing processes to determine if any differences were noted, especially given the recommendations made in the report to have state law changed to remove the licensing authority from DDSN. The fact that the report does not include DHEC's role is another testament to poor research design. The authors also state that to DDSN "licensure and certification represent the same, single-step process." This is incorrect. Had the report met the rigorous test of scientific studies, it would have commented on the RFP for approving providers, the quality assurance activities, and the work of the QIO.

No separation between management of licensing function and management of service delivery.

(1) The authors incorrectly state that the person who is "responsible for oversight of local DSN Boards and provider organizations who provide and/or coordinate services," is the same as the person over licensing. There are two associate state directors: policy and operations. The policy section houses the licensing division. The operations section is the area "responsible for oversight of local DSN Boards and provider organizations who provide and/or coordinate services."

(2) The statement, "on occasion, deficiencies cited in the licensing visits that would have required corrective action by the providers have been overturned by executive management. This "finding" is based on subjective information and not on fact. Any appropriate state operated system will always include an appeal mechanism. The authors did not request any information or clarification. They could have reviewed all of the appeals providers have made to date with the final decision. Appeals do not go to executive management as incorrectly stated in the report.

Insufficient resources dedicated to licensing function.

The finding is based on a lack of sufficient evidence. The study failed to show the results of having an efficient, internal licensing division combined with the work performed by the external QIO, when compared to other states. Every provider is licensed every year. As stated earlier, the authors themselves on page 26 refer to the best practice of moving away from site to site reviews to organizational improvement monitoring like DDSN is doing in South Carolina.

Lack of standardized licensing protocol

The report omits the fact that DDSN has already begun the process to standardize the licensing inspection document. In addition, the authors incorrectly conclude that "If case trends are identified, it is through informal discussion among licensing staff." DDSN has documentation to prove otherwise.

No separation of service provision and coordination functions. The statements made under this section are misleading. DDSN does in fact

have "external" service coordination providers beyond the DSN Boards. In fact, over 2090 people receive their service coordination via a private provider. DDSN's quality assurance system is designed to be the external "pairs of eyes" to monitor quality. This system has been reviewed and the result is the state has passed several times all completed CMS reviews of the waiver.

B. Quality Assurance/Quality Improvement Activities

The findings under this section imply that DDSN does not have multiple mechanisms in place to ensure that the programs and services are systematically being reviewed for quality improvement and assurance. This is incorrect. As stated earlier the authors failed to report that the comprehensive quality management system has many multi-tiered and intentionally redundant components and further that the state has successfully passed CMS reviews.

National Movement Toward Outcomes. This section fails to include DDSN's use of the CMS Quality Framework and also fails to include DDSN's use of the NASDDDS National Core Indicators and the Quality Enhancement Process developed and designed by The Council on Quality and Leadership and DDSN.

Need for stronger QA and QI processes. Considering the errors and omissions by the authors of all DDSN QM activities, this finding cannot be based on evidence, fact, or data. As stated previously, DDSN does supplement its processes just like "other states."

The report mentions on page 14 that some other states such as North Carolina partner with other organizations (e.g. UNC) for specific training yet the report fails to include the significant training to the DDSN system provided by USC, Center for Disability Resources. This collaboration in some areas (e.g., positive behavior support) has been described in the professional literature and applauded by one of the comparison states in the report.

Section VIII Recommendations

A. General Recommendation

This report does not document the need for a state law change in licensing authority. There are many errors and omissions. The findings are not accurate or trustworthy. Therefore, they are not useful and recommendations based on the findings are circumspect.

B. Recommendations for DHHS

Recommendations for DHHS – Since CMS has reviewed and renewed the Medicaid waivers operated by DDSN several times, DHHS can be assured that they meet the requirements of the HCBS waivers. As a result of previous DHHS audits, the sharing of information and data have already been strengthened. The CMS framework and National Core Indicators have already been used. The current rate setting mechanism meets all the requirements of both agencies.

C. Recommendations for DDSN

There are checks and balances now since the line of authority already exists in separate divisions. Adequate resources have been and are available now as a result of a comprehensive system similar to most states that the report did not acknowledge or recognize. The licensing tools are already being standardized. The report documented that two-thirds of the boards have already participated in the Quality Enhancement Process and but failed to acknowledge DDSN's established plan to complete the last third of DSN Boards and then begin with all the private providers. Currently all providers participate in quality improvement processes. Information is shared with DHHS. Agency standards and directives are being shared with the public now and additional ones are being added over time. Of the states compared, one-half separate service coordination and one-half, like South Carolina, do not. No evidence was presented confirming that either model resulted in better outcomes for consumers, the real test and ultimate goal.

Legislative Audit Council

A REVIEW OF THE DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

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Synopsis

Members of the General Assembly asked the Legislative Audit Council to conduct an audit of the South Carolina Department of Disabilities and Special Needs (DDSN). Our audit focused on issues specified by the audit requesters, including the health, safety, and welfare of DDSN's consumers; funding of consumers' services; availability of provider choice; use of state appropriations; and public information.

While DDSN operates competently in many respects, we found many areas where improvement is needed to ensure that DDSN is open, consistent, and accountable in its management practices. Our findings are summarized below.

Health, Safety, and Welfare

While numerous entities provide oversight for various aspects of consumer health, safety, and well-being, we identified gaps in oversight that may pose risks to DDSN's consumers.

- While DDSN routinely conducts licensing reviews of its residential facilities, it has not conducted follow-up reviews to ensure that providers correct the deficiencies identified. In our sample of 26 licensing reviews, there were only two follow-up reports for the 25 reviews for which they were needed.
- DDSN conducts licensing reviews of its adult facilities once every three years, less frequently than in the four other states we reviewed. Also, a report from the USC School of Public Health found that in other states, the licensing of community residential facilities was completed by a different entity, while DDSN licenses some of its own facilities. A lack of independent licensing creates the potential for conflicts of interest to impede objective reviews.
- Although DDSN has issued sanctions to facilities for non-compliance with licensing standards, it does not have criteria for what level or quantity of deficiencies warrants a particular sanction.
- The state law which requires a criminal history check for direct caregivers does not provide adequate controls over the hiring process. S.C. Code §44-7-2910 requires a SLED state criminal records check; however, it does not always require a check of records in other states. Other states require a national check for all.

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- We reviewed DDSN's procedures to handle threats to consumer safety and found that DDSN may not have ensured enforcement of its personnel policies related to abuse, neglect, or exploitation incidents.
- DDSN does not have an adequate system to ensure that caregivers dismissed for consumer safety infractions are not rehired elsewhere in the system. DDSN should mandate that specific information about employees be shared with other DDSN-contracted service providers.
- By examining DDSN's internal audits, we found that consumers' funds are often mishandled by disabilities and special needs (DSN) board staff. DDSN should strengthen its controls to ensure that consumers' funds are handled appropriately.
- DDSN has allowed providers' room and board policies to be inconsistent and has not ensured that they are communicated to consumers and the public. Because Medicaid does not pay for consumers' room and board, DDSN provides each provider with guidelines for determining room and board amounts. However, we found errors in DSN boards' application of these guidelines. DDSN should implement a public directive on room and board determination and require that room and board rates be annually approved by DDSN.

Barriers to Competition and Consumer Choice

Although federal regulations require recipients of services funded by Medicaid to have free choice of providers, we found that in South Carolina, DDSN's consumers often have little choice of providers. Most services are provided by DSN boards. As of December 2007, just 147 (3%) of 4,776 consumers of residential services were being served by providers other than the boards. We found that consumers in Georgia, Florida, and North Carolina have a greater choice of providers than those in South Carolina. We identified several barriers to competition and consumer choice.

- In South Carolina, service coordination and service provision are generally performed by the same entity, the local DSN board. This creates a conflict of interest and is a barrier to choice. We found that in Georgia, Florida, and North Carolina, service coordination is separate from service provision and cannot be done by the same entity.
- DDSN provides financial benefits to DSN boards that discourage participation by other service providers. DSN boards are paid upfront for serving consumers, while other providers are paid only after they have provided services. DSN boards continue to be paid for providing services for 60 days or more following a vacancy, while other providers are not paid for empty beds.

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- DDSN has provided the DSN boards with capital grant funds to purchase and maintain their residential facilities and for administrative facilities. Only recently has DDSN furnished capital funds to other providers.
- DDSN has not adequately implemented its contractual controls over DSN board performance. In many instances, DDSN has waived financial obligations of the DSN boards and has helped them out of financial difficulties by awarding them special one-time grants. Not requiring the boards to be financially accountable may limit and discourage competition. Also, if DSN boards know they can mismanage their funds with impunity, they have less incentive to manage prudently and with adequate oversight.
- DDSN's process for filling vacancies and developing new beds focuses on providers. Instead of allocating new residential placements to consumers who are determined to be the most in need, DDSN allocates new slots to providers. Funding providers instead of people may result in consumers who would otherwise receive residential placement not being placed or not being placed with their choice of provider.
- Evidence indicates there are not enough providers of services such as respite care, behavior support, and adult companion services. We identified problems with the provider qualification process and provider management. Also, DDSN has not made adequate efforts to recruit and support new providers.

Use of Funds

We reviewed the funding system DDSN uses as a budgeting tool to fund the DSN boards and other issues relating to DDSN's use of appropriations. DDSN should be more transparent in its use of funds and more effectively prioritize funding for services.

- We did not find material problems with the payment system, called the band payment system, and found it does not violate federal regulations. However, DDSN has not formalized a band funding policy and has no formal procedure and policy for systematically updating band funding amounts to account for cost-of-living increases.
- When the services needed by a DDSN consumer are significantly more expensive than the funding band allocated to the consumer, DDSN may authorize additional (outlier) funding. DDSN should formalize its outlier funding policy and make it accessible to the public.

- Prior audits of DDSN by the federal Centers for Medicare and Medicaid Services (2004) and the S.C. Department of Health and Human Services (2006) have recommended that DDSN's cost reports be independently audited. However, DDSN has not implemented these recommendations.
- We reviewed DDSN's use of new state appropriations to expand services and found that DDSN has not yet provided many of the new services for which it received funding over the past three years. We estimated that DDSN has developed approximately 380 (60%) of 630 new residential beds for which it received state appropriations beginning in FY 05-06.
- DDSN has been slow to implement a new program for children who have been diagnosed with a pervasive developmental disorder, resulting in more than \$9 million in state appropriations remaining unused or being used for different purposes. DDSN has not received millions in federal Medicaid dollars it could have collected if services were provided.
- During FY 05-06 and FY 06-07, DDSN spent approximately \$1.5 million for grants to private, non-profit organizations. In some cases, DDSN has funded the general operations of advocacy groups, which is a conflict of interest. Also, DDSN's funding process appears subjective; the agency does not have a grant application form or policy it follows when determining which organizations will be funded. If the General Assembly intends to fund private non-profit groups, it could fund them directly through the appropriations process.

Access to Information and Other Issues

We found that DDSN has not adequately disclosed its operations to the public. DDSN policies are contained in regulations, commission policies, and directives. We did not review the issue of whether DDSN should have more regulations because this issue is the topic of an ongoing legal action. Our findings in this area are summarized below.

- DDSN has not provided adequate public access to its directives. While some of DDSN's directives are available on the agency's website, others are only available on the DDSN extranet, to which consumers and the public have no access. We found that DDSN has not made public many directives that are applicable to consumers and the public.
- DDSN maintains obsolete information in its directives. Although DDSN policy requires an annual review of its directives, we found that more than half of the directives in our sample had not been reviewed in more than two years.

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- DDSN's website needs improvement. It does not contain information that citizens could expect to find there, it contains outdated and/or incomplete information, it has no search function, and is not easy to navigate. The site was designed in 1999 and has not been updated to conform to basic common content principles.
- The South Carolina Commission on Disabilities and Special Needs has narrowly interpreted its governance structure in a way that denies commission members access to public information and potentially hinders performance of their fiduciary duties.
- We found that DDSN has an appropriate reporting structure for its internal audit division. However, DDSN has not fully complied with recommendations made by the Institute of Internal Auditors to improve the internal audit function. The commission has had minimal involvement in the work of the internal audit division. Also, DDSN has not appropriately included the central and district offices in its audits and risk assessments, and internal audit has not reviewed DDSN's information systems.
- Several local DSN boards have hired the same certified public accountant (CPA) firms that conduct their financial audits to also provide consulting services. Providing consulting services may impair a firm's independence to conduct a board's financial audit. DDSN should strengthen its oversight of the audit process.
- We identified one former DDSN employee who worked simultaneously for DDSN and a DSN board while performing similar duties, which appears to be a conflict of interest. The same employee also worked for DDSN at the same time that he worked for a firm contracting with DDSN.

Synopsis

Introduction and Background

Audit Objectives

Members of the General Assembly asked the Legislative Audit Council to conduct an audit of the South Carolina Department of Disabilities and Special Needs (DDSN). The requestors' concerns focused on several issues including the health, safety, and welfare of DDSN's consumers, the funding of consumers' services, consumer choice of providers, and the agency's use of state appropriations. Our objectives are listed below.

- Determine whether DDSN has appropriate controls to ensure the health, safety, and welfare of its consumers.
- Determine whether there are barriers to competition and consumer choice within the current system operated by DDSN.
- Review DDSN's process for funding residential and other consumer services to determine whether funding is efficient, equitable, and ensures accountability.
- Review state appropriations to DDSN for expanded services to determine whether funds have been used in accordance with legislative intent.
- Determine whether DDSN has allowed sufficient public input and has provided adequate information and due process to members of the public regarding its services and operations.
- Determine whether internal and external audits of DDSN provide an appropriate system of accountability.
- Determine whether DDSN has ensured that there are no conflicts of interest involving its board, employees, contractors, or relevant advocacy groups.

Scope and Methodology

We reviewed the operations of the South Carolina Department of Disabilities and Special Needs including its quality assurance programs, funding for community-based residential and other consumer services, system for ensuring consumer choice of providers, and other areas relevant to our audit objectives. We did not review other aspects of the department's management, such as how it determines eligibility for its services, how it reports its performance to the General Assembly, or its management of the regional centers which provide institutional care.

The period of our review was generally FY 04-05 through FY 06-07, with consideration of earlier and more recent periods when relevant.

To conduct the audit, we used a variety of sources of evidence including those listed below.

- DDSN directives/policies/guidelines.
- Interviews of DDSN employees, employees of other state, local, and federal agencies, and private individuals.
- Meetings of DDSN commission and other organizations dealing with the DDSN population.
- Federal and state laws and regulations.
- DDSN contracts, financial records, human resources records, FOIA and appeals records, and agency reports.
- Audits, reports, and studies conducted by external entities regarding DDSN's operations.
- DDSN budget requests.
- DDSN board policies, contractual and financial records.
- Client records and case notes.
- Financial records from the Comptroller General's office.

Criteria used to measure performance included state and federal laws and regulations, agency policy, the practice of other states, and principles of good business practice and financial management. We used several nonstatistical samples, which are described in the audit report. We reviewed internal controls in several areas including DDSN's quality assurance process, consumer funds management, funding system, and the accountability of the DDSN boards and other providers. Our findings are detailed in the report.

Reliability of DDSN's Information and Data

DDSN has multiple information systems, many of which rely heavily on manual data input. The agency's information systems include those for accounting, service tracking, billing, and client information. There are also other small information systems created by one or a few staff members for purposes related to DDSN's programs (such as licensing, or managing the PDD waiver). This type of information system is without formal controls to ensure the accuracy of how the data is input and manipulated. When we asked for information about DDSN's programs, the agency often furnished ad hoc reports, coming from a variety of sources, compiled by a single staff person. DDSN's website contains information that is obsolete and incomplete (see p. 68).

We found that DDSN's information systems have not been reviewed by other entities. DDSN does not have an annual financial audit to determine whether its financial statements fairly represent the agency's financial position.

Instead, the State Auditor's office does an agreed-upon procedures review of the agency (see p. 74), which provides lesser assurance. DDSN's cost reports, which provide the evidence for its reimbursements from Medicaid, have not been audited (see p. 53). DDSN's internal audit division has not audited the agency's information systems (see p. 73).

In conducting our audit, we used information from several of DDSN's information systems. We could not audit or verify all of the information obtained from these multiple systems, and we concluded that it may be unreliable. However, we analyzed the information we received, and compared it with other sources and known evidence. Readers of this report should assume that amounts and numbers used in this report describing DDSN's activities are attributed to DDSN and are not audited figures. Overall, the use of unverified data was not central to our audit objectives, and we believe that the findings and conclusions in this report are valid. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

S.C. Code §44-20-250 requires the South Carolina Department of Disabilities and Special Needs (DDSN) to "... coordinate services and programs with other state and local agencies for persons with mental retardation, related disabilities, head injuries, and spinal cord injuries." DDSN is responsible for planning, developing, and providing a full range of services for these children and adults subject to the availability of fiscal resources.

As of FY 07-08, DDSN had 2,200 employees and 278 temporary employees located throughout the state. Approximately 90% of the employees are employed at the five regional centers (Midlands Center in Columbia, Whitten Center in Clinton, Coastal Center in Summerville, Pee Dee Center in Florence, and the Saleeby Center in Hartsville), with the remaining employees working at the central and two district offices.

Section 44-20-375, amended in 1991, requires that county boards of disabilities and special needs be created within a county or within a combination of counties by ordinance of local governing bodies. There are 39 disability and special needs (DSN) boards. Three of these boards, Babcock Center, the Charles Lea Center, and Berkeley Citizens, Inc., were not created by local ordinance, but are recognized as boards by DDSN.

because they existed prior to the law requiring that DSN boards be established. Each disability and special needs board is the administrative, planning, coordinating, and service delivery body for county disabilities and special needs services funded by Medicaid reimbursements and state appropriations.

The seven-member South Carolina Department of Disabilities and Special Needs Commission governs the agency. There is one member from each congressional district and one member at-large. Members are appointed by the Governor, with advice and consent of the Senate, and they serve four-year terms. The commission provides general policy direction and guidance and appoints the state director, who is the agency's chief executive officer.

Olmstead Decision

In June 1999, the U.S. Supreme Court ruled that:

...states are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. *Olmstead v. L.C.*, 527 U.S. 581 (1999)

DDSN officials have stated that they are attempting to move consumers from the most restrictive institutional placements to community residential facilities if they can be properly served in that setting. Agency records show that the number of consumers living in DDSN's regional centers decreased from 940 in 2005 to 838 in 2008, while the number of consumers obtaining residential services in the community increased from 3,571 to 4,028 during the same period.

Medicaid Funding

The South Carolina Department of Disabilities and Special Needs receives state appropriations; however, the majority of services to its consumers are funded by state and federal Medicaid funds. According to the South Carolina Department of Health and Human Services' (DHHS) 2007 annual report, DDSN was the second largest user of Medicaid funding in the state, behind hospital services. For FY 06-07, DDSN received \$450,866,073 in state and federal Medicaid funding. This amount includes funding of services for DDSN consumers that was billed directly to DHHS.

Table 1.1: DDSN Expenditures, FY 05-06 – FY 07-08

MAJOR BUDGET CATEGORY	ACTUAL EXPENDITURES					
	FY 05-06		FY 06-07		FY 07-08	
	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
Personal Services	\$65,785,837	\$48,635,902	\$64,943,012	\$48,615,240	\$65,584,079	\$50,728,064
Other Operating*	313,142,342	83,056,844	350,927,225	111,944,944	377,907,429	120,831,536
Special Items	426,175	174,175	326,000	200,000	4,326,000	4,200,000
Permanent Improvements	3,434,964	0	3,840,274	0	2,967,491	0
Case Services	9,876,259	1,461,518	11,379,585	1,782,364	15,463,627	6,308,091
Fringe Benefits	23,092,394	16,782,734	23,393,000	17,334,568	24,514,120	18,350,806
Non-recurring	0	0	0	0	0	0
TOTAL	\$415,757,971	\$150,111,173	\$454,809,096	\$179,877,116	\$490,762,746	\$200,416,497

* Other Operating is primarily funding to the statewide network of OSN boards and QPL providers.

Source: DDSN

Medicaid Waiver Services

Prior to 1991, the federal Medicaid program paid for services for a person with mental retardation and related disabilities, traumatic brain injury, and spinal cord injury *only* if that person lived in an institution. The approval of the federal Medicaid waiver programs allowed states to provide services to consumers in their homes and communities.

DDSN serves over 28,000 South Carolinians with mental retardation and related disabilities, autism, traumatic brain injury, and spinal cord injury. Approximately 4,900 consumers receive residential services in one of DDSN's regional centers or in community residential homes. The remaining consumers reside with family caregivers and receive services such as respite, day services, and other needed supports.

DDSN operates three Medicaid waiver programs. During FY 07-08, the number of people served through each of the three approved waivers was as follows:

- 5,802 — Mental Retardation or Related Disabilities (MR/RD) Program
- 638 — Head and Spinal Cord Injuries (HASCI) Program
- 301 — Pervasive Developmental Disorder (PDD) Program

The MR/RD waiver serves Medicaid-eligible persons diagnosed with mental retardation or a related disability. These individuals receive services through local disabilities and special needs boards or qualified (private) providers across the state. Services which may be reimbursed by Medicaid include:

RESIDENTIAL HABILITATION – In a residential setting, staff assists with daily living activities.

DAY HABILITATION – Assistance with the acquisition, retention, or improvement in self help, socialization, and adaptive skills that take place in a non-residential setting.

PRESCRIBED DRUGS – Consumers are eligible for two extra prescriptions above the Medicaid state plan limit.

THERAPY SERVICES – This includes speech, physical, occupational, and audiological services.

ADULT COMPANION SERVICES – Services that provide short-term relief for caregivers and needed supervision of consumers.

The HASCI waiver serves Medicaid-eligible persons with head and/or spinal cord injuries. These individuals can receive many of the same services as the consumers in the MR/RD waiver. In addition, peer guidance for consumer-directed care and health education is available.

The PDD waiver is primarily for children diagnosed with autism or other pervasive developmental disorders by the age of 8 and serves children ages 3 through 10. Case management and early intensive behavioral intervention are the primary services DDSN provides through this waiver, which began in FY 06-07.

Waiting Lists

DDSN does not have the resources to provide services to all who are eligible. As of June 30, 2008, DDSN had 2,006 consumers waiting for community residential services. Twenty-five consumers were listed on DDSN's critical waiting list (for consumers in life-threatening situations requiring immediate services) and 436 were on its Priority 1 waiting list (for consumers in urgent situations with features suggesting there is a probability they will require residential placement within one year). In addition, 29 consumers were waiting to be served in DDSN's regional centers, and 1,048 were waiting for day services.

Health, Safety, and Welfare

DDSN Quality Assurance and Oversight

We reviewed DDSN's oversight of residential facilities to determine whether the agency has adequate controls over service quality for consumers. We found that numerous entities provide oversight for various aspects of consumer health, safety, and welfare; however, there remain gaps in oversight that may pose risks to DDSN's consumers.

- While DDSN routinely conducts licensing reviews of its residential facilities, it has not conducted follow-up reviews to ensure that providers correct the deficiencies identified.
- DDSN conducts licensing reviews of its adult facilities once every three years. Other states we reviewed conduct similar reviews of facilities annually.
- Although DDSN has issued sanctions to facilities for non-compliance with licensing standards, it does not have criteria for what level or quantity of deficiencies warrant a particular sanction.
- DDSN has not made sufficient efforts to ensure that its providers are compliant with local zoning requirements as outlined in state law.

Overview

DDSN directives outline a "nine-tiered, multi-faceted, coordinated risk management/quality assurance/quality improvement program" based on person-centered outcomes and national best practices. This program includes efforts to ensure the quality of all of DDSN's services. We looked at parts of the program that relate directly to quality assurance in community-based residential facilities.

INTERNAL QUALITY ASSURANCE— The licensing and certification division within DDSN reviews facilities to ensure that they provide safe home environments, appropriate health services, and adequate staff. Community training homes (CTHs) and supervised living programs (SLPs), two types of supervised residential living situations that DDSN oversees, must undergo an initial licensing review to ensure that the facility is in compliance with basic safety measures, such as fire marshal inspections. DDSN reported that licensing and certification conducts annual licensing reviews of all providers each year. For adult residential services, DDSN visits one-third of each provider's facilities per year. Therefore, each adult residential living facility undergoes a licensing review every three years. DDSN reviews facilities for children annually.

EXTERNAL QUALITY ASSURANCE — DDSN contracts with a quality improvement organization (QIO) to review overall agency service quality. These reviews include observation of residential living facilities to assess providers' implementation of services and whether staff respect consumers' rights. The QIO conducts file reviews, interviews, and consumer observations for all DDSN services, including residential and day services. The QIO visits each provider annually.

QUALITY IMPROVEMENT — As part of DDSN's contract with the Council on Quality and Leadership (CQL), the quality enhancement (QE) unit within DDSN does periodic site reviews of DDSN facilities. DDSN documents state that the goal of the QE process is to improve consumers' overall satisfaction and quality of life by providing them more control and choice of services. However, DDSN does not require providers to participate in the QE process or to undergo site visits. Since reviews began in 2005, the QE division has visited 31 providers and 3 regional centers. The QE division is scheduled to visit three more by the end of 2008.

Oversight of DDSN Facilities

The federal Centers for Medicare and Medicaid Services (CMS) periodically reviews and renews DDSN's Medicaid waivers (see p. 5). CMS has found that DDSN's waiver management substantially meets its standards for protecting the health, safety, and welfare of consumers.

DDSN facilities are also subject to oversight by other state agencies. The Department of Health and Human Services (DHHS), the Medicaid agency for South Carolina, oversees DDSN's delivery of Medicaid services. According to a memorandum of agreement between the two agencies, DHHS must approve all policies, rules, and regulations related to waiver services (see p. 5) prior to issuance and implementation by DDSN. Also, DHHS conducts periodic file reviews of consumers served by DDSN boards and has the authority to withhold Medicaid reimbursement funds should DDSN fail to ensure its contracted service providers' compliance with Medicaid requirements. DHHS officials also have access to all reports issued by DDSN's contracted QIO.

The state long-term care ombudsman in the Lieutenant Governor's office began periodically reviewing DDSN facilities in 2007. The State Law Enforcement Division (SLED) refers reports of abuse or neglect that do not include a criminal aspect to the ombudsman. Investigators from the ombudsman's office review complaints and issue reports to the executive director of the respective DDSN board as well as to DDSN. In addition to these

investigations, investigators perform periodic, unannounced site visits to DDSN facilities to assess their adherence to basic safety and health measures. Since February 2007, the ombudsman's office reported that it has opened 371 investigations of DDSN facilities and made 1,207 routine visits. A DDSN official stated that the agency monitors these reports for patterns of deficiencies.

Coordination of Quality Assurance Entities

As described above, several entities perform different aspects of quality reviews for DDSN. However, this does not necessarily ensure coordinated use of quality improvement information derived from various QA processes.

A 2008 study by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) reviewed quality assurance and quality improvement initiatives at DDSN. The report noted that the design of DDSN's quality assurance efforts was comprehensive and succeeded in gathering data on program effectiveness. However, the report also stated that "... the overall process of remediation leading to quality improvement is not achieving its intended goal." The report states, "The QA/QI system design does not operate through an established protocol to guide DDSN central office staff in making use of information gathered ... to remediate and improve service delivery statewide." While DDSN's quality assurance efforts are well-designed and provide useful information to the agency, this information often does not lead to remediation of deficiencies or continuous quality improvement.

In response to the NASDDDS report, DDSN officials stated that the agency is taking steps to fulfill the recommendations. For example, the agency reported it has established "thresholds," overall levels of quality using data from licensing and QIO reviews, to monitor whether providers may require extra assistance to improve their services. DDSN officials reported that operations staff from DDSN visit providers that do not adhere to these thresholds to ensure that the plan of correction leads to remediation of deficiencies and overall quality improvement. Also, DDSN officials state that they are working toward an integrated system that combines all provider quality information — licensing, QIO, and QE — and enables the agency to produce overall profiles of different providers.

Recommendation

1. The Department of Disabilities and Special Needs should ensure that information derived from its quality assurance processes is integrated and used to remediate problems identified.

Issues of Non-Compliance

We reviewed DDSN's processes for identifying and correcting situations where residential service providers fail to comply with standards of quality. DDSN licensing and certification has not adequately followed up on its findings of deficiencies.

Follow-Up Reviews

DDSN requires providers to create plans of correction within 30 days following annual licensing reviews to address areas of deficiency. DDSN departmental directives state that licensing and certification should conduct follow-ups to their reviews to assess providers' progress in addressing deficiencies. In numerous cases where licensing reviews found potential threats to consumers' health, safety, and welfare, DDSN did not conduct a follow-up review.

We reviewed reports from DDSN licensing and certification for the years 2005–2007 to assess the licensing process. We reviewed a nonstatistical sample of 26 licensing reviews, 6 of which were furnished by DDSN. We reviewed available files for licensing reports, providers' plans of correction, and documentation of follow-ups. We found licensing reports for all 26. One review found no deficiencies. Additionally, for the 25 reports that should have had a follow-up review, there were only two follow-up reports. We found no other documentation to suggest that follow-ups to these reviews took place.

In our sample of licensing reviews, we did not find documentation of follow-ups assessing providers' progress or completion of their plans of correction. Not all deficiencies require a physical re-inspection of the facility. For example, providers may correct some deficiencies by submitting documentation that they have provided necessary training to staff. However, without follow-ups, DDSN cannot know whether the deficiencies identified continue to affect the safety and well-being of DDSN consumers.

Revisitation of Facilities

The DDSN licensing directives applicable to our 2005–2007 sample did not provide specific criteria for which deficiencies require a re-visit to the facility. However, based on DDSN departmental directives implemented in December 2007, physical re-inspections of facilities were warranted more often than they occurred.

The DDSN certification and licensing directive gives the following guidance for revisits: "Unannounced follow-up visits will be conducted in situations where the severity and/or prevalence of deficiencies may adversely impact someone's health and safety and will determine if deficiencies have been corrected." This December 2007 revision also classified deficiencies by degree of severity. Those deficiencies posing immediate danger to consumers (Class I) require correction before the licensing reviewers leave the premises. The next most severe class of deficiencies (Class II) must be addressed in the plan of correction. Class II deficiencies, though not posing immediate danger to consumers, include any issues "... which could put the person's physical, emotional, and financial well being in jeopardy." We concluded that Class II deficiencies pose a threat to consumers' safety and welfare that necessitates an unannounced follow-up visit.

Nine sampled reports occurring after January 2007 identified deficiencies by class. Within these reports, there were more than 100 Class II deficiencies. The number per report ranged from 1 to more than 50. These deficiencies included failure to document that medication was being appropriately administered, presence of expired foods in consumers' residences, missing smoke detectors, and hot water heaters set at temperatures too hot for consumers. We found no documentation that any follow-up visits to these facilities took place. Based on the language in its departmental directives, DDSN should conduct unannounced visits to ensure that providers fully implement their plans of correction. Also, DDSN should ensure that all providers complete plans of correction in response to licensing reviews.

DDSN may improve its departmental directive by specifying criteria for appropriate and sufficient documentation to address deficiencies. DDSN officials stated they plan to create a protocol for follow-ups that will outline this information. Additionally, they stated that future follow-ups will include documentation of correction of all identified deficiencies, including revisitation of facilities where needed.

Sanctions

DDSN departmental directive 104-01-DD gives DDSN the authority to sanction providers when the "... severity and/or prevalence of deficiencies may adversely impact someone's health and safety" However, DDSN does not have specific criteria to determine whether sanctions are warranted. These sanctions may include granting probationary licenses or revoking licenses already issued. We reviewed records of sanctions issued by DDSN licensing to verify that instances of non-compliance were being addressed. We found that in cases of persistent failure to correct deficiencies, DDSN has sanctioned facilities by granting probationary licenses, contingent on correction of deficiencies.

DDSN reported that for 2005–2007, eighteen facilities under three providers received sanctions for failure to correct deficiencies. These sanctions included deficiencies in areas related to homes being sanitary, free from hazards, and consumers receiving timely health care. In most cases, DDSN sanctioned the facilities in question by issuing a temporary license which would be extended to a standard license only when the deficiency was adequately corrected.

DDSN officials reported that in two cases they sanctioned providers, rather than their facilities, because of the number, severity, or persistence of deficiencies at several facilities they operated. In these cases, DDSN took more drastic measures to ensure correction of deficiencies. In one case, DDSN did not allow a provider to develop new beds that had previously been authorized to it. In another case, DDSN reported that they reduced a provider's size to effectively one-half of its initial capacity and placed some of its facilities under the care of other service providers. However, DDSN did not provide criteria for the specific conditions that resulted in more severe punishment for the two providers. According to DDSN officials, both of these extreme cases occurred following excessive deficiencies at several facilities where the overall level of quality of service was not adequate.

We requested documentation of corrections of the deficiencies leading to sanctions. DDSN could not provide documentation to confirm that the specific issues in each case had been corrected. However, DDSN officials reported that all of the issues were resolved and that each of the providers in question has undergone a licensing review since the sanctions were issued.

Since there are no specific criteria for what requires a sanction of either a facility or a provider, decisions on whether to issue sanctions could be subjective. While DDSN has sanctioned facilities for failure to comply with licensing standards, the lack of documentation in follow-up reviews makes it difficult to establish when and how deficiencies are corrected. Without follow-ups to verify whether deficiencies have been corrected, there is no way to determine whether there may be other instances of non-compliance that may warrant sanctions.

Recommendations

2. The Department of Disabilities and Special Needs should conduct follow-up reviews to ensure that providers implement their plans of correction and address risks that may endanger the health, safety, or welfare of DDSN consumers.

3. The Department of Disabilities and Special Needs should adequately document follow-up reviews with reports assessing provider progress toward completion of plans of correction.
4. The Department of Disabilities and Special Needs should revise its licensing directive to include specific criteria that defines when follow-up visits are warranted and the type of documentation that is sufficient to demonstrate implementation of the plan of correction.
5. The Department of Disabilities and Special Needs should revise its licensing directive to include specific criteria for when sanctions are warranted and document instances when they occur.

Criteria for Oversight

We reviewed the level of oversight from licensing and quality control entities over DDSN-licensed facilities to determine whether it was sufficient to ensure the health, safety, and welfare of consumers. Though DDSN's oversight is comparable, in some respects, to other states' and other South Carolina agencies', the current level of review may not be sufficient.

Comparison to Non-DDSN-Licensed Facilities

DDSN licensing and certification staff review community training homes (CTHs) and supervised living programs (SLPs) for individuals who require limited supervision. Intermediate care facilities for the mentally retarded (ICF/MRs) are more structured residential living situations that provide greater supervision. These facilities, although operated by DDSN, are licensed by the South Carolina Department of Health and Environmental Control (DHEC). We compared DHEC licensing standards to DDSN licensing standards to assess levels of oversight provided to these facilities.

We found that DDSN licensing standards are comparable to DHEC licensing standards in the areas they cover, although DHEC standards cover most areas in greater detail. For example, DHEC licensing standards for ICF/MRs devote a section specifically to fire safety precautions, while DDSN has one licensing standard for CTHs that requires a comprehensive disaster preparedness plan. This difference is, to some degree, expected since the facilities licensed by DHEC usually serve more individuals and those requiring greater supervision. DHEC reviews facilities once every 24 months. DHEC officials stated that this cycle previously was once every 12 months and changed only due to the necessity of providing additional assistance to non-compliant facilities.

Comparison Between DDSN Licensing Process and QIO Reviews

The request for proposal (RFP) for DDSN's most recently contracted QIO includes criteria for follow-up reviews. The RFP states that the contractor "... will conduct a follow-up review to assure that all elements detailed in the provider's plan of correction have been implemented." Follow-up reviews must be completed within 120 days (4 months) from acceptance of the provider's plan of correction, which must be submitted within 30 days after the end of the review period. The QIO reported that it conducted follow-ups to all 22 reviews it performed in the first and second quarters of FY 07-08. Nine more follow-up reviews were scheduled for reports issued during the third quarter of FY 07-08.

The QIO's reviews are based on an assessment of key indicators of quality in four categories and structured interviews using national core indicator consumer surveys (see p. 34). DDSN's licensing and certification division recently developed key indicators for licensing standards and began using them in their reviews in August 2008. DDSN officials stated that these indicators provide specific guidance for determining providers' compliance with DDSN licensing standards.

Comparison to Similar Agencies in Other States

We examined licensing, certification, and quality assurance efforts in other states — Georgia, Florida, Tennessee, and North Carolina. In addition, we reviewed what other studies have found regarding DDSN's licensure and certification. We found that while South Carolina's approach to this process is not unlike that of other states, DDSN conducts licensing reviews less frequently than any other state we reviewed.

All states that we reviewed stated that they perform annual reviews of all facilities. A 2008 study conducted by the University of South Carolina (USC) School of Public Health compared numerous aspects of DDSN's service delivery and quality assurance efforts to those of several other states, including three of the states we surveyed. The USC report found no state except South Carolina that conducted licensing reviews of facilities less often than once annually.

Although DDSN reviews each provider annually, only one-third of its adult facilities are examined during each review; each of these facilities undergoes a licensing review only once every three years. Allowing this much time between licensure reviews is a significant departure from the practice of all other states surveyed as well as the schedule set by DHEC for licensure of other DDSN-run facilities. This schedule of reviews may not provide adequate oversight to ensure that providers' facilities are complying with licensing standards. Annual reviews of all DDSN-licensed facilities would

decrease the incidence of deficiencies and increase the likelihood that situations detrimental to residents of the facilities would be identified and corrected more quickly.

Table 2.1 provides an overview of the resources that DDSN has allocated to various areas of quality assurance.

Table 2.1: DDSN Quality Assurance Expenditures, FY 07-08

QUALITY ASSURANCE ENTITY	EXPENDITURES
DDSN licensing and certification	\$389,135
Quality improvement organization	\$1,110,647
Council on Quality and Leadership	\$63,550

*Expenditures for DDSN licensing and certification are payroll, while the expenses for the QIO and CQL are contract costs.

Source: DDSN

The USC School of Public Health report also noted that in South Carolina, unlike in most other states reviewed, residential facilities for the developmentally disabled are licensed by a unit within the agency. In six of the seven other states reviewed, these facilities are licensed by a different entity. DDSN's response to the USC report stated that some of their consumers reside in facilities, such as community residential care facilities, that are licensed by DHEC. However, a large number of DDSN consumers reside in community training homes and supervised living programs, which are still licensed by DDSN. Of the related agencies in the four states we surveyed, only one (Florida) in addition to DDSN licenses its own residential facilities. The other three are licensed by different entities (see Table 2.2).

Designating an external entity to conduct licensing reviews ensures independence to the process. When DDSN licenses its own facilities, there is a potential for conflicts of interest to interfere with objective reviews. In the worst case scenario, this can pose risks to the health, safety, and welfare of consumers.

Table 2.2: Comparison of DDSN's QA Structure to Other States

STATE	AGENCY OPERATING HOME AND COMMUNITY-BASED SERVICES/WAIVER	LICENSING ENTITY	CERTIFICATION ENTITY	OTHER REVIEWS
SOUTH CAROLINA	Dept. of Disabilities and Special Needs	DDSN (Licensing)	DDSN RFP/evaluation of providers	Contracted QIO, State Long-Term Care Ombudsman
FLORIDA	Agency for People with Disabilities	Agency for People with Disabilities	Medicaid provider enrollment; ADP and Agency for Health Care Administration (state Medicaid agency)	Contracted QIO
GEORGIA	Div. of Mental Health, Developmental Disabilities, and Addictive Diseases' Office of Developmental Disabilities	Dept. of Human Resources, Office of Regulatory Service	Certification Unit of the Div. of Mental Health, Developmental Disabilities and Addictive Diseases	Accreditation by national authority
NORTH CAROLINA	Div. of Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS)	Div. of Health Services Regulation	"Endorsement" by Individual Licensing Management Entities (analogous to DSN boards)	MHDDSAS performs Medicaid audits; providers must be accredited
TENNESSEE	Div. of Mental Retardation Services	Dept. of Mental Health and Developmental Disabilities	Div. of Mental Retardation Services	TennCare (state Medicaid agency) annual state assessments, follow-up surveys, focused surveys, and other oversight activities

The term "certification" refers to the initial approval process for providers of Medicaid services. However, terminology is not consistent among the states we reviewed. Some use the term "enrollment" or "endorsement" to describe this process, while DDSN uses the terms "licensing" and "certification" interchangeably.

Source: Documentation from officials in state agencies providing services for developmentally disabled.

Recommendations

- The General Assembly should amend state law to delegate the Department of Disabilities and Special Needs' licensing function to another state agency, such as the Department of Health and Environmental Control.
- If the licensing function remains within the Department of Disabilities and Special Needs, the agency should perform annual licensing reviews of each facility to ensure that providers are compliant with licensing requirements.

Communication with Other Agencies and Municipalities

DDSN should periodically share lists of all facilities it operates (either directly or under contract with a private service provider) with other state agencies. S.C. Code §44-7-260(B)(2) requires DDSN to provide updated lists to DHEC. DDSN must also provide quarterly updated lists to SLED as required in a memorandum of agreement between the agencies. DDSN officials reported that they also provide these updated lists to the Attorney General and the state long-term care ombudsman quarterly. Although DDSN furnished the updates in April 2008, it has not provided updates on a regular schedule.

We reviewed documentation of lists originally provided to these agencies, and found that not all have received updates on a quarterly basis. Officials from other agencies reported that they had not received updates quarterly and sometimes updated lists themselves when they received complaints regarding a facility that did not appear on their list. DDSN sent updated lists of all facilities in December 2007 and again in April 2008. We did not find documentation that the list of DDSN facilities was updated for all of these agencies on the appropriate schedule from February 2007 until December 2007.

Some of these agencies provide services that contribute to DDSN's overall mission and goal to ensure the safety, health, and welfare of DDSN consumers. Failure to communicate regularly with these agencies not only makes providing services to consumers more difficult, but in some cases may compromise the safety of DDSN consumers if appropriate agencies are unaware of the existence of some facilities. DDSN should provide updated lists of facilities to these agencies quarterly.

Local Zoning Issues

We reviewed DDSN's process for granting initial licenses to residential facilities and found that DDSN's initial licensing process has not adequately ensured provider compliance with local zoning laws.

The DDSN directive addressing the certification and licensure of residential and day facilities states: "No residential, day or respite facility shall provide services and supports unless the service provider is...compliant with applicable federal, state, and local laws." S.C. Code §6-29-770(E) outlines exemptions to zoning ordinances, including homes:

...serving nine or fewer mentally or physically handicapped persons provided the home provides care on a twenty-four hour basis and is approved or licensed by a state agency or department or under contract with the agency or department for that purpose.

However, the law additionally states:

Prior to locating the home for the handicapped persons, the appropriate state agency or department or the private entity operating the home under contract must first give prior notice to the local governing body administering the pertinent zoning laws, advising of the exact site of any proposed home.

DDSN stated that the Federal Fair Housing Amendments Act supercedes the state law. However, only a court can make that determination.

Local zoning authorities reported cases of becoming aware of the existence of DDSN homes for which they had received no notice prior to their establishment in the community. Although DDSN licensing standards require that the facility be in compliance with local laws, a DDSN official stated that the initial licensing process does not include checking to see whether the provider establishing the home has notified local zoning authorities of its location. There is not sufficient oversight to determine whether providers are compliant with local laws.

Although DDSN-licensed facilities may not be subject to zoning ordinances, the code does require them to provide notice to local zoning authorities regarding the location of any such home prior to its establishment. There is no way to easily determine how many homes may be in operation for which local zoning authorities have not received notice.

Recommendations

8. The Department of Disabilities and Special Needs should provide DHEC, SLED, the state long-term care ombudsman, and the Attorney General with updated lists of DDSN-operated and DDSN-contracted facilities on a quarterly basis.
9. The Department of Disabilities and Special Needs should verify and document that service providers are compliant with state law that requires them to notify local zoning boards before establishing a group home.

Criminal History Checks

The state law which requires a criminal history check for direct caregivers does not provide adequate controls over the hiring process. S.C. Code §44-7-2910 requires a State Law Enforcement Division (SLED) state criminal records check; however, it does not always require a check of records in other states.

This law applies to residential direct care entities operated, or contracted for operation, by certain state agencies, including DDSN. DDSN's direct caregivers are people who have physical contact with consumers served by DDSN and its contractors. If the caregiver cannot prove residency in South Carolina for at least one year prior to employment, state law requires that the provider complete either a Federal Bureau of Investigation (FBI) check or a state criminal history check from the previous state of residence. An applicant can prove residency by presenting South Carolina identification, a rent or mortgage receipt, bank records, or a pay stub.

Prior to October 2007, DDSN's residential licensing standards were more stringent than the statute. They required proof of ten years of residency in South Carolina to avoid a criminal history check from the previous jurisdiction of residence. This applied to caregivers serving children or adults in a community training home II or adults in a supervised living program or community residential care facility. The standards required a federal check, regardless of length of residency, for all caregivers serving children in a community training home I.

However, in October 2007, DDSN removed the ten-year residency requirement and made DDSN standards consistent with state law for all caregivers except community training home I facilities serving children. According to an agency official, DDSN adjusted the standards to become consistent with federal regulations requiring providers to follow state law regarding criminal history checks. Currently, if a potential caregiver can prove residency in South Carolina for one year preceding hire, the provider conducts only a SLED state check.

We examined statutes from five Southeastern states (Florida, Georgia, North Carolina, Tennessee, and Virginia) to determine what criminal history checks are required for direct caregivers. Three require a national check for all; one requires a national check based on residency; and one allows for but does not require a national check (see Table 2.3).

Table 2.3: Other States' Criminal History Check Requirements

REQUIREMENT	STATE
FBI Criminal History Check for All	Georgia, Florida, and Virginia
FBI Criminal History Check with a Residency Requirement.	North Carolina
Allows for FBI Criminal History Check	Tennessee

Source: State statutes.

North Carolina is most similar to South Carolina because it only requires an FBI check if the person has not lived in the state for a specified length of time. Unlike South Carolina, North Carolina requires at least five years of residency to avoid a federal check. Also, when North Carolina conducts an out-of-jurisdiction check, it is an FBI check, capturing criminal activity from all parts of the FBI's jurisdiction, as opposed to data from just one other state.

If South Carolina's statute were amended to require a federal check for all direct care staff, the maximum increase in cost, based on current costs, for each hired employee would be \$19.25. The total spent on criminal history checks could range between \$23.25 and \$44.45 per hired caregiver. Costs vary because some entities are nonprofits or have a statutorily discounted rate.

By conducting an FBI criminal history check on all direct caregivers, DDSN and its providers could ensure that the most complete criminal history information is obtained. This would lower the risk of employing:

- Convicted predators from another state.
- South Carolinians who commit crimes in other states.
- Staff who may abuse and neglect DDSN consumers.

For example, SLED conducted an FBI check on a suspect in an abuse and neglect investigation and discovered that he had a criminal conviction from another state. The crime was one that would have precluded him from hire had the provider known about it. The employee was eventually terminated, but had the provider initially run a federal check, he would never have been hired.

Recommendations

10. The General Assembly should amend §44-7-2910 to require Federal Bureau of Investigation criminal history checks for all direct caregivers without regard for the length of residency in South Carolina.
11. The Department of Disabilities and Special Needs should amend its licensing standards to require Federal Bureau of Investigation criminal history checks for all direct caregivers upon hire.

Name-Based Criminal History Searches

S.C. Code §44-7-2920 requires that criminal history checks of direct caregivers be accomplished by fingerprinting. There are civil fines associated with violating these procedures. In response to our inquiry about reference checks (see p. 24), some of DDSN's providers stated that they use the SLED Citizens Access to Criminal Histories (CATCH) system, which is a name-based search tool. On the homepage for the CATCH system, the searcher is advised that fingerprint searches are the most reliable way to conduct criminal history checks and the least likely to result in a false positive or false negative result. SLED offers this system as an alternative when fingerprint-based searches are inconvenient. Other than the cost of obtaining fingerprints at a local fingerprinting site, there is not a cost savings attached to using the CATCH system.

Recommendation

12. The Department of Disabilities and Special Needs should comply with S.C. Code §44-7-2920 and specify in its licensing standards that the required SLED criminal history check be obtained through a fingerprint search.

Threats to Consumer Safety

We reviewed DDSN's procedures to handle threats to consumer safety and found that DDSN may not have ensured enforcement of its personnel policies related to abuse, neglect, or exploitation incidents. Also, DDSN does not have an adequate system to ensure that caregivers dismissed for consumer safety infractions are not rehired elsewhere in the system.

Background

DDSN has procedures in place to react to incidents or threats to consumer health, safety, and welfare. When someone reports abuse, neglect, or exploitation, DDSN implements both internal and external investigation procedures. S.C. Code §43-35-10 provides the following definitions:

- **Abuse** is intentionally inflicting physical injury on a vulnerable adult or deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior.
- **Neglect** is a caregiver omitting or failing to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult.
- **Exploitation** is causing or requiring a vulnerable adult to engage in improper labor; improper use of funds, assets, property, or power of attorney, or causing a vulnerable adult to purchase goods or services for the advantage of someone else through undue influence, harassment, duress, force, coercion, or swindling.

DDSN determines, through its internal review process, whether or not the accused violated provider policy. At the conclusion of the investigation, the facility administrator/executive director must follow the provider's personnel policy to discipline the caregiver, address any training issues or procedural changes identified during the review, make necessary environmental changes, and notify licensure/certification boards of licensed or accredited employees.

In addition to initiating the internal investigation, staff must immediately contact the appropriate external investigative agency following an incident or threat. Only the investigative agency can substantiate abuse, neglect, or exploitation. A 2006 amendment to the Omnibus Adult Protection Act (§43-35-5 *et seq.*) assigned external investigative duties to the Vulnerable Adults Investigations Unit of the South Carolina Law Enforcement Division (SLED); however, SLED may not conduct each investigation. SLED may direct an investigation to local law enforcement, the Attorney General's office (financial exploitation), or the Long Term Care Ombudsman (non-criminal investigations). From January 30, 2007, to January 30, 2008, SLED received 1,129 abuse and neglect reports; 625 were related to DDSN-operated or contracted facilities. The Department of Social Services' out-of-home abuse and neglect unit investigates incidents involving consumers age 17 and under. If an external investigation substantiates abuse, neglect, or exploitation, then the provider must terminate the perpetrator within 24 hours. If the victim is a child, then the perpetrator's name will also be entered on the Central Registry of Child Abuse and Neglect.

There is not a registry of abusers of vulnerable adults. Currently, the Adult Protection Coordinating Council is researching potential parameters of an adult abuse registry for South Carolina. The council, created in the Omnibus Adult Protection Act (OAPA), includes representatives of all of the agencies involved in serving and protecting vulnerable adults. If a registry is proposed, legislatively approved, and implemented, it will be an important resource for employers of people who work with vulnerable adults. The names listed on the registry from DDSN would be those perpetrators involved in substantiated cases. If a DDSN internal review finds that a person violated a disciplinary policy related to the health, safety, and welfare of a consumer, but the person is not criminally convicted, his name may not appear on the registry.

Abuse and Neglect Policy Implementation

DDSN may not have ensured that service providers comply with its policy regarding personnel actions related to a report of abuse, neglect, or exploitation. DDSN directive 534-02-DD requires that alleged perpetrators of abuse and neglect be immediately placed on administrative leave without pay, as a part of the safety plan for the consumer. According to initial reports submitted by the providers to DDSN between January 30 and July 30, 2007, there were 332 total incident reports involving staff. There were 244 administrative leaves and 16 terminations recorded in initial reports for that same time period, leaving 72 (22%) cases where the provider did not follow the safety plan.

In addition, directive 534-02-DD also requires that alleged perpetrators be terminated if the case is substantiated by an external investigative agency. During the same time period, there were 70 substantiated cases involving staff. According to DDSN records, there were 59 substantiated cases that resulted in termination, leaving 11 (16%) where the policy was not followed.

Although DDSN took more than two months to compile the data reported above, in October 2008, the agency provided a third report reflecting 100% compliance with personnel policies in directive 534-02-DD. DDSN did not provide documentation to allow us to verify the new data; therefore, the evidence is not sufficient to support a conclusion about provider compliance.

Recommendation

13. The Department of Disabilities and Special Needs should enforce abuse and neglect directive 534-02-DD by reviewing provider reports and documenting the follow-up with providers if a required action is not taken.

Reference Checks

DDSN does not have an adequate system to ensure that direct caregivers who are dismissed for consumer safety-related disciplinary infractions are not rehired elsewhere in the system. If a caregiver at a DDSN-operated facility is terminated or resigns because of an abuse or neglect incident, staff enters a code on his personnel file. If the person reapplies to a DDSN-operated facility, the hiring official has access to this information. However, there is no equivalent system maintained for local DSN boards or other providers.

Several DDSN agency officials reported that although DDSN does not have a centralized system for boards and other providers to check, they encourage detailed reference checks. S.C. Code §41-1-65 provides immunity from liability when employers respond to written reference requests with factual information contained in the employee's personnel file. This includes performance information. We contacted the local DSN boards and found that most boards exchange only minimal information such as dates of employment and position held. They do not generally exchange performance information, even if it is in the personnel record.

Although a completed job application should include information about past consumer safety incidents, the employer does not have a guarantee of receiving complete information. DDSN has a few options that would make the hiring process less risky for the providers. One possible solution is to develop an internal registry. Following an LAC recommendation, the Department of Social Services (DSS) implemented a system to track individuals allowed to resign before disciplinary action can be taken against them. According to an agency official, DSS requires supervisors at the county offices to check this system before making a final hiring decision. However, DDSN officials stated that a systemwide registry could expose the agency to unnecessary liability.

Another option is to formalize reference check procedures. DDSN officials agreed that they could mandate, through the contracts with the DSN boards and QPL providers, that specific information about employees be shared with other DDSN-contracted service providers, if requested in writing. Agency officials stated that this plan presents significantly less risk than an internal registry, would not be too difficult to implement, and would accomplish the goal of greater consumer safety.

Recommendations

14. The Department of Disabilities and Special Needs should amend its contracts with the DSN boards and other providers to require that they formally record whether they would rehire a separating employee.
15. The Department of Disabilities and Special Needs should amend its contracts with the DSN boards and other providers to require that they make all requests for references in writing.
16. The Department of Disabilities and Special Needs should amend its contracts with the DSN boards and other providers to require that they respond in writing to a written request from another system provider with the following information, documented in personnel records:
 - Written employee evaluations.
 - Official personnel notices that formally record the reasons for separation.
 - Whether the employee was voluntarily or involuntarily released from service and the reason for the separation.
 - Information about job performance.

Omnibus Adult Protection Act

The Omnibus Adult Protection Act (OAPA) should be revised to criminalize neglect of a vulnerable adult through reckless behavior. The OAPA was passed to provide protection for vulnerable adults — people 18 years or older with a physical or mental condition which substantially impairs the person from providing for his own care or protection. The OAPA defines specific crimes and provides for prosecution and punishment of perpetrators of abuse, neglect, or exploitation of a vulnerable adult. Through their representatives on the Adult Protection Coordinating Council (APCC), agencies charged with serving and protecting vulnerable adults have expressed a desire to amend the criminal portion of the OAPA.

During the course of our review, the legislative committee of the APCC presented a proposed OAPA amendment that would make neglecting a vulnerable adult as a result of acting or failing to act due to *reckless disregard* for his health or safety a misdemeanor criminal offense. Currently, all offenses are felonies that require knowing and willful commission of the crime, with the exception of a misdemeanor for failing to report abuse, neglect, or exploitation. Council members believe that the addition of the misdemeanor offense will aid in prosecuting those whose behavior, though reckless, does not rise to the level of knowingly or willfully harming a vulnerable adult.

The developmentally disabled population and other vulnerable adults can be compared to children in that they cannot provide for their own care or protection. The Children's Code provides for a Central Registry of Child Abuse and Neglect (S.C. Code §20-7-680). It also contains an offense of "cruelty to children" which is a misdemeanor that carries a lesser penalty than other crimes against children.

Recommendation

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17. The General Assembly should amend the Omnibus Adult Protection Act to add a misdemeanor level charge and penalty to the criminal acts directly against vulnerable adults.
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Consumer Funds

DDSN should strengthen its controls to ensure that consumers' funds are handled appropriately. DDSN has several agency directives governing the handling of consumers' funds, and the agency performs reviews of the DSN boards and other providers to verify that they are following these directives. DDSN's licensing division, DHEC's division of certification, the agency's contracted quality improvement organization, and the DDSN internal audit division all perform reviews on the handling of consumers' funds. By examining DDSN's internal audits, we found that consumers' funds are often mishandled by board staff.

In our review of DDSN's internal audits from FY 04-05 through March 2008, we found that the division regularly finds problems at the boards/providers when they perform audits of consumer funds. Some of the problems that internal audit found repeatedly include:

- Consumers' personal checks not being filled out correctly.
- Missing receipts for consumers' purchases.
- Consumer property without the consumer's name on it.
- Questionable purchases made on behalf of the consumers.
- Consumers' cash-on-hand ledgers not maintained properly.

The audit results indicate that many of the boards/providers have problems ensuring the proper management of consumer funds. One cause of inappropriate use of consumer funds could be a lack of proper training to board/provider staff. Another may be the choice of some board/provider staff to take advantage of the vulnerable population they serve. Improved employee hiring practices, such as more detailed reference checks, should ensure that qualified staff are hired (see p. 24).

The internal audit division performs training on how to properly maintain consumer funds at the request of the board or other providers. According to an agency official, most boards/providers train new employees on the use of consumer funds themselves, by having existing employees train the new employees.

According to an agency official, DDSN's internal audit has not conducted mandatory training for the boards/providers on consumer funds in approximately four years. Since they consistently find problems in this area, DDSN should conduct mandatory consumer funds training for every board and other provider. Internal audit staff should also encourage providers with questions on how to handle consumer funds to contact internal audit staff directly for guidance.

Recommendation

18. The Department of Disabilities and Special Needs should conduct mandatory training for all board/provider staff handling consumer funds and inform board/provider staff to contact internal audit staff with questions regarding consumer funds.

Room and Board

DDSN has allowed providers' room and board policies to be inconsistent and has not ensured that they are communicated to consumers and the public. The Medicaid program does not pay for the room and board of consumers; therefore, it is generally the responsibility of residential consumers to pay for their room and board. DDSN allows each board/provider to establish room and board amounts based on guidelines issued by the agency. These room and board amounts may include: rental charges, utilities, food, maintenance, exterminating, etc.

DDSN provides each board/provider with guidelines to follow to determine room and board calculations. While we found these internal guidelines adequate, the guidelines should be strengthened by establishing an agency directive on room and board that is available to the public.

We spoke with agency officials and interested parties about this issue. According to agency officials, while room and board amounts may change from board to board, the amounts should not change within a given county unless there are unusual circumstances where a particular residence's costs are above or below the norm. Also, private providers determine their own room and board amounts separately from the county DDSN boards.

However, while a board may set its room and board for all its consumers, it is limited to a consumer's ability to pay. For example, if the room and board for a given county is \$600 a month, then all consumers in that county are expected to pay \$600. However, if a consumer only receives \$500 a month in unearned and earned income, that consumer cannot be expected to pay the full \$600 and will pay a lower amount. Consumers who receive more than \$900 a month in unearned and earned income may have to pay the full room and board amount.

DDSN allows boards/providers to use one of three methods to determine the rental charge portion of their room and board calculations. The three methods are:

- Surveying local rental amounts or using the U.S. Department of Housing and Urban Development's (HUD) fair market rent calculations (annual calculations for average rental amounts, searchable at the county level).
- Using a home's monthly mortgage payment.
- Using a home's depreciation over the life of the home.

We reviewed three DSN boards' room and board calculations. During our review of the three boards, we found that all three did not apply DDSN's guidelines correctly. Also, according to an agency official, it may be inappropriate for the DSN boards/providers to continue to use HUD's fair market rent calculations, as those numbers are based on low-income housing rental amounts, and DDSN's homes are of a higher value.

Also, according to an agency official, the boards/providers calculate their room and board amounts themselves or have their CPA firms do it for them. DDSN does not approve the amount. DDSN should review its methods of calculating rental charges and determine a single method to implement statewide. DDSN should also implement controls to ensure that each board's/provider's calculations are correct.

Finally, DDSN's agency appeal process, outlined in department directive 535-11-DD, does not clearly state that room and board calculations may be appealed by consumers and their families. According to an agency official, however, this is the method for appeal for room and board disputes. DDSN should update its agency appeal process to clearly state that room and board calculations may be appealed by consumers and their families if they dispute the charges.

Recommendations

19. The Department of Disabilities and Special Needs should examine its methods for calculating rental charges and implement a statewide public directive specifying a single method for boards and other providers to use.
20. The Department of Disabilities and Special Needs should require each board and provider to have its room and board calculations approved annually by the agency.
21. The Department of Disabilities and Special Needs should update its agency appeal directive (535-11-DD) to specifically include room and board calculations.

Human Rights Committees

Provider human rights committees have not complied with DDSN's policy and may not fully protect consumer rights or ensure consumer welfare. S.C. Code §44-26-70 requires that human rights committees of at least five members be established for each regional center and county DSN board. The committee is appointed by the state director or his designee and must include a family member of a person with mental retardation, a client of the department, and a member of the community at large with expertise or interest in the care and treatment of persons with mental retardation and related disabilities. Committee responsibilities include the following:

- Review and advise the provider on policies pertaining to client rights.
- Hear and make recommendations to the provider on research proposals which involve consumers.
- Review and advise the provider on program plans for behavior.
- Receive notification of abuse, neglect, exploitation, or critical incidents.
- Advise the provider on other matters pertaining to consumer rights.

The statute directs the department to establish policy for the operation of the committees. DDSN directive 535-02-DD applies to all regional centers, the autism division, DSN boards, and contract service providers, although contract service providers are not required to have a board. The directive expands human rights committee membership to at least six people, requiring a community professional with behavioral or medical expertise, a member of a related organization, and other community members. In addition, the directive requires that the "family member" be related to a DDSN consumer, as opposed to the statute's requirement that the person be related to someone with mental retardation. The directive also provides specific instructions on case review and minimal training requirements:

During the first three quarters of FY 07-08, DDSN's quality improvement organization (QIO) found that just 11 of 28 (39%) eligible providers reviewed adhered to DDSN policy regarding human rights committees composition, confidentiality, and training directives. Detailed reviewer comments revealed that although committees were active in providing oversight of board activities, providers often received a "Not Met" because neither meeting minutes nor board training records contained a record of human rights committee training. An agency official stated that other reasons for receiving a "Not Met" determination included incomplete committee composition, and having an insufficient number of meetings.

It may be difficult for providers to find a person meeting each of the qualifications, who is willing to volunteer his time. It also may not be necessary for committees providing oversight of smaller boards to meet as often as the directive requires. The agency official stated that in those cases a provider should request an exception to the human rights committee licensing requirement. Between January 1, 2005, and December 31, 2007, four providers requested an exception to that requirement. According to an agency official, if after the QIO's follow-up review, the provider still has not met this indicator, the provider will receive technical assistance from the district office.

Although the QIO found that committees were active in providing oversight of board activities, the committees were frequently unable to meet DDSN's requirements. Appropriate committee composition and training are important to ensuring consumer welfare.

Recommendations

22. The Department of Disabilities and Special Needs should evaluate whether or not the statutory requirements for human rights committee composition could be effective, and if so, amend the directive to be consistent with the statute.
23. The Department of Disabilities and Special Needs should monitor whether facility/agency directors schedule human rights committee training at least once a year or more often as needed.

Direct Caregiver Training

We reviewed DDSN's direct caregiver minimum training requirements and DSN board training curriculum outlines to determine if board policies complied with DDSN policy. We found that, with few exceptions, the DSN boards' outlines met DDSN's minimum training requirements. However, training coordination and procedures may need to be reviewed further.

According to an agency official, the last major statewide curriculum revision was more than eight years ago. After that revision, training coordination duties were shifted from the central office to the regional offices. In 2007, DDSN staff and trainers from around the state updated the agency's training directive, which includes policies and a list of required topics. They are in the process of updating the DDSN-recommended training curriculum. According to an agency official, the revision process has created a forum for trainers from around the state to discuss training-related practices and issues from their counties. Also, the updated curriculum will eventually be posted online.

During our review, we determined issues for DDSN to review further:

- Abuse and neglect training may be inadequate. Early QIO reports show that, although most providers are able to document a staff person's receipt of abuse and neglect training, upon observation, staff do not demonstrate an understanding of the issue or reporting process. From July to December 2007, the QIO observed that of 17 providers documenting annual abuse and neglect training, 12 (71%) had staff that could not demonstrate knowledge from the training.
- Online availability of training information is very limited, and neither DDSN's website nor its extranet contains a list of training opportunities in different counties. The extranet is a password-protected internal site. During the course of our review, we observed that Florida's Agency for Persons with Disabilities website contains comprehensive lists of training available in the agency's geographic regions.
- Centralized training coordination may be beneficial in terms of providing technical assistance and sharing of best practices and training opportunities.

Recommendation

24. The Department of Disabilities and Special Needs should communicate training availability through its website.

Chapter 2
Health, Safety, and Welfare

Barriers to Competition and Consumer Choice

Federal regulations (42 CFR §431.51) require recipients of services funded by Medicaid to have free choice of the providers who are willing to provide the service to them. We were asked to identify barriers to competition and consumer choice within the DDSN system. We found that in South Carolina, DDSN's consumers often have little choice of providers. Most services are provided by the local disabilities and special needs (DSN) boards. We identified several barriers to competition and consumer choice that are discussed below.

Availability of Provider Choice

In the past, local disabilities and special needs boards provided nearly all services for DDSN's consumers. Beginning in 1998, DDSN began to implement a service-delivery approach called "person-centered services," which was designed to give consumers and their families more choice and control of the services they received from DDSN. DDSN gradually began to allow qualified service providers other than the DSN boards to provide services to its consumers. In 2003, DDSN solicited proposals from providers who wanted to serve its consumers, and more providers were qualified through the process that was administered by the Budget and Control Board. Providers on the qualified provider list are called QPL providers. According to procurement records, as of January 2008, DDSN had added 17 non-board providers through this process. We found that 4 of the 17 providers procured from 2003 through 2008 are no longer providing services. In October 2008, DDSN submitted information about new providers qualified through its August 2008 solicitation. The information showed that 15 new providers have been qualified to offer some services.

As of FY 06-07, just five providers of residential and day services to DDSN's consumers had been added through DDSN's solicitation for services. According to DDSN, as of December 2007, just 147 of 4,776 residential consumers were being served by these QPL providers. In FY 06-07, DDSN paid approximately \$5.6 million to these providers, 3% of its total expenditures of \$163 million for residential and day services. Early intervention is the only service where there was a significant choice of providers. In FY 06-07, DDSN paid 5 QPL providers \$4.8 million for early intervention, approximately 37% of its expenditures for this service.

In many parts of the state, consumers have no choice of provider for residential services. We reviewed a list of residential facilities and found that there are 35 counties where a consumer would have no local choice of provider for any residential service.

Over the past few years, the federal Centers for Medicare and Medicaid Services (CMS) and the South Carolina Department of Health and Human Services (DHHS), the state Medicaid oversight agency (see p. 8), have recommended that DDSN take action to bring more providers other than DSN boards into the system. A 2004 CMS review of the MR/RD Medicaid waiver operated by DDSN recommended "... the continued enrollment of non-DSN board providers in order to increase choices of consumers and family members." This review also advised "... that actions be taken to assure that all potential providers have the opportunity to enroll to increase consumer and family choice."

DDSN requires service coordinators to offer choices to consumers and to have the consumer sign a form stating that they were offered a choice of providers. DDSN's quality assurance contractor reviews consumer files to make sure that these forms are in the files. However, if there are no providers to choose from, having consumers sign this form is, in many cases, a meaningless activity.

DDSN participates in a national core indicators survey conducted by the National Association of Directors of Developmental Disabilities Services and the Human Services Research Institute. The survey asks a sample of DDSN's consumers about their experiences and perceptions. Based on data from the 2005-2006 survey, in which 20 states participated, DDSN's consumers' responses did not vary from the national average when asked questions about whether they had choice in making life decisions. However, when asked whether they had looked at more than one home or more than one job, just 4% – 6% indicated that they had, percentages far below those in all of the other participating states.

We contacted South Carolina's neighboring states to determine how many providers of residential services are available in those states. We found that consumers in Georgia, Florida, and North Carolina have a greater choice of providers than those in South Carolina. Florida's website lists 200 residential providers, Georgia's provider list includes 141 providers of residential services, and a North Carolina official stated that North Carolina has 80–100 residential providers at any one time. Including DDSN and the DSN boards, South Carolina has 45 providers of residential services. Removing some of the barriers to entry faced by providers in South Carolina should result in more choice, which could result in improved services for DDSN's consumers.

Barriers Related to the Board System

The South Carolina Mental Retardation and Related Disabilities Act of 1990 provided that a statewide network of local boards of mental retardation be established. Section 44-20-385 states that county boards of disabilities and special needs are "... the administrative, planning, coordinating, and service delivery body for county disabilities and special needs services" The law does not require the boards to provide services directly. They may contract with other providers to carry out the department's programs. Historically, the boards and other entities recognized by DDSN as boards (see p. 3) have planned and coordinated services and also directly provided the substantial majority of the services received by DDSN's consumers. As implemented by DDSN, the board system creates barriers to other service providers who might be qualified and wish to provide service to DDSN's consumers.

Lack of Independent Service Planning

In South Carolina, service coordination and service provision are generally performed by the same entity, the local DSN board. This creates a conflict of interest and is a barrier to choice. When a consumer's service coordinator, who informs the consumer about different providers available, is employed by one of the providers, the service coordinator's independence is compromised. Also, the board's service coordinator is responsible for determining the consumer's needs, which affects the funding allocated to services for that consumer. If that board receives those funds as a service provider, the independence of this process could be compromised. Further, when service coordination and service provision are combined, oversight is lessened and quality of service may be compromised.

According to a recent study of DDSN's quality management functions by the USC School of Public Health, national experts suggest that the service coordination function be at arm's length from service providers. The separation of these functions creates necessary "firewalls" that prevent conflicts of interest, facilitate functional outcomes, and serve as an independent oversight mechanism. The study pointed out that the separation of the two functions allows for multiple "pairs of eyes" to monitor quality, and recommended that DDSN require the separation of service provision and coordination. The S.C. Department of Health and Human Services (DHHS) has separated service coordination and service provision for the Medicaid waiver programs that it manages directly. A 2007 DHHS audit of DDSN's service coordination points out that most counties in the state only have a choice of one provider for regular service coordination. The audit stated that "DDSN should continue to find a way to bring more qualified providers into the system even if they are only neighboring DSN boards in order to provide actual choice."

We found that in Georgia, Florida, and North Carolina, service coordination is separate from service provision and cannot be done by the same entity. In each of these states, service coordination and service provision were formerly done by the same entity. In Georgia, House Bill 100, passed in 1993, found that the state had an obligation and responsibility to develop and implement planning and service delivery systems in which "... the functions of service planning, coordination [and] ... contracting ... should be separated from the actual service delivery programs." According to officials in those states, similar changes to ensure independence of service coordination occurred in Florida in the 1990s and in North Carolina around 2002.

According to a 2006 survey conducted by the National Association of State Directors of Developmental Disabilities Services, 27 states reported they do not permit providers to offer other direct services to consumers for whom they provide case management, while 20 states reported that providers could offer both case management and other direct services. Six of the 20 states reported they require case management units to operate at arms length from other agency operating units.

In its 2003 solicitation for new providers, DDSN mandated that providers responding to the solicitation could not offer both service coordination and service provision. According to a DDSN official, this was to prevent conflicts of interest. However, DDSN has continued to allow the DSN boards to provide both to the majority of their consumers.

DDSN is required by statute (S.C. Code §44-20-370) to use the most modern methods of providing services to its clients. It should require the separation of service coordination and service provision to ensure independent consumer choice. In October 2008, DDSN reported that six new providers of service coordination have been qualified through its August 2008 solicitation for services. Having independent providers available should ease the implementation of this new requirement.

Financial Barriers to Entry for Non-Board Providers

DDSN provides financial benefits to DSN board providers that discourage participation by other providers of services. When board providers are serving a consumer, DDSN pays the board an upfront payment called a band payment (see p. 47), while QPL providers are paid for services only after they have been provided and do not receive the upfront payments. For example, a board provider would be paid \$6,168 per month in advance for providing services to a single consumer in a high management group home. Delayed payments can create cash flow problems for the QPL providers. The DSN boards also have a favorable financial situation when vacancies occur

in their facilities. The boards continue to be paid for providing services for 60 days or more following vacancies, while the QPL providers are not paid for empty beds. Also, until July 2008, QPL providers had to bill the DSN boards, their competitors, for some services, which can create delays. It was also inefficient, as the same provider might serve consumers in multiple counties, and it would have to bill each board separately. Beginning in July 2008, QPL providers may bill DDSN directly for additional services.

Funds for Capital Development

DDSN has provided the DSN boards capital grant funds to purchase and maintain their residential facilities and for administrative facilities. Table 3.1 summarizes the capital grant amounts awarded by DDSN for the past three years. The majority of funds (59%) were for administrative facilities. According to DDSN, many of these facilities also house day programs for consumers.

Table 3.1: DDSN's Capital Grants, FY 04-05 – FY 06-07

FY/PE	FY 04-05	FY 05-06	FY 06-07	TOTAL
Residential	\$665,751	\$2,624,068	\$4,048,194	\$ 7,338,013 (41%)
Non-Residential	1,792,296	1,997,979	6,725,213	10,515,488 (59%)
TOTAL	\$2,458,047	\$4,622,047	\$10,773,407	\$17,853,501 (100%)

Source: DDSN

Financial Accountability

DDSN has not adequately implemented its contractual controls over board performance. DDSN's contracts with the DSN boards contain comprehensive provisions for DDSN to withhold or reduce payments to the boards for violations of DDSN policy, financial requirements, or service provision standards. The contracts can be terminated for breach of contract or the board's insolvency. In one instance, DDSN sanctioned a provider, Babcock Center, by forcing it to reduce its services by approximately one-half (see p. 12). As a result, other providers had an opportunity to expand their services and bring more choice into the system. In Richland and Lexington counties, 64% and 33%, respectively, of residential facilities are operated by providers other than Babcock, the DDSN-recognized "board" in these counties. However, we found that DDSN has waived financial obligations of the boards in many instances or has helped them out of financial difficulties. This is done through a process of forgiving the boards' obligations to DDSN or awarding special one-time grants to the boards. Some examples of DDSN's assistance are listed below.

- Although the DSN boards are required to reimburse DDSN when they sell property that was purchased with a capital grant from DDSN, it allowed the Chester/Lancaster and York boards to keep proceeds owed to DDSN in the total amount of \$151,000 from FY 05-06 through FY 06-07.
- When Babcock Center was required to downsize, DDSN furnished a grant of \$96,000 for furniture for its facilities being transferred to other boards. DDSN is still owed more than \$2 million by Babcock. According to officials, it will forgive this debt when all of Babcock's transferred property has been officially transferred to other providers.
- In FY 07-08, DDSN assisted the Charleston DSN board with its financial difficulties. As part of its agreement with the board, DDSN will pay for the agency's leases in the amount of \$108,000 for FY 06-07 and \$110,856 for FY 07-08.
- In FY 04-05, DDSN provided special one-time grants to the Georgetown DSN board in the total amount of \$267,204. One of these grants was for "one-time settlement of IRS lien."

According to DDSN officials, they cannot allow the boards to go out of business. They think of the boards not as separate stand-alone entities, but as part of DDSN's budget. They "work with" the boards so that they can continue to operate. This gives the boards a strong financial advantage compared with the QPL providers. While DDSN, beginning in FY 06-07, has given one-time grants to QPL providers and has extended the period over which they can repay penalties found in audits, prior to FY 07-08, it had not given significant financial assistance to these providers. In FY 07-08, DDSN awarded \$475,065 in capital grants to one QPL provider of residential services.

Not requiring the boards to be financially accountable can have other effects in addition to limiting and discouraging competition from other providers. If the boards know they can mismanage their funds with impunity, they have less incentive to manage prudently. They also have less incentive to ensure that their services protect the health, safety, and welfare of their consumers. Many findings of DDSN's internal audits of the boards were recurring problems (see p. 26). DDSN should ensure that it requires the boards to be accountable. If a board does not manage its resources appropriately, DDSN should implement its contractual controls and, if needed, contract with other providers of services for its consumers.

Recommendations

25. The Department of Disabilities and Special Needs should require that a consumer's service coordination and service provision be performed by separate entities.

26. The Department of Disabilities and Special Needs should hold the DDSN boards accountable for their fiscal management. If a board is not financially responsible, DDSN should implement its contractual controls, and, if needed, contract with other providers for services.

Allocation of Beds

DDSN's method of distributing new funding for residential services has also created barriers to providers and consumer choice. Instead of allocating new residential placements to consumers who are determined to be the most in need of these services, DDSN allocates new slots to providers. In FY 05-06, DDSN was appropriated \$2.3 million in state funds as the state match to allow them to develop 130 new beds to serve consumers not previously served. In FY 06-07, they received an additional \$9.2 million in state appropriations to allow for 500 new beds.

DDSN has used a process for filling vacant beds and developing new beds that focuses on providers. When an existing bed becomes vacant, DDSN allows the provider to locate a new person who has need for services to fill this vacancy. When funding became available for the 500 new beds in FY 06-07, DDSN used the following process to gather information before allocating the new beds to specific providers:

- DDSN solicited providers' proposals for new beds.
- DDSN obtained information on geographic location of consumers waiting for residential services.
- DDSN obtained data on the existing residential capacity as a percentage of total county population.

According to a DDSN official, they also considered the type of residential service needed, with the goal of increasing beds in the least restrictive categories. In addition, they considered the population served, wanting to increase services for consumers with head and spinal cord injuries and autism, who had been previously underserved. They also decided to allocate more beds to private (QPL) providers than had been allocated in the past. DDSN officials evaluated the information they obtained and then allocated new beds to specific providers. They specified what level of service would be provided in each case and from which waiting list(s) the consumer filling the beds must come. They did not designate individual consumers to receive the placements. Although DDSN had asked providers to identify the consumers they would serve if they received new beds, a review of their proposals revealed that many did not. Also, in at least one case, a provider requested the slots to meet the needs of potential consumers, and DDSN authorized the

provider to provide a different level of residential service, for which it did not have demand.

In Georgia, Florida, and North Carolina, when funding becomes available to provide residential services to clients not previously served, funds and services are allocated to specific consumers and not to providers or facilities. The consumers who are authorized to receive services then select the provider(s) that they want, often interviewing and considering various providers available.

By allocating beds to providers instead of to people, DDSN has not encouraged consumer choice. In some cases, this method of funding can result in consumers who would otherwise receive residential placements not being placed or not being placed with their choice of provider. For example, we reviewed records of four consumers who were eligible for residential placement and had chosen their preferred qualified providers. However, the providers they chose did not have beds allocated from DDSN. Two of the consumers agreed to be placed with another provider who was not their choice, and two of them preferred to wait until their preferred providers had "slots" available. When the money follows the bed instead of the person, it is another barrier to competition and consumer choice. Although most QPL residential providers are qualified to provide services in all parts of the state, according to one of these providers, when they wanted to serve consumers in new parts of the state, DDSN did not allow this. According to another provider, they have decided to stop offering services in South Carolina because they could not obtain enough slots from DDSN to make their services economically feasible.

Recommendation

27. The Department of Disabilities and Special Needs should allocate funding for services to individuals and not to providers.

Lack of Reciprocity

If a DSN board wants to provide a service that it provides in its own county in a neighboring county, it is required to apply to be a qualified provider in the other county. We could not determine any reason why a provider qualified in one county would not be qualified to provide the same service in another county. This is another disincentive to free choice of providers for consumers. One DSN provider stated that the resources they would use to go through the application process would be better spent elsewhere in service delivery.

Recommendation

28. The Department of Disabilities and Special Needs should allow DSN boards to provide services they provide in their own jurisdiction in other areas of the state without going through the provider qualification process.

Availability of Providers

As discussed previously, often there are not enough available residential service providers for consumers to have a choice of providers. Evidence indicates that other types of services needed by consumers are often not available. Three services mentioned to the LAC as not available were the following:

- Respite — service provided to care for the consumer temporarily because of the absence or need for relief of persons normally providing care, either in the home or at a different site.
- Companion — non-medical care, supervision, and socialization provided to an adult consumer.
- Behavior support — services which use research-validated methods to identify the cause of, intervene to prevent, and appropriately react to problematic behaviors.

DDSN files quarterly reports with DHHS regarding services that are needed but unavailable. We reviewed the quarterly report filed in February 2008 and noted that there were 102 reports of unavailable services. Most frequently reported as unavailable were respite care, behavior support services, and adult companion services. We consulted Babcock Center, the primary provider of respite and companion services for Richland and Lexington counties. Babcock maintains lists of qualified providers who might be available to provide respite and companion services. Just 18 respite providers and 6 companion providers were on the list as of March 2008. Based on data from DDSN, as of June 30, 2008, approximately 2,280 consumers in

Richland and Lexington counties were eligible for respite and 370 were eligible for companion services.

Consumers in the Medicaid waiver operated by DDSN are dropped from the program if they don't receive any services in 30 days. If a consumer didn't use services because they were not available, he has 90 days to begin using services during which he may return to the waiver program. Neither DDSN or DHHS compiles reports on how often consumers must leave the program because providers are not available. We reviewed the enrollment and disenrollment forms for the DDSN Medicaid waiver for calendar year 2007 and found 76 instances when consumers were disenrolled because they had not received services in 30 days. The forms did not usually indicate the reason that the consumer had not used services, but in six cases there were specific notes referring to provider unavailability.

Reasons cited for the difficulty in recruiting respite and companion providers included the low pay, training, requirements to be qualified, and the difficulty and part-time nature of the work. DDSN stated that its new solicitation for providers issued in August 2008 makes it easier for individuals to complete the paperwork and go through the qualification process. They are also redesigning services in a new waiver application to respond to the problem of availability of providers. These include a site where respite services could be provided for flexible hours based on family needs.

Management of Provider Qualification

DDSN's qualification process for providers of psychological services needs improvement. Since 2000, DDSN has been responsible for determining which providers are qualified to offer psychological services to its clients through the MR/RD waiver (see p. 5). Psychological services include counseling, testing, and behavior support services. Behavior support services have not been available to all who need them (see p. 41). As of March 31, 2008, according to DDSN's provider list, there were just 26 qualified providers of behavior support services who were accepting new clients. From FY 04-05 through FY 06-07, DDSN records show that just 56% (10 of 18) new applicants to provide behavior support services were determined by DDSN to be qualified. We reviewed DDSN's provider qualification process to determine whether it provided appropriate controls to verify qualifications. Applicants must possess the required education and experience and submit a work sample. To be found qualified, applicants must also pass an interview, in which one or two DDSN employees or contractors conduct an oral interview with the applicant.

The use of an interview to determine whether applicants are qualified is questionable, as it could be subjective and may not meet professional testing standards of validity and reliability. Although DDSN uses structured interview questions, there are no written policies for grading or scoring the interview. There is no assurance that the interview would provide consistent results or be defensible if challenged. DDSN also uses interviews to determine whether providers of psychological counseling services and testing services are qualified. Other means to determine qualifications, such as requiring the passage of a written exam or specific courses of study, would likely be more objective, valid, and reliable.

Renewal and Review of Qualified Providers

Beginning in 2002, DDSN required stringent renewal and review requirements for all providers of all psychological services which could discourage potential providers from applying. We found that DDSN did not enforce these requirements, which calls their purpose into question. Beginning in 2002, DDSN required that providers renew their qualification every two years and submit documentation of 20 hours of appropriate continuing education credits to DDSN. Also, DDSN required that providers' performance be reviewed annually. In the annual review for behavior support services, a person skilled in applied behavior analysis evaluates a sample of the provider's work to determine if it met 13 criteria established by DDSN during the qualification process. If criteria were not met, DDSN would require the provider to submit a corrective action plan and undergo a follow-up review.

We reviewed the files of 8 (31%) of the above 26 behavior support providers and found that the renewal requirements had not been enforced; providers were not required to renew every two years or submit documentation of their continuing education to DDSN. Also, the annual reviews had not been completed in most cases. Four of the providers for whom reviews would have been required since 2002-2004 had no record of ever having an annual review. After the LAC disclosed the sample findings to DDSN, DDSN management sent out notices requiring providers to send in documentation of their continuing education going back to 2004.

According to a DDSN official, they have been concerned about getting the providers they need to furnish behavior support services. DDSN has regularly made USC courses in applied behavior analysis available to its providers, staff, and interested professionals at no cost. DDSN should also revise its qualification and review process to ensure that it contains adequate, but not excessive quality controls, is objective, and consistently enforced.

Recommendations

29. The Department of Disabilities and Special Needs should ensure that barriers to individuals desiring to provide services are minimized.
30. The Department of Disabilities and Special Needs should regularly evaluate the level of response to its solicitation for providers and amend the solicitation as indicated to encourage new providers to enter the system.
31. The Department of Disabilities and Special Needs should discontinue the use of an oral interview to qualify providers and ensure that its process is based on objective criteria and documented results.
32. The Department of Disabilities and Special Needs should ensure that it enforces stated provider requirements for renewal and review.

Marketing and Provider Communication

We reviewed DDSN's marketing and communication to providers to determine whether the agency made adequate efforts to broaden the choice available to consumers by encouraging and supporting new providers. We did not find substantial evidence of recruitment or support. While DDSN issued a solicitation for new providers in 2003, we found little evidence that DDSN attempted to evaluate the response to the solicitation or make changes to encourage more providers to apply. Focus groups who participated in the USC School of Public Health study agreed that a cause for the lack of choice in the South Carolina system was "... in large part, due to the complexity in the process for private providers to obtain licensure or certification."

Only when the 2003 solicitation neared expiration in 2008 did DDSN consider amendments and changes to the solicitation. For example, it is considering allowing providers of 6-bed homes to provide services that were previously limited to providers of 4-bed homes. DDSN also plans to solicit providers to act as fiscal agents for consumers who do not want a DSN board to handle their funds.

However, DDSN does not see itself as responsible for recruiting providers. According to DDSN officials, who cited a U.S. Supreme Court decision not to review an appeals court decision in the state of Colorado, DDSN is not required by Medicaid law to provide services or ensure that they are provided.

DDSN does not offer training or orientation sessions to new providers to ease their way into providing services effectively. A DDSN official stated that when a provider responds to the solicitation for services, DDSN expects that they have certain knowledge, background, and experience. Georgia requires several days of new provider orientation and training that is offered twice a year. Florida has an extensive and ongoing system for new provider training. One South Carolina provider within the DSN system stated that it was difficult for his board to begin offering a new service, and they are already working in and familiar with the DDSN system.

Evidence indicates that DDSN does not have regular communications to ensure that all providers have the information they need or have the same access to assistance. One provider obtained the right to bill DDSN directly and had the frequency of its billing changed to twice a month. This billing frequency is not granted to the other QPL providers. DDSN has not ensured that all assistance was communicated or available to all providers equally.

Recommendations

33. The Department of Disabilities and Special Needs should recruit new providers by ensuring that provider requirements are not unnecessarily restrictive.
34. The Department of Disabilities and Special Needs should provide regular and intensive training and assistance to new providers.
35. The Department of Disabilities and Special Needs should pay all non-board providers of residential services on a bi-monthly schedule.
36. The Department of Disabilities and Special Needs should ensure that it provides the same benefits to all providers and that its policies are comprehensive and readily available to all providers.

Conclusion

DDSN officials stated that private providers did not want to come to South Carolina because of the low rates paid for their services in the state. However, they did not provide evidence to support this assertion. We did a limited review of rates paid to private providers for residential services (non-institutional) in Florida, Georgia, North Carolina, and South Carolina. As shown in Table 3.2, based on limited evidence about the current rates paid in these states for different levels of residential service, there is nothing to suggest that South Carolina's provider rates are too low to attract providers.

Table 3.2: Rates for Residential Services in Four Southeastern States

STATE	RATE PER DAY
NORTH CAROLINA	\$102 – \$175
SOUTH CAROLINA	\$73 – \$209
GEORGIA	\$156
FLORIDA	\$40 – \$248

Source: DDSN and FL, GA, and NC records.

As discussed, there are many barriers to competition and consumer choice in the South Carolina system that is managed by DDSN. DDSN should take action to increase the choices available to the consumers it serves. Provider choice should work hand-in-hand with accountability. North Carolina has recently been criticized because many of its providers, especially for mental health services, were billing the state for services that may not have been needed, and the state did not have adequate controls over quality of service. According to a North Carolina official, the consumers did not have budgets or controls over the amount spent for their services; they had blank checks to purchase whatever services they wanted. DDSN has controls to ensure that services are needed and allocates budgets to individual consumers. If South Carolina is able to recruit more providers and offer more choice to its consumers, DDSN should ensure that it provides accountability for services offered by all of its providers.

Use of Funds

Band Funding

Our objective was to determine if DDSN's band payment system is effective, efficient, and accountable. The band payment system is used as a budgeting tool to fund DSN boards, which provide or arrange for consumer care. These funds are used later to pay board expenses and to make payments to providers — they are not direct payments to providers. We did not find material problems with the band payment system and found it does not violate any federal regulations. However, DDSN has not formalized a band funding policy and has no formal procedure and policy for systematically updating band funding amounts to account for cost-of-living increases. Band funding in itself does not provide accountability — as band funding was not designed to account for a consumer's services or service payments.

Background

The band payment system, modeled after a similar system in the state of Arizona, is an advance payment system designed to pre-fund county disability and special needs (DSN) boards. This budgeting tool determines the amount of funding provided to the boards. State funds are appropriated to DDSN by the South Carolina General Assembly and are paid to the DSN boards a month in advance to be available to the boards for their consumers' care. The amount of funding to the boards for each consumer is determined by the band assigned. Each band is assigned a specific dollar amount, which is the average of the costs of consumers in that band based upon prior year actual costs. The band assignment to the consumer is based upon the service needs of the consumer as determined by an assessment administered by DDSN and DSN board personnel.

Pre-funding is necessary because the boards receive their primary funding from DDSN and have few other sources of funding except for Medicaid. The boards have to meet their ongoing administrative costs and the costs of providing services. They are not "stand-alone" entities, such as other state agencies, which are funded directly by the General Assembly. They exist primarily to provide or arrange for services to DDSN consumers.

A consumer's band funding may be more or less than the amount that is paid for his services. According to agency officials, the level of services received is always based upon consumer needs, not on band amounts. The cost analysis division of DDSN analyzes funding bands assigned to individual consumers every month in order to determine if funding bands need to be changed.

"Money Follows the Person"

DDSN asserts that it has a "money follows the person" philosophy regarding funding for consumer services. This concept was begun in 1992 in connection with the migration of consumers from regional institutional settings to smaller group home residential settings, in what is referred to as "depopulation." DDSN "moves" the budgeted amounts for services with the person to the new residential setting. This philosophy has been carried over to the band funding and consumer movement from service provider to service provider within a board's domain, from board to board, and from board (or board provider) to private providers, called QPL providers (see p. 33). QPL providers do not receive pre-funded band funding, but the rates they receive for providing services are based on the band amounts.

We found that there is a lack of clarity about exactly what "money follows the person" means. Some consumers, consumers' families, and advocates may think that a consumer is "entitled" to money assigned the consumer through band funding. However, we found that band funding represents *budgeted* funds and makes those funds available for consumer care, but the amount of money spent is based upon the actual service *needs* of the consumer, regardless of the band amount. The services needed are what the consumer is entitled to — not the specific amount of money in the funding band. If the services are not in the plan of care, then they are not needed. The services will not be received, and money will not be spent for them. Service needs and their cost may be more or less than the band amount assigned.

Misunderstanding about the band funding may have caused consumers and interested parties to become suspicious and fostered the belief that DDSN has not made the proper expenditures in the procurement of services for the consumers. A written policy available to the public should provide a better understanding of the purpose and application of band funds and reduce uncertainty and suspicions regarding services purchased.

Other Budgeted Funds

DSN boards are also paid a monthly rate in advance for consumers not assigned a funding band, but who receive service coordination and some other services. These would include early intervention therapy and training for children from birth through five years, services to HASCI (head and spinal cord injury) consumers in the waiver (see p. 5), respite care that is state funded, and other individual and family supports.

Band Development

DDSN initially developed the funding bands during 1997 and 1998, culminating in the creation of five bands to provide funding for services for classifications based upon consumers' level-of-care needs. Two bands were for consumers who reside in their homes and were as follows:

- Band A consumers receive day program services.
- Band B consumers receive day program services and enhanced waiver support services.

The residential bands were assigned based on the type of residential placement the consumer needed and were as follows:

- Band C included placements in community training homes (CTHI), and supervised living programs (SLP I and II).
- Band D consumers were low needs residents in community residential care facilities (CRCF) and community training homes (CTH II).
- Band E consumers resided in high needs intermediate care facilities for the mentally retarded (ICF/MR), and high needs CRCF and CTH II placements.

Addition of Band F

We reviewed the DDSN band F, an additional band implemented in 2002. This band was created as a part of a pilot program contractually agreed upon by DDSN and the Babcock Center. Band F provided supplemental funding for consumers in CTHI residences, which are foster care placements where consumers reside with their caregivers in their caregivers' homes. According to officials, the additional funding was needed to induce new caregivers into the program by paying for more respite care to relieve the caregivers of some of the burden of their foster care duties. The agency encourages the use of less restrictive consumer placements, based upon the decision in the Olmstead case (see p. 4).

We could find no evidence that DDSN properly documented the pilot program. We found no evidence that it was announced to or known by the general public, or perhaps even known to interested parties, such as disabled consumers and their advocates. This could lead to misunderstanding, suspicion, and mistrust regarding the program and its funding. We also found no evidence that DDSN evaluated the results of the pilot program. Agency data shows no growth in the number of enhanced CTHI placements from 2003 to 2008. Proper documentation and publication of any future pilot programs should provide improved openness and transparency of DDSN's operations.

Adjustments to Band Amounts

In its February 2006 audit report, the Division of Audits of the Department of Health and Human Services (DHHS) recommended that DDSN update its band funding levels so that the amounts of the bands more closely resembled the actual costs of services.

DDSN re-based the bands in 2006. In doing so, it increased the number of bands to eight (see Table 4.1) so the bands would be more representative of actual costs. However, this re-basing was a one-time adjustment of band amounts. DDSN has updated band amounts annually, to coincide with pay raises and insurance increases for employees of DSN boards. However, it has not required regular consideration of other cost-of-living data in agency formal policy or procedure. We concluded that DDSN should develop a systematic plan to update the bands for cost-of-living factors, such as fuel and vehicle maintenance, contingent on availability of funds. This would minimize the risk of inadequate funding caused by band amounts below actual costs, which could potentially affect providers' ability to furnish consumer care.

Table 4.1: DDSN Band Funding Levels, FY 07-08

BAND	PLACEMENT	ANNUAL AMOUNT
A	Day supports only	\$9,079
B	At home waiver supports	\$12,598
C	Supported residential (SLP II)	\$28,315
D	Supported residential (SLP I)	\$18,106
E	Supported residential (CTH 1)	\$22,301
F	Supported residential – Enhanced CTHI	\$36,574
G	Residential low needs	\$54,190
H	Residential high needs	\$74,022

Source: DDSN

Medicaid Payments

The DSN board provides, or arranges for, the services required by the consumers' individual plans of care and sends notice of the expenditures to the DDSN central office. DDSN bills DHHS for the Medicaid-reimbursable portion of these services. These payments made for services provided are eventually reconciled with final cost statements for the year DDSN sends to DHHS, with DHHS acting as the fiscal intermediary for Medicaid.

Recommendations

37. The Department of Disabilities and Special Needs should develop a formal policy regarding the process for band funding and post the policy on its website.
38. The Department of Disabilities and Special Needs should develop a plan to update band amounts for cost-of-living adjustments annually.
39. The Department of Disabilities and Special Needs should develop a policy requiring the agency to document pilot programs including their structure, purpose, scope, monitoring, and evaluation.
40. The Department of Disabilities and Special Needs should make information about pilot programs available on its website.

Outlier Funding

When the services needed by a DDSN consumer are significantly more expensive than the funding band allocated to the consumer, DDSN may authorize outlier funding to supply additional funds for consumers' care. As a part of our objective to determine if DDSN's band funding system is effective, efficient, and accountable, we reviewed outlier funding since it is a part of the budgeting DDSN uses to fund the boards. We found that even though DDSN has an outlier policy it uses to approve and re-justify outlier funding, it has not formalized an overall outlier funding policy and made it accessible to the public. We also found that DDSN does not have written guidelines or written criteria for making outlier funding decisions.

Background

There are three types of outlier funds available to consumers:

- High needs residential (band H) — usually to pay for additional staff supervision.
- Enhanced home services (band B) — usually to pay for additional personal care assistance.
- Nursing — to pay for medically-authorized nursing services.

DDSN considers outlier funds for bands B and H when a consumer's annual budget exceeds a certain dollar amount "trigger." Currently the triggers are \$94,583 for band H and \$28,202 for band B (see p. 50). The local board in the area where the consumer resides is responsible for applying to the DDSN district office for outlier funds, both initially and annually when the outlier must be re-justified. The DDSN central office approves outlier funding.

Nursing outliers are allowed based upon a physician's order without question. However, they are subjected to DHHS-imposed daily and weekly limits, per consumer, of the number of hours of nursing services received. The cost analysis division of DDSN automatically reviews the nursing outliers quarterly for the amount of services being received and adjusts the next quarterly budget accordingly.

Review of Outlier Funding

Beginning in 2004, DDSN required that providers annually re-justify outlier funds allocated to its consumers. In its 2006 audit report, the DHHS division of audits performed a review of the annual outlier re-justifications and found no material problems. As a result, we did not review re-justifications further. However, we did review whether or not a consumer's outlier funds are impacted by a move from a DSN board or board provider to a QPL provider to determine if a consumer is disadvantaged financially because of his choice of provider. This may be an issue because QPL providers are not pre-funded as are board providers, and they are competitors of the boards. In a limited sample, we found that consumers who received services from QPL providers retained outlier funding after moving from boards or board-contracted providers.

DDSN has no comprehensive outlier funding policy available to the public. As we have seen with band funding, the lack of a policy may create consumer and advocate misunderstanding about consumers' "entitlement" to outlier funds. A written policy available to the public should provide a better understanding of the purpose and application of outlier funds and reduce uncertainty and suspicions regarding services purchased.

DDSN does not have written guidelines or criteria which would better ensure that requests for outlier funding are evaluated consistently. These criteria would provide more clarity to funding decisions.

Recommendations

41. The Department of Disabilities and Special Needs should develop a formal policy regarding outlier funding and post the policy on its website.
42. The Department of Disabilities and Special Needs should establish written criteria for outlier decisions.

Cost Reports

Cost reports are an annual compilation of costs DDSN incurs in order to provide care for its consumers. DDSN submits cost reports to the Department of Health and Human Services (DHHS) at the end of each fiscal year to claim Medicaid-allowable costs. DHHS is the Medicaid claims processor, making Medicaid payments to DDSN for Medicaid-allowable costs. Prior audits by the federal Centers for Medicare and Medicaid Services (CMS) and DHHS have recommended that DDSN's cost reports be independently audited. We found the cost reports have not been independently audited.

The process of cost reporting is an annual reconciliation between DDSN's costs and federal Medicaid reimbursement. Adjustments are made if the process reveals that DDSN's allowable costs were more or less than the reimbursements it received from interim payments throughout the year. The annual cost settlement completes the funding cycle begun by the band payments that DDSN used to pre-fund the boards. There is no reconciliation to the pre-funded band amounts, which are budgeted amounts. DDSN's costs are reconciled to the amounts reimbursed for actual services provided to consumers.

DDSN submits four regional cost reports, one each for the Midlands, Piedmont, Coastal, and Pee Dee areas. DDSN includes costs for the three waiver programs — MR/RD, HASCI, and PDD — and DDSN's other Medicaid-eligible programs. DDSN's costs for administering the programs are also reimbursed by Medicaid. DDSN uses the regional cost reports to allocate its costs to the four regions, to the waiver programs, and to its other programs. DDSN allocates its direct salary and benefits expenses, administrative costs for the central state office in Columbia, plus overhead and other general costs. In 2007 DDSN allocated approximately \$64.7 million in administrative, general, and other overhead costs to the waivers and other programs, 14% of total program Medicaid costs of \$451 million. Total DSN board administrative costs for fiscal year 2006 were \$27.7 million, 9% of total DSN board program costs of \$309.9 million.

In addition to being the basis for cost settlements made by DHHS and DDSN, the cost reports are used for setting future rates for Medicaid reimbursement of DDSN's waiver programs services. These rates include both service and administrative costs.

The Centers for Medicare and Medicaid Services, in a 2004 audit of the MR/RD waiver program, found that the state should have independent waiver-focused audits performed on Medicaid-filed cost reports. Correspondence from the federal auditors about the audit report reported concerns with DDSN's cost allocations, reimbursement and cost settlement

methodologies, as well as the correct reimbursement rate for the DSN boards' costs.

The DHHS division of audits recommended, in a 2006 limited-scope audit of the MR/RD waiver program, that DDSN obtain an external audit of the four regional cost reports. The DHHS division of audits found, in a March 2008 follow-up audit of the MR/RD waiver program, that DDSN had not complied with the recommendation. DHHS' division of audits completed an audit of DDSN's fiscal years 2005 and 2006 cost reports for service coordination, a very small portion of DDSN's overall service costs. Our review of the audit report found errors in DDSN's methodology in creating the cost reports. However, DHHS, which is involved in the cost reporting process, is not adequately independent to complete audits of DDSN's cost reports due to its relationship with DDSN. The State Auditor's office must approve procurement of audit services. As of October 2008, the auditor had not received a proposal from DDSN. DDSN's failure to implement repeated recommendations to have the cost reports audited leaves a significant gap in accountability for millions of dollars.

Recommendations

43. The Department of Disabilities and Special Needs should arrange for independent audits of all of its most recent fiscal year Medicaid-filed cost reports.
44. The Department of Disabilities and Special Needs should arrange for independent audits of all of its Medicaid-filed cost reports periodically as is appropriate based upon initial audit results.

Use of Funds for New and Expanded Services

We were asked to determine whether DDSN used state appropriations for new and expanded services in accordance with legislative intent. We reviewed DDSN's use of new state funds appropriated for the following services:

- Additional community residential beds.
- Treatment for children diagnosed with autism or other pervasive developmental disorders.
- Rehabilitation services for consumers with traumatic brain or spinal cord injuries.

Table 4.2 shows the funds appropriated to DDSN to provide these services for the period FY 05-06 through FY 07-08.

Table 4.2: DDSN Appropriations
for New and Expanded Services,
FY 05-06 – FY 07-08

FISCAL YEAR	NEW AND EXPANDED SERVICES					
	NEW RESIDENTIAL BEDS		AUTISM SERVICES		HEAD & SPINAL CORD INJURY REHABILITATION	
	AMOUNT INCREASED	TOTAL NEW FUNDS	AMOUNT INCREASED	TOTAL NEW FUNDS	AMOUNT INCREASED	TOTAL NEW FUNDS
05-06	\$2,311,828	\$2,311,828				
06-07	9,231,000	\$11,542,828	\$3,000,000	\$3,000,000		
07-08		\$11,542,828	\$4,500,000	\$7,500,000	\$2,100,000	\$2,100,000
TOTAL		\$25,397,484		\$10,500,000		\$2,100,000

Source: S.C. Budget and Control Board.

We found that DDSN has not yet provided many of the new services for which it received funding. The agency has carried forward, or used for other purposes, the unspent funds. In addition, DDSN has not recouped millions in federal Medicaid dollars it could have received if services were provided.

Use of Funds for New Beds

DDSN has not developed all of the new residential placements anticipated when it received state funds for that purpose. When DDSN requested funding for new residential placements beginning in FY 05-06, it asked for funds to serve individuals in need of residential placement with autism, mental retardation and related disabilities, and head or spinal cord injuries. The funding was to address the state's need to:

- Respond to individuals who have been awaiting residential care for too long.
- Respond to aging parents and caregivers who cannot provide care at home any longer.
- Respond to the increasing number of persons awaiting residential care and to the national trend to resolve this need by litigation through the courts.

The General Assembly appropriated \$2.3 million in FY 05-06 to fund approximately 130 new beds and an additional \$9.2 million in FY 06-07 for an additional 500 new beds for a total of 630. Although we could not determine exactly how many beds DDSN developed to serve those not previously served, we found that DDSN had approximately 380 more people receiving residential services on June 30, 2008, than were receiving residential services on June 30, 2005.

We reviewed DDSN's planning process for developing the new beds and how it tracks bed development. For the 500 beds first funded in FY 06-07, DDSN followed a process of asking providers to request new beds, evaluating provider requests to develop beds in conjunction with other information about population and service capacity, and formally allocating the new beds to providers. (As discussed on page 39, DDSN allocated beds to providers instead of to individuals in need of those placements.)

DDSN management has tracked the development of beds as a result of new funding received in both FY 05-06 and FY 06-07. According to these tracking reports, which are used to work with the boards and other providers and to brief DDSN's commission on the status of bed development, DDSN developed 476 (76%) of the anticipated 630 new beds over the three-year period. We reviewed the back-up for the tracking reports and determined that their accuracy could not be verified and they were unreliable. DDSN then provided information showing that the agency had developed 449 (71%) of the anticipated new beds. This information was based on changes in DDSN's contracts with the DSN boards and other providers. However, these documents did not provide a method to verify whether new beds were offset by decreases in other beds formerly operated by providers or whether the beds were providing residential services to those not previously served. We concluded that information from DDSN's client data base showing how many consumers were receiving residential services, adjusted to include vacant beds that DDSN was paying for, provided the most reliable approximation of how many additional residential consumers were served over the period. Based on this information, DDSN developed approximately 380 (60%) of the anticipated 630 beds for which it received appropriations.

Use of Funds

DDSN requested state appropriations for the new beds based on the anticipated funds needed to operate the beds. The beds are funded by the federal and state governments through Medicaid; the state contributes approximately 30% and the federal government contributes approximately 70%. According to its budget requests to the General Assembly, DDSN increased its estimate of the annual state cost to operate a bed from \$17,200 to \$19,120 (11%) over the period FY 05-06 through FY 08-09. We used DDSN's operating cost projections and its information about the number of consumers served in the new beds to estimate the amount it spent to operate the new beds from FY 05-06 through FY 07-08. We estimated that DDSN spent just \$7.6 of the \$25.4 million appropriated to operate new beds. When DDSN did not spend state appropriations to operate new beds for its consumers, it did not receive the federal funds associated with these beds.



SUMMARY



A Review of the Non-Emergency Medical Transportation Program of the Dept. of Health and Human Services

MISSION

The Legislative Audit Council conducts performance audits to find ways to reduce the cost and improve the performance of state agencies and programs. Our audits must be requested by members of the General Assembly or required by state law.

Audits by the Legislative Audit Council are conducted in accordance with generally accepted government auditing standards as set forth by the Comptroller General of the United States.

Approximately 18 months after the publication of most audits, we initiate a follow-up review to determine whether our recommendations have been implemented.

Members of the General Assembly asked us to review the non-emergency medical transportation (NEMT) program managed by the South Carolina Department of Health and Human Services (DHHS). The department operates this program to give Medicaid clients rides to and from medical facilities for non-emergency reasons, such as physician appointments, dialysis, and physical therapy. The objective of the program is to provide better assurance that clients are receiving the services covered by Medicaid.

Until 2007, the department managed the NEMT program by contracting directly with independent transportation providers throughout South Carolina. Under this in-house system, clients called DHHS staff to arrange trips.

In 2007, the department entered into contracts with two private brokers to subcontract with independent transportation providers and to arrange trips for clients. The length of these contracts is three years, ending in 2010, with an option for two one-year extensions. Total DHHS payments to the brokers are projected to be approximately \$140 million for a three-year contract period up to \$233 million for a five-year period.

OVERALL FINDING

We found no evidence indicating whether an in-house management system or a broker-based system is inherently superior for minimizing cost or maximizing quality of service. Effective management by DHHS is important to the success of either system. However, the department did not use sufficient analysis or data in the operation of its former in-house system or in the process it used to purchase broker services. Although the department has improved its use of analysis and data in managing the NEMT program, further improvements are needed.

NEMT IN-HOUSE SYSTEM IN OPERATION UNTIL 2007

- DHHS contracted with local transportation providers without using the competitive procurement methods required by state law.
- Goals and performance measures were not established for the cost of the program.
- Goals and performance measures were not established regarding quality of service.
- Internal controls for deterring fraud and abuse were minimal until 2006.

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DDSN officials stated that they spent all of the funds appropriated for items related to the new beds. The officials stated that before new beds can begin operating, DDSN makes significant capital investment in new facilities and other start-up costs. DDSN makes capital grants to assist providers in purchasing homes (see p. 37). Based on information provided by DDSN about its capital grants to the DSN boards and other providers, we estimated that DDSN spent approximately \$10.7 million for residential capital grants over the three-year period. In addition, DDSN officials stated they made other infrastructure grants to the DSN boards and other providers during the period with an estimated total of \$12.4 million. Officials stated that these grants were associated with the residential growth because day programs and other administrative functions had to expand along with the residential growth. However, in many cases these expenditures did not appear to have any relationship to the bed expansion. For example, although Babcock Center was not awarded any new beds, DDSN granted Babcock approximately \$2.4 million in infrastructure grants for a new administrative building and other non-residential purposes during this period.

DDSN did not request funding from the General Assembly for capital grants to the DSN boards and other providers. There was no evidence that the General Assembly intended for DDSN to use funds appropriated for operating new residential beds to make capital grants of more than \$23 million to DSN boards.

We concluded that it was not reasonable to expect that DDSN could have been operating all of the new beds during the first year the funds were appropriated. However, it is not clear why DDSN did not develop more of the beds for which it received appropriations. As of June 2008, DDSN had 2,000 consumers waiting for residential services. DDSN tightly controlled the allocation of the new beds and refused requests of the boards and other providers to develop more beds (see p. 39). If DDSN had allowed private providers to develop more beds, its capital investment could have been less, leaving more funds to operate the beds. A DDSN official stated they are now planning not to develop 62 of the beds originally planned. However, DDSN requested new state appropriations for FY 08-09 for additional new beds, when it had not developed the beds for which it had received appropriations in FY 05-06 and FY 06-07.

Funding for Autism and
Other Pervasive
Developmental Disorders

DDSN has been slow to implement a new program for children who have been diagnosed with autism or other pervasive developmental disorders (PDD). These disorders are characterized by delays in the development of socialization and communication skills. This has resulted in more than \$9 million in state appropriations remaining unused or being used for different purposes.

In FY 06-07, DDSN received \$3 million in state appropriations to be used for treatment of children who have been diagnosed with PDD. DDSN had not requested funding for this program when the General Assembly authorized it as a pilot project for FY 06-07. DDSN officials worked with officials from the Department of Health and Human Services to develop a Medicaid waiver program for the children who would be served. The program was to provide case management and early intensive behavioral intervention services to eligible children ages three to ten. Each child may receive services for up to three years or through age ten. The federal Centers for Medicare and Medicaid Services approved the waiver program with a start date of January 1, 2007. According to DDSN, 102 children were enrolled in the program in FY 06-07. However, DDSN spent just \$10,454 of the \$3 million appropriated for services in that year. DDSN carried forward or used for other purposes almost \$3 million.

For FY 07-08 DDSN received more funding for the new program with a total of \$7.5 million in state funds appropriated. In FY 07-08, more children enrolled in the program, bringing the total enrolled to 273 by July 1, 2008. However, expenditures for services during FY 07-08 remained relatively low. DDSN spent just \$661,463 in FY 07-08, leaving \$6.8 million to be carried forward or used for other purposes. Based on DDSN's estimate that 85% of the children in the program are eligible for Medicaid, by not providing the funded services, the state did not receive an estimated \$13.6 million in federal Medicaid funds in FY 07-08. Those who were enrolled in the program obtained an estimated \$15,000 per capita in services, much less than the program's estimated \$37,000 budget per participant. According to DDSN, some services may have been received but not billed for at the end of the fiscal year. Also, the agency initially did not have enough providers to serve its consumers.

Out of \$10.5 million appropriated for this program over the past two years, DDSN has spent just \$671,917 (6%) for services. We could not determine how DDSN has used the additional funds it received for the autism program. Some of these funds have been carried forward by DDSN; the agency carried forward \$1.7 million from FY 06-07 to FY 07-08 and approximately \$6.7 million from FY 07-08 to FY 08-09. According to officials, funds carried forward are not designated for specific projects or purposes.

Rehabilitation Services
for Head and Spinal Cord
Injury (HASCI)
Consumers

DDSN used or has contracts to use approximately \$1,458,000 (69%) of \$2.1 million appropriated for FY 07-08 for post-acute rehabilitation for those with traumatic brain or spinal cord injuries. DDSN requested funding to fill an identified gap in services following an injured person's medical stabilization or discharge from the hospital.

In FY 07-08, the General Assembly appropriated \$2.1 million for this purpose. According to a DDSN official, Medicaid does not pay for in-patient rehabilitation in South Carolina, so the agency could not obtain federal reimbursement for these services. DDSN developed contracts through which authorized consumers could obtain rehabilitation services from the three facilities in or near South Carolina which are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The three hospitals in the area which have this accreditation are located in Greenville, S.C., Charlotte, N.C., and Augusta, Ga. According to DDSN officials, they set aside \$600,000 of the appropriation to use as an incentive to help additional hospitals in South Carolina become CARF-accredited.

During FY 07-08, services and equipment totaling \$1,458,317 were authorized for 23 consumers (\$721,012 paid in FY 07-08, with the remainder to be paid in FY 08-09). According to DDSN officials, no South Carolina hospitals used the funds set aside to become CARF-accredited. According to one of these officials, none of the unused funds were spent for other purposes, but all were carried forward as part of the \$6.7 million DDSN carried forward into FY 08-09. For FY 08-09, DDSN has reduced its agency budget by \$450,000 by cutting the allocation for this program, leaving \$1,650,000 to be spent for HASCI rehab services in FY 08-09. According to a program official, they will not have a problem using these funds as there are many unserved consumers.

Recommendations

45. The Department of Disabilities and Special Needs should ensure that it develops and provides services for which it has received appropriations from the General Assembly.
46. The Department of Disabilities and Special Needs should develop funded residential services prior to requesting more funds for additional beds.
47. If the Department of Disabilities and Special Needs needs state appropriations to make capital grants to the DSN boards and other providers, it should specifically request these funds from the General Assembly.

Aging Caregiver Waiting List Policy

DDSN has allocated new beds to its consumers based on their waiting list status. Directive 502-05-DD contains policies for waiting lists for DDSN's various programs. For placement in the new beds developed with the FY 06-07 appropriations, DDSN required that new residential consumers be on one of the following waiting lists:

- Critical needs waiting list — consumers in life-threatening situations requiring immediate services.
- Priority one waiting list — consumers in urgent situations with features suggesting there is a probability they will require residential placement within the next 12 months.
- Aging caregiver waiting list — consumers residing with caregivers age 65 or older.

According to a DDSN official, when they allocate a new bed to a provider, they work with the provider to try and identify a consumer with an urgent need to be served. They try to serve consumers on the critical list first. However, they also consider compatibility in making placement decisions. It is important for all consumers in a particular facility to be compatible, so they may select consumers who are on the priority one or aging caregiver lists instead of those on the critical waiting list.

We did not review the controls and operations of DDSN's waiting lists. However, we noted that while DDSN has policies regarding eligibility for its critical and priority one waiting lists, there are no policies defining the aging caregiver waiting list. According to DDSN, as this list is not formalized, there is no aging caregiver waiting list per se. They use this information to communicate with the Governor and members of the legislature, who have expressed interest in this issue. Sometimes people on the list have not

requested residential services. DDSN tries to anticipate needs that would be caused by the caregiver's unexpected decline in health.

We noted that consumers are eligible for residential placements based on their status as living with aging caregivers. Without a policy for the aging caregiver list, it is uncertain whether eligibility for this list is consistently applied and whether consumers on the list need priority for residential services. For example, it might be inappropriate for a consumer whose parents include one aging caregiver and one younger caregiver to be placed on the aging caregiver list and given priority over those with other types of needs, such as working single parents with other children. According to a DDSN official, the consumer's service coordinator designates the primary caregiver(s), but there is no written guidance for this process.

Recommendation

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48. The Department of Disabilities and Special Needs should implement appropriate controls over its aging caregiver list by establishing written policies for this list and for how service coordinators determine whom to designate as primary caregiver(s).
-

DDSN Grants to Private, Non-Profit Organizations

During FY 05-06 and FY 06-07, DDSN spent approximately \$1.5 million on grants to private, non-profit organizations. In some cases, DDSN has funded the general operations of advocacy groups, which is a conflict of interest.

We obtained and reviewed information on grants or donations made by DDSN and the DSN boards to private, non-profit organizations. In addition to the \$1.5 million mentioned above, DDSN has also awarded the Greenwood Genetic Center, its research facility, approximately \$7 million in grants in each of the past three fiscal years. This funding appears to be directly related to DDSN's mission. DDSN also funds capital grants which are discussed on page 37. Also, we found that a few of the DSN boards made donations to private, non-profit groups; the boards reported that the donations were made with local funds, and we did not identify a material problem.

Advocacy Group Funding

DDSN has funded the general operating expenses of several groups that advocate for the consumers whom DDSN serves. This funding, which is mostly state funds, was not for specific projects or services for DDSN consumers. DDSN officials stated that the grant money for the South Carolina Autism Society enables the organization to exist. Table 4.3 shows grant amounts for the general operating expenses for three of these advocacy groups.

Table 4.3: DDSN Operating Funding to Advocacy Groups

ADVOCACY GROUP	FY-05-06	FY-06-07
The Arc of South Carolina	\$27,900	\$28,400
South Carolina Autism Society	\$20,000	\$190,330*
Whitten Center Parents Club	\$14,400	\$14,400

* Includes a capital grant in the amount of \$170,330 for the purchase of an administrative office building.

Source: DDSN

These organizations' missions are to advocate for people with disabilities and their families. Advocates perform an accountability function for the agencies who serve the individuals they represent. Specifically, the constitution of the South Carolina Autism Society states the organization's purpose is "... to advocate continuously to service-providing agencies for appropriate lifelong services that will enable all persons with autism spectrum disorders to reach their maximum potential." Advocacy groups' ability to hold DDSN accountable is impeded by their dependence on DDSN's funding for their existence.

DDSN has also funded the operations of other advocacy groups. For other organizations, such as Family Connection and the South Carolina Spinal Cord Association, DDSN has funded specific projects in addition to providing operating funds.

No Formal Process for Grants

DDSN's funding process appears to be subjective. DDSN does not have a grant application form or policy it follows when determining which organizations will be funded. Also, there is no review committee evaluating whether organizations' requests for grants are the best use of state funds. According to staff, one agency official is responsible for authorizing the grant awards. When asked how the availability of grant money is advertised, the agency responded that the organizations who serve their consumers are aware that this funding is available.

According to officials, many organizations have received funding repeatedly over several years. We found no standard method used by the agency to determine whether or not an organization should continue to receive funding; however, the agency provided examples of grants that had been decreased. DDSN requires a year-end financial statement of most grantees. According to agency officials, the program staff is asked if the funded organizations are reaching the goals of any specific projects or services outlined in the grant awards. However, there is no programmatic review of organizations receiving operating funds since DDSN is basically funding their existence.

If the advocacy organizations found that DDSN's services were inadequate, they may be hesitant to comment negatively about DDSN since they depend on DDSN for funding.

Prevention Mini-Grants

In contrast to DDSN's practice of awarding operating grants to organizations, the process for funding the prevention mini-grants has appropriate controls. DDSN, through the Head and Spinal Cord Injury (HASCI) division, awards \$2,500 prevention mini-grants, primarily for projects regarding brain injury awareness such as a bicycle helmet safety seminar. Each year DDSN puts out a request for proposals for injury prevention projects. A panel reviews the proposals and rates them on how well they respond to the request, including whether the project's target population is defined, whether there are specific objectives to meet the stated goals, and whether the project has an ongoing, appropriate evaluation plan. In the past several years, the six top-rated proposals have been funded \$2,500 each. HASCI requires a six-month report of activities and expenditures. Staff conducts a site visit and offers technical assistance. We reviewed the files for this process in FY 07-08 and found that all steps of the process were documented appropriately.

Conclusion

The General Assembly has funded private, non-profit organizations such as the Special Olympics and the Greenwood Genetic Center through DDSN's budget. If the General Assembly intended for DDSN to fund the operations of other private, non-profit groups, it could fund them directly through DDSN's budget. The General Assembly funds South Carolina Share and the Alliance for the Mentally Ill, advocacy groups for mentally ill individuals, through the Department of Mental Health's budget.

If the advocacy groups are not funded by the General Assembly, DDSN should discontinue awarding grants for their operation. This money may be better used as the state match for federal funding for services for consumers. DDSN has long waiting lists of consumers who cannot obtain the services they need. The \$1.5 million of state funds used for grants could have generated an additional \$3.5 million in federal Medicaid funding (based on a 70/30 match) for services to consumers.

For all grants, DDSN should develop a standard grant application form and place it on the agency's website so all organizations can be aware of and apply for funding. By establishing a formal review process for all grants to private, non-profit organizations, the agency can better determine which services and/or projects offered by these organizations are the most beneficial to DDSN consumers and are the best use of state funds.

Recommendations

49. The Department of Disabilities and Special Needs should discontinue awarding grants for general operating expenses to private, non-profit advocacy organizations.
50. The Department of Disabilities and Special Needs should develop and implement a standard grant application for private, non-profit organizations.
51. The Department of Disabilities and Special Needs should establish a public directive for the review process of awarding and continuing grants to private, non-profit organizations.

Access to Information, Audits, and Other Issues

Communication of Agency Policies

DDSN's system for communicating agency policies should be more open to consumers and the public. Also, DDSN has not ensured that the policy information it communicates is current. The agency's documentation of its human resources policies also needs improvement.

DDSN policies are contained in regulations, commission policies, and directives. According to S.C. Code §1-23-10(4), regulations are "... each agency['s] statement of general public applicability that implements or prescribes law or policy or practice requirements of any agency." DDSN has regulations primarily for recreational camps and day programs. The agency has not promulgated new or revised regulations since 1986. In April 2007, South Carolina Protection and Advocacy for People with Disabilities, Inc. filed suit against DDSN and commission members for failing to promulgate regulations "... regarding issues of critical concern to applicants and recipients of its services, including but not limited to eligibility ... appeal procedures; [and] standards for operations of its residential programs" We did not review this issue because it is pending in the Richland County Court of Common Pleas.

In addition to regulations, DDSN has an internal communication system that includes commission policies and departmental directives. According to departmental directive 100-01-DD, a DDSN commission policy is "... a policy or philosophical statement issued by the SCDDSN Commission and implemented by the agency," and a DDSN departmental directive is "... a mandate requiring compliance by applicable Central Office, District Office, Regional Center, DSN Board or Contracted Provider staff." A directive may address policy and/or more specific implementation procedures. DDSN commission policies and departmental directives are available, in part, on the agency's website.

Public Access to Policies

DDSN has not provided adequate public access to its directives. While some of DDSN's directives are available on the agency's website, others are only available on the DDSN extranet. The DDSN extranet provides access to and dissemination of current and new information to DDSN's business partners (DSN boards and other community service providers). According to an agency official, all DDSN state employees and provider executive directors have access to the extranet. Provider executive directors can choose whether or not to allow access to their employees. Consumers and the public do not have access to this site.

The agency does not have a written procedure to determine which directives should be made public. However, according to an agency official, a small

committee decides whether or not to make a directive public. Their criterion for making this determination is whether or not the directive is applicable to consumers or the public. We compared the list of public directives with the list of private directives and found that DDSN did not make public many directives that are applicable to consumers and the public. Table 5.1 shows a few of the directives that are private, but should be made public according to DDSN's criterion. This list is not exhaustive.

Most of DDSN's directives are not available to the public. Some address purely internal matters, such as human resources policy, but many private directives address subjects that are relevant to consumers and the public. In making decisions on whether or not to post a directive on the website, DDSN should release it if it at all relates to the public or consumers.

Recommendation

52. The Department of Disabilities and Special Needs should post on its website all directives that contain information that would be of consumer or public interest.

Table 5.1: Private Directives Applicable to the Public

DIRECTIVE	TITLE	JUSTIFICATION
100-04-DD	Use of Adaptive Behavior Scales	The applicability section of the directive states that it is applicable to "all DDSN Service Recipients."
100-29-DD	Medication Error/Event Reporting	This directive is similar to directives 534-02-DD (procedures for reporting abuse and neglect) and 100-09-DD (critical incident reporting), in that it provides system-wide definitions of a health, safety, and welfare risk and procedures for reporting any infractions.
133-02-DD	Freedom of Information Act Requests	This directive explains where requests should be sent.
200-02-DD	Financial Management of Personal Funds	This directive lists consumer financial rights and provides information on both consumer and provider responsibilities with regard to those funds.
200-09-DD	Fees for Residential Services Provided by the South Carolina Department of Mental Retardation*	This directive explains the fee structure for consumer residences.
502-07-DD	Procedure for Handling Referrals of New DMH Admissions Suspected of Having Mental Retardation or Related Conditions	Like 502-01-DD, which addresses admissions of individuals to DDSN-funded community residential placements, this policy explains how Department of Mental Health consumers can be admitted for DDSN services.
535-09-DD	Review and Approval of Research Involving Persons Receiving Services	This directive explains DDSN's policy for approving research on its consumers.
600-10-DD	Individual Clothing and Personal Property-Regional Centers	This directive requires the provider to give consumer families the policy and includes the forms to provide to them.
603-09-DD	Management of Consumers Exposed to Potential Bloodborne Pathogens	This directive gives information on what happens when a consumer is exposed to this type of danger.
604-01-DD	Individual Clothing and Personal Property	Like 600-10-DD, this directive explains the management of individual personal property.
700-03-DD	Insuring Informed Choice in Living Preference for Those Residing in Community ICFs/MR	This directive explains consumer choice in living preferences. It also gives a list of services funded by the MR/RD Waiver, which is helpful to families who are not familiar with the services and what they should request.

* Former name of DDSN until 1993.

Source: DDSN and LAC analysis.

Obsolete Information

DDSN maintains obsolete information in its directives. According to an agency official, DDSN prefers the directive system over regulations because of the ease of updating. We found that DDSN has failed to maintain an up-to-date system.

Throughout this review, we looked to DDSN's directives for a current statement of its policies. There were instances where we were told that the directive posted online or on the extranet contained dated material and that they were operating using a different process. For instance, when asked about a process in directive 200-02-DD, financial management of personal funds, an agency official stated that the directive was out-of-date and that the process mentioned was not their current way of operating. Directive 200-14-DD is another example of a directive containing obsolete information. As of December 4, 2007, that directive contained references to other directives that were no longer in existence and a defunct review process. It had not been reviewed since 1992 — the date it was first issued.

According to directive 100-01-DD, DDSN's internal communication "... system requires an annual review process of such documents thereby eliminating the circulation of out-of-date documents and the promulgation of accurate and timely documents that are intended to govern actual practice." Each of these documents contains a date of issue, an effective date, a last review date, and a date of last revision. The last review date should be within the last year. We examined a random sample of 15 (10%) of the directives, to determine the time elapsed since the last documented review. Table 5.2 shows the results of our review.

Table 5.2: Annual Directive Review

TIME SINCE LAST REVIEW	NUMBER OF DIRECTIVES
Less than a year	5 (33%)
Between one and two years	1 (7%)
More than two years	9 (60%)

Source: DDSN

Two of the directives were last reviewed in the early 1990s. An agency official stated that a document manager annually sends a reminder to the person responsible for each directive. If the last review date is more than a year ago, it means that the person either reviewed the document and failed to notify them of the review, or that he had higher priorities on his desk. If agency staff complied with agency policies, it would lower the likelihood of out-of-date information, like that mentioned above, remaining posted year after year.

Recommendation

Human Resources Policies

53. The Department of Disabilities and Special Needs should comply with departmental directive 100-01-DD and document the annual review of its posted policies. DDSN should ensure that it corrects and updates policies as a part of this review.

DDSN's human resources policies are documented in more than one place. DDSN's departmental directives contain some of the agency's human resources policies. In 2002, DDSN also published *General Rules and Regulations: A Handbook for Employees*. Some of the online directives have different content from the same policies in the handbook. Some policies in the handbook are not included in the online directives, and vice versa. When asked whether or not the book is currently relevant and if it binds agency staff, two agency officials stated that both the online human resources directives and the book are in use. However, the content of the directive takes precedence over the handbook. This system is confusing; agency staff should not have to do a comparison of two different documents to determine what applies to them.

Recommendation

DDSN's Website

54. The Department of Disabilities and Special Needs should maintain only one comprehensive and authoritative source of human resources policies.

DDSN's website needs improvement. It does not provide adequate current information to citizens and is difficult to use. Also, it does not include provider quality information that would be useful to consumers.

- DDSN's website does not contain information that citizens could expect to find there. For example, the names and contact information for members of DDSN's commission are not on the website. Also, agency policies and directives that affect the public are not published on the website (see p. 65).
- DDSN's website contains outdated and/or incomplete information. For example, if a user selects "Autism Division" or "Practical Guide to Services," from the main menu, the information describing "Services for People with Autism" does not mention the Medicaid waiver program for children with autism which DDSN has operated since 2007 (see p. 58).

- DDSN's website has no overall search function. Within the site, if a user searches the Practical Guide to Services, he is not told what is being "searched." A user choosing to consult the site map to determine where to find desired information could find that the site map has not been updated to reflect changes to the website.
- The website is not easy to navigate, and there are few links between different parts of the site. If a user selects "Applying for Services," the site states that potential applicants must contact their local DSN board. There is no link to information about the DSN boards and the section the user is referred to, "List of Qualified Service Providers," does not offer a choice for finding your local DSN board.
- The links to information on the agency's home page are not comprehensive and do not always give an indication of content accessible through the links listed.
- The website was designed in 1999 and has not been updated to conform to basic common content principles such as using "contact us," "about us," and "frequently asked questions" pages.

Many citizens rely on the Internet to find information. A survey conducted by the Pew Internet & American Life Project in May 2008 showed that 73% of adults use the Internet, 89% of Internet users search the Internet to find information, and 66% visit government websites.

The public trusts government websites to provide current and accurate information. Citizens expect to use websites to find information about services they might use and also to conduct transactions, such as applying for government services. The U.S. government provides guidance in managing government websites (webcontent.gov) and publishes *Research-based Web Design and Usability Guidelines*. In our review of other states' agencies for this report, we noted that the website of Florida's Agency for Persons with Disabilities (APD) was user friendly and provided information that would be useful to consumers and families. For example, consumers searching for a provider of residential services can access data about a provider's performance on quality reviews, including information about their compliance with background screening and training requirements.

According to DDSN's webmaster, each area of the agency's website has a data content manager responsible for maintaining the information in that section. DDSN officials acknowledged that the agency's website could be improved in appearance and content, but, according to an agency official, as of August 2008, there was no official plan to do so.

Recommendation

55. The Department of Disabilities and Special Needs should take action to improve the content and usability of its public website.
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Commission Governance

The South Carolina Commission on Disabilities and Special Needs has narrowly interpreted its governance structure in a way that denies commission members access to public information and potentially hinders performance of their fiduciary duties.

The seven-person commission determines policy and promulgates regulations regarding the Department of Disabilities and Special Needs. The commission also appoints DDSN's director and is charged with public education regarding services for DDSN's consumer population. In addition to statutory definitions of its responsibilities, the commission formalized its governance structure by issuing related commission policies in January 2007. The governance structure is based on a model called policy governance. DDSN's policies include the commission's statement of the department's mission, how the commission will govern, limits on the actions of the director, and the relationship between the commission and DDSN staff. Prior to issuing the commission policies, the board received training from a former director of the University of South Carolina's Institute for Public Service and Policy Research, Governmental Research and Service Unit. A DDSN official stated that issuing the commission policies was simply a way to formalize how they were already operating.

During the course of this review, we learned of a possible hindrance of the roles and responsibilities of commission members caused by the governance structure. During our review of the agency's Freedom of Information Act requests, we noted that the governance structure was used to deny a commissioner access to public information. Though the department eventually provided the information, it took more than two months to respond, according to department records. Following the commissioner's request and before the department eventually provided the information, the commission chairperson denied the request on behalf of the commission and the agency. The chairperson cited commission policy that "...only decisions of the Commission acting as a body are binding upon the Director. Decisions, instructions or requests of individuals are not binding on the Director except as specifically authorized by the Commission."

The explanation of the sample board policy used as a model for DDSN commission policies, and presented as part of the commission's training on

policy governance, clarifies any limits on board members' access to information by stating, "Individual board members can surely get their questions answered unless their doing so burdens the organization." The commission member's request was for copies of documents already in existence at DDSN. We consulted with a governance expert about whether this type of governance structure would limit a commission member's access to public information. He stated that there is no reason why this should be the case. If anything, commission members should have more access to information than other citizens, since they have a responsibility to learn for and inform residents of the Congressional districts from which they were appointed. According to the expert, it is more likely that the DDSN commission's behavior was an example of interpersonal problems that should be addressed.

Recommendation

56. The South Carolina Commission on Disabilities and Special Needs should modify its directives to ensure that commission members' rights as citizens are not encumbered and that their fiduciary duties are not hindered.

Internal Audit

We reviewed the operations of DDSN's internal audit division. In 2005, the Institute of Internal Auditors (IIA) reviewed DDSN's internal audit. IIA found that DDSN "partially conforms" to the IIA standards and made recommendations for improvement. We reviewed DDSN's response to IIA's recommendations and found areas where more action is needed.

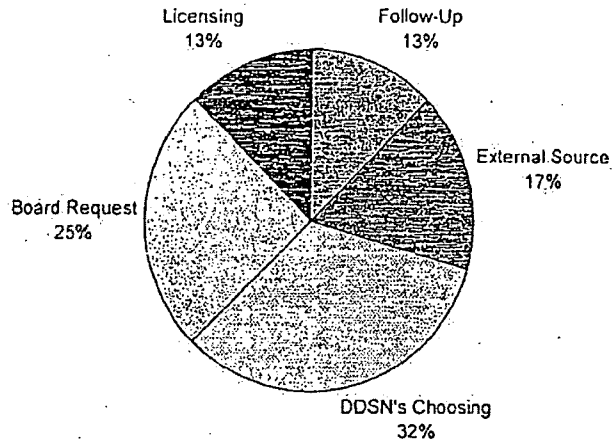
Background

DDSN's internal audit division has seven staff. The division staff perform the following types of audits: initial, follow-up, and special requests. Internal audit also performs technical assistance reviews on very specific topics at the request of DSN boards. The division also provides training to DSN board staff on consumer funds and property management.

We reviewed all of the division's audits and technical assistance reviews from FY 04-05 through March 2008. Most of the audits were of DSN boards. We found that only 2 of the 24 audits (8%) were of DDSN itself: one of an area of the finance division at the central office and one of a DDSN regional center.

Chart 5.3 shows why audits were initiated at DDSN for the period of FY 04-05 through March 2008.

Chart 5.3: Why Audits Were
Initiated, FY 04-05 – March 2008



Source: DDSN

Reporting Structure

In previous reviews of other agencies, we identified problems with the resources devoted to internal audit and the independence of the internal audit function. Internal audits are an important control that agencies can use to ensure that resources are being used appropriately. We found that DDSN has an appropriate reporting structure for its internal audit division. However, the role of the DDSN commission should be strengthened.

For administrative matters, the head of DDSN's internal audit division reports to the agency director. He also reports to the DDSN commission on audit planning and the division's activities. If the internal audit director must investigate complaints against the agency director, then he is required to coordinate directly with the commission chair. This reporting structure should ensure appropriate independence for the internal audit function.

However, the DDSN commission has had minimal involvement in the work of the internal audit division. The commission had abandoned its finance/audit sub-committee until it was reinstated in 2008. This sub-committee consists of three commission members. As of May 2008, the finance/audit sub-committee had met only once.

In 2005, the IIA recommended that DDSN develop an audit committee charter that addresses the committee's mission and other responsibilities. As

of May 2008, DDSN had not approved a charter for its finance/audit sub-committee. We also found that the sub-committee members do not review the audits before they are released and are not involved in determining which audits to perform.

Recommendation

57. The Department of Disabilities and Special Needs should approve a finance/audit sub-committee charter which provides for members to participate in audit planning and review of audits before they are released.

Audit Planning

In 2005, the IIA recommended that internal audit conduct a risk assessment of DDSN's audit universe and use the results of this assessment to guide the annual audit planning process. In 2007, the division completed a partial risk assessment plan of DDSN, but it does not always use this assessment to guide its auditing process. The partial risk assessment plan includes a completed risk assessment for the DSN boards and other providers but does not include the DDSN central office, the district offices, or the regional centers. The 2005 IIA report stressed that DDSN should assess audit risk of all parts of the agency. As of March 2008, the division has conducted only one audit of DDSN's central office and only one audit of a DDSN regional center.

There have also been no audits conducted on DDSN's information technology (IT) department. DDSN uses many different computer systems, and many of those systems have large amounts of manual entry of data. Manual data entry often leads to data error, which is risky for the agency. In October 2008, we received DDSN's FY 08-09 risk assessment which included the regional centers, but not DDSN's central or district offices.

The risk assessment plan for the DSN boards and other providers rates the boards/providers on the following factors:

- Number of critical incidents they have had.
- Risk based on findings in their external certified public accountant (CPA) audits.
- Number of previous internal audits and technical assistance reviews.
- Total number of consumers served by the board.

All of these categories are ranked from 1 to 3, with 3 being the highest risk. The internal audit division then adds up these numbers to calculate a total risk factor.

Recommendations

58. The Department of Disabilities and Special Needs should update its internal audit risk assessment plan to include the central and district offices.
59. The Department of Disabilities and Special Needs should ensure that the order of priority in its internal audit risk assessment plan is followed as closely as reasonably possible.
60. The Department of Disabilities and Special Needs should perform internal audits of its information technology systems.

External Audits of DDSN

DDSN also undergoes external audits and reviews. The Department of Health and Human Services (DHHS), the federal Centers for Medicare and Medicaid Services (CMS), the Office of the State Auditor (OSA), and the Budget and Control Board (B&CB) all perform various external reviews of DDSN.

DHHS is responsible for oversight of Medicaid funding and performs external audits of DDSN required by its Memorandum of Agreement (MOA) with DDSN. DHHS has performed various audits of DDSN and its policies, including audits of Medicaid waivers, DDSN centers, and service coordination. In one of DHHS's audits, and the related follow-up to that audit, DHHS recommended that DDSN have its Medicaid waiver cost reports audited (see p. 53).

CMS is required to perform external reviews of DHHS, and thus DDSN, due to the MOA between DHHS and DDSN. CMS reviews DHHS/DDSN because of the various Medicaid waivers the two agencies together operate for CMS. CMS reviews the two agencies to determine if the waiver requirements are being met, and whether the waivers should be renewed.

The OSA performs agreed-upon procedures reviews of DDSN every year. Agreed-upon procedures reviews do not express an opinion on the agency's financial statements. These OSA reviews are required by S.C. Code §11-7-20. OSA performs agreed-upon procedures instead of financial audits because of limited staffing, timeliness, and because it now conducts the

statewide single audit. Finally, the B&CB performs procurement audits of DDSN as required by S.C. Code §11-35-1230.

DDSN's internal audit division also issues audit policies to the DSN boards that require CPA audits of the boards. The policies state what information is to be included in each audit, and specify the procedures for the independent auditors to follow during the course of the audit.

According to an agency official, only one board is not required to have a CPA audit conducted, because it does not meet the financial threshold requirements.

CPA Firms Providing Consulting Services

Several county DSN boards have hired the same CPA firms that conduct their financial audits to also provide consulting services. Providing consulting services may impair a firm's independence to conduct a board's financial audit. DDSN should strengthen its oversight of the audit process.

We obtained information from all of the DSN boards to determine if the CPA firms who conducted their annual financial audits also provided consulting services. We identified six boards whose CPA firms were also paid for consulting services. According to board records, the boards paid their CPA firms for services such as setting up a board's computer systems, conducting cost analyses, helping with revenue entries, and handling other accounting issues.

DDSN directive 275-04-DD, provider audit policy, states that annual financial audits of the DSN boards must be performed in accordance with generally accepted auditing standards by an independent certified public accountant. Government auditing standards describe the types of services that impair independence to include:

- Maintaining or preparing the audited entity's basic accounting records or maintaining or taking responsibility for basic financial or other records that the audit organization will audit.
- Posting transactions to the entity's financial records.
- Designing, developing, installing, or operating the entity's accounting system or other information systems that are material or significant to the subject matter of the audit.
- Developing an entity's policies, procedures, and internal controls.

In response to accounting scandals of many large corporations, the federal Sarbanes-Oxley Act of 2002 was enacted to strengthen auditor independence

and require additional disclosures about the services provided by the independent accountant. This act listed prohibited services to include bookkeeping or other services related to the accounting records, financial statements of the audit client, and financial information systems design and implementation.

DDSN should clarify its directive to indicate what services provided by the DSN boards' CPA firms may impair the firms' independence to conduct the financial audit. DDSN officials stated that they are not aware that any boards have had the same CPA firm conduct both financial audits and consulting services for the same year. To ensure better oversight, DDSN should require the DSN boards to annually report to DDSN all services provided by any CPA firm. This requirement would help ensure that the boards are complying with generally accepted auditing standards.

Recommendations

61. The Department of Disabilities and Special Needs should revise its provider audit policy directive to include specific guidance on which consulting services should not be performed by the CPA firms conducting a DSN board's financial audit.
62. The Department of Disabilities and Special Needs should require DSN boards to annually report all services provided by any CPA firms.

Conflicts of Interest with Former DDSN Employees

We were asked to determine whether DDSN has ensured that there are no conflicts of interest involving former employees or other individuals. We found that at least 11 DDSN employees continued to work for DSN boards after leaving DDSN; however, we identified only 1 employee who worked simultaneously for DDSN and a DSN board while performing similar duties, which appears to be a conflict of interest. This same person also worked for DDSN at the same time that he worked for a firm contracting with DDSN.

DDSN Employee Working for DSN Boards

In 2002, DDSN hired a former state director of DDSN as a temporary employee to provide initial training and orientation to newly-hired executive directors of county DSN boards. This employee worked with one DSN board's executive director for four months. For the last month (October 2005), that DSN board entered into a contract with him and paid him \$1,600 in addition to his compensation from DDSN. The contract stated, in part, that

he would provide assistance to the board in developing and implementing a risk management system, a comprehensive plan, and to, "Provide leadership to key staff and or board members as requested"

Another DSN board paid the same employee \$1,000 per month to provide assistance to the new executive director from February through May 2005. According to DDSN payroll records, he then provided the same services as an employee of DDSN from July through December 2005. We could not determine why he could not have provided services from February through May as a DDSN employee.

DDSN Employee Working for Contractor

In October 2001, First Health Services Corporation hired the former DDSN state director to assist in developing a proposal for the contract to provide quality assurance reviews for DDSN. After First Health was awarded the contract, he was employed by First Health as liaison with DDSN officials. Subsequent duties involved local management issues, problem solving, and national marketing. According to the former state director's attorney, this employee was not engaged in any quality assurance work for any of the providers nor did he participate in any audits of providers. He continued to work for this contractor following his employment as a temporary employee with DDSN in 2002 through at least 2006.

In response to a complaint in 2006, the South Carolina Ethics Commission found that, while there did not appear to have been any violations of the State Ethics Act by this employee, this employee's simultaneous employment with DDSN, several DSN boards, and a DDSN contractor had the appearance of impropriety. The commission advised the employee to make every effort to avoid any situation which may appear to be a conflict with his public responsibilities. Although he was listed on DDSN's organizational chart as of August 2007, we found no evidence to indicate that he had worked for the agency after September 2006.

Payments by Boards

We reviewed allegations that DDSN encouraged the DSN boards to hire this employee in order to obtain favor with DDSN. We did not find evidence to indicate that this occurred. However, it is otherwise unclear why the boards would pay for management advice and training which could have been provided by DDSN.

Despite limited funds and the need for more money for consumer services, some boards paid between \$1,000 and \$1,600 per month to this employee for

various services. These services included "providing consultation" and providing "... information to the staff of new national and state developments regarding current best practices on specific topics and general trends." Table 5.4 shows the amounts county DSN boards paid this employee over a three-year period.

Table 5.4: DSN Board Payments to Consultant (2005 – 2007)

	2005	2006	2007	TOTAL
DSN Boards*	\$124,400	\$155,800	\$62,950	\$343,150

* Represents 14 different DSN boards.

Source: Documentation from DSN boards.

Two DSN boards paid this employee more than \$40,000 over this period for various consulting work. As of February 2008, the employee continued to contract with some of the DSN boards.

According to a DDSN official, DDSN district managers perform some of the same functions for the boards that were performed by this former employee. DDSN should provide needed management advice to the boards and training for board members. DDSN should ensure that DSN board executive directors can obtain technical assistance from the agency. This would help ensure that DSN boards would not have to expend limited funds by hiring consultants.

Recommendation

63. The Department of Disabilities and Special Needs should provide adequate training and technical assistance to the DSN boards' executive directors.

Agency Comments
