SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

MINUTES

March 21, 2019

The South Carolina Commission on Disabilities and Special Needs met on Thursday, March 21, 2019, at 9:00 a.m. at the Department of Disabilities and Special Needs Central Office, 3440 Harden Street Extension, Columbia, South Carolina.

The following were in attendance:

COMMISSION

Present:
Eva Ravenel, Chairman
Gary Lemel – Vice Chairman
Vicki Thompson – Secretary
Sam Broughton, Ph.D.
Lorri Unumb

DDSN Administrative Staff

Director Mary Poole; Mr. Pat Maley, Deputy Director; Mr. Rufus Britt, Associate State Director, Operations; Ms. Lisa Weeks, Chief Financial Officer; Mrs. Susan Beck, Associate State Director, Policy; Mr. Robb McBurney, Ms. Colleen Honey, Administrative Coordinator (For other Administrative Staff see Attachment 1 – Sign In Sheet).

Guests
(See Attachment 1 Sign-In Sheet)

Coastal Regional Center (via videoconference)
(See Attachment 2 Sign-In Sheet

Pee Dee Regional Center (via videoconference)
(See Attachment 3 Sign-In Sheet)

Whitten Regional Center (via videoconference)
(See Attachment 4 Sign-In Sheet)

Pickens County DSN Board

News Release of Meeting

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

Adoption of the Agenda

On motion of Commissioner Broughton, seconded by Commissioner Unumb, the Commission adopted the March 21, 2019 Meeting Agenda. (Attachment A)

Executive Session

On motion of Commissioner Broughton, seconded by Commissioner Unumb, the motion passed to enter into Executive Session to discuss a contractual matter.

Enter into Public Session

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

Invocation

Commissioner Unumb gave the invocation.

Approval of the Commission Meeting Minutes

On motion of Commissioner Broughton, seconded by Commissioner Lemel, the Commission approved the minutes of the February 21, 2019 Commission Meeting.

Public Input

The following individuals spoke during Public Input: Deborah McPherson, Patricia Harrison, Susan John and Beth Bunge.

Commissioners' Update

Commission Lemel spoke about attending the subcommittee at the State House regarding who can become a Commissioner to no avail as the meeting was adjourned before the issue came up for discussion. He also spoke about a local individual who is participating in the International Special Olympics and how proud everyone was of his achievements.

State Director's Report

Director Poole reported on various topics. (Attachment B)

Brain Injury Awareness Month

Ms. Melissa Ritter, Director of the HASCI Division, gave a presentation.

Legislative Oversight Committees Update

Mr. Robb McBurney gave an update on the various Bills relating to the agency. He also gave an update on the budget. Commission Thompson asked for a monthly update. (Attachment C)

Strategic Plan

Mr. Pat Maley provided a detailed update on the agency's strategic plan. (Attachment D)

Case Management and Early Intervention Update

Director Poole gave a detailed update regarding the timeframe surrounding the CM rate changes and issues surrounding this topic for providers. A discussion followed.

Update on Use of Cameras in Community Settings

Mr. Rufus Britt gave an update on the RFP for installation of cameras in the Regional Centers. Answers to previous questions regarding use in community settings were included in their binders for review. (Attachment E)

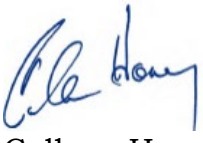
Budget and Financial Update

Ms. Weeks provided an overview of the agency's financial activity and the agency's current financial position. It was noted that Mr. McBurney had earlier given the budget update. (Attachment F)

Next Regular Meeting

April 18, 2019.

Submitted by,



Colleen Honey

Approved:

Commissioner Vicki Thompson
Secretary

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
March 21, 2019

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1.	Deborah Heather McPherson	Richland County
2.	Susan Ihly	Horry Co DSN
3.	Melissa Ritter	DDSN
4.	Jerry C. Mize	Oconee DSN
5.	Ben Drew	DDSN
6.	Mike Moss	Calhoun DSNB
7.	Kathleen Lord	Aging with Flair
8.	Dale Purvis	DDSN
9.	Joyce Davis	BIASC
10.	Brooke Russell	Babcock
11.	Michelle Shaffer	Max Abilities
12.	Patricia Harrison	Atty/Advocate
13.	Mike Kent	Marion-Dillon DSN
14.	Beth Franz	PTA
15.	Alfredia Stevenson	Chester-Lancaster
16.	Kelly Cox	AdviCoach
17.	Beth Bunge	Bright Start
18.	SBraunsch	Spinal cord injury
19.	Jennifer Robinson	SC DHHS
20.	[illegible]	Aiken Co/TPC

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
March 21, 2019

Guest Registration Sheet

(PLEASE PRINT) **Name and Organization**

21. Mary B. Ruschkofski — Midlands Center Family Council
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
March 21, 2019

Guest Registration Sheet

(PLEASE PRINT) **Name and Organization**

1. Suzanne Johnson Parent at Coastal Center
2. Felita Martino DDSN District II
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
March 21, 2019

Guest Registration Sheet

(PLEASE PRINT) **Name and Organization**

1. Amy McLean - Pee Dee Regional Center
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
March 21, 2019

Guest Registration Sheet

(PLEASE PRINT) **Name and Organization**

1. PAT FLAHERTY SCDDSN
2. Sherry Caldwell Brain Injury Association of S.C.
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SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

A G E N D A

South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Conference Room 251
Columbia, South Carolina

March 21, 2019 **9:00 A.M.**

1. Call to Order — *Chairman Eva Ravenel*
2. Welcome - Notice of Meeting Statement — *Commissioner Vicki Thompson*
3. Adoption of Agenda
4. ***Executive Session – discuss contractual matter***
5. ***Enter into Public Session – at approximately 10:00 a.m. or later***
6. Invocation — *Commissioner Lorri Unumb*
7. Introduction of Guests
8. Approval of the Minutes of the February 21, 2019 Commission Meeting
9. Public Input
10. Commissioners' Update — *Commissioners*
11. State Director's Report — *Director Mary Poole*
12. Business:
    - A. Brain Injury Awareness Month — *Ms. Melissa Ritter, Director, DDSN HASCI Division*
    - B. Legislative Updates — *Mr. Robb McBurney*
    - C. Strategic Plan — *Director Mary Poole*
    - D. Case Management and Early Intervention Update — *Director Mary Poole*
    - E. Update on Use of Cameras in Community Settings — *Mr. Rufus Britt*
    - F. Budget Update — *Ms. Lisa Weeks*
    - G. Financial Update — *Ms. Lisa Weeks*
13. Next Regular Meeting (April 18, 2019)
14. Adjournment

Director's Report March 21, 2019

In addition to Disabilities Awareness Month and Brain Injury Awareness Month – today 3-21 is World Down Syndrome Day.

3rd month 21st day – Trisomy 21 – blue and yellow colors and crazy socks mark the day.

1. **Answers to Commissioner Questions**
    1. **Question:** The Commission approved a plan of action and response that went to the House Legislative Oversight Committee in August of 2018 we will be providing an update on this particular report in this meeting. The plan said that Mercer would produce a report in the Fall of 2018 recommending future payment system options and that Mercer would update all DHHS service rates with DDSN with a report due in early 2019.

        ANSWER: SCDHHS owns the report and is paying the consultant to help it set its rate to DDSN and provide input on DDSN's band payment system. SCDHHS has the report in DRAFT and working with Mercer to finalize. DDSN has no certain date of release, but it appears to be soon. Informal communications with SCDHHS appear to indicate the band system has many unfavorable risks. We have yet to see the report.

    2. **QUESTION**: An update of the Direct Care Provider staffing crisis in the Regional Centers. (If the crisis continues, we were supposed to develop a contingency plan).
        1. **ANSWER:** DDSN has established a new monthly reporting system to capture DSPs and nurses "on

the floor" staffing at each Regional Center to measure progress on critical staffing issue on a monthly basis. Nursing is at about 85% of staffing needs. DSPs staffing varies.

2. PEE DEE and MIDLANDS appear to be out of the woods with just above 90% DSP staffing, but WHITTEN and COASTAL are still in the mid 70% staffing level range.
3. With Coastal is doing marginally better in February and running two orientation classes a month and Whitten having an exceptionally large applicant pool last month submitting 40 applications for review, Executive staff is cautiously optimistic that recent aggressive recruiting efforts, to include using private recruiting tools (ZIP recruiter/Indeed), will significantly improve the situation.
4. That being said – we do have contingency plans in a worst case scenario and at this point that situation is most likely to occur at Whitten. Whitten is significantly higher in population than any of the other centers. We can move 18 consumers from Whitten to Pee Dee which has a building ready and Pee Dee staffing is approaching 100% staffing. This building was being groomed for triage beds, but lack of funding has slowed that effort. Not stopped it just slowed it.
5. 2nd contingency is MIDLANDS which has healthy staffing, but currently the available building being utilized while another is being overhauled.

3. **QUESTION:** An update on policy/training on Direct Care Provider's "reactions to behaviors". ("2/3 of ANE's

leading to arrests are preceded by volatile consumer behaviors".

1. We are currently updating Abuse/Neglect training to better fit the learner – while this is being done, we continue to train our staff at the centers with the current curriculum. We have also added increased number of unannounced facility checks by management, increased supervisor presence in the units. Staff trainers are being encouraged to train at the point of interaction in real time as they too, conduct oversight reviews. In addition we share information about incidents to the staff and are encouraging staff to request help when needed.
2. After the March Executive RM Meeting, we will be sending out another provider bulletin with ideas and suggestions to help their staff manage their behavior when dealing with a consumer's escalating behavior.
3. We are currently reviewing indicators internally and with the help of the Quality Management work group to look for ways to ensure meaningful care plans and the development of effective internal systems.
4. We are also looking at redesigning the Residential Support Plans as well as the development of an acuity based model for staffing.
5. The model we have developed to measure the Mentor HM homes will be used to review all HM providers.
6. The fact that we are looking at plan and staffing quality will drive provider improvement, whereas

prior poor Alliant scores have not motivated such a change

4. **QUESTION:** An update on the Laurens County High Need Bed Development (was to be operational by the end of 2018)

ANSWER: Lauren's high needs house has been given to Lauren's DSN Board. It was licensed in February and four consumers have been identified for placement; 2 from Whitten and 2 from Critical Needs List.

5. **Question:** An update on the establishment of triage beds to address critical cases
    1. The development of the Triage beds has been slowed due to lack of internal funding and the fact that the House budget did not support our request
    2. I have reengaged with the senate finance committee to once again explain our need
    3. We have building capacity at Pee Dee (if not used to move the Whitten Center individuals) or at Midlands once building updates are complete - with near 100% staffing awaiting funding.
    4. We just reviewed all non-service contracts and will be looking at those without measureable outcomes to help us fund this more immediate need.

Director's report ends here and the update on EI and CM continues

UPDATE ON CM AND EI

- Baby Net is a program operated by DHHS and will be going fee for service on July 1.
- Director Baker has completed 4 regional trainings for providers discussing some details and informing providers that they need to become an enrolled provider with Medicaid.
- BabyNet children under 36 months will be direct billed to Medicaid\
- 36 – 6, if DDSN eligible and in need of EI services will direct bill to SCDDSN
- We will resume our EI committee meetings 2nd Wednesday of the month
- DDSN continues to offer technical assistance to providers.
- Private providers are already doing fee for service billing

CM-

1. Just as a refresher _ the change to CM billing was originally established quite some time ago.
    a. The beginning goes back to 2012 and a few Medicaid state directors ago.
    b. In 2012 SCDHHS under the leadership to Tony Keck submitted a state plan amendment to CMS which requested moving all MTCM to market rates.
    c. The rates were developed with DHHS, DDSN and providers all sitting at the table.
    d. Two rates were developed – one for MTCM and later one for WCM which was a new service being developed for the waivers.
    e. The plan required provider MTCM cost based rates to be incrementally reduced with new blended rates over a 30 month period starting on 1/1/13.
    f. These new blended rates were to be gradually implemented starting with a blended rate composed of 75% cost based and 25% market rate. This rate would drop incrementally to 50/50, 25/75 and finally to a .100% full market rate of $20/unit for a face to face and $15 for all other at the end of 30 months which was July 1, 2015.
    g. Now remember that MTCM was the only service available so all cases – including waiver cases fell under this category.

h. During this time the amendment for waiver case management was submitted and approved – however the service was never implemented.
i. There are significant difference in WCM and MTCM so a DHHS established a different rate – it was established in the same manner with providers and DDSN at the table. The rate is 25.20 f/f and 15.50 for office. Tis rate was established in October 2013 and expected to be implemented on 07/1/2014. However since WCM was not implemented the rate was never instituted. It was decided to maintain the existing blended rate at the time 75/25 which was $40/39 per unit or $160/156 per hour.

2. Prior to Spring of 2018, what steps were taken to meet that mandate? During 2012-2013 when the blended rate was to be introduced and completed by 7/1/2015, DDSN and its providers were doing what we are doing now--emphasizing billing efficiency and generating monthly feedback reports on progress. However, when it became clear the blended rate step-down process was stalled or stopped, emphasis on billing efficiency dimmed leading the poor 31% billing efficiency compared to monthly band payment in March 2018 (month before SC DHHS advised of the re-start). We were also waiting for the new service to start and it never did.

3. Since Spring of 2018, what new deadlines have been put in place? IN the spring of 2018 – According to the commission meeting minutes, it was April of 2018 when Pat first informed the commissioners and the provider community that the market rate SPA had been approved. SCDHHS initial "desire" was to start on 7/1/2018, which was three months after SC DHHS notified DDSN of the re-starting CM market rates. This "desire" quickly disappeared and SC DHHS provided DDSN latitude to re-boot providers' billing efficiency without a deadline, but 12/31/2018 seemed to be a general target. When I came on board my message was no market rate without Waiver Case Management. It was obvious that Waiver Case Management Policy/Procedure must come with implementation, which then moved SC DHHS to evolve into settling on 7/1/2019 which is a hard deadline from SC DHHS. AS we continue to incur liability as long

4. How did the July 1st date get finalized? So I would like to say that it was mutually agreed upon based on the need for WCM to developed into an actual service –
5. What is the current status as far as viability of providers? Although it is useful to gauge improvement by measuring billing efficiency against the $138 monthly capitated rate, it is not helpful to consider achieving less than 100% of this $138 month benchmark as failure after implementing market rates. The $138/month rate was financed with SC DHHS's substantially higher reimbursement of $160/$156 per hour reimbursement rates. On July 1, 2019, SC DHHS will lower its CM reimbursement rate to DDSN to the market rate of $100/$60 per hour. SC DHHS has done its due diligence and stands by this rate as reasonable aided by providers' low billing efficiency (6 hours/annually per consumer & 46% billing efficiency break-even point for $100/$60). The best way to understand viability is understand each provider's is to understand their individual "break-even" point. Break-even points vary between providers based on overhead and management proficiency. A high over-head (state retirement; state health insurance; state leave benefits) has an estimated break-even point in the low 60% and a low-overhead (little fringe benefits & virtual workplace) has an estimated break-even% in the low 40%. Anecdotal data from providers seem to be in the 50-60% break-even range.

6. What is the availability of other options to cover CM if some providers get out of that business?

    a. Our survey shows we have and adequate number of additional providers in each county for both CM and EI – especially EI. Although we mat be a little thin on EI coverage in Hampton County
    b. Our survey has also shown we have a few boards who are willing to expand into other counties so we are looking at our RFP process to see if it is a stumbling block to allow this to

happen when these providers are already providing the service and are known to the agency. We will need to ensure that they will not provide a direct service (residential or day)

c. We have developed a case transition process (of which I have a copy) and we have already started the process with Easter Seals for CM and Darlington County DSN for ID individuals. We have found the process that has been developed works rather well.
d. Remember that when an agency stops doing CM they will be eliminating a department – this gives the new providers ready access to qualified staff – although they would have to determine if it is a good fit for their company. The opportunity is there.
e. We are looking into a possible prospective step down rate for the first quarter – this has financial implications for DDSN for example If we provide the 60% band payment, those providers that fail in July with billing efficiency can still make payroll. The "live fire" test under CM market rates failed, but we will still have time to move cases underpinned by both contract and our subsidy.
    i. We have a contract with a discontinuance of service clause
    ii. We have a procedure for Termination of Case Management which has been tested

iii. We have a sample termination notice to participant letter and sample provider fair letters

We have the current Contract Language

Discontinuance of Service

In the event that the Contractor desires to discontinue service provision prior to the contract expiration date, or does not desire to renew or enter into a new contract upon expiration, The Agency and the service user's Financial Management entity, may at their option, require the Contractor to continue to provide services to service user(s) for a period of at least sixty (60) days past the termination or expiration of a contract or until appropriate alternate arrangements or placements are made. Under these circumstances, the Contractor will be reimbursed at the payment rate specified in the contract. The Contractor shall cooperate with The Agency and the service user's Financial Management entity to find appropriate alternate arrangements or placements.

Closing thoughts:

Susan John is right, we have not given the providers the WCM manual – however the increased requirements have been communicated - there are just a few details to hammer out – none of which will lower the potential billing opportunities but will actually increase them. Payment for FF visit with travel has reverted back to the original intent and there is no difference with how many people you see at that site as long as it isn't group case management - you can only charge for the time you spend working with the individual.

Here are a couple of very interesting facts -

For a year we have been preaching that the new WCM service will have requirements which makes monthly contact and quarterly face to face visits mandatory so they should begin acting in that manner now and they will see that their billing would increase because the requirements have basically doubled. I wanted to measure if CM entities were doing the monthly contacts for each case or are they just sticking to the current standards and not making additional contacts. I asked for an analysis of monthly billing and the results were very disappointing –

<u>One year sample period analysis:</u>
140,412 months - 103,583 billable months = 36,529 months (26.2%) ***without*** service note activity.
36,529 months X $138/month capitated band payment = **<u>$5,041,002/year</u>** in monthly band payments without any documented work.
This says we paid $5 M for NOTHING.

If we increase the current billing to include all of the missing months – boards will be fine and those we support will be receiving a better product.

In addition:

Currently for non-waiver consumers providers bill MTCM and are paid *retrospectively* at the *market rate of $20 (and change) and $15 (and change) per 15-minute unit*. Last February the number of consumers receiving MTCM was 1,720 and the providers billed $54,065. February 2019 providers billed $116,245 – more people enrolled? Not really – the number of folks enrolled is 1757 – ***that is an increase of only 37 people or 2.11% yet billing has increased by 115%***

They have proven it can be done.

Procedure for Termination of Case Management Contract

This procedure must be followed when a DDSN contractor wishes to terminate its contract or the Case Management portion of its contract.

Contractors must provide written notice to the State Director of DDSN at least 90 days prior to the intended termination date.

Written notice must include a proposed Transition Plan. DDSN will have 30 days to approve/amend the Transition Plan. The contract termination date shall not be less than 60 days after the date the Transition Plan is approved by DDSN. When approved, based on the elements of the Transition Plan, DDSN will specify the frequency with which the contractor must provide progress reports on the status of the transition.

The Transition Plan must include specific benchmarks with anticipated completion dates to be achieved during the transition. Benchmarks must be specific and verifiable by DDSN.

The required elements of a Transition Plan are:

For Consumers Receiving Active Case Management

- Method(s) and target dates by which all consumers/guardians will be notified of the provider's intent to no longer provide Case Management.
- Method(s)to be used to offer choice of any/all Case Management providers serving the areas / locations currently covered by the contractor. The date by which all affected consumers/guardians will be offered the choice. A description of how the offering of choice will be documented.
- A description of how the consumer's/guardian's choice of new CM provider will be documented.
- The plan for communicating with any/all chosen (receiving) provider(s) to ensure:
    - Provider is willing to accept the consumer and able to provide services seamlessly.
    - Service authorizations will be coordinated so that there is no break in authorized services during the transfer.

    - The plan for the transfer of physical (paper) records to ensure that records are not transferred electronically without physical (paper) records (file) delivery.
- Plan for the transfer of all consumers to the chosen provider(s).
- Method(s) for a final communication with each consumer/guardians to notify of the date of the transfer and to provide a contact name / phone number for the chosen provider.
- Attestation of the contractor's intent to continue to serve consumers until all are successfully transitioned to a new provider, including service beyond the approved contract end date if warranted.

<u>For Consumers Not Receiving Active Case Management</u>

- Method(s) for notification to consumers/guardians of the provider's intent to no longer provide Case Management and specific information about who/how to contact should need arise.
- Timeline for electronic transfer of records to a designated DDSN caseload.
- A plan for maintenance of all physical (paper) records in accordance with DDSN Directive 368-01-DD: "Individual Service Delivery Records Management", with access available to DDSN.

DDSN Commission Legislative Update –--March 21, 2019

1 **Budget**, **H. 4000**- The budget was passed in the House of Representatives on March 13. The House funded 3 of our Legislative priorities, including our number one priority, the 1 dollar and hour increase for Direct Care workers. They also funded our Child Protective Custody Transition program as well as 2 million in non-recurring funds for the Genomic Data Initiative at the Greenwood Genetic Center.

The budget will now go to the Senate, where the Senate Finance Committee is beginning its work on the budget in sub-committees over the next 2 weeks and the full Senate Finance Committee is expected to work on the budget the week of April 2-4, with Senate Floor debate on the week of April 15-18.

2. **H. 3824 DDSN Commissioner Qualifications and Training**-3-M Social Services, Mental Health and Children Sub-Committee

Bill was scheduled for sub- committee Debate on February 27, but the sub-committee ran out of time to take up the bill.

Debate will be rescheduled to the next meeting of the sub-committee.

3. **H 3825 and S. 529 – Medical decisions under the Adult Healthcare Consent Act**. - 3-M Health and Environmental Sub-Committee

We were able to get a companion bill introduced in the Senate on February 19 by Senators, Young, Setzler, and Massey.

We had a Sub-Committee Meeting yesterday. The 3-M Sub-Committee raised some questions regarding efforts that we make to locate family members. Those questions appear to be the main concerns that have been raised. We think that we can more thoroughly lay out our procedures and fine tune them if need be to get those concerns answered. There are also some technical changes that we need to make to the bill with an amendment. If we can get those things accomplished, we should be able to move this bill forward.

4. **H. 3273-Vulnerable Adult Abuse Registry**-Judiciary Special Laws Sub-Committee

Ann Dalton spoke about this bill last month in her presentation since then it has had 2 sub-committee hearing and work continues on the bill. There are significant due process and fiscal impacts on DSS and SLED that the sub-committee is studying.

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
Report Area	Legislative Recommendation	Agency Recommendation
A. Reorganization	1. The General Assembly may wish to clarify the roles and authority of the Department of Health and Human Services and that of the Department of Disabilities and Special Needs in providing services to consumers of DDSN services and in the development and implementation of the state waivers administered by DDSN through statute and/or proviso. **DDSN Action re Legislative A-1: None; not our lane.** 2. The General Assembly may wish to establish a governing authority to mediate disputes between DHHS and DDSN on Medicaid funded programs for individuals with disabilities. This could involve transferring DDSN to the Governor's cabinet, establishing a joint legislative committee or creating an appointed independent entity to arbitrate these disputes and make recommendations to the General Assembly. **DDSN Action re Legislative A-2: None; not our lane.**	
B. Commission Operations		1. To help prevent truncated terms, the agency should notify the Governor's Office in a timely manner when a Commissioner's term is expiring and inform the Governor if the Commissioner is willing to serve a subsequent term. **#B-1 Complete--DDSN Action: A policy has been established for the State Director's Administrative Assistant (Sandra) to provide notice to each Commissioner eight months prior to their respective term expiring. The Commission member then responds to the State Director's Administrative Assistant his/her willingness to serve a subsequent term or request**

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
Report Area	Legislative Recommendation	Agency Recommendation
		replacement at the end of their term. The State Director's Administrative Assistant will make notification with the appropriate person in the Governor's Office and advise the Commission Chairman for informational and planning purposes. 2. The Commission should debate and adopt policies that establish a governance model and adhere more closely to parliamentary procedure to facilitate debate during Commission meetings. **#B-2 Complete: DDSN bylaws requires the use of Robert's Rules of order. DDSN recognizes the Commission had internal friction and disagreements over the past several years. However, DDSN views the friction as necessary to drive positive change. A review of both the Senate and House Oversight Committee reports identified numerous operational issues to demonstrate Commission friction was needed for positive change. There has been no issues among Commission members and since staff changes in Commission members and executive staff in early 2018.** 3. The Commission should adopt a policy regarding who may represent the views of the Commission and the agency when speaking to the media. This could be the Chairperson or someone else designated by the members when speaking for the Commission. This could be the Director or their designee when speaking for the agency. If other Commissioners are authorized to speak to the media independently, they should either adhere to the positions adopted by the Commission or be required to indicate that they are speaking as private citizens and expressing their personal views.

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
Report Area	Legislative Recommendation	Agency Recommendation
		#B-3 Not Actioned: DDSN recognizes the Commission had internal friction and disagreements over the past several years. However, DDSN views the friction as necessary to drive positive change. A review of both the Senate and House Oversight Committee reports identified numerous operational issues to demonstrate Commission friction was needed for positive change. There has been no issues among Commission members and since staff changes in Commission members and executive staff in early 2018. 4. The Commission should debate and adopt policies formalizing how individual Commissioners communicate with agency staff. **#B-4 Not Actioned: DDSN recognizes the Commission had internal friction and disagreements over the past several years. However, DDSN views the friction as necessary to drive positive change. A review of both the Senate and House Oversight Committee reports identified numerous operational issues to demonstrate Commission friction was needed for positive change. There has been no issues among Commission members and since staff changes in Commission members and executive staff in early 2018.** 5. The agency should solicit input from the Commission to determine what subject matter training would benefit the members and provide the opportunity for the members to avail themselves of training provided by the agency on a schedule established by the Commission. **#B-5--Complete—DDSN Action: Since January 2018, DDSN staff focused on individual detail briefings of DDSN operations to new**

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
Report Area	Legislative Recommendation	Agency Recommendation
		and existing Commissioners to assist them climbing the steep learning curve of DDSN's complex operations. This then stimulated the need to provided standard quarterly enterprise-wide reporting to Commissioners of critical DDSN operations to further their understanding, stimulate questions to better understand, and bring all Commissioners up to the same level of organizational understanding. DDSN has established an annual requirement to query Commissioners for training needs. 6. The Commission should evaluate providers based upon compliance with agency policies and directives when assessing provider performance in the case of negative events concerning consumers. If the provider followed established procedures, then the Commission should determine if the policies in place are reasonable and adequate. Should the Commission determine that policies are insufficient to address the situation then the policies should be revised to ensure that policy compliance will serve to appropriately protect consumers. This evaluation practice should be applied uniformly to both local DSN boards and private providers. The policies should also establish thresholds for adequate compliance and the ramifications of failure to meet these minimum thresholds. **#B-6 Complete—DDSN Action: From an ANE perspective regarding "negative events," DDSN completed a review of its ANE program and determined its policies and practices are consistent with national best practices as set forth by NASDDDS. Inasmuch as DDSN is prohibited from investigating allegations of ANE, which is the predominant form of negative provider event, DDSN does not comment on such events in the normal course of business. Under Director Poole, she has instituted a monthly risk management review of all ANE incidents from across the state.**

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		7. In addition to the existing two committees, Policy and Finance/Auditing, the Commission should establish a Legislative committee to coordinate the agency's legislative agenda and ensure that the Commission's position on all relevant legislation is accurately conveyed to the General Assembly. **#B-7 Complete--DDSN Action: This Commission established a Legislative Committee.**
C. Allocation of Resources		1. DDSN should adopt a process of provider reimbursement that is essentially a fee for service model or direct reimbursement which pays local DSN Boards and private providers in the same manner. This would allow the agency to concentrate on ensuring that the services being purchased are provided in compliance with agency policies and Medicaid rules. While DHHS could eventually make the actual payment for services for providers, DDSN should take the primary role in establishing reimbursement rates. **#C-1 DDSN Actin: Decision Complete; Implementation Plan Held in Abeyance until Consultant Report Completed. DDSN conducted an internal assessment. The assessment's conclusion was approved by both the DDSN Executive Management and the Commission, which was set forth in a DDSN letter (8/28/2018) to the House Oversight Committee stating, "DDSN's most significant organizational issue is a deficient capitated payment system supporting community service providers known as the "band system." This payment system causes a multitude of problems."** **In January 2018, SC DHHS & DDSN initiated a joint project to have a subject matter expert (Mercer Healthcare Consultants) review DDSN's payment system, particularly the band system, and make recommendations to modify/replace,**

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		along with rebasing SC DHHS community service rates. The Mercer payment system report due in earl 2019. 2. The agency should clearly articulate the process for allocating other funding. In lieu of the current process of awarding a single grant, it might be possible to establish a time limited additional reimbursement rate for consumers at new facilities to help defray the cost of building or buying a new house, supported work site, etc. **#C-2 Complete—DDSN Action: DDSN has stopped making one-time capital grants to community providers while waiting for the Mercer report (see C-1 above). DDSN envisions extricating itself from capital improvements and delivery system real estate development. DDSN agrees rolling capital expansion cost/financing into future provider service rates is the direction for equity and simplicity in the payment system.**
D. Consumer Advocacy	1. The General Assembly may wish to establish a Disabilities and Special Needs Consumer Advisory Committee with requirements that the members represent the various communities that DDSN serves and specify the role of this committee in formally providing input into shaping the agency's policies. **DDSN Comment re Legislative D-1: Although this recommendation is to the General Assembly, this issue will be held and presented to the new State Director for consideration of advocating this recommendation.**	
E. Agency Directives		1. At the beginning of directives, the agency should enumerate those programs impacted by the directive. This would allow private providers to readily determine which directives apply to their programs and reduce the possibility of these providers ignoring pertinent information.

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		#E-1 Complete—DDSN Action: DDSN has implemented this recommendation into its directive process.
F. Consumer Finance		1. The agency should explore adopting a policy requiring providers to utilize a specialized debit card system designed for individuals with disabilities. Some providers already use these tools to manage consumer finances alleviating some of the risks that handling cash entails. **#F-1 Complete—DDSN Action: DDSN Internal Audit addressed this issue. The debit card system was efficient, but it created an increased risk of a perpetrator having access to a consumer's entire back account escalating the potential size of loss. However, it has been determined a similar model known as "stored value cards" has promise. The stored value card provides the same efficiency yet works like an EBT or store bought gift card with finite funding available until refreshed by an independent fiscal agent. Technique endorsed by DDSN and disseminated to providers. Use will be encourage on a voluntary basis. Mandatory use will only be considered after the system gains more experience on a voluntary basis. Internal Audit will review providers' use during routine audits and provide feedback to provider network.**
G. Inventory Control		1. DDSN should investigate establishing a standardized inventory system that utilizes available technology and digital pictures of the belongings that would allow electronic monitoring of consumer property inventories. **#G-1 Complete—DDSN Action: DDSN has examined and implemented its statewide electronic inventory module in Therap, which is its enterprise-wide information system. Technique endorsed by DDSN and disseminated to providers. Use will be**

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
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		encourage on a voluntary basis. Mandatory use will only be considered after the system gains more experience on a voluntary basis. Internal Audit will review providers' use during routine audits and provide feedback to provider network.
H. Financial Audits		1. The Commission should consider revising the current policy to exclude providers that do not provide residential services from the requirement to furnish an annual financial audit. Instead, a less expensive and onerous accountant's Report on Applying Agreed-Upon Procedures (RoAAP) should be required. **#H-1 Complete—DDSN Action: DDSN has implemented this recommendation.**
I. Conflict Free Case Management		1. DDSN should work cooperatively with DHHS to phase in a system of conflict free case management that meets the federal requirements and provides minimal disruption to consumers while maximizing consumer options. Encouraging a larger cohort of private providers to offer case management services should be part of this overall strategy. **#I-1 In-Process—DDSN Action: DDSN is fully engaged with SC DHHS on implementing conflict free case management. However, this issue has been intentionally slowed for several reasons, to include avoiding destabilizing the delivery system. Factors include 76% of all case managers' work for DSN Boards and the planned reduction of the case management reimbursement rates in mid-calendar year 2019 may undermine other case manager providers expanding to meet market needs. SC DHHS and DDSN have until 2022 to fully implement.**
J. Technology		1. DDSN should ensure that Therap can be customized to meet the changing needs of the agency and the provider community and proceed with full implementation.

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		#J-1 In-Process—DDSN Action: DDSN is committed to customize Therap to meet the provider community needs and fully implement. To meet these objectives, DDSN has slowed implementation due to providers' inability to absorb the changes with adequate staffing and time to train. DDSN is also reviewing the remaining system functions to be implemented to ensure implemented in a value-added manner. It is likely some remaining functions will be modified or even eliminated if there is an inadequate cost/benefit to the provider community. 2. In implementing phase II of the Provider Dashboard, the agency should utilize additional input from the provider community, consumer groups and other stakeholders to make revisions which provide a more useful tool for consumers and their families. **#J-2 In-Process—DDSN Action: DDSN's internal organizational review earlier in 2018 determined its oversight performance indicators were still too compliance driven. As a result, DDSN has emphasized maturing its outcome base performance tool (Residential Observations) and re-examine existing compliance tools to lower administrative footprint and increase measure's correlation with true performance. Changing the "Provider Dashboard" was held in abeyance until the new State Director was named to develop strategy. The new State Director sees the same issues and will establish a permanent provider/stakeholder committee focusing on DDSN oversight to collaborate and vet changes to improve quality of indicators. This will then lead to an updated Provider Dashboard "2.0." Providers & stakeholders will have ample input in the process to increase ownership and acceptance of the results to stimulate positive change.**

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K. Waiting List	1. Providers and the agency argue that local providers should not be compelled to accept consumers that they are not able to safely serve. However, this is a unique perspective for providing state/federally funded services. Most state and local government agencies cannot turn away individuals due to an inability to provide services. Instead, they must develop the capacity to serve the person or find an alternative. This applies to public schools, prisons, and even private hospitals. The General Assembly may wish to change the law to require local DSN boards to specifically justify not taking a consumer needing the services they provide when funding is available. **DDSN Comment re Legislative D-1: Although this recommendation is to the General Assembly, this issue will be held and presented to the new State Director for consideration of advocating this recommendation.**	1. DDSN should develop a voluntary questionnaire requesting consumers and their families to provide information about their circumstances upon entry in a waiting status. The agency could then use this information to categorize individuals on the waiting list among those that are potentially qualified for services, those not qualified at this time, those electing to not respond and the relative urgency of need among those on the waiting list. This would better illustrate the actual status of the unmet need for services in the community. **#K-1 Complete—DDSN Action: DDSN fully agrees with being able to better analyze the waiting list to understand the unmet need for services in the community. DDSN measures the waiting list from two optics. First, DDSN has adopted a best practice from other states to measure each waiver's "conversion rate" of consumers receiving waiver slots actually enrolling into the waiver. Once this conversation rate is established, DDSN can estimate the percent of each waiting list that will actually enroll for services, which is the unmet community need. Further, additional analysis can turn the conversion rate into the amount of state funds required to eliminate the unmet need. This data is updated monthly for the Commission and management team. Second, the list is analyzed based on each consumer's situation in six categories. This demonstrates the vast majority of the waiting list is composed of duplications, already in another waiver, and youth with statewide Medicaid benefits equating to waiver benefits except for respite.** 2. Although the agency voiced concern about compliance with federal laws mandating that consumers be treated in the least restrictive environment, the agency should explore using

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		excess capacity at the regional centers to temporarily provide services to some consumers on the critical needs waiting list to stabilize their circumstances until a local provider can be found to accept the individual. **#K-2 In-Process—DDSN Action: DDSN is in full support of using Regional Centers as triage critical needs, which is a change in strategy from the previous DDSN Executive Management. DDSN developed a plan to add 12 triage beds at Regional Centers in mid-2018 for crisis consumers on the critical needs waiting list while waiting for final placement. However, due to funding limitations in the current FY, this project has been placed on hold. The FY 2020 budget request contains a request to fund this initiative.**
L. DDSN Owned Community Properties		1. DDSN should seek to divest itself of properties within the communities. In the case of state operated facilities, the agency should make any needed repairs to the property and work out an agreement with the local provider to take over the operation of these properties. **#L-1 DDSN Action: Decision Complete; Implementation Plan Held in Abeyance until Consultant Report on payment system completed. DDSN Executive Management concurs with this recommendation. DDSN has stopped all grants for real estate. DDSN has analyzed its existing community property inventory, which is 59 buildings containing 11% of available community beds. DDSN is waiting for the early 2019 Mercer payment system report. After receiving this report, DDSN then will build a comprehensive plan to move from the bands to another payment system, which will include divesting itself of its community real estate back to the providers as part of the process.**

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		2. Instead of making special grants to local providers to encourage them to expand capacity, the agency should incentivize expansion by developing a temporary add-on reimbursement for new facilities that ties the funding to the consumers using that facility. This would give local providers additional funding to develop additional capacity that they would own, maintain and operate. **#L-2 DDSN Action: Decision Complete; Implementation Plan Held in Abeyance until Consultant Report on payment system completed. DDSN Executive Management concurs with this recommendation. DDSN anticipates the consultant report to include capital as a component of a fee-for-service model rate. DDSN agrees rolling capital expansion cost/financing into future provider service rates is the direction for equity and simplicity in the payment system.** 3. The agency should consider limiting the length of time that a "reverter clause" remains in effect, in essence devaluing the agency's investment. DDSN could eventually turn over properties to the local providers once a minimum utilization timeframe had been met. This would allow providers to better manage the physical assets of the entity. **#L-3 DDSN Action: Decision Complete; Implementation Plan Held in Abeyance until Consultant Report on payment system completed. This recommendation is similar to #L-1, #L-2, and #C-2 above. DDSN has ceased using grants for property transactions in anticipation of a new payment system that will not include DDSN involvement in real estate purchases. DDSN envisions extricating itself from capital improvements and**

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		delivery system real estate development. The existing "reverter clauses" adds additional logistics for DDSN to deed properties to providers, but it is not a substantive issue.
M. Agency Relationship with Providers		1. The agency should treat all providers as contractors from whom they are purchasing services rather than extensions of DDSN that have to be managed to ensure the success of the provider. Treating all providers equally in terms of resources and other assistance may entice more private providers to enter the market place in South Carolina. In this environment, providers would compete for clients and better managed entities would have an advantage in recruiting clients and generating a profit. This could allow the agency to concentrate on ensuring that the purchased services are being provided adequately in the manner required by the Commission's policies. **#M-1 DDSN Action: Decision Complete; Implementation Plan Held in Abeyance until Consultant Report on payment system completed. As noted in #C-1 above, SC DHHS & DDSN initiated a joint project to have a subject matter expert (Mercer) review DDSN's payment system, particularly the band system, and make recommendations to modify/replace. DDSN has concluded the band system's deficiencies requires a new payment system, most likely a fee-for-service model. DDSN agrees its new system needs to be more objective and market based to clarify roles & responsibilities between DDSN and providers, as well as incentivize existing providers to expand and new providers to enter the SC market to deliver ID/DD services.**
N. Monitoring/ licensing		1. DDSN should continue to expand and implement a system of person centered monitoring that emphasizes interviews and observation of the actual consumers as well as reviewing

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
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		files. This would allow for an impression of the consumers actual well-being such as nutrition, dental care, cleanliness and help ensure the veracity of the documentation in the files. **N-1 Complete—DDSN Action: DDSN has implemented the Residential Observation (RO) monitoring/audit technique in FY 2018 and continues to mature its capabilities. DDSN conducts ROs at all day programs and 25% of residential settings (350 residences/year), which includes interviewing all staff and consumer. This is an outcome based focus with maximum consumer input on person centered services provided.** 2. DDSN should proceed with plans to conduct unscheduled visits to observe staff interaction with consumers to ensure best practices are being implemented. **N-2 Complete—DDSN Action: DDSN has implemented the Residential Observation (RO) monitoring/audit technique in FY 2018 and continues to mature its capabilities. DDSN conducts unannounced ROs at all day programs and 25% of residential settings (350 residences/year), which includes interviewing all staff and consumer. This is an outcome based focus with maximum consumer input on person centered services provided.**
O. Abuse, Neglect & Exploitation Reporting		1. DDSN should work with law enforcement to more accurately classify the results of abuse, neglect and exploitation reports and improve the way that these are used for informing consumers and the public and make recommendations to the General Assembly for statutory changes if needed. **#O-1 Complete—DDSN Action: DDSN classifies ANE reports as those with a criminal nexus and those administrative (standard of care) in nature. This assists the public to better understand ANE**

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
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		results in proper context. DDSN provides public quarterly reporting to the Commission and the public on both categories, along with a five year trend analysis. This ANE data is incorporated into provider rating dashboard using a 5-star performance scale.
P. Agency Roles/ Responsibilities	1. The General Assembly may wish to adopt in statute language that clearly differentiates the responsibilities of DHHS and DDSN for the disabilities programs operated by DDSN. **DDSN Action re Legislative P-1: None; not our lane.** 2. Since the two agencies have no unified governing authority under the current State Government structure the General Assembly may wish to establish an authority to mediate disputes between these agencies regarding Medicaid funded programs. This entity could have direct authority or make recommendations to the General Assembly for issue resolution as needed. **DDSN Action re Legislative P-2: None; not our lane.**	
Q. Responsibility/ Public Perception		1. DDSN should recognize when the system fails and hold the responsible entity and/or individual accountable for the failure. This accountability should include not just the provider but the agency if the monitoring failed to uncover the problem and the Commission if appropriate policies were not in place to prevent the incident. Steps should then be taken to correct these failures and policies adopted to address any deficiencies. **#Q-1 Complete—DDSN Action: From an ANE perspective regarding "negative events," DDSN completed a review of its ANE program and determined its policies and practices are**

Summary of Recommendations from the Senate Medical Affairs Report - November 2017		
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		consistent with national best practices as set forth by NASDDDS. Inasmuch as DDSN is prohibited from investigating allegations of ANE, which is the predominant form of negative provider event, DDSN does not comment on such events in the normal course of business. Under Director Poole, she has instituted a monthly risk management review of all ANE incidents from across the state. **From an enterprise perspective, DDSN Executive Management has committed to a Process Management approach to leading DDSN, as illustrated in its August 28, 2018 report to the House Legislative Oversight Committee and its Process Management Training Program for all DDSN managers initiated by State Director Poole. DDSN has initiated an Enterprise Performance Management (EPM) program to support a discipline approach to process management throughout the agency to ensure a systematic approach to policy development, policy application to provider situations, and resolutions to situations with action and policy changes, if needed.** 2. At the same time, after an appropriate investigation, the Commission and agency should defend the system when policies are followed but an unfortunate outcome occurs due to something beyond either the agency's or the providers' reasonable ability to control. **#Q-2 Complete--DDSN Action: DDSN has adopted a transparent approach to organizational management as illustrated by its EPM which highlight both the good and the bad organizational results. As denoted in Q-1, DDSN Executive Management has committed to a Process Management approach to leading DDSN, as illustrated in its August 2018**

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		report to the House Legislative Oversight Committee and its Process Management Training Program for all DDSN managers initiated by State Director Poole. DDSN has initiated an Enterprise Performance Management (EPM) program to support a discipline approach to process management throughout the agency. 3. The agency should ensure that all providers are treated similarly and consumers all have equal access to appropriate services/resources as determined by their case manager. Transitioning the agency's focus from allocation of resources to ensuring service delivery complies with agency policy should resolve some of these concerns. **#Q-3 Complete—DDSN Action: DDSN is committed to fair treatment of all providers and consumers. From the provider perspective, the two big issues were the bands and grants. Grants have been stopped. DDSN Executive Management and the Commission has concluded the band system's deficiencies require a new payment system, most likely a fee-for-service model. This was documented in DDSN's report to the House Legislative Oversight Committee in August 2018. The Mercer payment system report due in earl 2019. From the consumer perspective, DDSN has implemented the Waiver Administrative Division to ensure across the board fairness in approving needed consumer services consistent with established criteria approved by SC DHHS.**
Total	6	28

House Legislative Oversight Committee Report on DDSN
17 Recommendations

#1: Expand Potential Pool of Direct Care Professionals

Recommendation #1: *The Department of Disabilities and Special Needs should seek funding to create a grant program or incentives for providers to expand the pool of Direct Care Professionals through shadowing programs, recognition programs, grassroots campaigns and training efforts designed to expand awareness about the profession and encourage greater participation by potential employees, specifically students preparing to graduate high school.*

DDSN Action #1: Partnership with DOE re high school program and establishment of a permanent DSP Committee.

#2: Provide Progress Report the Committee

Recommendation #2: *The State Director should report to the Committee in six months regarding changes implemented as a result of the Legislative Oversight process and the agency's internal improvement processes. This update should also include the status of additional mechanisms of feedback from stakeholders.*

DDSN Action #2: It has only been a little over three months since the report, but meeting this expectation is not a problem.

#3: Expand Commissioner Training

Recommendation #3: *The Department of Disabilities and Special Needs should further develop training for new Commissioners, including expanded onboarding and continuing education.*

DDSN Action #3: Representative Taylor has drafted bill awaiting its first reading. DDSN plans on modular-based orientation training for its new commission members. However, since there are so many on-going changes, updates, regulatory and legislative issues, DDSN has implemented a written report that goes out from the Director's office to the commissioners 2-3 times per month based on need, which informs them of the upcoming issues which will be requiring their attention. As a part of this report is a survey asking commissioners if they have training needs or subject matter clarification.

#4: Review Agency Regulatory Environment

Recommendation #4: *The Commission should undertake a complete review of the agency's regulatory environment, including existing and needed regulations. If that review reveals regulations that should be promulgated, amended, or repealed, the Commission should proceed through the procedures in Title 1, Chapter 23 of the South Carolina Code of Laws, related to state agency rulemaking.*

DDSN Action #4: Complete; see memo analyzing DDSN's regulatory environment.

#5: Amend DDSN's Suggested Changes to Existing Regulations

Recommendation #5: *The Committee should formally communicate to the House Regulations and Administrative Procedures Committee that the Commission on Disabilities and Special Needs has reviewed some regulations and determined they should be amended. This study will be available as a resource whenever the Commission promulgates new regulations or proposes amendments to existing regulations.*

DDSN Action #5: DDSN has filed notice with the General Assembly to amend or repeal 13 regulations.

#6: Create a Cabinet Agency

Recommendation #6: *The General Assembly should consider making the Department of Disabilities and Special Needs a cabinet agency. Specifically, the Governor, with the advice and consent of the Senate, should appoint the agency head. In addition, the Commission on Disabilities and Special Needs should continue to exist in an advisory capacity. All responsibilities currently assigned to the Commission, should devolve to the Department.*

DDSN Action #6: None—not our lane.

#7: Develop Criteria for Commission Membership

Recommendation #7: *The General Assembly should consider amending S.C. Code Ann. § 44-20-210 to establish knowledge and expertise criteria for membership on the Commission on Disabilities and Special Needs.*

DDSN Action #7: Representative Taylor has drafted bill awaiting its first reading (within same bill as recommendation #3).

#8: Redefine Role of County Boards

Recommendation #8: *The General Assembly should consider amending S.C. Code Ann. § 44-20-30 such that the county disabilities and special needs boards serve in an advisory capacity to the county director. All responsibilities currently assigned to county boards, including hiring of the county director, should devolve to the Department. The county disabilities and special needs board office should become a county office of the Department of Disabilities and Special Needs.*

DDSN Action #8: None—not our lane.

#9: Clarify Entities Providing Services -- S.C. Code Ann. § 44-20-370 (A)

Recommendation #9: *The General Assembly should consider amending S.C. Code Ann. § 44-20-370(A) to reflect that services are offered through private qualified providers as well as county DSN boards. In addition, the Committee recommends the agency develop a definition of "qualified provider," for inclusion in Title 44, Chapter 20 of the S.C. Code of Laws.*

DDSN Action #9: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

#10: Repeal Self Sufficiency Fund -- S.C. Code Ann. § 44-28-10 through § 44-2880

Recommendation #10: *The General Assembly should consider repealing S.C. Code Ann. § 44-28-10 through § 44-28-80 because the fund was not established and in 2016, the General Assembly established the South Carolina ABLE savings program, which serves the same purpose, and is made possible by the federal Achieving Better Life Experience Act.*

DDSN Action #10: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

#11: Repeal Disability Trust Fund -- S.C. Code Ann. § 44-28-310 through § 44-28370

Recommendation #11: *The General Assembly should consider repealing S.C. Code Ann. § 44-28-310 through § 44-28-370 because the fund was never established and in 2016, the General Assembly established the South Carolina ABLE savings program, which serves the same purpose.*

DDSN Action #11: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

#12: Make Definitions of Intellectual Disability Consistent -- S.C. Code Ann. § 44-23-10 (22)

Recommendation #12: *The General Assembly should consider amending S.C. Code Ann § 44-23-10(22) so that the definition of intellectual disability is consistent with the definition in S.C. Code Ann. § 44-20-30(12).*

DDSN Action #12: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

#13: Replace Mental Deficiency with Intellectual Disability -- S.C. Code Ann. § 44-25-20(g)

Recommendation #13: *The General Assembly should consider amending S.C. Code Ann. § 44-25-20(g), to replace "mental deficiency" and its definition with "intellectual disability" and its definition as stated in S.C. Code Ann § 44-20-30(12). In addition, the Committee recommends that "mental deficiency" be replaced with "intellectual disability" throughout Title 44, Chapter 25.*

DDSN Action #13: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

#14: Correct Inconsistency with Federal Fair Housing Law -- S.C. Code Ann. §6-29-770

Recommendation #14: *The General Assembly should consider amending S.C. Code Ann. § 6-29-770 to remove the requirement that notice be given for a home for persons with disabilities, as it violates federal Fair Housing Laws.*

DDSN Action #14: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

#15: Adjust Priority List of Persons Who Can Make Health Care Decisions -- S.C. Code Ann. §44-66-30(A)

Recommendation #15: *The General Assembly should consider amending S.C. Code Ann. § 44-66-30(A) to give DDSN last priority in health care decisions for persons unable to consent, as "a person given authority to make health care decisions for the patient by another statutory provision." Section 44-26-40, § 44-26-50, and § 44-26-60(C) should all be amended to refer to the correct priority number in § 44-66-30.*

DDSN Action #15: Representative Taylor has filed a bill to address this issue, and the Senate is preparing to submit a companion bill in support of the House bill.

#16: Add Day Program To -- S.C. Code Ann. §43-35-10(4)

Recommendation #16: *The General Assembly should consider amending S.C. Code Ann. § 43-35-10(4) to include day programs in the definition of "facility" in the Omnibus Adult Protection Act.*

DDSN Action #16: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

#17: Definition of Facility Require Sharing of Case Disposition With Agency - S.C. Code Ann. § 43-35-60

Recommendation #17: *The General Assembly should consider amending S.C. Code Ann. § 43-35-60 to require investigating agencies to share specific abuse, neglect, or exploitation case dispositions with the relevant state agency.*

DDSN Action #17: DDSN has provided a package to each of its Medical Oversight Committees for eight statues (HLOC recommendations # 9, 10, 11, 12, 13, 14, 16, and 17) to be considered for modification to add clarity or functionality to the existing statute.

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August 28, 2018

Chairwoman Phyllis J. Henderson
Healthcare and Regulatory Subcommittee, House Legislative Oversight Committee
522B Blatt Bldg.
Columbia, South Carolina 29201

Re: Department of Disabilities and Special Needs' (DDSN) Recommendations;
House Legislative Oversight Committee Performance Evaluation of DDSN

Dear Chairwoman Henderson,

DDSN is effective in accomplishing its mission of serving persons with intellectual disabilities, autism, head & spinal cord injuries, and conditions related to each of these disabilities. DDSN's service delivery system supports 40,339 eligible consumers with 24,622 consumers currently receiving services. However, DDSN is under stress to keep up with service needs, adequacy of provider reimbursement rates, and improve infrastructure efficiencies to support its efforts.

The below recommendations are structured into eight major issues and corresponding recommendations; a ninth issue/recommendation area encompasses 22 individual improvement initiatives; and a tenth area reports on the results of DDSN's five "internal initiatives" set forth in its May 2017 initial interrogatory to the House Legislative Oversight Committee. The ordering of the recommendations below does not infer a priority order inasmuch as all recommendations need to be addressed.

The below recommendations may appear voluminous, but the agency is recovering from a period of management tentativeness from many years of friction with a variety of stakeholders. Friction can be viewed as negative, but it can also stimulate needed positive change. Getting all the issues "on the table" in detail for complete transparency tends to unite; focuses energy on problem solving; and breaks the cycle of ruminating on past friction points and moving forward. Clear targets creates the transparency for high expectations and accountability to support and motivate the agency towards progress/results. DDSN has opportunities to improve effectiveness primarily through management improving its systems and processes to better support those operating within the service delivery system.

A concern in preparing these DDSN recommendations is the risk of hamstringing incoming State Director Poole's latitude in assessing DDSN's challenges differently, as well as approach to address. In state government, if an agency agrees to do something, it is somehow perceived to be etched in stone forever and must be carried out regardless of the actual changing operational conditions on the ground. I disagree, and I suggest the House Legislative Oversight Committee would as well. Agencies need a plan, but plans are expected to be periodically revisited and nimbly changed as conditions dictate, to include a new leaders' differing views on issues and solution approaches. Agencies just need to be accountable to justify the "why" for the change and move out in the adjusted direction.

As an aside, one of DDSN's issues has been developing high altitude static strategic plans, but management has been reluctant or lethargic to convert substantial portions of these strategic plans into actionable tactical plans from which to be held accountable. There is no reluctance to commit in this memo. A commitment to a specific, transparent, and measurable plan is needed at this time to regain some of the lost confidence and trust from stakeholders.

ISSUE #1: DDSN's most significant organizational issue is a deficient capitated payment system supporting community service providers known as the "band system." This payment system causes a multitude of problems to include:

- Lack of transparency in non-actuarially based band payments causes systemic distrust and dissatisfaction by providers, advocates, and consumers.
- Lack of residential service standards for staffing (direct care; nurses; 1st line supervisors) prevents establishing appropriate funding levels. Additionally, a lack of a formal/auditable process to establish transparent and accountable staffing levels (mandatory or provider developed) creates a risk of understaffing—proper staffing is the primary factor impacting the health, safety, and welfare of consumers.
- Time consuming and lengthy cost settlement process undermines having recent and reliable data for consideration to adjust the system and justify possible rate increases.
- Does not maximize opportunity for more state funds to obtain Medicaid match.
- Does not incorporate a consumer needs assessment tool to adjust funding to match a consumer's acuity; this is increasingly reducing access for higher needs consumers.
- Undermines DDSN's quality assurance mission by consuming too much time and relationship goodwill with providers on payment issues.
- The band benefits (i.e., vacancy rates, Medicaid ineligible risk, Medicaid billing, capital needs) can be duplicated, if so desired, in a simpler fee-for-service model except for the prospective payment.

RECOMMENDATION #1: DDSN will address its current payment system weaknesses through an evidence based process incorporating stakeholder input and industry best practices. In June 2018, Mercer Healthcare Consultants (Mercer) initiated a review of the DDSN payment system, which includes stakeholder input and incorporating national best practices. Mercer will produce a report due in the Fall 2018 recommending future payment system options to meet the needs of the DDSN service delivery system. Equally important, nearly all stakeholders have arrived at the conclusion the DDSN payment system has to be substantially changed, which is critical to support such a system-wide endeavor. Further, Mercer will update all SC DHHS service rates with DDSN via a second formal report in early 2019.

DDSN ACTION: Until the Mercer report is finalized by SC DHHS, DDSN can't finalize a payment system change plan with stakeholders, which will require Commission final approval. Report should be released in March/April 2019, but no exact date has been set.

In the meantime, DDSN has been engaging in a variety of tasks in preparation a payment system change to include:

- Stopped capital improvement grants to the community.
- Examined all non-service costs (i.e., consultants and special community grants) in "the system" but not included in DDSN overhead costs. The vast majority of these costs will be eliminated or brought "in-house" to develop and maintain DDSN expertise lost over many years of outsourcing.
- Examined the 65 DDSN properties operated by community providers to develop both short-term plans and long-term plans for DDSN to "get out of the real estate business" and move toward a market based model emphasizing fairness, equity, and expanded consumer choice from fair market competition. Short-term options be developed include providing annual funding for expenses while still owned by DDSN to simplify maintenance for all parties and long-term return packages for win/win between providers/DDSN.
- Initiating fee-for-service for case management, board early intervention, and state funded at-home on 7/1/2019.
- Developing a plan to initially bring at-home waiver bands (band B-IDRD; band I-CSW) back to DDSN and providers bill fee-for-service. This will also eliminate boards as financial managers, which is an overly complex activity and lessens the risk for conflict with board case management.
- Freeze on all positions unless approved by the State Director.
- Building a plan to internally reorganize to support a fee-for-service model with enhance service line program management skills.

ISSUE #2: DDSN's most significant operational issue is recruiting/retaining direct care workers at regional centers and in residential community settings. Regional centers bobble between barely manageable to a near crisis as illustrated by currently experiencing a 44% turnover rate. Residential providers' problem has more variability across the state, but turnover still ranges from 20% to 40+%. Adequate staffing levels generally require over-reliance on overtime. This stress on the direct care staff has escalated since 2015. Historically, direct care staffing is challenged during economic upswings and tends to resolve when the economy slows. However, given the hiring pool demographics and the need for direct care workers throughout the healthcare field as baby boomers age, DDSN cannot rely on an economic downturn as a solution. Short-term plans and long-term plans are needed to ensure direct care staffing meets quality staffing level thresholds with sufficient capacity to lower overtime causing burnout and turnover. We have to continue to work the issue as a crisis.

RECOMMENDATION #2a: DDSN will continue to pursue direct care wage improvements through the legislative appropriation process sufficient to create a full and stable workforce to meet the needs of consumers.

DDSN ACTION: DDSN's FY2020 budget request to increase direct care by $1/hour has been included in the House's current budget. Senate's initial budget is still pending.

RECOMMENDATION #2b: DDSN will pursue a career track for direct care, to include a tiered wage system to promote professional advancement and retention.

DDSN ACTION: This recommendation has been held in abeyance until after the $13/hour rate has been established as a baseline. Emphasis is on first triaging basic hourly direct support professional (DSP) rates to reduce the crisis condition of having adequate on-board staffing prior to building a longer-term formal pay structure with some differentiation for upward mobility. It should be noted there is some informal pay differentiation within the DSP job description.

RECOMMENDATION #2c: DDSN will pursue the use of technology and corresponding policies to support consumers and mitigate the gap in hiring/retaining direct care workers for the foreseeable future.

DDSN ACTION: DDSN is drafting an RFP to be released after first absorbing the Mercer report results, which will include service definition/standards/quality. This RFP will cover establishing a long-term service array consistent with consumers' needs, consumer/national demographic trends, and Medicaid projected funding trends. It is anticipated greater access and use of technology will be a key component in future DDSN's future service array.

RECOMMENDATION #2d: DDSN will solidify formalized targeted staffing levels in Regional Centers and the future community residential payment system rates should incorporate staffing level requirements based on consumer acuity.

DDSN ACTION: Formal DSP & nurse target staffing levels (TSL) have been established in Regional Centers. Nurse staffing is at 85% of TSL. DSP is also at 85%, except there is wide variation among Regional Centers: Pee Dee (94%), Midlands (94%), Coastal (83%); and Whitten (70%).

Consumer acuity will play a role community residential rates and staffing expectations, but detailed plans cannot be established until after first receiving the still pending Mercer report.

RECOMMENDATION #2e: In conjunction with the development of a new/modified payment system, DDSN will re-examine its portfolio of services and policies with an emphasis on making adjustments consistent with the future likelihood of challenges in hiring/retaining direct care workers.

DDSN ACTION: This recommendation has the same solution/action as recommendation #2c above. DDSN is drafting an RFP to be released after first absorbing the Mercer report results. This RFP will cover establishing a long-term service array consistent with consumers' needs, consumer/national demographic trends, and Medicaid projected funding trends. A key component will be accommodating the projected likelihood of fewer available DSPs due to "baby boomers" healthcare will require more direct care workers and Medicaid revenues not likely to keep up with ID/DD consumer needs.

RECOMMENDATION #2f: DDSN will continue to support, mature, and potentially expand a grass roots direct care professional training program provided through a local technical college.

DDSN ACTION: DDSN has established a program with SC Department of Education (SC DOE) to strategically place DSP certification curriculum in high schools to increase DSP pool and provide career opportunities for high school students upon graduation.

RECOMMENDATION #2g: DDSN will examine its policies and practices to proactively identify community setting opportunities to serve Regional Center consumers.

DDSN ACTION: DDSN has asked for 36 new high management beds and 4 youth beds in residential settings in FY2020 budget. The House did not approve this request in its budget.

DDSN building standardized procedures and assessments in its Critical Needs List (CNL) process to ensure existing finite resources are used in a optimal manner serving those most in need.

Plans to self-fund new residential housing by converting youth group home and Correct Care state funded beds into community residential CTH IIs receiving Medicaid match.

RECOMMENDATION #2h: DDSN will start contingency planning beyond obtaining additional wage increases for direct care workers to safely staff Regional Centers to meet the needs of consumers if the direct care hiring/retention crisis is not reversed.

DDSN ACTION: Pee Dee has readied a building to accommodate 18 consumers for either a triage program or movement of consumers from Whitten, which has also improved its staffing situation. Midlands will have an extra building available after renovations are completed. If a decision is made, DDSN has the physical facilities to accommodate moving one building from Whitten which would substantially help Whitten's staffing shortage.

ISSUE #3: DDSN management needs to mature its capabilities to be more proactive with emphasis on a system/process improvement approach to problem solving. General business acumen training needs include factoring financial implications into operation and policy decisions; greater use of information to manage; and enhanced involvement in developing internal operating budgets and contributions to the agency's annual legislative budget requests. In short, DDSN tends to have a reactive posture rather than leaning forward towards continuous improvement.

RECOMMENDATION #3a: DDSN will establish a formal management training program to develop its management in a structured manner in both management/business acumen skills and a continuous improvement management philosophy. Much of DDSN's real and perceived reactive crisis management style can be traced to a lack of management investment in planning and system/process improvement to prevent problems from occurring.

DDSN ACTION: DDSN has prepared the management training curriculum and power point. Training has been announced and will take place for Division Directors and supervisors in April.

Implemented agency-wide personnel management training and completed implementation/compliance with basic personnel management through the state's Employee Personnel Management System (EPMS). All employees' plans will have the same cycle to simplify administrating and training, which coincides with the agency's fiscal year.

RECOMMENDATION #3b: DDSN will redirect audit resources from community contract audits to conduct internal operational audits to provide assurance of effective operations through adequate objectives, process mapping, management information systems, and controls/performance measures.

DDSN ACTION: DDSN Internal Audit (IA) staff has been reduced by one auditor during current employee freeze. IA staff have been re-directed to priority internal DDSN issues to include performance reviews of non-service costs; Respite Program; Individual Employment Program; and Medicaid ineligible operational controls. IA has been noticed it will begin recurring operational audits in early calendar year 2019 after operational work units complete process maps and accurate & reliable performance reporting. Until this occurs, IA does not have an adequate operational framework to even conduct an operational audit.

During the 4th Quarter of FY 2019, DDSN being examining its quality management oversight of community providers, which will include IA's financial audit program. This process will shape IA audit role in the community consistent with resources and free up resources for permanent internal DDSN audit capacity.

ISSUE #4: There have been legislative hearings, proposed legislation, and public debate as to the proper organizational structure to support DDSN's mission, to include as a cabinet agency, a component of SC DHHS, or remain as a Commission.

RECOMMENDATION #4: DDSN recommends continuing its mission in its current structure as an independent Commission. A Commission form of governance permits heightened involvement by the families, stakeholders, and consumers through seven volunteer citizen leaders to ensure DDSN executes its mission with excellence to meet the complex needs of a highly vulnerable population. A single mission agency also creates the needed focus to support our highly vulnerable population.

The Commission recognizes stress in the DDSN delivery system over the past several years has caused some to question the proper organizational structure to support its mission. The Commission believes the stress was natural and needed as a precursor to stimulate deep change in DDSN due to complacency as well as resistance to change and transparency. The Commission's interventions has led to a new State Director being selected along with healthy executive staff turnover, a noticeably calmer operating environment with stakeholders, and management's proactive posture to engage issues backed up in the system as evident by the recommendations in this memo. The Commission believes its form of governance with greater stakeholder and citizen access

and responsiveness can more reliably stimulate positive change than a more bureaucratic form of governance.

DDSN ACTION: Outside of the recent legislative oversight agency reviews, DDSN has not provided any data or be asked to provide testimony on this topic.

ISSUE #5: DDSN does not have a systematic approach to performance management across the agency; some work units lack relevant performance measures or inadequate information to support operational/performance management. DDSN has lost a level of trust and confidence from a variety of stakeholders in the manner it executes its mission, both financially and operationally, as illustrated with legislative oversight questioning the agency's information accuracy.

RECOMMENDATION #5: DDSN will operate in a more evidenced based manner through the continued use and maturing of its Enterprise Performance Management process and ensure public performance reporting to demonstrate transparency and accountability with accurate and reliable information to its many stakeholders.

DDSN ACTION: DDSN is nearing completion of its "1.0" model for an Enterprise Performance Management system (EPM). Expected completion date by 4/15/2019. The purpose of EPM is:

- Performance feedback to work unit supervisor and staff (**most important**);
- "Insight into operations" to sort out the complexity of an operation to ensure staff & supervisor understand how all their activities combine into a tangible result(s) (cost/quantity/quality/time), as well as permits the entire chain to understand the key components within key operations & identify early signs of potential issues;
- Work unit accountability and budget justification, as well as a focused tool to simplify maintaining adequate oversight by all levels of management;
- Feeds into monthly Risk Management Report (last Monday of month) for analysis and action as appropriate;
- Maintain due diligence organizational control/oversight of $700 million and 2000 employees to ensure its strategies are achieving intended results (provide a steering wheel & gauges to inform issues & potential actions);
- Enables Commissioners to robustly fulfill their statutory oversight fiduciary duties to citizens, stakeholders, and taxpayers.
- Enables DDSN to meet its SC statutory legal test to, *"establish objectives to accomplish the mission and **performance measures** that show the degree to which objectives are being met...link program expenditures to **key financial and performance results measures**."* (Annual Accountability Report).
- Ready reference tool to obtain accurate key operational & performance data needed on a day-to-day basis for internal analysis or external reporting. This reporting negates many ad hoc data requests because the reports will be sufficiently current & accurate to meet the vast majority of issues/questions or at least establish a firm starting point for additional inquiry.

Monthly reports include: a) DDSN Eligibility-IDRD, HASCI, EI; b) DDSN Eligibility-Autism; c) Environmental Modifications; d) Waiver Administrative Division; e) Waiver Enrollment; f) HR Personnel On-Board; g) HR Regional Center DSP Recruiting & Hiring

Summary; h) Regional Center Budget Execution; i) Regional Center DSP & Nurse Staffing; j) Critical Needs List; k) Residential Placement & Vacancy; l) FY Year-to-Date Expenditures; m) Risk Management (Under Development); and o) Service Utilization (Under Development).

Quarterly reports include: a) Abuse, Neglect, and Exploitation; b) Community Provider Performance/Risk Matrix; c) DDSN Eligibility & Consumers Served; d) INFOSEC; e) Facility Management Capital and Maintenance; and f) ICF Risk Matrix from DHEC Reporting (Under Development).

ISSUE #6: DDSN does not have a formalized project management process, which has contributed to a pattern of both real and perceived under-performance in implementing major initiatives.

RECOMMENDATION #6: DDSN will establish a formal project management process for longer term agency-wide initiatives to ensure proper operational planning, proactive communication plans, and timely execution.

DDSN ACTION: DDSN has established a SharePoint site to integrate project management, EPM, and key reference documents. DDSN has established a standard project management template for key long-term projects. DDSN has established a briefing methodology for the entire executive management team to more frequently and more effectively monitor key projects.

ISSUE #7: DDSN has experienced an inching up of Abuse, Neglect, & Exploitation (ANE) indicators over the past four years, particularly with providers serving high needs consumers. The uptick of these ANE indicators is not a function of inadequate ANE policies or management deficiencies to keep "predator" employees out of the system. Rather, it is a function of "real world" economic factors eroding direct care professionals' (DSP) capacity & capabilities, while the consumer population's increasing behavioral needs require DSPs with higher skill levels. DDSN's lack of required acuity based direct care staffing standards also contributed to this situation. This is not a crisis, however this capability "gap" is building pressure/stress is the delivery system driving the uptick. This is a national challenge not unique to South Carolina.

RECOMMENDATION #7a: DDSN will continue to deploy and refine its Residential Observation Audit technique to make unannounced residential setting visits to 25% of all settings (approximately 350/annually) and provide monthly reporting to the Commission. Of the first 147 residential settings audited, over 200 consumer and 170 staff (370 total) were interviewed; not one interview reported an ANE climate risk or a report of a previously unreported ANE allegation—most importantly, the consumers felt safe.

DDSN ACTION: Examining the Quality Management function, to include the Residential Observation (RO) tool, is planned for 4th Quarter FY 2019. The RO tool is still operational, but it requires better focusing discrete questions to discrete measurable outcomes with emphasis on ANE given its current climate.

RECOMMENDATION #7b: DDSN will continue a robust participation in the National Core Indicators Program (NCI). The NCI has produced annual reports for 20 years and is considered the highest quality measurement tool in the Intellectual Disability service arena. The NCI survey obtains DDSN consumer input through interviews conducted

by independent interviewers on wide variety of service areas. In Fiscal Years 15-17, South Carolina providers distinguished themselves in the area of consumer safety by being consistently rated at or near the top on four key safety questions compared to 32 other states.

DDSN ACTION: FY 18 NCI report just released in March 2019. DDSN scored extremely well on the two consumer safety questions, to include the best score in one question (*"Have someone to go to for help if they ever feel scared"*—99% yes).

RECOMMENDATION #7c: DDSN will continue to pursue wage enhancements for direct care workers and establish residential staffing standards based on acuity in its anticipated new payment system to address the current direct care capability gap.

DDSN ACTION: $1 direct care worker pay increase requested in the FY2020 budget. The House has included this increase in its current budget. The Senate is still deliberating on its budget, which will then be reconciled with the House.

RECOMMENDATION #7d: DDSN will develop a formal process to collect "lessons learned" from ANE arrests.

DDSN ACTION: DDSN published its first ANE lesson's learned document in January 2019 regarding ANE arrests during FY 2018. DDSN plans providing quarterly non-attributable vignettes of ANE arrests and corresponding lessons' learned to maintain awareness in community providers and Regional Centers.

RECOMMENDATION #7e: DDSN will develop statewide policy and awareness training to address direct care workers' reaction to non-compliant/volatile consumer behaviors which precedes nearly 2/3rd of all ANE incidents leading to an arrest.

DDSN ACTION: The awareness component of this recommendation was addressed in above Recommendation #7d, but the training policy has not been addressed to date.

RECOMMENDATION #7f: DDSN will examine the direct care worker duties and compliance requirements, which have aggregated overtime. These increased duties may be undermining direct care workers habilitative responsibilities, which, in turn, lessons the direct care workers' ability to positively impact consumers' behaviors and prevent situations escalating into ANE incidents.

DDSN ACTION: This has not been addressed to date.

RECOMMENDATION #7g: DDSN will develop recurring safety bulletins based on lessons learned from ANE incidents, particularly vignettes (without attribution) from actual incidents to stimulate learning and continual awareness.

DDSN ACTION: This has been initially addressed in #7d and will be supplemented by quarterly vignettes & lessons learned. Further, DDSN has established system-wide monthly risk management function chaired by the State Director, which will also disseminate relevant safety bulletins and provider risk data on a more recurring and timely basis.

RECOMMENDATION #7h: DDSN will continue to mature its ANE Program data collection through similar enhancements as refining Critical Incident classifications clarifying issues of concern and the provider rating system.

DDSN ACTION: A complete review of the Quality Management Program, to include ANE data collection, is planned for the 4th Quarter FY 2019. The State Director has established a standing monthly provider committee to assist in this effort with provider input/vetting.

ISSUE #8: DDSN has determined 22 existing South Carolina statutes impacting the agency would benefit from revisions or elimination to assist the agency in accomplishing its mission.

RECOMMENDATION #8: DDSN requests these 22 SC statutes modifications or eliminations as set forth in Attachment A be adopted by the House Legislative Oversight Committee for legislative action.

DDSN ACTION: The 22 SC statute modification or eliminations were proposed to the House Legislative Oversight Committee (HLOC) in the Fall 2017. Based on the HLOC final recommendations in November 2018, all regulatory changes have been started through the legislative notification. All statute changes have been addressed with two in pending bills, nine hand-carried referrals to appropriate legislative committee, and two on how to position in the state organizational structure not addressed because it is not in DDSN's lane.

ISSUE #9: DDSN established a defensive posture for many years based on a variety of factors, which has led to a tentativeness to proactively address issues. Improvement initiatives to address backlogged operational issues include:

RECOMMENDATION #9a: DDSN will develop a residential setting building capacity and funding strategy for high needs consumers, as well as timely execution of appropriations to restore legislative confidence. Strategy will include establishing triage beds to address critical cases; enhanced tracking/measuring system capacity, needs, and placement times; and develop a legislative appropriation strategy to better communicate this critical need to justify a consistent future funding stream to keep pace with residential setting needs.

DDSN ACTION: DDSN has built an accurate tracking/measuring system addressing bed capacity and the critical needs list through a monthly report. The triage bed plan (12 beds at Pee Dee & Midlands) has been held in abeyance due to lack of resources and inadequate direct care support. However, the $12/hour direct care rate and increased recruiting efforts during FY 2019 have improved both Pee Dee and Midlands direct care staffing to be able to accommodate triage beds at this time. The FY2020 budget request for triage beds was not addressed in the current House budget and the Senate budget will not be final until April. If DDSN does not get funded, DDSN will likely have to make cuts to existing services or expenses to create needed funding for this priority project.

RECOMMENDATION #9b: DDSN will conduct a risk based review of licensing, contract review, residential observations, ANE Program (ANE; CI; Deaths), and other provider contract controls to identify opportunities to lesson or eliminate existing controls and corresponding administrative burden. A critical analysis will yield substantial risk

mitigation and administrative cost/burden savings by combining higher quality controls to support the elimination of redundant controls or controls with a low cost/benefit.

DDSN ACTION: A complete review of the Quality Management Program, to include ANE data collection, is planned for the 4th Quarter FY 2019.

RECOMMENDATION #9c: DDSN will implement a Waiver enrollment improvement plan to speed enrollment processing times, reduce the waiting list, and restore confidence to legislative appropriators of DDSN's ability to effectively execute budget enhancements.

DDSN ACTION: The plan has been favorably vetted through providers and has been sent to the Commission's Policy Committee for review.

Factors driving this stagnation include receiving a waiver slot without Medicaid eligibility; consumer/family confusion sorting out the DDSN case manager's role and the Medicaid financial lookback case worker's role; not understanding waivers; holding waiver slots while attempting to secure a service provider, particularly respite; and no process time constraints on holding a waiver slot. **DRAFT** process changes to address these factors in a reasonable and compassionate manner include:

- Upon DDSN eligibility determination, DDSN will engage at multiple points prior to waiver slot award to guide and encourage non-Medicaid eligible consumers to obtain Medicaid. If a consumer is still not Medicaid eligible three months prior to receiving a waiver slot, the consumer will be assigned a Case Manager to assist in Medicaid eligibility, as well as being placed on a Medicaid Processing list until Medicaid eligible prior to receiving a waiver slot.

- Consumers will be contacted by DDSN three months prior to receiving a waiver slot and assigned a Case Manager, as well as be briefed and provided written materials explaining the waiver enrollment process in preparation of receiving a waiver slot.

- Medicaid financial lookback worker's role will be delayed until after the DDSN Case Manager makes initial contact to explain the process, which will prevent confusion.

- Case Manager's level of care will be coordinated to be held until after Medicaid completes its 118A financial lookback form.

- Establish a "soft" 6 month deadline requiring justification approved by the Executive Director of the case management provider to extend in 30 days intervals up to 12 months. Not enrolling based on waiting to secure a service provider will not be an acceptable reason.

RECOMMENDATION #9d: DDSN will compare Regional Center requirements and current budgets to assess adequate funding, equity between centers, and basis for legislative budget request for maintenance of effort resources.

DDSN ACTION: Nurse staffing levels were at approximately 85% of target staffing level (TSL) needs. As a result, 29 additional LPN nurses are needed in DDSN's Regional Centers at a cost of approximately $700,000.

An analysis of the direct care staffing shortages at Whitten (26%) and Coastal (28%) would require 71 ($2.3 million) and 50 ($1.6 million) direct care worker ($3.9 million), respectively. Currently, the lack of funding does not need legislative appropriations because, fortunately or unfortunately, Regional Centers have no expectations of sufficient candidates to address these shortages. Midlands and Pee Dee have challenges, but are at the 90+% staffing level.

DDSN maintains adequate maintenance reserves to address Regional Centers' maintenance components that have failed or near failure. However, the funding has not kept up with delayed maintenance short of a crisis, particularly in the interior of the facilities. Delayed maintenance estimate at the four centers is $8.6 million with $5.9 million as a top tier need. The highest priority needs, Tier 1, include such items as carpeting, flooring, furniture, remodeling bathrooms, food service chillers, buses, vans, wheelchairs, hospital beds, blinds, security cameras, campus lighting, gym bleachers, keyless entry, building door/window frames, PT equipment, drainage, and degraded HVACs.

Based on budget analysis, the Regional Centers need rebalancing to provide an equitable starting point despite lacking 100% funding for all of its needs.

RECOMMENDATION #9e: DDSN will develop an "at-risk" inspection protocol by subject matter experts for suspected "failed" residential settings based on Alliant residential observations triggering an "at-risk" inspection. The DDSN Quality Management process understands providers' service levels may fluctuate due to a variety of short-term factors which DDSN can address through traditional audit findings, provider corrective action plans, and technical assistance. However, DDSN does not have a process to address major "failed" residential settings in a manner that both addresses operational deficiencies and addresses provider management's failure to deter similar situations in the future. Additional emphasis needs to be placed on a strategy to improve residential providers systemically on the low end of performance scores.

DDSN ACTION: A complete review of the Quality Management Program, to include ANE data collection, is planned for the 4th Quarter FY 2019.

RECOMMENDATION #9f: DDSN will establish at least a $2 million annual cost settlement escrow account, which has not been done in the past six years creating a contingent liability likely in excess of $20 million.

DDSN ACTION: DDSN completed its FY 15/16 cost settlement calculation which requires approximately $1.7 million payback, which is less than estimated. With five cost settlements pending and using a one-way settlement methodology, DDSN will had additional paybacks, but the $20 million estimate looks more like a ceiling than an

estimated liability. DDSN's net revenue and costs are estimated to be zero during FY 19, but any excess revenue (cash) will be escrowed to reserve for this future known liability.

RECOMMENDATION #9g: DDSN will re-engineer its Comprehensive Permanent Improvement Plan (CPIP) capital account funded with ICF consumer fees to minimize excessive capitalization of routine maintenance needs in CPIP preventative maintenance accounts. This prevents unhealthy stockpiling of unused resources; streamlines project prioritization/execution; and improves capacity to execute through delegation of smaller maintenance projects to Regional Centers.

DDSN ACTION: DDSN has established a formal quarterly meeting and report to review CPIP projects and Regional Center maintenance needs. This permits a logically winding down of CPIP over-funding through maintenance CPIPs and annual consumer fees for maintenance needs.

DDSN has stopped the practice of establishing maintenance CPIPs. The May 2017 SPIRS balance was approximately $7.7 million dollars. Since that time, CPIPs have been closed, with the 12/31/2018 Treasury balance of $2.4 million from closed projects and accumulated interest. The 12/31/2019 SPIRs balance was $5.3 million, of which $1.8 million encumbered in pending contracts or obligations. This leaves an available unencumbered balance of $3.5 million in CPIP funds.

The quarterly meetings requires all Regional Center input. Expenditures in excess of $25,000 requires both the CFO and ASD Operation approval to ensure funding is targeted at the highest priority needs based on a prioritization list developed through the quarterly reporting/meetings. Delegation of funding has been increased to Regional Centers during the FY. The goal DDSN is moving towards is integrating annual operating funding through internal Regional Center budgets, CPIP funds, and annual consumer fee revenue stream into one system.

RECOMMENDATION #9h: As an interim step to whatever future payment system is approved by the Commission, DDSN will conduct a feasibility study to relieve DSN Boards' as fiscal agents for in-home waiver bands (Band B – ID/RD; Band I – CS) with this function being absorbed by the Central Office Accounting Division. If feasible, this will achieve three outcomes: 1) relieve DSN Boards of this increasingly complex administrative function; 2) simplify QPL billing; and 3) convert $17 million in residual state funds in B & I Bands not generating a Medicaid reimbursable match to be available to provide initial funding of Mercer community rate increases due in early 2019. This $17 million in state dollars to fund new rates would create a Medicaid match to generate $40 million additional service dollars in the community residential delivery system.

DDSN ACTION: DDSN has initiated a review on this issue. DDSN has coordinated hiring an external subject matter expert to "red team" DDSN's internal work product to provide assurance of the benefits and possible unintended consequences. Still waiting for Mercer report before establishing a timeline for final decision and possible implementation.

RECOMMENDATION #9i: DDSN will develop a specific program to lower the current average census of 25 consumers at Correct Care (state funded locked facility) through building additional dedicated community residual high needs capacity (Medicaid

match). A reasonable goal would be to remove 15 current Correct Care consumers at a total net service savings of $1.8 million per year, as well as improve the quality of services for these 15 consumers.

DDSN ACTION: FY 2019 started with approximately 27 Correct Care consumers and the current census is 17.

RECOMMENDATION #9j: DDSN will review all non-service expenses, assess value, and prioritize; appears historical approach has been to renew prior FY's commitment without assessing value and compare to other needs, particularly given limited funds in this area.

DDSN ACTION: DDSN staff conducted contract performance reviews in January 2019, which resulted in a complete review by the entire executive staff in early March 2019. Of the over $3 million review, substantial contract reductions are expected starting 7/1/2019 with funding redirected to higher priority needs.

RECOMMENDATION #9k: DDSN will pursue pre-file legislation prior to the next legislative session to address ambiguity in the Adult Health Care Consent Act.

DDSN ACTION: Bills have been introduced in both the House and Senate to address the AHCA Act issue.

RECOMMENDATION #9l: DDSN will decentralize budget execution from currently residing almost exclusively with the Associate State Director for Administration to other Associate State Directors. Decentralized decision making will make better tradeoffs and more timely decisions when operating within clear resource constraints. This will be particularly beneficial for Central Office and Regional Centers to improve clarity in fixing roles, responsibilities, and accountability to both establish initial FY budget allocations and execution throughout the FY.

DDSN ACTION: Budget roles and responsibilities have been clarified between Regional Centers and Central Office. ASD Operations own all four Regional Center budgets with the requirement to operate within the overall budget. Most importantly, a formal budget development process between Regional Centers and Central Office will occur each June prior to the start of each FY to set an equitable, fact-based Regional Center budget prior to the start of the FY.

RECOMMENDATION #9m: DDSN will develop a mechanism to improve communications with community providers focusing on standardized format, authority level to send, targeted distribution email lists, and a one webpage repository.

DDSN ACTION: In November 2018, DDSN launched a new process (DDSN Executive Memos) to disseminate important information to community providers using a standardized format, authority level to send, targeted distribution email lists, and a one webpage repository.

RECOMMENDATION #9n: DDSN will identify all residential consumers Medicaid ineligible for over 12 months to identify issue(s), which will lead to developing policy to minimize this situation and future occurrences; currently 91 non-Medicaid residential

consumers create the opportunity cost loss of $4.5 million in Medicaid match reimbursements annually.

DDSN ACTION: This process has started on multiple fronts. First, specific District Office personnel assigned responsibility as a collateral duty. This addressed short-term Medicaid ineligibility but significant progress on long-term state funded consumers was not sufficient. DDSN is recruiting a Medicaid eligibility subject matter expert to take on this program which requires high level skill and knowledge on addressing excess asset/income issues with available trusts or programs (i.e., Able). Second, DDSN is building processes within our information technology framework to quickly identify and address consumers' losing Medicaid eligibility to coordinate with providers to address inasmuch as this will be a high need with any new payment system.

RECOMMENDATION #9o: DDSN will review Respite Program delivery; respite is key to serving families, yet access and service availability is still an issue.

DDSN ACTION: DDSN Internal Audit and the Respite Program Manager initiated a review of this program in January 2019. The program has a variety of issues hindering the program's overall effectiveness. Results can generate immediate short-term improvements, but the problems also require consideration for major program changes to simplify, improve access, quality control, and speed to on-board respite workers.

RECOMMENDATION #9p: DDSN will conduct a staffing and capabilities assessment of its financial operations, which have incrementally eroded since the 2010 recession creating a significant organizational risk, particularly with the unique knowledge base required to operate or modify the capitated band system.

DDSN ACTION: Obviously DDSN is hesitant to increase any overhead. Opportunities to improve have been identified, but DDSN is hesitant to increase personnel overhead prior to the final Mercer report and a finalizing a specific course of action for a new payment system. Lack of band payment system knowledge of the entire system and its idiosyncrasies continues to be a high risk, and retaining personnel with this knowledge is a priority.

RECOMMENDATION #9q: DDSN will review the individual employment program for opportunities to address current areas of ineffectiveness through training, policies, active monitoring, and authorization controls.

DDSN ACTION: Program reviewed numerous opportunities to improve to include robust training, Therap enhancements, review provider Therap notes, and building policy with more specific requirements. Finalizing all aspect of program waiting for Mercer report and final payment system decisions coupled with new SC DHHS rates for employment services in the Mercer report.

RECOMMENDATION #9r: DDSN will ensure Autism Program's eligibility process benchmarks are solidified and training/consulting resources targeted towards DDSN's core mission. Increase cost effectiveness of Autism residential settings operated by DDSN through filling vacancies or contract with a provider to serve these consumers; if DDSN retains operations, consider moving this function from the Policy Division to the Operations Division.

DDSN ACTION: Autism Eligibility process has established performance benchmarks along with monthly performance reports. Autism consultants have been reassigned to Operations to move away from a teaching/awareness mission to one of direct support of DDSN consumers and Critical Needs List triage/admission. DDSN has decided to move Autism residential settings (6) to the provider network. However, DDSN needs to refine its business protocols and staffing consistent with the provider network standards to attract a provider to take over successfully operated homes. Autism residential setting have been under ASD Operational control during this period prior to recommending formal organizational changes to the Commission. The Autisms private office space in Spartanburg is being closed and the few remaining personnel are being relocated to available space at Whitten.

RECOMMENDATION #9s: DDSN will revitalize the environmental modification process to reduce backlog from high of 200 in early 2018. Additional system refinements needed to coordinate or simplify operational execution between two divisions.

DDSN ACTION: The backlog still persists due to staff turnover and coordination issues between two divisions. Responsibility has been fixed with HASCI Division and staffing increased by two new FTEs with home construction remodeling and CAD drawing system experience. Environmental Modification Program provides a monthly performance report.

RECOMMENDATION #9t: DDSN will build infrastructure to support new Commission initiative to review new policy and recurring three-year policy updates on a quarterly basis in an efficient. Policies will be stratified by priorities to ease processing by stakeholders.

DDSN ACTION: Chairman has provided specific guidance on the process of addressing the higher volume of policies requiring periodic review and update, which.

RECOMMENDATION #9u: DDSN will shift all employees to a universal performance review cycle (July 1 to June 30) to improve accountability, training, quality, and integrate into an annual equitable assessment to consider personnel merit increases.

DDSN ACTION: Employees converted to the new Employee Performance Management System with a common review cycle coinciding the DDSN's fiscal year.

RECOMMENDATION #9v: DDSN will examine Early Intervention Program to ensure consumers eligible for Medicaid become enrolled to maximize Medicaid reimbursement; in the recent past, Medicaid enrollment has dropped from 80% to currently at 65%.

DDSN ACTION: This has been informally reviewed without convincing results. This issue will be rolled into a single person to be responsible for all aspects of maximizing Medicaid eligibility for consumers using reasonable and compassionate approaches to address this serious revenue issue.

In DDSN's May 2017 submission to the House Legislative Oversight Committee, it set forth five "internal initiatives" to improve. These five initiatives are set forth below with an update on progress/results located on Attachment B:

- Evaluation of Abuse, Neglect, and Exploitation reporting and follow up system.
- Changes to the tracking and reporting of critical incidents.
- Direct service operations.
- Plan review and service authorization.
- DDSN outcome-based provider evaluation.

The recommendations contained in this letter have been approved by the DDSN Commission.

Thank you in advance for your consideration of DDSN's recommendations. I am available 24/7 to discuss further and provide any clarifications needed.

Sincerely,

Patrick J. Maley
Interim State Director

Summary of Preliminary Data
Questions for Consideration for Development of
Community Video Surveillance Camera
March 15, 2019

Preliminary information is included below in response to the DSN Commission and Policy Committee list of questions. Information may be used to inform development of a community video surveillance camera directive.

1) **National Trends**

Survey responses have been received from 40/49 state DD agencies. DDSN staff have called and email for follow-up after the initial survey request was posted in February 2019. Staff have also completed policy web searches from the remaining 9 with no results.

See attached spreadsheet for compiled information focused on the presence of an existing requirement to use video surveillance cameras in residential settings. In conclusion, video surveillance cameras are not routinely required, but are often permitted. Some states have developed policies, while others have not chosen to do so.

2) **What type of programs have the highest level of ANE's? (CTH's, High Management CTH's, vans, etc.)**

FY19

Location Type	Number of ANE Allegations	%
CTH-II	171	72.77
CTH-I	1	.43
CRFC	12	5.11
ICF	14	5.96
SLP-I and II	8	3.4
Day Programs	29	12.34
Total	235	

3) **What locations or providers have the highest rates of ANE's?**

Settings
CTH-II 73%
Day Services 12%
Others (CTH-I, SLP-I and II, ICF and CRCF) 15%

Total Count of ANE Reported Allegations and Incidents for FY 19
**An Incident Report may involve more than one type of ANE allegation or may involve more than one person.*

Providers
Babcock- 18 allegations (14 incidents)
Calhoun DSN Board- 12 allegations (6 incidents)
Community Options- 16 allegations (16 incidents)
Fairfield DSN Board- 17 allegations (10 incidents)
Mentor – 25 allegations (19 incidents)

4) **What percentage of the clients involved in ANE's are non-verbal?**

7% non-verbal

Additionally:

77% reported verbal Communication with staff.
7% reported non-verbal Communication with staff.
16% did not indicate the preferred communication method with staff.

**8% were designated as using both verbal and non-verbal communication with staff.*

5) **What is the percentage of ANE's when cameras *have* been in place?**

A survey was completed in February and March 2019 asking providers to indicate specific settings with camera usage currently in place. Using this data, reports of ANE allegations will be compared to determine the percentage of settings where ANE Allegations have been reported when cameras have been in place. This analysis should be complete during the month of April 2019.

6) **What are the costs involved?**

Based on number of facilities below and general estimates obtained from a few providers, a rough estimated total implementation cost for hardware and installation in all community residential and day program common areas is $4, 254, 800. Additional cost variables would include staffing to manage equipment/footage, maintenance costs, periodic hardware replacement, etc.

FACILITY TYPE	TOTAL LICENSED
4-bed CTH II	750
SLP I	262
SLP II	392
8-bed CRCF	47
ICF Community	59
All Residential (excludes 150 CTH I and Regional Center)	1510
Day	95

7) **What type of cameras – video only, audio and video?**

Camera quotes have been obtained with visual/video only capabilities.

8) **What are the requirements we need in place when cameras are used?**

To be determined. In the prior directive focused on the use of cameras in the regional centers, the following were included:

Required Safeguards:
Review by Human Rights Committee
Written Informed Consent Requirement
Access Requirements
Training Requirements
Breach Contact Procedure

Procedures:
Signs
Consent
Video Recording Overwrite Requirements
Recording Associated with Critical Injury or Allegations of ANE
DDSN Review Requirements
Release of Recording
Tampering/Breach of Misuse of Cameras or Recordings

National Survey of Required Surveillance Cameras 3/14/2019

State	Required to Use?	Policy Details
AL	No	
AZ	No	May be used
CO	No	May be used
DC	No	
DE	No	
FL	No	May be used
GA	No	May be used
HI	No	N/A
IA	No	
ID	No	May be used and have them in ICF/Inst
IL	No	May be used
IN	No	May be used
KS	No	May be used-common areas; some community ICFs/IID-used for training purposes/system improvement
KY	No	Use in ICF due to regulation though not in policy or statute
LA	No	
ME	No	In some individual SLPs; remote monitoring only
MI	No	May be used
MN	No	Providers can use cameras in residential settings to monitor staff so long as the people who live there and/or their Guardians provide written, informed consent.The waiver does not fund the use of cameras to monitor staff however, so this would be a provider cost.
MO	No	"Not promoting but on its way because of interest"
MS	No	May be used in day programs only; used in institutional ICFs/IID-common areas only
MT	No	Used in 1 secured institution & may be used by providers in res/day programs-common areas only; all individuals must be aware of use; video only-no audio; must have access to video during investigations
NC	No	Use in ICF due to regulation though not in policy or statute
ND	No	Used by some providers; common areas
NE	No	
NH	No	
NJ	No	May be used
NM	No	May be used, but requires HR approval
NV	No	State operated ICFs use cameras
NY	No	
OH	No	May be used/State operated ICFs use cameras
OK	No	May be used
SD	No	Some providers use-common areas; all individuals aware ofuse-due process; 1/2 in SLPs-bedrooms only at night; camers in ICFs common areas(2); state ICF-common areas/parking lot (1)
TX	Yes	Use in common areas of state operated ICFs
UT	No	May be used
VA	No	May be used following proper HR review; common areas only-institutional ICFs/IID (2)
VT	No	Prohibited - violation of privacy
WA	No	
WV	No	May be used-residential only-common areas; some community ICF/IIDs
WY	No	

NO RESPONSE RECEIVED

AK	left v/m 3/4; email 3/8
AR	left v/m 3/4; email 3/7
CA	email 3/4 and 3/7
MD	email 3/4 and 3/7
NM	left v/m 3/6
OR	left v/m 3/7
RI	left v/m 3/5; email 3/8; v/m 3/13
TN	left v/m 3/5; email 3/8
WI	left v/m 3/5; email 3/8

Attachment F

Chart | Filter | Information

FY 18/19 Legislative Authorized & Spending Plan Budget VS Actual Expenditures (as of 2/28/2019)

Funded Program - Bud	Original Budget	Budget Adjustments	Current Budget	YTD Actual Expense	Balance
ADMINISTRATION	$ 8,256,999.00	$ 0.00	$ 8,256,999.00	$ 3,976,761.76	$ 4,280,237.24
PREVENTION PROGRAM	$ 657,098.00	$ 0.00	$ 657,098.00	-$ 15,495.00	$ 672,593.00
GREENWOOD GENETIC CENTER	$ 13,185,571.00	$ 0.00	$ 13,185,571.00	$ 9,600,435.00	$ 3,585,136.00
CHILDREN'S SERVICES	$ 16,302,094.00	$ 18,414,500.00	$ 34,716,594.00	$ 21,196,474.58	$ 13,520,119.42
BABYNET	$ 5,587,500.00	-$ 5,587,500.00	$ 0.00	$ 0.00	$ 0.00
IN-HOME FAMILY SUPP	$ 89,589,626.00	$ 3,378,716.77	$ 92,968,342.77	$ 39,491,507.86	$ 53,476,834.91
ADULT DEV&SUPP EMPLO	$ 81,402,958.00	-$ 4,560,970.00	$ 76,841,988.00	$ 55,912,812.68	$ 20,929,175.32
SERVICE COORDINATION	$ 22,656,140.00	$ 0.00	$ 22,656,140.00	$ 14,808,176.91	$ 7,847,963.09
AUTISM SUPP PRG	$ 26,355,826.00	$ 0.00	$ 26,355,826.00	$ 10,257,167.23	$ 16,098,658.77
Pervasive Developmental Disorder (PDD) Program	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
HD&SPINL CRD INJ COM	$ 5,040,532.00	$ 0.00	$ 5,040,532.00	$ 3,078,943.73	$ 1,961,588.27
REG CTR RESIDENT PGM	$ 84,032,118.00	$ 729,533.00	$ 84,761,651.00	$ 45,730,898.47	$ 39,030,752.53
HD&SPIN CRD INJ FAM	$ 28,742,377.00	$ 540,000.00	$ 29,282,377.00	$ 12,326,690.87	$ 16,955,686.13
AUTISM COMM RES PRO	$ 29,739,084.00	$ 0.00	$ 29,739,084.00	$ 22,235,917.34	$ 7,503,166.66
INTELL DISA COMM RES	$ 317,799,720.00	$ 2,031,476.00	$ 319,831,196.00	$ 222,685,783.80	$ 97,145,412.20
STATEWIDE CF APPRO		$ 0.00	$ 0.00	$ 0.00	$ 0.00
STATE EMPLOYER CONTR	$ 32,745,158.00	$ 1,198,348.00	$ 33,943,506.00	$ 17,952,580.21	$ 15,990,925.79
DUAL EMPLOYMENT		$ 0.00	$ 0.00	$ 0.00	$ 0.00
Legislative Authorized Total	**$ 762,092,801.00**	**$ 16,144,103.77**	**$ 778,236,904.77**	**$ 479,238,655.44**	**$ 298,998,249.33**
Legislative authorization capacity above actual spending plan budget			**-$59,703,587.77**		
DDSN spending plan budget			**$ 718,533,317.00**	**$ 479,238,655.44**	**$ 239,294,661.56**
Percent of total spending plan budget			100.00%	66.70%	33.30%
% of FY completed (expenditures) & % of FY remaining (available funds)			100.00%	66.67%	33.33%
Difference			0.00%	0.03%	-0.03%

REASONABLE

Carry Forward + Cash Flow Analysis Indicates Sufficient Cash to Meet FY 19 Estimated Expenditure Commitments: YES_X_ ; At-Risk___ ; NO___

Expenditures categorized to provide insight into direct service consumers costs vs. non-direct service costs:

Expenditure	FY 18 - % of total	FY 17 - % of total
Central Office Admin & Program	2.37%	2.36%
Indirect Delivery System Costs	1.56%	1.42%
Lander University	0.00%	0.05%
Board & QPL Capital	0.14%	0.59%
Greenwood Autism Research	0.03%	0.10%
Direct Service to Consumers	95.90%	95.48%
Total	**100.00%**	**100.00%**

NOTE: Prior FY data will be calculated and presented to provide assurance as to the consistent pattern of direct service & non-direct service expenditures and explanation for increases/decreases

Methodology & Report Owner: DDSN Budget Division

South Carolina Department of Disabilities and Special Needs
FY 2019-2020 Budget Request Items In Priority Order
Approved by the Commission on 12/13/2018

	Program Need – Recurring Funds	Budget Request for FY 2019-2020	House of Representatives
1	**Safety and Quality of Care/Workforce Needs** Workforce issues must be addressed in order to recruit and retain quality staff who provide essential 24/7 care to consumers. This request is the third year of a multiyear request and has two components: (1) Increase the hiring wage for direct care staff and immediate supervisors. Direct care wages are not competitive. An increased hiring wage of at least $13.00 per hour is needed to be competitive. This request supports moving toward that goal by increasing the hiring wages to $13.00 per hour, an increase of 8.3 percent from $12.00 an hour. Potential candidates will not apply if the starting pay is not reasonable. Experience has demonstrated that direct support employees can be hired, but often terminate within the first year to seek employment with large private companies like Walmart and Lowe's with similar pay and easier jobs than the demands of a direct support caregiver in a 24/7 operation. The current 44% turnover rate in DDSN regional centers is a direct result of erosion of pay, forced overtime and inability to take earned leave days. Flexibility will be requested to give providers some latitude to incentivize new hires, such as $13/hour starts after a probationary period, but all funds must be only be used for direct care staff. (2) Retain essential staff to maintain service quality. Service quality cannot be reduced and staffing ratios must meet compliance standards and be maintained. Wage compression exists at supervisory and manager levels where longtime quality employees make the same wage as new hires. Loss of longtime quality employees due to wage levels not keeping up with industry benchmarks increases turnover, affects the quality of consumer care, results in higher contract costs and increases the cost of training new staff to perform these vital services.	**$10,400,000** **Increase Hiring Wage $9.1M** **Compression & Retention $1.3M**	**$10,400,000**
2	**Community Service Rates:** Community service provider rates have not been rebased across the board since 2006. Through survey, interview, and cost analysis, all evidence suggests community service provider rates are not adequate to meet current level of provider costs for services. Mercer Healthcare Consultants, Inc. (Mercer) is currently conducting a payment system review and a community service rate study, to include Community ICFs, due in January 2019 at the earliest. DDSN does not have a validated rate study from which to seek increase appropriations to meet consumer needs. However, given the estimate of receiving the Mercer rate study early in calendar year 2019, DDSN plans, if time available after receiving the rate study, to submit an amended budget request to address this critical funding issue in the DDSN service delivery system. DDSN's current $5 million estimate is likely only a partial payment of the anticipated rate increase needs. This $5 million with its Medicaid match would be a 3.2% increase in community service rates (FY 2018-2019 budget $543 million). DDSN anticipates a multi-year budget request approach to implement recommendations from the rate study.	**$5,000,000**	

South Carolina Department of Disabilities and Special Needs
FY 2019-2020 Budget Request Items In Priority Order
Approved by the Commission on 12/13/2018

	Program Need – Recurring Funds	Budget Request for FY 2019-2020	House of Representatives
3	**Intermediate Care Facility (ICF) Regional Center Service Rates:** DDSN's four ICF Regional Centers have undergone significant de-population over the past two decades requiring shifting resources to community providers creating a substantial risk of under-resourcing ICF Regional Centers. Under new agency leadership and having operated with an interim executive staff for nearly nine months, DDSN addressed this situation through an internal cost study during the Fall 2018. <u>Result of Cost Study</u>: 29 additional LPN nurses are needed in DDSN's Regional Centers. This is based on the fact current on-board nurse resources (LPN & RN) are insufficient to meet nurse Targeted Staffing Level (TSL) needs by approximately 15%. Required nurse resources were short of actual staffing needs even after including substantial nurse supplements in the form of state temps, contractors, and overtime (63% FTE & 37% supplemental). DDSN's current hiring salary for LPNs is $38,000, which is below market and not attracting sufficient LPN candidates. As a result, the LPN hiring range requires an increase to $41,000 - $43,000 based on the candidate's experience ($42,000 average) to attract sufficient qualified candidates. The cost for this increase is $517,040 plus $100,860 to increase on-board LPNs to be equitably raised to the minimum thresholds to prevent turnover for a total of $617,900. As LPNs are hired to reduce stress in the system from nurse shortages, the increased LPN salary will be used to attract additional LPNs to replace existing dependency on supplemental resources (state temps, contractors, and overtime). An analysis of the direct care staffing shortages at Whitten (26%) and Coastal (28%) would require 71 ($2.3 million) and 50 ($1.6 million) direct care worker ($3.9 million), respectively. Currently, the lack of funding does not need legislative appropriations because, fortunately or unfortunately, these two Regional Centers have no expectations of sufficient candidates to address these shortages. It is hopeful "Budget Priority #1 - $1 raise" will stimulate applicants for hire at Whitten and Coastal Centers. Midlands and Pee Dee have challenges, but are at the 90+% staffing level. DDSN maintains adequate maintenance reserves to address Regional Centers' maintenance components that have failed or near failure. However, the funding has not kept up with delayed maintenance short of a crisis, particularly in the interior of the facilities. Delayed maintenance estimate at the four centers is $8.6 million with $5.9 million as a top tier need. The highest priority needs, Tier 1, include such items as carpeting, flooring, furniture, remodeling bathrooms, food service chillers, buses, vans, wheelchairs, hospital beds, blinds, security cameras, campus lighting, gym bleachers, keyless entry, building door/window frames, PT equipment, drainage, and degraded HVACs. The requested $882,100 funds will start the process of re-constituting while establishing a more robust recurring maintenance program to maintain operations at higher levels rather than operate to failure as is the current practice.	**$1,500,000** **_____** **Nursing Resources $617,900** **Delayed Maintenance $882,100**	
4	**Intermediate Care Facility (ICF) Regional Center Institutional Respite:** To increase system capacity by creating 12 institutional respite beds for individuals at-home and in a waiver who exhibit high behaviors and need intense respite intervention. This institutional respite would provide time limited intensive supports by highly trained staff in temporary residential services and may be used for medication stabilization, dually diagnosed behavior interventions and other services recommended by a physician. This institutional respite service is critical to the system as the ultimately goal is to return the individual to his/her home or to a less restrictive residential setting in the community. Addressing this intense, short-term need would prevent emergency hospitalizations, more expensive long-term residential placements and also incentivize providers to accept individuals with high behavior needs for initial placement.	**$580,500**	

South Carolina Department of Disabilities and Special Needs
FY 2019-2020 Budget Request Items In Priority Order
Approved by the Commission on 12/13/2018

	Program Need – Recurring Funds	Budget Request for FY 2019-2020	House of Representatives
5	**Increase and Improve Access to Residential Supports:** This request will provide necessary residential supports and services to 36 individuals with aggressive, intensely challenging behaviors requiring high management and/or forensic residential beds. These funds will be used to develop eleven homes and day supports in the community, including one-time capital and startup costs associated with the new services, and provide necessary residential and day supports and services for 33 individuals. Additionally, the funds will be used for one home developed and operated directly by DDSN staff to provide immediate residential services to judicially committed consumers suitable for a community setting with intensive supervision. Costs will include one-time capital and startup costs associated with the new services, and provide necessary residential and day supports and services for three (3) individuals. This population can be very difficult to serve as they often are a threat to themselves and/or others. The number of providers willing to serve this population is extremely limited. If rates are not adequate to cover the actual cost of high management services, the state cannot increase the service capacity necessary to address this ongoing need. Each year DDSN receives more court ordered residential placements for individuals with challenging behaviors and the agency must comply with judges' orders. DDSN requests a four bed CTH II for juveniles in the community meeting Medicaid requirements for reimbursement. DDSN's current juvenile residential capacity of 22 beds is full. Eight beds are eligible for Medicaid reimbursement and 14 are state funded due to institutional group home settings. If funded, the new four-bed residence will provide immediate capacity. DDSN will also work on a cost savings plan to self-fund new four-bed residences meeting Medicaid requirements to provide better services at less cost to juveniles suitable for the community currently in state funded group homes.	**$1,533,575** **_____** **High Management/ Forensic Residential Beds $1,440,000** **4 Bed CTH II – Juveniles $93,575**	
6	**Child Protective Custody Transition:** Annually, DDSN avails residential services to DDSN eligible children who are approaching the age of majority in the custody and or care of the South Carolina Department of Social Services (SCDSS). It is the intent of our agency to provide residential habilitation to these individuals in a community training home I or specialized family home setting. This residential model allows children and adults eligible for SCDDSN services and requiring long-term residential care to live in the home of a vetted caregiver offering care, supervision, skills training, and ancillary support based on the individual's needs. The home will require licensure and serve a maximum of two consumers. DDSN is requesting $140,000 to develop 5 community training home I or specialized family home settings. This initiative will cost effectively serve approximately 10 individuals.	**$140,000**	**$140,000**
7	**Early Intervention:** DDSN has absorbed BabyNet and Early Intervention (EI) service increases through internal reallocations for many years without requests for corresponding budget increases. There exists no capacity for increased early intervention services to three through six-year-old children without additional funding to meet increase consumers eligible for EI services.	**$800,000**	

South Carolina Department of Disabilities and Special Needs
FY 2019-2020 Budget Request Items In Priority Order
Approved by the Commission on 12/13/2018

	Program Need – Recurring Funds	Budget Request for FY 2019-2020	House of Representatives
8	**Increase Access to Post-Acute Rehabilitation that is Specialized for Traumatic Brain or Spinal Cord Injuries:** DDSN has a recurring appropriation of $3.6 million to provide a post-acute rehabilitation program for individuals who experience a traumatic brain or spinal cord injury. During the last three months of the FY 17/18, DDSN only funded one new TBI/SCI inpatient due to a lack of funds. This resulted in an estimate of 12 TBI/SCI uninsured/under-insured citizens not receiving treatment. The lack of funding is estimated at $500,268 (12 patients x $41,689 avg. inpatient cost). This request for additional permanent funding of $500,000 would serve an additional 12 individuals and bridge the funding gap at the estimated number of TBI/SCI consumers in the upcoming FY 19/20. For best outcomes, specialized rehabilitation should begin as soon as possible following medical stabilization or discharge from acute care. Without appropriate rehabilitative treatment and therapies in the first weeks or months after injury, people are not able to achieve optimal neurological recovery and maximum functional improvement. Research shows these results in more substantial levels of permanent disability and limits the ability to work. As a consequence, there are greater needs for long-term care, and other health, mental health and social services. Lack of rehabilitation options causes extended acute care hospital stays following injury for many people. There are also higher rates of subsequent hospitalizations for people who do not receive rehabilitation.	**$500,000**	
	TOTAL RECURRING FUNDS	**$20,454,075**	**$10,540,000**

South Carolina Department of Disabilities and Special Needs
FY 2019-2020 Budget Request Items In Priority Order
Approved by the Commission on 12/13/2018

	Program Need – Non-Recurring Funds	Budget Request for FY 2019-2020	House of Representatives
1	**South Carolina Genomic Medicine Initiative:** This request will assure statewide access to genetic services for individuals with complex developmental disabilities and their families. It also supports development of a systematic and comprehensive application of new genomic technologies. Despite the success of the collaboration between DDSN and Greenwood Genetics Center (GGC), we are still unable to identify the underlying cause for intellectual disability in approximately 40% of the individuals evaluated. For individuals with autism, we are unable to determine an underlying cause in 80% of those evaluated. The lack of a specific cause is not acceptable to families and physicians, and significantly limits optimum medical management, treatment options and informed reproductive decision making. The GGC is embarking on a major genomic initiative that will have a transformative impact on the GGC, the state, and the provision of personalized medicine for South Carolinians. This South Carolina Genomic Medicine Initiative will combine clinical care, a "multi-omics" technological approach and big data/machine learning to create a powerful and unique resource serving patients, healthcare providers, and state agencies. This bold initiative is being pursued to significantly increase the diagnostic yield for individuals with intellectual disabilities and autism, with the ultimate goal of providing information necessary to provide personalized and precise medical treatment and management for patients with disabilities and autism. In addition, the data accumulated with this initiative will provide precise genomic information that will help develop and guide personalized public health policies. The request of $2,000,000 non-recurring state funds is in conjunction with funds from the private sector. Anticipated partners include the private sector, such as foundations, Clemson University, other academic partners and individual donors. It is the intention of the GGC to work with SCDHHS to pursue an administrative Medicaid match for this project to demonstrate the impact and value of this approach to CMS.	**$2,000,000**	**$2,000,000**
	TOTAL NON-RECURRING	**$2,000,000**	**$2,000,000**
	TOTAL FUNDS REQUESTED	**$22,454,075**	**$12,540,000**