Healthcare and Regulatory Subcommittee Meeting
Tuesday, October 10, 2017

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AGENDA

South Carolina House of Representatives

Legislative Oversight Committee

HEALTHCARE AND REGULATORY SUBCOMMITTEE
Chairman Phyllis J. Henderson
The Honorable William K. Bowers
The Honorable MaryGail K. Douglas
The Honorable Bill Taylor

Tuesday, October 10, 2017
10:00 a.m.
Room 110-Blatt Building

Pursuant to Committee Rule 6.8, S.C. ETV shall be allowed access for internet streaming whenever technologically feasible.

AGENDA

I. Approval of Minutes

II. Discussion of study of the Department of Disabilities and Special Needs

III. Adjournment

MEETING MINUTES

Legislative Oversight Committee

South Carolina House of Representatives

Post Office Box 11867
Columbia, South Carolina 29211
Telephone: (803) 212-6810 • Fax: (803) 212-6811

Healthcare and Regulatory Subcommittee Meeting
Monday, September 18, 2017, at 10:00 am
Blatt Building Room 110

Archived Video Available

I. Pursuant to House Legislative Oversight Committee Rule 6.8, South Carolina ETV was allowed access for streaming the meeting. You may access an archived video of this meeting by visiting the South Carolina General Assembly's website (http://www.scstatehouse.gov) and clicking on *Committee Postings and Reports*, then under *House Standing Committees* click on *Legislative Oversight*. Then, click on *Video Archives* for a listing of archived videos for the Committee.

Attendance

I. The House Legislative Oversight Committee is called to order by Chair Phyllis Henderson on Monday, September 18, 2017, in Room 110 of the Blatt Building. All members of the Committee are present for all or a portion of the meeting except, Representative Bill Taylor.

Minutes

I. House Rule 4.5 requires standing committees to prepare and make available to the public the minutes of committee meetings, but the minutes do not have to be verbatim accounts of meetings. It is the practice of the Legislative Oversight Committee to provide minutes for its subcommittee meetings.

II. Representative Douglas moves to approve the meeting minutes from the July 18, 2017 meeting.

Representative Douglas moves to approve the meeting minutes from the July 18, 2017 meetings	Yea	Nay	Not Voting (Absent)	Not Voting (Present)
Rep. William K. Bowers			✓	
Rep. MaryGail Douglas	✓			
Rep. Henderson	✓			
Rep. Taylor	✓			

Meeting

I. Chair Henderson explains that the Subcommittee has completed its meetings with DHEC, and that this is the first meeting with the Department of Disabilities and Special Need (DDSN).

II. Chair Henderson explains that the full committee received testimony from the public about the agency in March of this year, and that the purpose of this meeting is to learn about the agency's history, strategic plan, major programs, products and services.

III. Chair Henderson reminds everyone that has previously been sworn in that they remain under oath for any testimony before this Subcommittee or the full Committee.

IV. Chair Henderson swears in Tom Waring, DDSN Associate State Director.

V. Dr. Beverly A. H. Buscemi, DDSN State Director, provides testimony. Topics discussed included:

a. Mission/roles/governing structure
b. of Provider Network Structure
c. SCDDSN Districts
d. Prioritization of Services
e. Changing populations
f. Service expansion/Waiting lists
g. Risk Management
h. Quality Assurance Process - Contract Compliance
i. Quality Assurance Process Licensing
j. Incident Management Reporting
k. Reporting Procedures for Allegations of Abuse, Neglect and Exploitation
l. Public Reporting of Provider Performance
m. Current Challenges
n. Pending System Changes
o. Future Challenges
p. Agency Criticism

VI. Subcommittee members ask questions, which different agency representative's answer. Topics questioned include:

a. Local disability boards
b. Private service providers
c. Abuse, neglect, and exploitations
d. Turnover
e. Case management services
f. Direct/indirect services cost and overhead
g. Base funding
h. Providers per geographic area
i. Medicaid spending
j. Provider scoring
k. Opioid addiction
l. Other States
m. Natural Disaster

V. There being no further business, the meeting is adjourned.

STUDY TIMELINE

Study Update - Department of Disabilities and Special Needs

- March 2015 - Agency submits its **Annual Restructuring and Seven-Year Plan Report**, which is available online.

- January 11, 2016 - Agency submits its **2016 Annual Restructuring Report**, which is available online.

- January 10, 2017 - **Full committee votes to schedule the Department of Disabilities and Special Needs for study**. Video of the meeting is available online.

- February 9, 2017-March 13, 2017 - Committee solicits input from the public about the agency in the form of an **online public survey.** The results of the public survey are available online.

- March 2, 2017 - Committee holds **public input meeting** about Department of Archives and History; DDSN; and John de la Howe School. Video of the meeting is available online.

- May 1, 2017 - Agency submits its **Program Evaluation Report**, which is available online.

- September 18, 2017 - Subcommittee holds meeting to discuss agency **history, governance, services, and customers**.

- Ongoing - Public may submit written comments on the Oversight Committee's webpage on the General Assembly's website (www.scstatehouse.gov).

AGENCY OVERVIEW

Snapshot

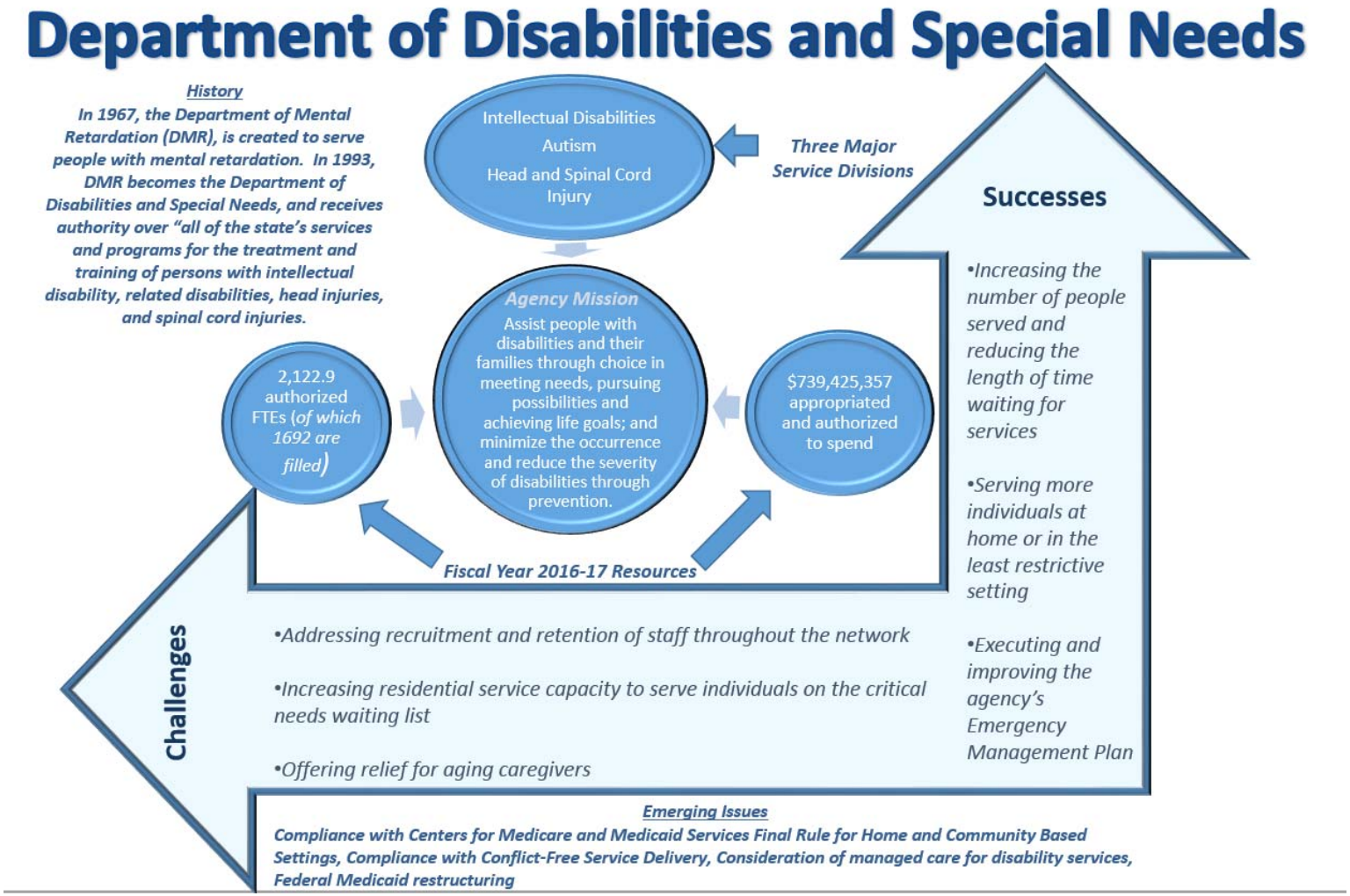


Figure 1. Snapshot of agency that includes its history, mission, resources, successes, challenges, and emerging issues. Source: Agency PER

FINANCES

In its Program Evaluation Report (PER), DDSN responded to questions about its strategic spending and strategic budgeting. Strategic spending and budgeting are the agency's allocation of resources across the goals, strategies, and objectives of its strategic plan. The agency's 2015-2016 strategic spending chart is on pages 13-14, and the 2016-2017 strategic budgeting chart is on pages 15-17.

In the PER, the Committee also asked the agency about requests to restructure or realign its General Appropriations Act programs. That response is on page 18.

During the September 18, 2017 meeting, Subcommittee members asked questions related to the both the agency's finances and how service providers are funded. Those questions were as follows:

- What specific items are included in the room and board paid by DDSN consumers? Please provide the types of income sources used to pay the room and board.
- What are the anticipated impacts of changes to Medicaid? What innovations could be achieved if Medicaid funding was in the form of a block grant?
- Please provide a breakdown of each county board's budget, including but not limited to, direct and indirect costs. Please define direct and indirect costs in the context of the county board's budgets.

Responses to the questions are on pages 19 - 137.

Agency Finances

Strategic Spending (2015-2016)
Strategic Budgeting (2016-2017)
Realignment of General Appropriations Act Programs
Projected Expenditures (2017-2018)

Agency Responding	Department of Disabilities and Special Needs
Date of Submission	4/28/2017

Note: The details are requested to avoid agencies "arbitrarily" assigning numbers

Does the agency have any money that is not tracked through SCEIS? (Y/N) (If yes, please outline further by responding to Line 15 under Part B1)	Yes

2015-16 Strategic Spending Chart

PART A1 - Cash Balances and Revenue Generated

--> The amounts below relate to the agency's cash.

--> The Committee understands the (a) agency is only permitted to spend amounts appropriated or authorized, which is addressed in Part A2; and (b) agency may have more cash than it is permitted to spend.

Funding Source	Total							
Funding Source (if funding sources are combined, do not combine recurring with one-time)	n/a	n/a	General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Funds	General Fund Appropriations Non-Recurring
2014-15 Total revenue generated	$367,726,628	n/a	$0	$364,058,775	$3,131,563	$257,915	$278,375	$0
2015-16 Total revenue generated	$387,983,650	n/a	$0	$385,234,319	$2,543,340	$31,891	$174,100	$0
Fund # and Description (Expendable Level - 8 digit) (full set of financials available for each through SCEIS)	n/a	n/a	10010000 General Fund	37640000 Medicaid Asst Payable	Other Earmarked Funds (3000)	49730000 Educ Improvement	Federal Funds (5000) (FEMA & IDEA Grant)	10010000 General Fund

Cash Balances	Total	n/a						
Fund # and Description (Expendable Level - 8 digit) (full set of financials available for each through SCEIS)	n/a	n/a	10010000 General Fund	37640000 Medicaid Asst Payments	30000000 Other Earmarked Funds	49730000 Educ Improvement	50000000 Federal Funds (FEMA & IDEA Grant)	10010000 General Fund
Cash balance as of June 30, 2015 (end of FY 2014-15)	$3,349,739	n/a	$0	$1,830,962	$1,383,722	$268,788	-$133,733	$0
Cash balance as of June 30, 2016 (end of FY 2015-16)	$6,421,636	n/a	$0	$3,527,877	$2,877,569	$0	$16,190	$0

PART A2 - Funds Appropriated and Authorized for 2015-16 (i.e. Allowed to spend)

--> The Committee understands the agency may be appropriated or authorized to spend additional money during the year.

Funding Source								
Funding Source	n/a	n/a	General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Grant Funds	General Fund Appropriations Non-Recurring
Recurring or one-time?	n/a	n/a	Recurring	Recurring	Recurring	Recurring	Recurring	Non-Recurring

Appropriation and Authorization Details	Totals - Start of year	Totals - End of year	End of Year	End of Year				
Amounts appropriated, and amounts authorized, to the agency for 2014-15 that were not spent AND the agency can spend in 2015-16	**$1,030,471**	**$1,030,471**	$1,030,471	$0	$0	$0	$0	$0
Amounts appropriated, and amounts authorized, to the agency for 2015-16	**$678,517,212**	**$678,517,212**	$224,552,876	$449,693,900	$2,216,782	$613,653	$340,000	$1,100,001
Total Appropriated and Authorized (i.e. allowed to spend)	**$679,547,683**	**$679,547,683**	$225,583,347	$449,693,900	$2,216,782	$613,653	$340,000	$1,100,001

PART B1 - Utilization of Funds in 2015-16

--> The Committee understands amount the agency budgeted and spent per objective are estimates from the agency. The information is acceptable as long as the agency has a logical basis, which the Committee may ask the agency to explain, as to how it reached the numbers it provided.

Funding Source	Totals							
Funding Source	n/a	n/a	General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Grant Revenue & FEMA Grant Revenue	General Fund Appropriations Non-Recurring
Database(s) through which expenditures are tracked (See instructions for further details)	n/a	n/a	SCEIS (State)	SCEIS (state); ADL (agency)	SCEIS (State)	SCEIS (State)	SCEIS (State)	SCEIS (State)
Recurring or one-time?	n/a	n/a	Recurring	Recurring	Recurring	Recurring	One-time	One-time
External restrictions (from state or federal government, grant issuer, etc.), if any, on how the agency can use the money from each funding source	n/a	n/a	Per Proviso 36.14: For the current fiscal year, the department is authorized to carry forward any balance of General Funds appropriated for the reduction of the department's waiting lists in the prior fiscal year and must utilize these funds for the same purpose in the current fiscal year. All other expenditures are limited to those authorized in the budget.	Per Proviso 36.5: The department is authorized to continue to expend departmental generated revenues that are authorized in the budget.	Per Proviso 36.5: The department is authorized to continue to expend departmental generated revenues that are authorized in the budget. Per Proviso 36.1: Funds are to be used for other operating expenses and/or permanent improvements of these Work Activity Programs.	EIA (Restricted to program items allowable under State Education Improvement Act.)	Restricted to program items allowable per federal grant provisions	Per Proviso 118.14 (SR: Nonrecurring Revenue) (24 a,b,c) Autism Services , Special Family Resources, Savannah's Playground
State Funded Program # and Description	n/a	n/a	0100 - Administration 9500 - Fringe Benefits 400* - Program Services	0100 - Administration 9500 - Fringe Benefits 400* - Program Services	0100 - Administration 400* - Program Services	9500 - Fringe Benefits 400* - Program Services	9500 - Fringe Benefits 400* - Program Services	400* - Program Services

Current Strategies	Totals Planned to Utilize - Start of year	Totals Utilized - End of year	End of Year	End of Year	End of Year	End of Year	End of Year	End of Year
			General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Grant Revenue & FEMA Grant Revenue	General Fund Appropriations Non-Recurring
Strategy 1.1: Greenwood Genetics Center Services to Prevent & Mitigate Birth Defect	$10,432,176	$10,366,281	$3,434,300	$6,931,981	$0	$0	$0	$0
Strategy 1.2: Early Childhood Developmental Delay Services	$30,978,087	$23,336,768	$6,892,188	$16,196,108	$0	$0	$148,472	$100,000
Strategy 1.3: Post Acute Traumatic Brain or Spinal Cord Injury Rehabilitation Services	$2,726,828	$2,692,717	$2,692,717	$0	$0	$0	$0	$0
Strategy 1.4: Pervasive Developmental Disorder (Autism) Services	$10,378,398	$8,111,577	$7,082,254	$1,029,323	$0	$0	$0	$0
Strategy 2.1: In-Home Support Services (least restrictive community setting	$97,799,040	$66,851,682	$46,640,124	$19,180,823	$30,735	$0	$0	$1,000,000
Strategy 2.2: Community Residential Services (residential services while still in a community setting	$322,630,197	$314,137,241	$65,245,061	$248,340,330	$409,279	$142,571	$0	$0
Strategy 2.3: Regional Center Residential Services (severe or profound disabilities	$95,451,750	$86,111,572	$54,372,535	$31,148,197	$422,108	$158,108	$10,624	$0
Strategy 2.4: Adult Development & Employment Services	$74,262,075	$71,934,699	$24,709,698	$46,253,353	$971,648	$0	$0	$0
Strategy 2.5: Service Coordination	$23,939,774	$18,542,692	$7,719,319	$10,823,373	$0	$0	$0	$0

Strategy 3.1: Quality Assurance Monitoring of Provider Contract & Licensing Compliance	$1,827,922	$1,827,922	$277,092	$1,550,830	$0	$0	$0	$0
Strategy 3.2: Monitor Provider Financial Management & Operational Requirement	$585,352	$585,352	$567,690	$17,662	$0	$0	$0	$0
Strategy 4.1: Monitor Organizational Effectiveness through Benchmark	$8,536,084	$7,169,393	$5,010,809	$2,156,373	$2,211	$0	$0	$0
Strategy 4.2: Organizational Initiatives to Improve Effectiveness	embedded in 4.1	embedded in 4.1						
Total utilized on Agency Strategies in 2015-16	$679,547,683	$611,667,896	$224,643,787	$383,628,353	$1,835,981	$300,679	$159,096	$1,100,000

Unrelated Purpose (pass through or other purpose unrelated to agency's strategic plan)	Totals Planned to Utilize - Start of year	Totals Utilized - End of year	End of Year	End of Year
Unrelated Purpose #1 - insert description:	n/a	n/a		
Unrelated Purpose #2 - insert description:				
Insert any additional unrelated purposes				
Total utilized on purposes unrelated to Agency Strategies in 2015-16				

PART B2 - Appropriations and authorizations remaining at the end of 2015-16

Totals	Start of Year	End of Year						
Funding Source	n/a	n/a	General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Grant Revenue & FEMA Grant Revenue	General Fund Appropriations Non-Recurring
Appropriated and authorized	$679,547,683	$679,547,683	$225,583,347	$449,693,900	$2,216,782	$613,653	$340,000	$1,100,001
(minus) Utilized on Agency Strategies in 2015-16	$679,547,683	$611,667,896	$224,643,787	$383,628,353	$1,835,981	$300,679	$159,096	$1,100,000
(minus) Utilized on purposes unrelated to Agency Strategies in 2015-16	$0	$0	$0	$0	$0	$0	$0	$0
Amount of appropriations and authorizations remaining	$0	$67,879,787	$939,560	$66,065,547	$380,801	$312,974	$180,904	$1
Amount remaining as % of total appropriations and authorizations	0.00%	9.99%	0.42%	14.69%	17.18%	51.00%	53.21%	0.00%

Explanation for Amount Remaining:
Excess authorization in Other Funds account for the$67.6M remaining. Funds could only be expended if State Funds were available and expended to generate Medicaid revenue. Other Funds authorization may be lower or higher than actual revenue. Agencies may spend the lesser of actual revenue or the amount of authorization in the budget. To spend Other Funds an agency must have cash (revenue) and authorization.

Agency Responding	Department of Disabilities and Special Needs
Date of Submission	4/28/2017

Note: The details are requested to avoid agencies "arbitrarily" assigning numbers.

Line #		
1	Does the agency have any money that is not tracked through SCEIS? (Y/N) (If yes, please outline further by responding to Line 15 under Part B1)	Yes

2016-17 Strategic Budging Chart

PART A1 - Cash Balances and Revenue Generated

--> The amounts below relate to the agency's cash.

--> The Committee understands the (a) agency is only permitted to spend amounts appropriated or authorized, which is addressed in Part A2; and (b) agency may have more cash than it is permitted to spend.

Line #	Funding Source	Total							
2	Funding Source (if funding sources are combined, do not combine recurring with one-time)	n/a	n/a	General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Funds	General Fund Appropriations Non-Recurring
3	2015-16 Total revenue generated	$387,983,650	n/a	$0	$385,234,319	$2,543,340	$31,891	$174,100	$0
4	2016-17 Total estimated revenue	$390,571,874	n/a	$0	$385,234,320	$3,743,414	$548,653	$1,045,487	$0
5	Fund # and Description (Expendable Level - 8 digit) (full set of financials available for each through SCEIS)	n/a	n/a	10010000 General Fund	37640000 Medicaid Asst Payable	Other Earmarked Funds (3000)	49730000 Educ Improvement	Federal Funds (5000) (FEMA & IDEA Grant)	10010000 General Fund

	Cash Balances	Total	n/a						
6	Fund # and Description (Expendable Level - 8 digit) (full set of financials available for each through SCEIS)	n/a	n/a	10010000 General Fund	37640000 Medicaid Asst Payments	30000000 Other Earmarked Funds	49730000 Educ Improvement	Federal Funds (FEMA & IDEA Grant)	General Fund Appropriations Non-Recurring
8	Cash balance as of June 30, 2016 (end of FY 2015-16)	$6,421,636	n/a	$0	$3,527,877	$2,877,569	$0	$16,190	$0

PART A2 - Funds Appropriated and Authorized for 2016-17 (i.e. Allowed to spend)

--> The Committee understands the agency may be appropriated or authorized to spend additional money during the year.

Line #	Funding Source								
9	Funding Source	n/a	n/a	General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Grant	General Fund Appropriations Non-Recurring
10	Recurring or one-time?	n/a	n/a	Recurring	Recurring	Recurring	Recurring	Recurring	Non-Recurring

	Appropriation and Authorization Details	Totals - Start of year	Totals - End of year	End of Year	End of Year				
11	Amounts appropriated, and amounts authorized, to the agency for 2015-16 that were not spent AND the agency can spend in 2016-17	$939,561	n/a	$939,561	$0	$0	$0	$0	$0
12	Amounts appropriated, and amounts authorized, to the agency for 2016-17	$738,485,796	n/a	$240,153,324	$494,201,528	$2,236,804	$548,653	$1,045,487	$300,000
13	**Total Appropriated and Authorized (i.e. allowed to spend)**	$739,425,357	n/a	$241,092,885	$494,201,528	$2,236,804	$548,653	$1,045,487	$300,000

PART B1 - Utilization of Funds in 2016-17

--> The Committee understands amount the agency budgeted and spent per objective are estimates from the agency. The information is acceptable as long as the agency has a logical basis, which the Committee may ask the agency to explain, as to how it reached the numbers it provided.

Line #	Funding Source	Totals							
14	Funding Source	n/a	n/a	General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Grant Revenue & FEMA Grant Revenue	General Fund Appropriations - Non-Recurring
15	Database(s) through which expenditures are tracked (See instructions for further details)	n/a	n/a	SCEIS (State)	SCEIS (state); ADL (agency)	SCEIS (State)	SCEIS (State)	SCEIS (State)	SCEIS (State)
16	Recurring or one-time?	n/a	n/a	Recurring	Recurring	Recurring	Recurring	One-time	Non-Recurring
17	External restrictions (from state or federal government, grant issuer, etc.), if any, on how the agency can use the money from each funding source	n/a	n/a	Per Proviso 36.14: For the current fiscal year, the department is authorized to carry forward any balance of General Funds appropriated for the reduction of the department's waiting lists in the prior fiscal year and must utilize these funds for the same purpose in the current fiscal year. All other expenditures are limited to those authorized in the budget.	Per Proviso 36.5: The department is authorized to continue to expend departmental generated revenues that are authorized in the budget.	Per Proviso 36.5: The department is authorized to continue to expend departmental generated revenues that are authorized in the budget. Per Proviso 36.1: Funds are to be used for other operating expenses and/or permanent improvements of these Work Activity Programs.	EIA (Restricted to program items allowable under State Education Improvement Act.)	Restricted to program items allowable per federal grant provisions	Per Proviso 118.16 (SR: Nonrecurring Revenue) (26) Lander Equestrian Center
18	State Funded Program # and Description	n/a	n/a	0100 - Administration 9500 - Fringe Benefits 400* - Program Services	0100 - Administration 9500 - Fringe Benefits 400* - Program Services	0100 - Administration 400* - Program Services	9500 - Fringe Benefits 400* - Program Services	9500 - Fringe Benefits 400* - Program Services	400* - Program Services

19	Current Objectives	Totals Planned to Utilize - Start of year	Totals Utilized - End of year	Budgeted to utilize - Start of year	Budgeted to utilize - Start of year	Budgeted to utilize - Start of year	Budgeted to utilize - Start of year	Budgeted to utilize - Start of year	Budgeted to utilize - Start of year
				General Fund Appropriations	Medicaid Reimbursements	Other Earmarked Funds	Restricted Funds Education Improvement Act	Federal Grant Revenue & FEMA Grant Revenue	General Fund Appropriations - Non-Recurring
	Strategy 1.1: Greenwood Genetics Center Services to Prevent & Mitigate Birth Defects	$11,811,376	n/a	$3,934,300	$7,877,076	$0	$0	$0	$0
	Strategy 1.2: Early Childhood Developmental Delay Services	$31,479,472	n/a	$6,835,563	$24,420,909	$0	$0	$223,000	$0
	Strategy 1.3: Post Acute Traumatic Brain or Spinal Cord Injury Rehabilitation Services	$3,100,000	n/a	$3,100,000	$0	$0	$0	$0	$0
	Strategy 1.4: Pervasive Developmental Disorder (Autism) Services	$10,323,590	n/a	$7,023,590	$3,300,000	$0	$0		$0
	Strategy 2.1: In-Home Support Services (least restrictive community setting)	$128,148,699	n/a	$57,477,479	$70,566,220	$90,000	$0	$15,000	$0
	Strategy 2.2: Community Residential Services (residential services while still in a community setting)	$339,047,125	n/a	$77,841,008	$259,273,570	$1,006,588	$220,472	$705,487	$0
	Strategy 2.3: Regional Center Residential Services (severe or profound disabilities)	$100,833,502	n/a	$56,499,910	$43,406,945	$496,466	$328,181	$102,000	$0
	Strategy 2.4: Adult Development & Employment Services	$80,338,186	n/a	$15,342,935	$64,060,251	$635,000	$0	$0	$300,000
	Strategy 2.5: Service Coordination	$22,893,752	n/a	$6,675,217	$16,218,535	$0	$0	$0	$0
	Strategy 3.1: Quality Assurance Monitoring of Provider Contract & Licensing Compliance	$1,883,953	n/a	$283,704	$1,600,249	$0	$0	$0	$0
	Strategy 3.2: Monitor Provider Financial Management & Operational Requirements	$658,546	n/a	$621,302	$37,244	$0	$0	$0	$0
	Strategy 4.1: Monitor Organizational Effectiveness through Benchmarks	$8,907,156	n/a	$5,457,877	$3,440,529	$8,750	$0	$0	$0

	Strategy 4.2: Organizational Initiatives to Improve Effectiveness	embedded in 4.1	n/a	$0	$0	$0	$0	$0	$0
	Total planned to utilize on Agency Strategies in 2016-17	$739,425,357	n/a	$241,092,885	$494,201,528	$2,236,804	$548,653	$1,045,487	$300,000

	Unrelated Purpose (pass through or other purpose unrelated to agency's strategic plan)	Totals Planned to Utilize - Start of year	Totals Utilized - End of year	Budgeted to utilize - Start of year	Budgeted to utilize - Start of year
	Unrelated Purpose #1 - insert description:	n/a	n/a		
	Unrelated Purpose #2 - insert description:	n/a	n/a		
	Insert any additional unrelated purposes	n/a	n/a		
	Total planned to utilize on purposes unrelated to Agency Objectives in 2016-17	n/a	n/a		

	PART B2 - Appropriations and authorizations remaining at the end of 2015-16				
	Totals	Start of Year	End of Year		
	Funding Source	n/a	n/a		
	Appropriated and authorized	$739,425,357	n/a		
20	(minus) Planned to utilize on Agency Objectives in 2016-17	$739,425,357	n/a		
	(minus) Planned to utilize on purposes unrelated to Agency Objectives in 2016-17	$0	n/a		
	Amount of appropriations and authorizations remaining	$0	n/a		
	Amount remaining as % of total appropriations and authorizations	0.00%	n/a		

Line #	**Explanation for Amount Remaining:**
	The agency spending plan outlines $670.4M in expected expenditures for FY 17. This would leave approximately $69m in excess authorization at the end of FY 17.

Please provide the following regarding the agency's information in the General Appropriations Act.

a) **Does the agency have the ability to request a restructuring or realignment of its General Appropriations Act programs? (Y/N)**

Yes, the Agency has the ability to request a restructuring or realignment of its appropriation.

b) **In what year did the agency last request a restructuring or realignment of its General Appropriations Act programs? (see example of what is meant by General Appropriations Act programs to the right)**

In September 2016 as part of the budget plan for FY 2018, the department requested some realignment of the Agency's appropriation budget to better align the budget authority by the projected level of spending.

c) **What was requested and why?**

The realignment was requested to better align the Agency's base funds. A request was made to move $2.4 million in state funds appropriated for service and fringe programs to other service areas within the Agency's budget. The realignment properly allocates the base funds already appropriated for the Agency to the needed service area.

d) **Was the request granted? (Y/N) If no, who denied the request and why was it denied?**

This requested realignment is in both the House and Senate versions of the 2018 budget plan thus far through the budget process.

e) **Would an individual be able to clearly see how much the agency is spending toward each of the goals in its Strategic Plan by looking at the hierarchy of agency General Appropriation Act programs? (Y/N)**

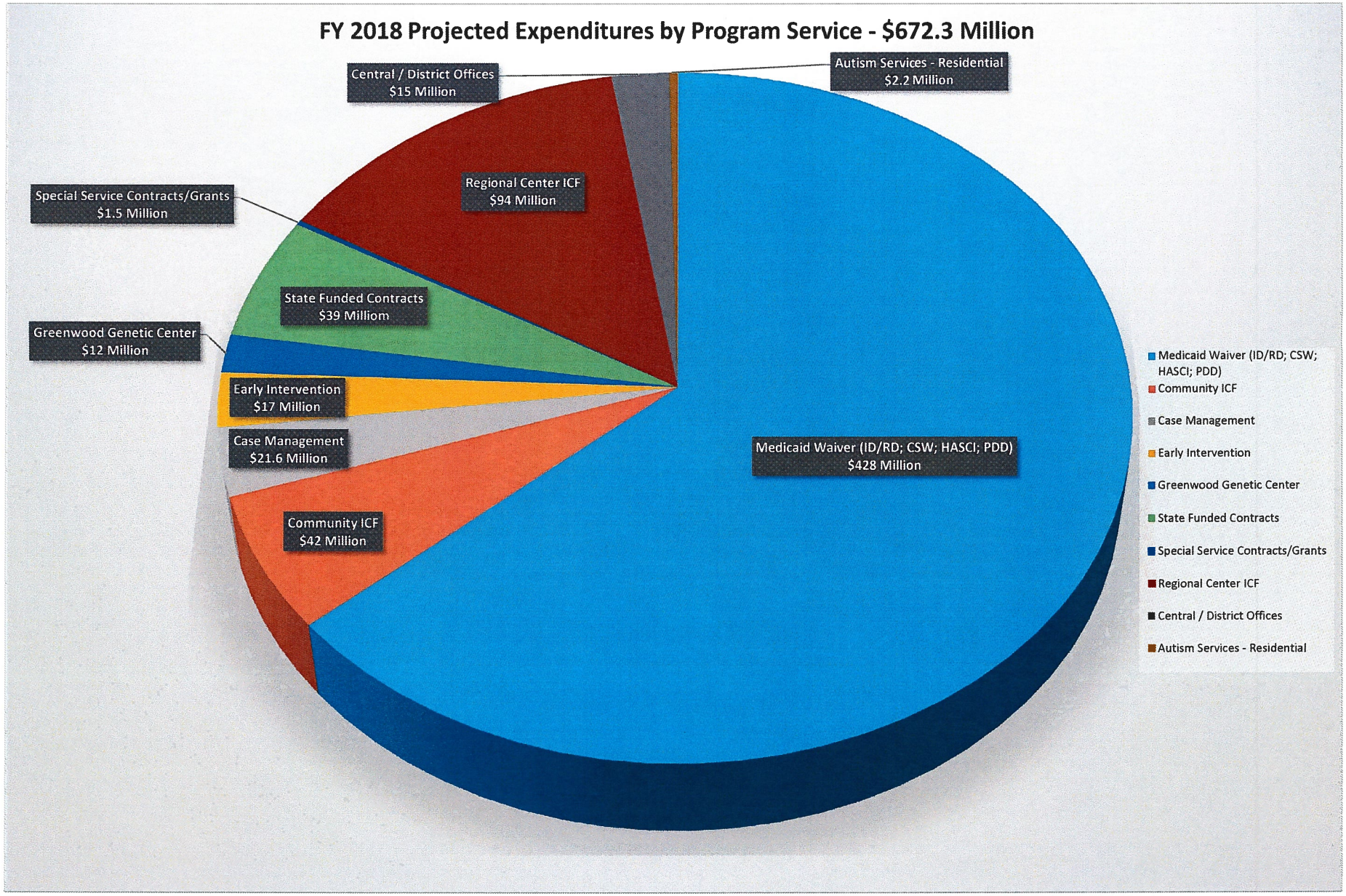
Yes, an individual would be able to clearly see how much the agency is spending towards the strategic plan goals.

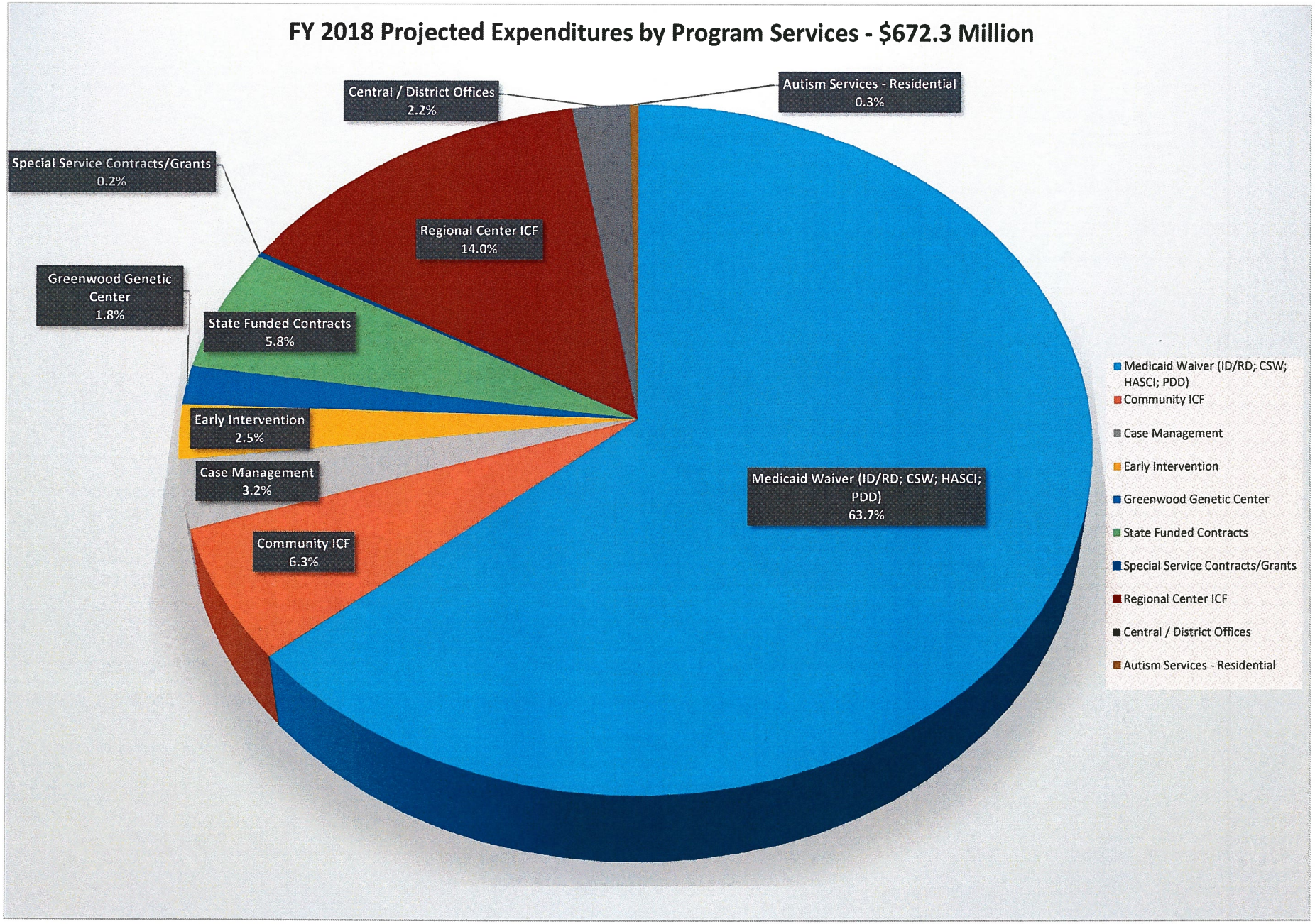
f) **Could the agency make a request to the Executive Budget Office, Senate Finance Committee, and House Ways and Means Committee to realign or restructure its General Appropriations Act programs so that the agency's goals from its strategic plan were the highest level of its General Appropriations Act programs in the hierarchy? (Y/N)**

Yes

South Carolina Department of Disabilities and Special Needs
Total and State Expenditures for Fiscal Years 2017, 2016 and 2015

Program/Title	*FY 2016-17 Expenditures*		*FY 2015-16 Expenditures*		*FY 2014-15 Expenditures*	
	TOTAL	General	TOTAL	General	TOTAL	General
I. Administration	**$ 6,875,549**	$ 4,325,212	**$ 6,146,063**	$ 4,063,329	**$ 6,208,162**	$ 4,066,424
II. Program & Services:						
II. A. Prevention Program	**$ 11,991,131**	$ 3,934,300	**$ 10,366,281**	$ 3,434,300	**$ 9,666,376**	$ 2,934,300
II. B. Intellectual Disabilities - Family Support Program	**$ 173,038,597**	$ 65,598,921	**$ 155,399,994**	$ 75,536,933	**$ 152,589,797**	$ 55,824,647
II. C. Autism Family Support Program	**$ 18,464,256**	$ 7,416,667	**$ 17,149,228**	$ 9,508,157	**$ 16,362,607**	$ 10,530,415
II. D. Head & Spinal Injury Family Support Program	**$ 18,317,081**	$ 9,963,656	**$ 17,231,035**	$ 10,153,601	**$ 14,606,766**	$ 6,858,471
II. E. Intellectual Disability Community Residential Program	**$ 308,455,302**	$ 82,000,178	**$ 290,029,688**	$ 58,163,074	**$ 272,859,478**	$ 71,966,398
II. F. Autism Community Residential Program	**$ 13,518,539**	$ 4,519,189	**$ 20,758,405**	$ 4,798,508	**$ 21,209,226**	$ 4,906,382
II. G. Head & Spinal Cord Injury Community Residential Program	**$ 4,062,845**	$ 944,691	**$ 3,413,491**	$ 1,042,113	**$ 2,818,161**	$ 940,024
II. H. Regional Centers Residential Program	**$ 68,045,706**	$ 40,555,939	**$ 65,130,696**	$ 38,402,578	**$ 65,245,508**	$ 37,902,960
III. Employee Benefits	**$ 25,774,998**	$ 20,002,096	**$ 24,943,015**	$ 19,541,194	**$ 24,862,095**	$ 18,892,260
IV. Non-Recurring Appropriations:						
Lander Equestrian Center	**$ 300,000**	$ 300,000	**$ -**	$ -	**$ 300,000**	$ 300,000
Autism Services			**$ 1,000,000**	$ 1,000,000	**$ 1,150,000**	$ 1,150,000
Special Needs Park - Savannah's Playground - Myrtle Beach			**$ 100,000**	$ 100,000	**$ 200,000**	$ 200,000
Charles Lea Center					**$ 100,000**	$ 100,000
Total Agency Expenditures	**$ 648,844,004**	$ 239,560,849	**$ 611,667,896**	$ 225,743,787	**$ 588,178,176**	$ 216,572,281


FY 2018 Projected Expenditures by Program Service - $672.3 Million
Central / District Offices $15 Million
Autism Services - Residential $2.2 Million
Regional Center ICF $94 Million
Special Service Contracts/Grants $1.5 Million
State Funded Contracts $39 Million
Greenwood Genetic Center $12 Million
Early Intervention $17 Million
Case Management $21.6 Million
Community ICF $42 Million
Medicaid Waiver (ID/RD; CSW; HASCI; PDD) $428 Million
Medicaid Waiver (ID/RD; CSW; HASCI; PDD)
Community ICF
Case Management
Early Intervention
Greenwood Genetic Center
State Funded Contracts
Special Service Contracts/Grants
Regional Center ICF
Central / District Offices
Autism Services - Residential


FY 2018 Projected Expenditures by Program Services - $672.3 Million
Central / District Offices 2.2%
Autism Services - Residential 0.3%
Special Service Contracts/Grants 0.2%
Regional Center ICF 14.0%
Greenwood Genetic Center 1.8%
State Funded Contracts 5.8%
Early Intervention 2.5%
Case Management 3.2%
Community ICF 6.3%
Medicaid Waiver (ID/RD; CSW; HASCI; PDD) 63.7%
Medicaid Waiver (ID/RD; CSW; HASCI; PDD)
Community ICF
Case Management
Early Intervention
Greenwood Genetic Center
State Funded Contracts
Special Service Contracts/Grants
Regional Center ICF
Central / District Offices
Autism Services - Residential

Provider Funding

High-Level View of DDSN's Mission in Relation to County DSN Boards, QPL Providers, and DDSN Direct Services
Residential Habilitation Service Models Listing
Funding for Services (Directive 250-10-DD)
Cost Principles for Grants and Contracts with Community Providers (Directive 250-05-DD)
Calculation of Room and Board (Directive 250-09-DD)
Provider Contract Services by County

High-Level View of DDSN's Mission in Relation to County DSN Boards, QPL Providers & DDSN Direct Services

MISSION STRATEGY & PLANNING -----DDSN Establishes Statewide Service Delivery System

Mission

- Establish and maintain a Statewide Service Delivery System designed to meet Intellectually Disabled & Developmentally Disabled (ID/DD) consumers' needs with a focus on consumer choice, serving consumers in the least restrictive environment, and providing a safe and healthy environment, while also being cost/effective to maximize funds available to serve consumers waiting for services;

Strategy & Planning for a Statewide ID/DD Service Delivery System

- Managed by 163 DDSN employees; 151 (93%) in Columbia Central Office & 12 (7%) in two field divisions at a cost of $15 million (2.2% of total agency costs);
- Operate consumer eligibility for services administered through DDSN with appeal process;
- Operate consumer eligibility for the Medicaid Home & Community Based Services (HCBS) waiver with appeal process & manage entire Medicaid HCBS system, to include a new centralized review process to improve consumer equity and cost control;
- License providers serving Medicaid HCBS and DDSN consumers;
- Establish administrative and operational policies for DDSN providers serving HCBS and DDSN consumers;
- Operate a centralized information technology platform for the service delivery system;
- Provide training and technical assistance to providers;
- DDSN directly operates the Intermediate Care Facilities (ICF) located in four regional centers and four residences for Autism consumers transferred from the Department of Mental Health;
- Establish and obtain budget for the Statewide ID/DD Service Delivery System through coordination with SC DHHS, Governor's Office, and Legislative approval for appropriations;
- Operate provider payment system, to include the band payment system for DSN County Boards and fee-for-service for QPL providers;
    - Band payment system for DSN Boards initiated in 1998 using a capitated model emphasizing statewide delivery service & financial stability through prospective payments, one-time grants, residential capital funding, DDSN bills Medicaid & assumes Medicaid ineligible/audit risk, 30 day residential vacancy funding, and 80% attendance allowance in adult day & residential. Currently under review based on variety of issues.

MISSION EXECUTION ---- Procure Service Delivery Primarily through Contracts
$672.3 million current FY 17/18 budget

Contract Providers through DSN County Boards (85%) and QPLs (15%)							DDSN		
Medicaid Waivers (ID/RD; HASCI; PDD; CSW)	Community ICFs	Case Manage-ment	Early Intervention	Green-wood Genetics	Special Service Contracts	State Funded Contracts (direct service)	Regional Centers ICFs	Autism Resident Services	DDSN General & Program Overhead
Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Non-Med.	Medicaid	Medicaid	Medicaid
$428 mil	$42 mil	$21.6 mil	$17 mil.	$12 mil.	$1.5 mil.	$39 mil.	$94 mil.	$2.2 mil.	$15 mil.
63.7%	6.3%	3.2%	2.5%	1.8%	0.2%	5.8%	14.0%	0.3%	2.2%
83.5%							**16.5%**		

Waiver Waiting Lists

MISSION ACCOUNTABILITY ---- DDSN Oversight & Contract Management of Providers

DDSN

- DDSN audit of provider financial systems, to include individual consumer accounts;
- Assurance of financial condition through required annual external certified financial audit with additional agreed upon procedures;
- Abuse, Neglect, and Exploitation Reporting System;
- Critical Incident Reporting System;
- Annual survey of participants using the National Core Indicators;
- Annual licensing of residential facilities and day centers; and
- Unannounced independent on-site quality reviews to measure provider contract compliance and contract outcomes.

DDSN & DHEC

Both inspect CRCF residences (6% total residences)

DHEC

Inspects Regional Centers

Residential Habilitation Service Models Listing

Within the DDSN Provider Network, the following six (6) community residential models are used to provider services:

Community Training Home-I Model (Foster Care)

In the Community Training Home-I Model, personalized care, supervision and individualized training are provided, in accordance with a service plan, to a maximum of two (2) people living in a support provider's home where they essentially become one of the family. Support providers are qualified and trained private citizens. CTH-I homes meet Office of State Fire Marshal Foster Home Regulations.

Community Training Home-II Model

The Community Training Home-II Model offers the opportunity to live in a homelike environment in the community under the supervision of qualified and trained staff. Care, supervision and skills training are provided according to individualized needs as reflected in the service plan. No more than four (4) people live in each residence. CTH-II homes located in one and two family dwellings, as well as townhouses, shall meet International Residential Code (IRC) standards. CTH-II homes located in apartments shall comply with R2 criteria of the International Building Code (IBC). CTH-II residential models are not care facilities.

Community Integrated Residential Services (CIRS)

This model was created to promote personal development and independence in people with disabilities by creating a customized transition from 24-hour supervised living to a semi-independent living arrangement. Participants are responsible for selecting support providers, house mates and housing. A lease support agreement connects participants with landlords and provides an extra level of support which might be needed to facilitate a positive landlord/tenant relationship. CLOUD homes located in one and two family dwellings, as well as townhouses, shall meet International Residential Code (IRC) standards. CLOUD residential models are not care facilities.

Supervised Living Model-II

This model is for people who need intermittent supervision and supports. They can handle most daily activities independently but may need periodic advice, support and supervision. It is typically offered in an apartment setting that has staff available on-site or in a location from which they may get to the site within 15 minutes of being called, 24 hours daily. SLP-II homes located in one and two family dwellings, as well as townhouses, shall meet International Residential Code (IRC) standards. SLP-II homes located in apartments shall comply with R2 criteria of the International Building Code (IBC). SLP-II residential models are not care facilities.

Supported Living Model-I

This model is similar to the Supervised Living Model-II; however, people generally require only occasional support. It is offered in an apartment setting and staff are available 24 hours a day by phone. SLP-I homes located in apartments shall comply with R2 criteria of the International Building Code (IBC). SLP-I residential models are not care facilities.

Community Residential Care Facility (CRCF)

This model, like the Community Training Home-II Model, offers the opportunity to live in the community in a homelike environment under the supervision of qualified, trained caregivers. Care, supervision and skills training are provided according to identified needs as reflected in the service plan. See SC DHEC Regulation Number 61- 84 for specific licensing requirements. Note: The DHEC licensing requirements must be met by a CRCF provider who wishes to become a residential habilitation provider using their CRCF as the setting.

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Reference Number:	250-10-DD
Title of Document:	Funding for Services
Date of Issue:	May 1, 2009
Effective Date:	May 1, 2009
Last Review Date:	January 9, 2017
Date of Last Revision:	January 9, 2017 **(REVISED)**
Applicability:	All DSN Boards, All Financial Managers, All Contracted Service Providers

I. PURPOSE

This document describes the system for funding services used by the South Carolina Disabilities and Special Needs (DDSN). In all cases, DDSN is required by law to serve consumers in the least restrictive environment. Funding for services is subject to changes in DDSN's budget.

II. FINANCIAL MANAGERS

In their administrative role, the DSN Boards, and those grandfathered in as DSN Boards, act as Financial Managers for the majority of community-based services. If approved through a Request For Proposal (RFP) process through the State Fiscal Accountability Authority (SFAA), a Self-Directed Support Corporation (SDSC) may also act as a Financial Manager for the people for whom the SDSC was established. Funds for community-based services are managed by the applicable county DSN Board or SDSC. The DSN Board either provides the service itself or subcontracts with a qualified provider for the services rendered. The SDSC would not provide service itself, but rather arrange for services and pay the service provider. DDSN, at its option, may contract directly with and pay qualified providers. Qualified providers are those service providers who are qualified through the State Medicaid Agency's service provider enrollment process or through a request for proposal (RFP) process in place through the State Procurement

Office (SPO). Contracted qualified providers have the option of billing Medicaid directly for Medicaid eligible consumers.

DDSN allocates funds for services in one of two ways:

(1) Through a capitated system based on funding bands, or
(2) Through a non-capitated fee for service system.

III. CAPITATED SYSTEM

The funding band system is a budgeting system that assigns one of twelve different funding levels to consumers based on their needs. The amount of funding assigned to each level is an average cost of services in each level. Each consumer's needs are different and, as such, the associated costs to fund services to meet those needs vary. The amount of funding attached to a given funding level is not an entitlement; all services provided to a consumer must be based on assessed needs and properly justified in their approved plan. Financial Managers are expected to utilize all available funds to meet the needs of all consumers to whom they provide services. Financial Managers are required to inform DDSN when funds are not available to address identified needs listed in a consumer's current plan. Additional funding is possible through an outlier request system when a consumer's circumstances and needs are substantially higher than the average. Certain threshold levels must be reached before outlier funding may be considered. The outlier request system is described in detail in DDSN Directive 250-11-DD: Outlier Funding Request System – Capitated Funding System.

There are nine (9) residential budgeting levels and three (3) non-residential (persons living at home) budgeting levels. A description of each level follows. The current funds allocated for each level and the outlier thresholds are listed in Attachment A: Statewide Individual Funding Levels.

A. Residential

Residential funding bands are sufficient on average to cover the following services:

- Residential Habilitation
- Day Services
- Employment Services
- Enhanced Supports

The following enhanced supports are included as part of the residential habilitation service definition. The cost for these enhanced supports is included in the residential habilitation reimbursement rate. Payment for the following enhanced supports is the responsibility of the residential habilitation service provider:

- Psychological Services, which includes counseling and behavior support services

People in residential placements can also receive the following enhanced supports. These enhanced supports are not included as part of residential habilitation service definition. The cost for these services is included in the residential funding band, but is not included in the residential habilitation reimbursement rate. As such, the contracted residential service provider is not responsible for the cost of the following services: (Please note that Financial Managers receiving the funding band for residential consumers are responsible for the cost of the following services.)

- Adult Companion Services (only allowed if consumer is living in an SLP-I)
- Adult Dental
- Adult Vision
- Audiology
- Assistive Technology
- Prescription Drugs (limit of two (2) over the Medicaid State Plan limit)

Transportation to/from day supports is the responsibility of the residential service provider.

The Residential Funding Bands are as follows:

BAND R **Individuals Moving from a Regional Center to the Community**

Usually consumers residing in:

- ICFs/IID
- Community Residential Care Facility – Higher Needs
- Community Training Home II – Higher Needs

BAND H **Residential Higher Needs**

Usually consumers residing in:

- ICFs/IID
- Community Residential Care Facility – Higher Needs
- Community Training Home II – Higher Needs

BAND G **Residential Lower Needs**

Usually consumers residing in:

- Community Residential Care Facility – Lower Needs
- Community Training Home II – Lower Needs

BAND F **Supported Residential – Enhanced Community Training**

Usually consumers living in Enhanced Community Training Home I

BAND E **Supported Residential – Community Training Home-I**

Usually consumers living in Community Training Home-I

BAND D **Supported Residential – Supervised Living Program I**

Usually consumers living in Supervised Living Program I

BAND C **Supported Living – Supervised Living II**

Usually consumers living in Supervised Living Program II

BANDS K and L **CIRS**

Usually consumers living in a Community Inclusive Residential Supports Placement.

B. Non-Residential, "At Home" Levels

"At home" funding bands are sufficient on average to cover the following services:

- Day Services
- Employment Services

Transportation to/from day supports for consumers living at home (Bands A, B and I consumers) is the responsibility of the day supports provider.

The Non-Residential, "At Home" Funding Bands are as follows:

BAND B **Family Supports – Home Supports - Intellectual Disabilities/Related Disabilities Home and Community Based Waiver**

Consumers who:

- Reside at home, and
- Are in the IID/RD Home and Community Based Waiver, and
- Receive a combination of Day Services, Employment Services, and/or Enhanced Supports.

Enhanced Supports that may be received include:

- Adult Companion Services
- Adult Dental
- Adult Vision
- Audiology

- Assistive Technology
- Nursing
- Personal Care I
- Personal Care II
- Prescription Drugs (limit of two (2) above State Medicaid Plan)
- Psychological Services, including counseling, and behavior support services
- Respite

BAND I **Family Supports – Home Supports - Community Supports Home and Community Based Waiver**

Consumers who:

- Reside at home, and
- Are in the Community Supports Home and Community Based Waiver, and
- Receive a combination of Day Services, Employment Services, and/or Enhanced Supports.

Enhanced Supports that may be received include:

- Personal Care I
- Personal Care I
- Psychological Services, including counseling, and behavior support services
- Respite

BAND A **State Funded Community Supports**

Consumers who reside at home and are not enrolled in a waiver.

There is a Budget Calculator on DDSN's Business Tools Portal which lists available services.

C. Outlier Thresholds

When a consumer's circumstances and needs are substantially higher than the average, additional funding is possible through an outlier request system.

Residential Band H: Consumers whose budgets exceed the outlier threshold may be considered for outlier status.

At Home Band B: Consumers whose budgets exceed the outlier threshold may be considered for outlier status. The majority of the approved outliers are for people with high levels of nursing service needs.

When a consumer is given outlier status, the Financial Manager is given funding in addition to the funding band to cover the cost of the approved higher level of services. If the consumer is designated as needing a residential outlier and is served by a contracted qualified provider, the additional approved funding will be added to the contracted qualified provider's reimbursement rate.

IV. NON-CAPITATED SYSTEM

The non-capitated system pays the Financial Manager for specific types of services, rather than for groups of services. The services include:

- For people with Intellectual Disabilities – Related Disabilities or Autism: Case Management, Respite (for those not enrolled in the Home and Community Based Waivers), Individual Rehabilitation Supports, and Early Intervention.
- For people with Head and Spinal Cord Injuries: Case Management, Supported Employment, Individual Rehabilitation Supports, Residential Habilitation, Day Habilitation, Prevocational Services, and Respite.

V. HOW CHOICE WORKS WITH THE FUNDING SYSTEM

A Request For Proposal process is in place through the State Procurement Office to increase the choices available to consumers by identifying and approving providers of services. When a consumer is satisfied with the current services and supports he/she is receiving, it is likely that no changes will be made. However, when services are necessary, justified by an assessment, included in the consumer's approved plan, and the consumer desires another service provider, the consumer may select another service provider from the Qualified Provider List. Funding follows the consumer if he/she elects to change service provider. If another service is appropriate to meet a consumer's needs, he/she may opt for the other service and then select a contracted qualified provider to provide the new service.

If a consumer chooses another contracted qualified provider, the Financial Manager will:

- Document the consumer's/guardian's choice of a qualified provider;
- Obtain the consumer's/guardian's permission (through signature) to transfer the original file and related information specific to the service being delivered; and
- Transfer the original file and all related information to the selected qualified provider.

The Financial Manager will receive the band payment or other funding allocated to the consumer. If the qualified provider elects not to bill Medicaid directly and instead bills the Finance Manager for Medicaid eligible consumers, the Financial Manager will contract with and pay the qualified provider upon delivery of service and submission of appropriate service reporting information including bills presented. If the qualified provider chooses to bill Medicaid directly for those consumers who are Medicaid eligible, the State Medicaid Agency will make payments directly to the provider of a covered service furnished to an eligible consumer in accordance with Section 1902(a)(32) of the Social Security Act. Any amounts paid by the State Medicaid Agency to a qualified provider will be deducted from the funding band payment to the Financial Manager. DDSN may also contract directly with and pay qualified providers.

VI. ASSIGNMENT OF FUNDING BANDS

A. Analyzing the Data

Every month the Cost Analysis Division will download data from three (3) of DDSN's mainframe applications:

- Consumer Data Support System (CDSS); and
- Service Tracking System (STS); and
- Waiver Tracking System (WVR).

The Cost Analysis Division will run different queries and reports and analyze the data.

- Residential reports will be produced to determine who has moved into or out of a residential placement and if a funding band needs to be assigned or changed. In addition, the Cost Analysis Division will sign off on all residential admission/discharge/transfer forms. The form with all approvals will be scanned into a PDF file and sent to the residential service provider. The form indicates what funding band will be assigned to the consumer when he/she moves. If the consumer is moving to a service provider from the Qualified Provider List, the form will also indicate what rate will be paid.

- Reports will be produced to determine which consumers have been enrolled in an "at-home" family support waiver slot and have an approved budget. The reports will also indicate which consumers have been terminated from an "at home" family support slot. Band B funding is provided from the month the waiver budget starts through the month the waiver budget ends. If the consumer attends center-based day supports and that service is in his/her waiver budget, a day program slot will be awarded.

If the consumer initially does not receive center-based day supports (a slot was not awarded), but later started receiving center-based day supports, a day program can be requested at that time.

- Other reports will indicate which consumer living "at home" receives day supports funded either by facility-based rehabilitation support, state funds, or other. It will indicate who has been admitted or discharged from center-based supports and supported employment. Consumers' Band A funding designations will be made as appropriate. This does not affect the amount of funding received, but it does indicate if a provider has vacancies or is over-enrolled.

B. New Residential Admissions

Consumers moving from "at home" in the community will be automatically funded at the following levels unless otherwise justified through review of the available needs assessments.

- Band G level for ICF/IID, CRCF, and CTH-II placements; or
- Band C level for SLP-II placements; or
- Band D level for SLP-I placements; or
- Band E level for CTH-I placements; or
- Band F level for Enhanced CTH-I placements

In accordance with DDSN Directive 502-01-DD: Admissions/Discharge of Individuals to/from DDSN Funded Community Residential Settings, only those consumers pre-approved by DDSN officials for residential admission will be funded.

Funding Band Changes: If the residential service provider feels a different funding band level is warranted, the residential service provider must provide detailed justification along with supporting documentation (behavioral support plan, behavioral data, the annual plan or Needs Assessments). This justification must be submitted to the appropriate DDSN District Office along with the Community Residential Admissions/Discharge Report. This information, along with any other information DDSN may have, will be staffed and a determination will be made.

Outlier Funding: If the residential service provider feels outlier funding is warranted, the residential service provider must submit the "Initial Request for Outlier Funding" to the appropriate DDSN District Office.

C. Residential Transfers

Consumers moving from DDSN Regional Centers or Alternative Placements will be funded at the following levels, unless otherwise indicated through internal review of assessments of need:

- Band H level for ICF/IID, CRCF, and CTH-II placements; or
- Band C level for SLP-II, Band D level for SLP-I, Band E level for CTH-I, and Band F level for Enhanced CTH-I.

SLP-II, SLP-I, CTH-I and Enhanced CTH-I consumers moving to more restrictive placements in CTH-II's, CRCF's, and ICFs/IID will be funded at the Band G level unless otherwise justified.

Consumers moving to SLP-II, SLP-I, CTH-I, and Enhanced CTH-I placements will be funded at the funding band level appropriate for that type of residential placement

Tom Waring
Associate State Director-Administration
(Originator)

Beverly A.H. Buscemi, Ph.D.
State Director
(Approved)

Related Directives: 250-11-DD
502-01-DD

To access the following attachment, please see the agency website page "Attachments to Directives" under this directive number at: http://www.ddsn.sc.gov/about/directives-standards/Pages/AttachmentstoDirectives.aspx.

Attachment: Statewide Individual Funding Levels

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Reference Number:	250-05-DD
Title of Document:	Cost Principles for Contracts and Grants with Contracted Providers
Date of Issue:	April 1, 1989
Effective Date:	April 1, 1989
Last Review Date:	November 3, 2016
Date of Last Revision:	November 3, 2016 **(REVISED)**
Applicability:	All DSN Boards, All Financial Managers, All Contracted Service Providers

I. PURPOSE

This directive establishes principles for determining costs of services provided under contracts, grants and other agreements between the South Carolina Department of Disabilities and Special Needs (DDSN) and Disabilities and Special Needs Boards, Financial Managers, and other contracted service providers hereafter referred to collectively as "providers." The principles are designed so that the state and federal governments bear their fair share of costs except where restricted or prohibited by law. The principles do not attempt to prescribe the extent of funding for contracts, grants, or other agreements. Provisions for profit or other increments above cost are outside the scope of this directive.

II. APPLICABILITY

These principles shall be used in determining the costs of work performed by providers under contracts, grants, and other agreements issued by DDSN. All of these instruments are hereafter referred to as "awards."

III. GENERAL PRINCIPLES

A. Basic Considerations

1. Composition of Total Cost

The total cost of a service is the sum of the allowable direct and allocable indirect costs less any applicable credits. Applicable credits would include cost reductions such as purchase discounts, rebates or allowances, insurance recoveries, and adjustments of overpayments.

2. Allowable Costs

To be allowable under an award, costs must meet all of the following general criteria. They must:

a. Be reasonable for the performance of the award and be allocable thereto under these principles.

b. Conform to any limitations or exclusions in the award or as stated in Attachment 1.

c. Be consistent with policies and procedures that apply uniformly to both state and federally financed/other activities of the organization.

d. Be accorded consistent treatment.

e. Be determined in accordance with generally accepted accounting principles.

f. Be adequately documented.

g. In the case of Medicaid (Title XIX, Social Security Act) funded programs, be consistent with applicable federal regulations and guidelines set forth in the Health Care Financing Administration's Provider Reimbursement Manual and the South Carolina State Medicaid Plan. For Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) contracts with DDSN, the federal regulations for ICF/IID shall take precedence over the State Medicaid Plan, as interpreted by DDSN.

3. Reasonable Costs

A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by a prudent person under the prevailing

circumstances at the time the decision was made to incur the cost. Reasonable costs would be those required to be incurred by standards set by DDSN and program requirements established by the federal government for Medicaid-funded programs, as interpreted by DDSN. In determining the reasonableness of a given cost, consideration should be given to:

a. Whether the cost is of a type recognized in standards, regulations, and other guidelines as ordinary and necessary for the operation of the organization or the performance of the award.

b. The restraints or requirements imposed by such factors as generally accepted sound business practices, arms-length bargaining, federal and state laws and regulations, and terms and conditions of the award.

c. Whether the individuals concerned acted with prudence in the circumstances, considering their responsibilities to the organization, its members, employees and consumers, the public at large, and the government.

d. Significant deviations from the established practices of the organization which may unjustifiably increase the award costs.

4. Allocable Costs

a. A cost is allocable or assignable to an award in accordance with the relative benefits received. A cost is allocable to a DDSN award if it is treated consistently with other costs incurred for the same purpose in like circumstances and if:

i. It is incurred specifically for the award, or

ii. It benefits both the award and other work and can be distributed in reasonable proportion to the benefits received, or

iii. It is necessary to the overall operation of the organization, although a direct relationship to any particular award cannot be shown.

b. Any cost allocable to a particular award or other cost objective under these principles may not be shifted to other DDSN awards to overcome funding deficiencies or to avoid restrictions imposed by law or by the terms of the award.

B. Direct Costs

1. Direct costs are costs that can be identified specifically with a particular award.

2. Any direct cost of a minor amount may be treated as an indirect cost for reasons of practicality when the accounting treatment for such cost is consistently applied to all final cost objectives. For these minor cost areas, the accounting effort in charging costs directly is not commensurate to the results achieved.

C. Indirect Costs

1. Indirect (overhead) costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular award or other final cost objective. Direct costs of minor amounts may be treated as indirect costs under the conditions described in paragraph B. 2 above. After direct costs have been determined and assigned directly to awards or other work as appropriate, indirect costs are those remaining to be allocated to benefiting awards. A cost may not be allocated to an award as an indirect cost if any other cost incurred for the same purpose, in like circumstances, has been assigned to an award as a direct cost.

2. Because of the diverse characteristics and accounting practices of provider organizations, it is not possible to specify the types of costs which may be classified as indirect costs in all situations. However, typical examples of indirect costs for provider organizations may include the costs of operating and maintaining shared facilities and general administrative costs for executive directors, financial officers and shared secretarial staff, including salaries, fringe benefits and support costs.

IV. COST ALLOCATION PROCEDURES

A. Definitions

1. Cost Allocation Plan

A cost allocation plan is a document explaining the system used by a provider to measure and assign costs to awards and other cost objectives. When indirect costs are distributed among two (2) or more programs, the plan must explain methodology used to distribute these costs.

2. Cost Center

A cost center is a separate accounting unit to which costs are charged for an organization. A cost center may be established for each award or for each indirect cost center which needs to be allocated. A final cost center

is one established for an award: the costs charged there are not further charged or allocated. An intermediate cost center is an accounting unit whose costs are further allocated to other cost centers. For example, if operational and maintenance costs for a shared building are to be allocated or charged out, the separate cost center established for these costs is known as "intermediate."

B. Plan Preparation Requirements

Each provider shall maintain a cost allocation plan in accordance with the principles stated in this directive. The plan must include adequate narratives and schedules to explain the methodology used to distribute shared costs. The plan must include a detailed budget for all costs that are allocated. Any changes in methodology to cost allocation plans must be approved in advance by DDSN.

C. Allocation Methods

1. Simplified Allocation Method

a. Applicability:

When a provider does not operate Medicaid-funded programs, the simplified allocation method may be used.

b. Procedure for Charging Joint Costs:

Under this method all costs of the organization are treated as direct costs with the exception of general administrative costs. Joint shared costs such as rent, operation and maintenance of facilities, and telephone costs are prorated individually as direct costs to each award using the base most appropriate to the particular cost being prorated. Examples of allocation bases are listed in Attachment 2 to this directive.

c. Treatment of Indirect Costs:

Under the simplified method, indirect costs include only general administrative costs including costs of the Executive Director's office, accounting and clerical services, audit costs, and other costs not readily assignable to awards. These indirect costs are allocated to awards on the basis of total direct costs of the awards.

d. Plan Preparation Steps:

The following steps should be followed in preparing a cost allocation plan using the simplified method.

i. Establish clearly definable cost centers with the advice of auditors.

ii. Identify cost centers as either final or intermediate. Final cost centers are client service programs usually with separate contracts or grants. Charges to intermediate cost centers (for example: administration) must be further spread through the cost allocation plan.

iii. Estimate the total annual costs for all cost centers based on prior year actual figures or the current year budget. For contracts based on standardized award amounts, direct program costs – not DDSN established payment levels – should be used for the purpose of cost allocation.

iv. Determine the most reasonable allocation basis for each intermediate cost center. The bases chosen should closely reflect benefits received from service areas and also be feasible in terms of data collection. For allocating administrative and general management costs, including costs of DSN board executive director offices, total direct costs should generally be used. A list of possible allocation bases can be found in Attachment 2 to this directive.

v. Allocate all intermediate cost centers to all final cost centers that they benefit.

vi. Total the costs for all final cost centers. The totals represent the estimated full costs of operating the service programs.

2. Step-Down Allocation Method

a. Applicability:

When a provider operates Medicaid-funded facilities, the step down allocation method must be used. Providers without Medicaid-funded programs may use this method if it will make a significant difference in the allocation of indirect costs.

b. Overview of Plan Preparation:

Under this method of plan preparation, joint shared costs are pooled into intermediate cost centers. A separate intermediate cost center should be established for each cost area to be separately allocated. Typical

intermediate cost centers for DSN Boards include but are not limited to the following:

- Administration,
- Transportation,
- Facility costs including rent, utilities, and maintenance, and
- Day program costs when the day program serves the residential facilities funded by Medicaid.

Each intermediate cost center should be allocated to all other benefiting cost centers whether they are final or intermediate.

Three basic rules govern the allocation process:

i. Allocate first the cost centers benefiting the greatest number of other cost centers.

ii. A cost center should not be allocated back to itself.

iii. Once an intermediate cost center is allocated, it should receive no further allocations.

c. Plan Preparation Steps:

The following steps should be followed in preparing a cost allocation plan using the step-down method.

i. Establish clearly definable cost centers with the advice of auditors.

ii. Identify cost centers as either final or intermediate. Final cost centers are client service programs usually with separate contracts. Charges to intermediate cost centers must be further spread through the cost allocation plan.

iii. Estimate the total annual costs for all cost centers, based on prior year actual figures or the current year budget. For contracts based on standardized award amounts, direct program costs – not DDSN established payment levels – should be used for the purpose of cost allocation.

iv. Determine the order in which the intermediate cost centers should be allocated. Those centers that benefit the greatest number of other cost centers should generally be allocated first.

v. Determine the most reasonable allocation basis for each intermediate cost center. The bases chosen should closely reflect benefits received from service areas and also be feasible in terms of data collection. For allocating administrative and general management costs (home office costs), total direct costs must be used for Medicaid purposes when the organization provides a variety of services in addition to residential programs. A list of possible allocation bases can be found in Attachment 2 to this directive.

vi. Begin with the first intermediate cost center and allocate its cost to all other cost centers including intermediate and final. The costs of the cost center should not be allocated back to itself.

vii. Allocate, in succession, each of the other intermediate cost centers to all other cost centers except for centers that have already been allocated. Each cost center allocated is "closed out" and receives no further allocations. Continue the process until the costs of all intermediate cost centers are allocated to final cost centers.

viii. Total the costs for all final cost centers. The totals represent the estimated full costs of operating the service programs.

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(Originator)

Beverly A.H. Buscemi, Ph.D.
State Director
(Approved)

To access the following attachments, please see the agency website page "Attachments to Directives" under this directive number located at http://www.ddsn.sc.gov/about/directives-standards/Pages/AttachmentstoDirectives.aspx.

Attachment A: Limitations on Costs for Awards with DDSN
Attachment B: Sample Allocation Bases for Shared Cost Areas

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Reference Number:	250-09-DD
Title of Document:	Calculation of Room and Board for Non-ICF/IID Programs
Date of Issue:	May 1, 2009
Effective Date:	July 1, 2014
Last Review Date:	December 16, 2015
Date of Last Revision:	December 16, 2015 **(REVISED)**
Applicability:	All DSN Boards, All Financial Managers, All Contracted Residential Service Providers.

I. PURPOSE

The purpose of this document is to state policy and procedures for calculating room and board charges for DDSN non-ICF/IID programs and applying consumers' income toward room and board.

II. POLICY

All DSN Boards and QPL Residential Service Providers must establish an official policy for charging consumers for the cost of room and board. This policy must address at a minimum both applying consumers' income toward the cost of room and board and the determination of the room and board charge. The monthly charge must be fair and equitable. In no circumstance may the charge for room and board exceed the actual cost of room and board.

DSN Boards and QPL Residential service Providers will review their room and board costs and room and board charges at least on an annual basis.

Room and board calculations will be based on the previous fiscal years audited financial statements. Room and Board calculations must be submitted to the Cost Analysis Division by November 30 each year. Approved rates will be effective January 1 of the following year.

All room and board calculations and any subsequent changes to the policies must be submitted on one of the attached worksheets in excel format (no PDF files will be accepted), and approved by the Director of Cost Analysis or his/her designee.

III. PROCEDURES

1. Calculating Room and Board

   Consumer Income

   Both unearned and earned income can be applied toward the cost of room and board. Consumers must retain the required minimum of $50 of unearned income per month and a minimum of 50% of earned income per month.

2. HUD Facilities

   RENT: No rent costs are included in the calculation for HUD facilities. HUD determines the "contract rent" for a HUD facility based on the costs of the HUD Corporation as submitted to HUD on Budget Worksheet HUD-92547-A.

   BOARD: For the "board" portion, the residential service provider may average the "board" costs across all HUD properties. The "board" costs are on the books of the residential service provider and will be limited to food, household supplies, and administration allocation.

3. Non-HUD Facilities

   Community Residential Care Facilities (CRCF) and Community Training Home II (CTH-II)

   The room and board charge may be residence specific or an average of all similar residences. For example: all CTH-II's in a specific geographical area.

   For non-HUD facilities, the residential service provider will calculate both the room (rental) component and board component of room and board.

   Room and Board charges to a consumer may not exceed the actual cost of room and board. Use of average costs fulfills this requirement.

   Examples of cost categories to consider:

Food	Water	Cable/Satellite Television
Telephone (consumer use)	Exterminating	Furnishings
Electricity	Trash Removal	Household Supplies
Property taxes and insurance	Yard Maintenance	
Maintenance (contractual and supplies)	Rental Charge - only depreciation and interest expenses may be used.	

Additional Costs: The cost of additional services consumers may request (e.g., separate telephone lines, cell phone and plans, or special cable services) will be the responsibility of the individual consumers in addition to the basic room and board charge.

4. Supplemental Nutrition Assistance Program (SNAP)

For consumers receiving SNAP, the amount of their individual SNAP benefit must be deducted from each individual's room and board charge before applying their income toward the approved room and board charge.

5. Supervised Living I and II

Consumers in these programs will be responsible for their own rent, utilities, food, furnishing, and household suppliers. The following cost elements will be included in the SLP-I/II rent charges for those consumers living in agency-owned housing:

- Rental charge based on depreciation expense or mortgage expense for provider owned units. Actual rental charge must be used for individually rented units.
- Maintenance of residence and grounds.
- Property taxes and insurance.
- Pest Control.

6. Community Training Home I (CTH-I)

CTH-I consumers must retain a minimum of $50.00 of unearned income and 50% of earned income. The remainder of their monthly benefits can be applied to room and board as long as the amount does not exceed the HUD published Fair Market Rental (FMR) for the county in which they reside.

7. Allocation of Administrative Costs

A portion of administrative costs must be allocated to room and board. The costs can only be allocated to costs actually incurred by the board/provider. To calculate percentage, divide total administrative costs by total organization operation costs.

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Attachment A: Calculating Room and Board Example (Non-HUD Property)
Attachment B: Calculating Room and Board Example (HUD Property)

SERVICE PROVIDER	# OF CONSUMERS	CONTRACT AWARD AS OF 2018
Early Intervention Contracts	3,725	$ 13,780,503
Special Grants	-	$ 16,855,078
Aiken County DSN Board	95	$ 456,809
Aldersgate	14	$ 829,843
Allendale/Barnwell DSN Board	190	$ 6,458,336
Anderson DSN Board	422	$ 9,418,759
ARC of the Midlands	20	$ 272,264
ARC of South Carolina	-	$ 45,573
Babcock Center	1,383	$ 37,082,246
Bamberg County	77	$ 2,704,549
Beaufort County	312	$ 6,053,011
Berkeley Citizens	390	$ 10,260,031
Bright Start	1,053	$ 4,041,632
Burton Center	421	$ 14,223,983
Calhoun County	129	$ 5,516,089
Care Focus	44	$ 3,964,768
Charles Lea Center	831	$ 29,757,955
Charleston County	771	$ 21,185,156
Cherokee County	162	$ 4,139,067
Chesco	371	$ 18,285,688
Chester/Lancaster Counties	260	$ 6,657,406
Clarendon County	151	$ 5,563,437
Colleton County	178	$ 4,919,196
Community Options	147	$ 9,604,006
Darlington County	186	$ 4,720,130
Dorchester County	382	$ 10,374,130
ECM Consulting	2	$ 79,009
Excalibur	24	$ 2,570,797
Fairfield County	84	$ 4,292,989
Florence County	473	$ 13,220,221
Georgetown County	170	$ 4,298,593
Thrive Upstate (Greenville County)	1,024	$ 25,226,563
Growing Homes	12	$ 497,900
Hampton County	80	$ 1,748,623
Horry County	441	$ 9,061,930
Jasper County	95	$ 11,735,709
Kershaw County	140	$ 3,394,415
Laurens County	269	$ 9,416,657
Lee County	103	$ 4,514,138
LifeShare	12	$ 712,315
Lutheran Family Services	57	$ 4,604,195
Marion/Dillon Counties	225	$ 6,113,125
Marlboro County	92	$ 1,657,942
MIRCI	12	$ 1,037,556
Newberry County	155	$ 5,029,046
Oconee County	277	$ 6,670,071
Orangeburg County	351	$ 11,326,309
PADD	6	$ 369,387
Pickens County	197	$ 7,203,494
Pine Grove	12	$ 1,000,085
Richland/Lexington Counties	156	$ 1,974,685
SAFY	8	$ 421,087
SC Autism	-	$ 154,535
SC Mentor	189	$ 17,051,290
Sumter County	241	$ 8,520,343
Tri-Development Center	517	$ 16,558,255
UCP	92	$ 6,408,199
Union County	94	$ 3,682,370
Williamsburg County	133	$ 3,379,398
Willowglen Academy	16	$ 1,318,380
MaxAbilities of York	499	$ 13,895,600
	17,972	**$ 456,314,857**

EARLY INTERVENTION PIRVATE PROVIDERS	# OF CONSUMERS	CONTRACT AWARD AS OF 2018	COUNTIES SERVED
About Play	266	$ 899,730	Chester, Darlington, Dillon, Faifield, Florence, Lancaster, Lee, Lexington, Marion, Newberry, Richland, Sumter, Unoion, York
Advantage EI	2	$ 13,842	Statewide
Aging with Flair	280	$ 968,940	Statewide (Also provides Case Management)
Ahead Start	424	$ 1,799,460	Statewide
All About Children	108	$ 392,190	Abbeville, Aiken, Anderson, Bamberg, Barnwell, Edgefield, Greenwood, Laurens, McCormick, Saluda
Amazing Kids	58	$ 184,560	Statewide
Awesome Kids	22	$ 73,824	Aiken, Edgefield
Better Beginnings	9	$ 33,221	Statewide
Beyond EI	164	$ 599,820	Kershaw, Laurens, Lexington, Newberry, Richland, Sumter
Brilliant Beginnings	71	$ 392,190	Greenville
Carolina Behavior and Beyond	178	$ 645,960	Aiken, Calhoun, Edgefield, Laurens, Lexington, Newberry, Orangeburg, Richland, Saluda
Carolina Early Intervention	23	$ 78,438	Darlington, Florence
Coastal Early Intervention	100	$ 357,585	Berkeley, Charleston, Dorchester
Cornerstone Support	25	$ 138,420	Statewide
Creative Development	21	$ 59,982	Kershaw, Lexington, Orangeburg, Richland
Easter Seals	475	$ 1,799,460	Statewide (Also provides Case Management)
Epworth	32	$ 108,298	Lexington, Richland
Great Kids and Awesome Adults	139	$ 415,260	Beaufort, Chesterfield, Colleton, Darlington, Dillon, Dorchester, Florence, Georgetown, Hampton, Horry, Jasper, Marion, Marlboro, Orangeburg, Williamsburg (Also provides Case Management)
Hands on Development	78	$ 253,770	Cherokee, Chesterfield, Dillon, Greenville, Laurens, Marlboro, Spartanburg, Union
I Shine	81	$ 299,910	Statewide
Kids 1st	42	$ 129,192	Statewide
Kids in Development	188	$ 645,960	Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Clarendon, Colleton, Dorchester, Florence, Georgetown, Hampton, Horry, Jasper, Lee, Marion, Orangeburg, Sumter, Williamsburg (Also provides Case Management)
Palmetto Early Intervention	112	$ 415,260	Cherokee, Greenville, Spartanburg
Path Finders Team Services	90	$ 276,840	Berkeley, Charleston, Clarendon, Dorchester, Orangeburg (Also provides Case Management
Pattison's Dream Academy	50	$ 179,946	Berkeley, Charleston, Dorchester (Also provides Case Management)
Pediatric Therapy of Aiken	54	$ 207,630	Aiken, Edgefield, Lexington
Pee Dee Kids	67	$ 253,770	Anderson, Chesterfield, Darlington, Dillon, Florence, Greenville, Laurens, Marion, Marlboro, Pickens, Spartanburg, Williamsburg
Pee Dee Professional Intervention	3	$ 13,842	Darlington, Dillon, Florence, Marion (Also provides Case Management)
Playworks	217	$ 876,660	Statewide
Promising Futures	99	$ 433,716	Statewide
Therapy Solutions	96	$ 322,980	Aiken, Allendale, Bamberg, Barnwell, Edgefield, Lexington, McCormick, Richland, Saluda
Tina Greene	22	$ 87,666	Berkeley, Charleston, Dorchester
Tiny Feet	22	$ 80,745	Greeville, Pickens
Upstate Support	51	$ 175,332	Greenville, Spartanburg
Vision Institute	56	$ 166,104	Abbeville, Aiken, Anderson, Barnwell, Edgefield, Greenville, Kershaw, Lexington, Oconee, Pickens, Richland, Spartanburg, Sumter, Union
	3,725	**$ 13,780,503**	

	SPECIAL GRANTS	#	$
*	Brain Injury Association of SC	-	$ 62,500
	Carolinas Rehab - TBI/SCI Post-Acute Rehabilitation	-	$ 815,000
*	Children's Trust Fund - Safe Kids Injury Prevention	-	$ 5,000
*	Family Connection - Family Support Network	-	$ 65,000
*	Family Connection - Education and Training	-	$ 20,650
*	Greenwood Genetics Center - Autism Research	-	$ 200,000
*	Greenwood Genetics Center - Neural Tube Defect Prevention	-	$ 678,600
	Greenwood Genetics Center - Genetic Testing and Counseling	-	$ 3,309,856
	Greenwood Genetics Center - Institutional Testing and Counseling	-	$ 3,448,295
	Greenwood Genetics Center - Metabolic Disorders	-	$ 3,839,625
*	Greenwood Genetics Center - Specialized Equipment & Testing	-	$ 315,000
*	Greenwood Genetics Center - Laboratory Equipment Purchase	-	$ 260,000
*	MUSC - Sponsorship of Special Dental Training	-	$ 2,500
	Rehab Without Walls - TBI/SCI Post-Acute Rehabilitation	-	$ 250,000
	Roger C. Peace Hospital - TBI/SCI Post-Acute Rehabilitation	-	$ 1,160,000
	Roper Rehab Hospital - TBI/SCI Post-Acute Rehabilitation	-	$ 875,000
*	SC Arts Commission	-	$ 6,700
*	SC Respite Coalition	-	$ 159,991
*	SC Special Olympics	-	$ 250,000
*	SC Spinal Cord Injury Association	-	$ 62,500
*	USC - Physician Services	-	$ 111,332
*	USC - Training Programs for Attendant Care	-	$ 200,000
*	USC - Training Programs and Technical Assistance for Staff	-	$ 749,529
	York Adult Day Care - Care Giver Relief	-	$ 8,000
TOTAL SPECIAL GRANTS		**-**	**$ 16,855,078**
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.		

AIKEN		#	$	
	Early Intervention	86	$ 330,699	
	HASCI Rebab Supports	9	$ 90,000	
	Family Support	-	$ 36,110	
TOTAL AIKEN CONTRACTS		**95**	**$ 456,809**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Case Management	522	$ 865,226	Aiken, Barnwell, Edgefield, Lexington, Saluda
	Early Intervention	86	$ 330,699	
	Day	9	$ 90,000	

ALDERSGATE		#	$	
	CTH 2	4	$ 214,197	
	CRCF	10	$ 615,646	
TOTAL ALDERSGATE CONTRACT		**14**	**$ 829,843**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	14	$ 829,843	Florence, Orangeburg

ALLENDALE/BARNWELL	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	28	$ 363,720	
Band I - At-Home CSW	45	$ 612,540	
Band D - Residential	6	$ 117,408	
Band G - Residential	31	$ 1,908,453	
Band H - Residential	39	$ 3,213,522	
Total Capitated Contract	**149**	**$ 6,215,643**	
Special Contracts			
Early Intervention	41	$ 224,744	
Family Support	-	$ 17,949	
Total Special Contracts	**41**	**$ 242,693**	
TOTAL ALLENDALE/BARNWELL CONTRACTS	**190**	**$ 6,458,336**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	120	$ 197,194	Allendale, Barnwell
Early Intervention	41	$ 224,744	Allendale, Bamberg, Barnwell
Day	102	$ 1,215,636	Allendale, Barnwell
Residential	76	$ 4,643,483	
At-Home Services	73	$ 374,473	

ANDERSON			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	99	$ 1,375,807	
		Band I - At-Home CSW	98	$ 1,333,976	
		Band C - Residential	18	$ 569,988	
		Band D - Residential	10	$ 195,680	
		Band G - Residential	35	$ 2,154,705	
		Band H - Residential	34	$ 2,906,574	
	Total Capitated Contract		**294**	**$ 8,536,730**	
	Special Contracts				
		Early Intervention	92	$ 276,389	
*		Child Day	22	$ 192,016	
		HASCI - Individual Rehab Supports	11	$ 112,500	
		Family Support	-	$ 56,116	
		State Funded Community Supports	3	$ 42,666	
*		Walgreen Employment Project	-	$ 202,342	
	Total Special Contracts		**128**	**$ 882,029**	
TOTAL ANDERSON CONTRACTS			**422**	**$ 9,418,759**	
*		Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.			
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	327	$ 543,002	Statewide
		Early Intervention	92	$ 276,389	
		Day	198	$ 2,480,240	Anderson
		Residential	97	$ 4,968,851	
		At-Home Services	197	$ 1,693,279	

ARC OF THE MIDLANDS		#	$	
	Supported Employment	9	$ 44,197	
	SLP 1	11	$ 228,067	
TOTAL ARC OF THE MIDLANDS CONTRACTS		**20**	**$ 272,264**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Day	9	$ 44,197	Statewide
	Residential	11	$ 228,067	

ARC OF SOUTH CAROLINA		#	$	
	Family Support	-	$ 20,573	
*	General Operating for Awareness Project	-	$ 25,000	
TOTAL ARC OF SC CONTRACTS		**-**	**$ 45,573**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.			
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Case Management	269	$ 442,042	Statewide
	In-Home Services		$ 20,573	
	Other Services		$ 25,000	

BABCOCK CENTER			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	663	$ 8,797,175	
		Band I - At-Home CSW	327	$ 4,451,124	
		Band C - Residential	42	$ 1,338,370	
		Band D - Residential	7	$ 136,976	
		Band F - Residential	6	$ 228,624	
		Band G - Residential	83	$ 5,109,729	
		Band H - Residential	165	$ 14,407,309	
		Band R - Residential	4	$ 362,116	
	Total Capitated Contract		**1,297**	**$ 34,831,423**	
	Special Contracts				
		HASCI Day		$ 172,555	
		HASCI Residential	4	$ 165,298	
		HASCI - Individual Rehab Supports	17	$ 191,250	
		Medically Fragile Home	8	$ 828,144	
		Caregiver Relief		$ 50,000	
		State Funded Follow Along	13	$ 69,550	
		State Funded Community Supports	33	$ 469,326	
		CIRS	5	$ 190,107	
*		Healthy Outcomes		$ 50,000	
*		Maintenance for Autism Home	-	$ 7,500	
		DDSN Autism Slot	1	$ 11,918	
		Regional Center Attending Day	5	$ 45,175	
	Total Special Contracts		**86**	**$ 2,250,823**	
TOTAL BABCOCK CONTRACTS			**1,383**	**$ 37,082,246**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Day	717	$ 8,098,656	
		Residential	324	$ 20,009,197	Lexington, Richland
		At-Home Services	990	$ 8,974,393	

BAMBERG	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	13	$ 190,166	
Band I - At-Home CSW	26	$ 353,912	
Band D - Residential	6	$ 117,408	
Band F - Residential	1	$ 38,104	
Band G - Residential	18	$ 1,108,134	
Band H - Residential	10	$ 823,980	
Total Capitated Contract	**74**	**$ 2,631,704**	
Special Contracts			
Family Support	-	$ 5,179	
Caregiver Relief	-	$ 25,000	
State Funded Community Supports	3	$ 42,666	
Total Special Contracts	**3**	**$ 72,845**	
TOTAL BAMBERG CONTRACTS	**77**	**$ 2,704,549**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	83	$ 136,392	Bamberg
Day	66	$ 793,500	
Residential	35	$ 1,694,332	
In-Home Services	39	$ 216,717	

BEAUFORT	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	67	$ 889,984	
Band I - At-Home CSW	96	$ 1,306,752	
Band D - Residential	7	$ 136,976	
Band E - Residential	1	$ 24,297	
Band F - Residential	1	$ 38,104	
Band G - Residential	20	$ 1,231,260	
Band H - Residential	22	$ 1,812,756	
Band R - Residential	1	$ 90,529	
Total Capitated Contract	**215**	**$ 5,530,658**	
Special Contracts			
Early Intervention	90	$ 330,699	
Family Support	-	$ 27,100	
Caregiver Relief	-	$ 65,000	
State Funded Community Supports	7	$ 99,554	
Total Special Contracts	**97**	**$ 522,353**	
TOTAL BEAUFORT CONTRACTS	**312**	**$ 6,053,011**	

SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	224	$ 368,095	Beaufort
Early Intervention	90	$ 330,699	
Day	198	2,375,892	Beaufort, Jasper
Residential	52	2,785,694	Beaufort
At-Home Services	163	$ 560,726	

BERKELEY CITIZENS	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	99	$ 1,286,010	
Band I - At-Home CSW	103	$ 1,402,036	
Band D - Residential	2	$ 39,136	
Band E - Residential	4	$ 97,188	
Band G - Residential	37	$ 2,277,831	
Band H - Residential	54	$ 4,491,440	
Band R - Residential	2	$ 181,058	
Total Capitated Contract	**301**	**$ 9,774,699**	
Special Contracts			
HASCI Residential	1	$ 82,398	
Early Intervention	84	$ 276,389	
Family Support	-	$ 33,627	
State Funded Community Supports	2	$ 28,444	
CIRS	2	$ 64,474	
Total Special Contracts	**89**	**$ 485,332**	
TOTAL BERKELEY CITIZENS CONTRACTS	**390**	**$ 10,260,031**	

SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	319	$ 524,206	
Early Intervention	84	$ 276,389	
Day	189	$ 2,257,110	Berkeley
Residential	102	$ 6,280,085	
At-Home Services	202	$ 1,446,447	

	BRIGHT START	#	$	
	Early Intervention	1,053	$ 3,921,900	
	Family Support	-	$ 74,348	
*	Mortgage Expenses	-	$ 45,384	
TOTAL BRIGHT START CONTRACTS		**1,053**	**$ 4,041,632**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.			
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Case Management	643	$ 1,056,629	Aiken, Anderson, Berkeley, Charleston, Cherokee, Chester, Dorchester,
	Early Intervention	1,053	$ 3,921,900	Greenville, Kershaw, Lancaster, Lexington, Newberry, Oconee, Pickens,
	In-Home Services		$ 74,348	Richland, Spartanburg, York

BURTON CENTER	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	85	$ 1,104,150	
Band I - At-Home CSW	131	$ 1,783,172	
Band C - Residential	19	$ 601,654	
Band D - Residential	9	$ 176,112	
Band E - Residential	4	$ 97,188	
Band F - Residential	1	$ 38,104	
Band G - Residential	37	$ 2,277,831	
Band H - Residential	90	$ 7,801,581	
Total Capitated Contract	**376**	**$ 13,879,792**	
Special Contracts			
Early Intervention	32	$ 124,618	
Family Support	-	$ 43,559	
State Funded Follow Along	1	$ 5,350	
State Funded Community Supports	12	$ 170,664	
Total Special Contracts	**45**	**$ 344,191**	
TOTAL BURTON CENTER CONTRACTS	**421**	**$ 14,223,983**	

SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	356	$ 592,590	Abbeville, Edgefield, Greenwood, McCormick, Saluda
Early Intervention	32	$ 124,618	
Day	271	$ 3,250,858	Abbeville, Edgefield, Greenwood, Laurens, Lexington, McCormick, Saluda
Residential	160	$ 9,848,342	Abbeville, Edgefield, Greenwood, Lexington, McCormick, Saluda
At-Home Services	216	$ 1,000,165	Abbeville, Edgefield, Greenwood, McCormick, Saluda

CALHOUN	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	32	$ 415,680	
Band I - At-Home CSW	35	$ 476,420	
Band G - Residential	10	$ 615,630	
Band H - Residential	46	$ 3,954,753	
Total Capitated Contract	**123**	**$ 5,462,483**	
Special Contracts			
Early Intervention	5	$ 31,155	
Family Support	-	$ 8,229	
State Funded Community Supports	1	$ 14,222	
Total Special Contracts	**6**	**$ 53,606**	
TOTAL CALHOUN CONTRACTS	**129**	**$ 5,516,089**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	89	$ 146,252	
Early Intervention	5	$ 31,155	
Day	70	$ 836,564	Calhoun
Residential	56	$ 4,284,351	
At-Home Services	67	$ 364,019	

CARE FOCUS		#	$		
	Low Needs CTH 2	1	$ 61,565		
	High Needs CTH 2	27	$ 2,224,766		
	HASCI Residential CTH 2	4	$ 333,362		
	Band R	4	$ 362,109		
	High Needs CTH 2 with Outliers	8	$ 974,506		
	Room & Board	-	$ 8,460		
TOTAL CARE FOCUS CONTRACTS		**44**	**$ 3,964,768**		
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**	
	Residential	44	$ 3,964,768	Statewide	

CHARLES LEA CENTER			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	254	$ 3,520,748	
		Band I - At-Home CSW	159	$ 2,164,308	
		Band C - Residential	16	$ 506,656	
		Band D - Residential	20	$ 391,360	
		Band E - Residential	1	$ 24,297	
		Band G - Residential	126	$ 7,756,938	
		Band H - Residential	100	$ 8,398,237	
		Band R - Residential	1	$ 90,529	
	Total Capitated Contract		**677**	**$ 22,853,073**	
	Special Contracts				
		HASCI Residential	1	$ 82,398	
		Early Intervention	106	$ 330,699	
		Family Support		$ 66,332	
		Medically Fragile Home	8	$ 973,848	
		State Funded Follow Along	1	$ 5,350	
		State Funded Community Supports	13	$ 184,886	
		CIRS	25	$ 834,834	
*		Healthy Outcomes	-	$ 50,000	
*		Maintenance for Autism Home	-	$ 7,535	
*		Fiscal Agent - Respite Admin	-	$ 62,000	
		Fiscal Agent - Respite Payroll	-	$ 4,307,000	
	Total Special Contracts		**154**	**$ 6,904,882**	
TOTAL CHARLES LEA CENTER CONTRACTS			**831**	**$ 29,757,955**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	633	$ 1,048,225	Statewide
		Early Intervention	106	$ 330,699	
		Day	431	$ 5,160,042	Spartanburg
		Residential	299	$ 16,647,278	
		At-Home Services	413	$ 3,250,936	
		Fiscal Agent		$ 4,369,000	Statewide

CHARLESTON			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	187	$ 2,549,702	
		Band I - At-Home CSW	230	$ 3,130,760	
		Band C - Residential	26	$ 823,316	
		Band D - Residential	19	$ 371,792	
		Band E - Residential	8	$ 194,376	
		Band F - Residential	2	$ 76,208	
		Band G - Residential	56	$ 3,447,528	
		Band H - Residential	109	$ 9,229,525	
	Total Capitated Contract		**637**	**$ 19,823,207**	
	Special Contracts				
		HASCI Day	-	$ 184,227	
		Early Intervention	75	$ 276,389	
		HASCI - Individual Rehab Supports	17	$ 191,250	
*		Child Day	11	$ 125,578	
		Family Support	-	$ 93,857	
		State Funded Follow Along	1	$ 5,350	
		State Funded Community Supports	30	$ 426,660	
*		Mortgage Expenses for Day Program	-	$ 58,638	
	Total Special Contracts		**134**	**$ 1,361,949**	
TOTAL CHARLESTON CONTRACTS			**771**	**$ 21,185,156**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	790	$ 1,314,249	Berkelel, Charleston, Colleton, Dorchester
		Early Intervention	75	$ 276,389	
		Day	513	$ 5,806,575	Charleston
		Residential	220	$ 11,997,505	
		At-Home Services	417	$ 3,104,687	

CHEROKEE			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	39	$ 506,610	
		Band I - At-Home CSW	44	$ 598,928	
		Band G - Residential	14	$ 861,882	
		Band H - Residential	22	$ 1,892,962	
	Total Capitated Contract		**119**	**$ 3,860,382**	
	Special Contracts				
		Early Intervention	33	$ 124,618	
		Family Support	-	$ 11,847	
		State Funded Community Supports	10	$ 142,220	
	Total Special Contracts		**43**	**$ 278,685**	
TOTAL CHEROKEE CONTRACTS			**162**	**$ 4,139,067**	
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	113	$ 185,691	
		Early Intervention	33	$ 124,618	
		Day	77	$ 970,726	Cherokee
		Residential	36	$ 2,528,402	
		At-Home Services	83	$ 515,321	

CHESCO			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	35	$ 577,899	
		Band I - At-Home CSW	49	$ 666,988	
		Band C - Residential	39	$ 1,234,974	
		Band D - Residential	7	$ 136,976	
		Band F - Residential	6	$ 228,624	
		Band G - Residential	48	$ 2,955,024	
		Band H - Residential	118	$ 10,013,977	
	Total Capitated Contract		**302**	**$ 15,814,462**	
	Special Contracts				
		Early Intervention	44	$ 155,773	
		Family Support	-	$ 15,466	
		State Funded Follow Along	3	$ 16,050	
		State Funded Community Supports	3	$ 42,666	
		CIRS	3	$ 118,396	
		High Management Homes	16	$ 2,015,793	
		Leisure Activities for Nursing Home Residents	-	$ 8,000	
*		Mortgage Expenses for Day Program	-	$ 99,082	
	Total Special Contracts		**69**	**$ 2,471,226**	
TOTAL CHESCO CONTRACTS			**371**	**$ 18,285,688**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	229	$ 376,311	Chesterfield
		Early Intervention	44	$ 155,773	
		Day	265	$ 3,252,560	Chesterfield, Kershaw, Lancaster, Lexington, Marlboro, Richland
		Residential	237	$ 14,248,656	
		At-Home Services	84	$ 628,699	Chesterfield

CHESTER/LANCASTER	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	86	$ 1,259,746	
Band I - At-Home CSW	69	$ 939,228	
Band C - Residential	7	$ 221,662	
Band G - Residential	23	$ 1,415,949	
Band H - Residential	29	$ 2,525,506	
Total Capitated Contract	**214**	**$ 6,362,091**	
Special Contracts			
Early Intervention	35	$ 124,618	
Family Support	-	$ 23,127	
State Funded Follow Along	1	$ 5,350	
State Funded Community Supports	10	$ 142,220	
Total Special Contracts	**46**	**$ 295,315**	
TOTAL CHESTER/LANCASTER CONTRACTS	**260**	**$ 6,657,406**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	230	$ 382,563	Statewide
Early Intervention	35	$ 124,618	
Day	121	$ 1,458,550	Chester, Lancaster
Residential	59	$ 3,943,849	
At-Home Services	155	$ 1,130,389	

CLARENDON	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	32	$ 436,987	
Band I - At-Home CSW	38	$ 517,256	
Band D - Residential	7	$ 136,976	
Band F - Residential	6	$ 228,624	
Band G - Residential	37	$ 2,277,831	
Band H - Residential	23	$ 1,895,154	
Total Capitated Contract	**143**	**$ 5,492,828**	
Special Contracts			
Early Intervention	8	$ 62,309	
Family Support	-	$ 8,300	
Total Special Contracts	**8**	**$ 70,609**	
TOTAL CLARENDON CONTRACTS	**151**	**$ 5,563,437**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	154	$ 253,065	Clarendon, Lee, Sumter
Early Intervention	8	$ 62,309	Clarendon
Day	123	$ 1,465,914	
Residential	73	$ 3,692,407	
At-Home Services	70	$ 342,807	

COLLETON	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	50	$ 678,825	
Band I - At-Home CSW	25	$ 340,300	
Band C - Residential	18	$ 569,988	
Band G - Residential	6	$ 369,378	
Band H - Residential	33	$ 2,719,134	
Band R - Residential	1	$ 90,529	
Total Capitated Contract	**133**	**$ 4,768,154**	
Special Contracts			
Early Intervention	44	$ 124,618	
Family Support	-	$ 12,202	
State Funded Community Supports	1	$ 14,222	
Total Special Contracts	**45**	**$ 151,042**	
TOTAL COLLETON CONTRACTS	**178**	**$ 4,919,196**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	127	$ 208,697	Colleton
Early Intervention	44	$ 124,168	
Day	98	$ 1,170,268	
Residential	58	$ 3,141,211	
At-Home Services	75	$ 483,549	

COMMUNITY OPTIONS	#	$	
SLP 1	10	$ 231,242	
HASCI Residential SLP 1	1	$ 17,445	
SLP 3	3	$ 96,327	
CTH 1	10	$ 307,690	
Low Needs CTH 2	10	$ 615,646	
High Needs CTH 2	64	$ 5,273,520	
HASCI Residential CTH 2	7	$ 590,570	
Band R	23	$ 2,082,128	
High Needs CTH 2 with Outliers	3	$ 335,333	
Supported Employment Services	16	$ 54,106	
TOTAL COMMUNITY OPTIONS CONTRACTS	**147**	**$ 9,604,006**	

SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Day	16	$ 54,106	Statewide
Residential	131	$ 9,549,900	

DARLINGTON	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	31	$ 424,220	
Band I - At-Home CSW	37	$ 503,644	
Band F - Residential	1	$ 38,104	
Band G - Residential	30	$ 1,846,890	
Band H - Residential	17	$ 1,558,545	
Band R - Residential	1	$ 90,529	
Total Capitated Contract	**117**	**$ 4,461,932**	
Special Contracts			
Early Intervention	68	$ 218,082	
Family Support	-	$ 25,894	
State Funded Community Supports	1	$ 14,222	
Total Special Contracts	**69**	**$ 258,198**	
TOTAL DARLINGTON CONTRACTS	**186**	**$ 4,720,130**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	173	$ 293,208	Chesterfield, Darlington, Dillon, Lee, Marlboro, Sumter
Early Intervention	68	$ 218,082	Darlington
Day	72	$ 860,400	
Residential	49	$ 3,176,528	
At-Home Services	68	$ 465,120	

DORCHESTER			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	118	$ 1,594,516	
		Band I - At-Home CSW	71	$ 966,452	
		Band C - Residential	7	$ 221,662	
		Band D - Residential	12	$ 234,816	
		Band G - Residential	60	$ 3,693,780	
		Band H - Residential	40	$ 3,295,920	
	Total Capitated Contract		**308**	**$ 10,007,146**	
	Special Contracts				
		Early Intervention	69	$ 251,899	
		Family Support	-	$ 36,819	
		State Funded Community Supports	5	$ 71,110	
*		Maintenance for Autism Homes	-	$ 7,156	
	Total Special Contracts		**74**	**$ 366,984**	
TOTAL DORCHESTER CONTRACTS			**382**	**$ 10,374,130**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	302	$ 496,271	
		Early Intervention	69	$ 251,899	
		Day	168	$ 2,013,744	Dorchester
		Residential	118	$ 6,487,976	
		At-Home Services	189	$ 1,620,511	

ECM CONSULTING		#	$	
	SLP 1	2	$ 79,009	
TOTAL ECM CONSULTING CONTRACT		**2**	**$ 79,009**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	2	$ 79,009	Statewide

EXCALIBUR		#	$	
	High Management CTH 2	24	$ 2,570,797	
TOTAL EXCALIBUR CONTRACT		**24**	**$ 2,570,797**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	24	$ 2,570,797	Greenville, Pickens

FAIRFIELD	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	17	$ 269,456	
Band I - At-Home CSW	11	$ 149,732	
Band G - Residential	23	$ 1,415,949	
Band H - Residential	24	$ 2,230,126	
Total Capitated Contract	**75**	**$ 4,065,263**	
Special Contracts			
HASCI Residential	1	$ 142,398	
Early Intervention	7	$ 62,309	
Family Support	-	$ 8,797	
State Funded Community Supports	1	$ 14,222	
Total Special Contracts	**9**	**$ 227,726**	
TOTAL FAIRFIELD CONTRACTS	**84**	**$ 4,292,989**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	68	$ 111,743	Fairfield
Day	58	$ 693,548	
Residential	48	$ 3,299,835	
At-Home Services	28	$ 299,606	

FLORENCE	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	132	$ 2,041,286	
Band I - At-Home CSW	97	$ 1,320,364	
Band C - Residential	34	$ 1,076,644	
Band E - Residential	2	$ 48,594	
Band G - Residential	43	$ 2,647,209	
Band H - Residential	67	$ 5,520,666	
Total Capitated Contract	**375**	**$ 12,654,763**	
Special Contracts			
Early Intervention	87	$ 330,699	
Family Support	-	$ 57,464	
Caregiver Relief	-	$ 12,500	
State Funded Community Supports	9	$ 127,998	
Leisure Activities - Manor House	-	$ 21,457	
Regional Center Attending Day	2	$ 15,340	
Total Special Contracts	**98**	**$ 565,458**	
TOTAL FLORENCE CONTRACTS	**473**	**$ 13,220,221**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	722	$ 702,236	
Early Intervention	87	$ 330,699	
Day	235	$ 2,834,427	Florence
Residential	146	$ 8,172,821	
At-Home Services	229	$ 1,882,274	

GEORGETOWN	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	57	$ 955,132	
Band I - At-Home CSW	30	$ 408,360	
Band G - Residential	15	$ 923,445	
Band H - Residential	21	$ 1,730,358	
Total Capitated Contract	**123**	**$ 4,017,295**	
Special Contracts			
Early Intervention	39	$ 124,618	
Family Support	-	$ 10,570	
State Funded Community Supports	5	$ 71,110	
CIRS	3	$ 75,000	
Total Special Contracts	**47**	**$ 281,298**	
TOTAL GEORGETOWN CONTRACTS	**170**	**$ 4,298,593**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	123	$ 202,123	Charleston, Georgetown, Horry, Williamsburg
Early Intervention	39	$ 124,618	
Day	95	$ 1,143,730	Georgetown
Residential	39	$ 2,311,673	
At-Home Services	87	$ 718,572	

THRIVE UPSTATE	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	314	$ 4,533,098	
Band I - At-Home CSW	281	$ 3,824,972	
Band C - Residential	41	$ 1,298,306	
Band D - Residential	11	$ 215,248	
Band G - Residential	91	$ 5,602,233	
Band H - Residential	94	$ 7,775,856	
Total Capitated Contract	**832**	**$ 23,249,713**	
Special Contracts			
HASCI Day	-	$ 184,551	
HASCI Residential	9	$ 546,576	
HASCI - Individual Rehab Supports	35	$ 393,750	
Early Intervention	131	$ 509,531	
Family Support	-	$ 100,668	
State Funded Community Supports	17	$ 241,774	
Total Special Contracts	**192**	**$ 1,976,850**	
TOTAL THRIVE UPSTATE CONTRACTS	**1,024**	**$ 25,226,563**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	751	$ 1,244,214	Greenville
Early Intervention	131	$ 509,531	Greenville, Laurens, Pickens
Day	488	$ 5,420,423	
Residential	246	$ 13,757,781	Greenville
At-Home Services	595	$ 5,538,828	

GROWING HOMES		#	$	
	TFH - Level 1	5	$ 126,418	
	TFH - Level 2	2	$ 75,373	
	TFH - Level 3	5	$ 260,355	
	Day Service Add-Ons	-	$ 35,755	
TOTAL GOWING HOMES CONTRACT		**12**	**$ 497,900**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	12	$ 497,900	Statewide

HAMPTON	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	25	$ 357,081	
Band I - At-Home CSW	22	$ 299,464	
Band D - Residential	3	$ 58,704	
Band G - Residential	4	$ 246,252	
Band H - Residential	8	$ 659,184	
Total Capitated Contract	**62**	**$ 1,620,685**	
Special Contracts			
Early Intervention	16	$ 93,464	
Family Support	-	$ 6,030	
State Funded Community Supports	2	$ 28,444	
Total Special Contracts	**18**	**$ 127,938**	
TOTAL HAMPTON CONTRACTS	**80**	**$ 1,748,623**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	66	$ 108,456	Hampton
Early Intervention	16	$ 93,464	
Day	52	$ 524,344	
Residential	15	$ 785,370	
At-Home Services	47	$ 345,445	

HORRY	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	139	$ 1,928,136	
Band I - At-Home CSW	76	$ 1,034,512	
Band C - Residential	15	$ 474,990	
Band D - Residential	8	$ 156,544	
Band E - Residential	2	$ 48,594	
Band G - Residential	26	$ 1,600,638	
Band H - Residential	30	$ 2,493,092	
Band R - Residential	2	$ 181,058	
Funded Vacancies	-	$ -	
Total Capitated Contract	**298**	**$ 7,917,564**	
Special Contracts			
HASCI Day	-	$ 145,805	
HASCI Residential	2	$ 140,088	
HASCI - Individual Rehab Supports	15	$ 157,500	
Early Intervention	111	$ 441,984	
Family Support	-	$ 49,731	
State Funded Follow Along	1	$ 5,350	
State Funded Community Supports	14	$ 199,108	
Special Family Support	-	$ 4,800	
Total Special Contracts	**143**	**$ 1,144,366**	
TOTAL HORRY CONTRACTS	**441**	**$ 9,061,930**	

SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	368	$ 614,837	Dillon, Georgetown, Horry, Marion
Early Intervention	111	$ 441,984	
Day	271	$ 2,784,101	Horry
Residential	85	$ 4,201,154	
At-Home Services	215	$ 1,634,691	

JASPER			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	19	$ 246,810	
		Band I - At-Home CSW	29	$ 394,748	
		Band G - Residential	8	$ 492,504	
		Band H - Residential	16	$ 1,347,880	
	Total Capitated Contract		**72**	**$ 2,481,942**	
	Special Contracts				
		Early Intervention	17	$ 62,309	
		Family Support	-	$ 7,236	
		HASCI - Individual Rehab Supports	5	$ 45,000	
		State Funded Community Supports	1	$ 14,222	
		Fiscal Agent - ID/RD Attendant Care	-	$ 400,000	
		Fiscal Agent - CS Waiver Attendant Care	-	$ 1,675,000	
*		Fiscal Agent - Self-Arranged Attendant Care	-	$ 185,000	
		Fiscal Agent - Respite Payroll	-	$ 2,680,000	
*		Fiscal Agent - Respite Payroll Admin	-	$ 85,000	
		Fiscal Agent - HASCI Self-Directed Care	-	$ 4,100,000	
	Total Special Contracts		**23**	**$ 9,253,767**	
TOTAL JASPER CONTRACTS			**95**	**$ 11,735,709**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	101	$ 169,391	Beaufort, Colleton, Hampton, Jasper
		Early Intervention	17	$ 62,309	
		Day	70	$ 821,974	Jasper
		Residential	24	$ 1,554,352	
		At-Home Services	48	$ 172,074	
		Fiscal Agent		$ 9,125,000	Statewide

KERSHAW	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	65	$ 1,094,360	
Band I - At-Home CSW	40	$ 544,480	
Band D - Residential	1	$ 19,568	
Band G - Residential	17	$ 1,046,571	
Band H - Residential	6	$ 494,388	
Band R - Residential	1	$ 90,529	
Total Capitated Contract	**130**	**$ 3,289,896**	
Special Contracts			
Early Intervention	8	$ 31,155	
Family Support	-	$ 14,047	
Caregiver Relief	-	$ 30,873	
State Funded Community Supports	2	$ 28,444	
Total Special Contracts	**10**	**$ 104,519**	
TOTAL KERSHAW CONTRACTS	**140**	**$ 3,394,415**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	148	$ 243,205	Kershaw, Lexington
Early Intervention	8	$ 31,155	Kershaw
Day	75	$ 898,458	
Residential	25	$ 1,388,860	
At-Home Services	105	$ 1,075,942	

LAURENS	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	50	$ 856,943	
Band I - At-Home CSW	54	$ 735,048	
Band C - Residential	14	$ 443,324	
Band D - Residential	12	$ 234,816	
Band G - Residential	32	$ 1,970,016	
Band H - Residential	54	$ 4,680,317	
Band R - Residential	1	$ 90,529	
Total Capitated Contract	**217**	**$ 9,010,993**	
Special Contracts			
HASCI Residential	1	$ 61,563	
Early Intervention	46	$ 193,837	
Family Support	-	$ 27,029	
Caregiver Relief	-	$ 52,125	
State Funded Community Supports	5	$ 71,110	
Total Special Contracts	**52**	**$ 405,664**	
TOTAL LAURENS CONTRACTS	**269**	**$ 9,416,657**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	209	$ 343,446	Abbeville, Anderson, Greenville, Greenwood, Laurens,
Early Intervention	46	$ 193,837	Newberry, Spartanburg, Union
Day	149	$ 1,787,302	
Residential	114	$ 6,431,781	Laurens
At-Home Services	104	$ 1,003,737	

LEE		#	$	
Capitated Contract				
	Band B - At-home ID/RD Waiver	7	$ 90,930	
	Band I - At-Home CSW	25	$ 340,300	
	Band C - Residential	10	$ 316,660	
	Band D - Residential	3	$ 58,704	
	Band G - Residential	23	$ 1,415,949	
	Band H - Residential	27	$ 2,224,746	
Total Capitated Contract		**95**	**$ 4,447,289**	
Special Contracts				
	Early Intervention	8	$ 62,309	
	Family Support	-	$ 4,540	
Total Special Contracts		**8**	**$ 66,849**	
TOTAL LEE CONTRACTS		**103**	**$ 4,514,138**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Case Management	83	$ 136,392	Darlington, Florence, Kershaw, Lee, Sumter
	Early Intervention	8	$ 62,309	
	Day	75	$ 893,850	Lee
	Residential	63	$ 3,467,831	
	At-Home Services	32	$ 90,148	

LIFESHARE		#	$	
	TFH - Level 1	1	$ 25,284	
	TFH - Level 2	2	$ 75,373	
	TFH - Level 3	9	$ 468,638	
	Day Service Add-Ons	-	$ 143,021	
TOTAL LIFESHARE CONTRACT		**12**	**$ 712,315**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	12	$ 712,315	Lexington, Richland

LUTHERAN		#	$	
	Low Needs CTH 2	1	$ 61,565	
	High Needs CTH 2	18	$ 1,483,908	
	HASCI Residential - CTH 2	2	$ 190,950	
	Band R	8	$ 724,218	
	High Needs CTH 2 with Outliers	10	$ 1,138,618	
	TFH - Level 1	2	$ 50,567	
	TFH - Level 2	4	$ 150,745	
	TFH - Level 3	12	$ 636,768	
	Day Service Add-Ons		$ 166,858	
TOTAL LUTHERAN CONTRACTS		**57**	**$ 4,604,195**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	57	$ 4,604,195	Statewide

MARION/DILLON	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	27	$ 386,531	
Band I - At-Home CSW	83	$ 1,129,796	
Band C - Residential	1	$ 31,666	
Band G - Residential	18	$ 1,108,134	
Band H - Residential	38	$ 3,131,124	
Total Capitated Contract	**167**	**$ 5,787,251**	
Special Contracts			
Early Intervention	57	$ 249,234	
Family Support	-	$ 22,418	
Caregiver Relief	-	$ 40,000	
State Funded Community Supports	1	$ 14,222	
Total Special Contracts	**58**	**$ 325,874**	
TOTAL MARION/DILLON CONTRACTS	**225**	**$ 6,113,125**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	179	$ 294,147	Dillon, Marion
Early Intervention	57	$ 249,234	
Day	155	$ 1,849,594	
Residential	57	$ 3,603,516	
At-Home Services	110	$ 410,781	

MARLBORO	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	30	$ 412,082	
Band I - At-Home CSW	20	$ 272,240	
Band D - Residential	4	$ 78,272	
Band G - Residential	10	$ 615,630	
Band H - Residential	2	$ 164,796	
Total Capitated Contract	**66**	**$ 1,543,020**	
Special Contracts			
Early Intervention	25	$ 93,464	
Family Support	-	$ 7,236	
State Funded Community Supports	1	$ 14,222	
Total Special Contracts	**26**	**$ 114,922**	
TOTAL MARLBORO CONTRACTS	**92**	**$ 1,657,942**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	68	$ 111,743	Marlboro
Early Intervention	25	$ 7,236	
Day	46	$ 550,532	
Residential	16	$ 691,846	
At-Home Services	50	$ 408,328	

MIRCI		#	$	
	CRCF - High Needs	6	$ 494,393	
	CRCF - Band R	6	$ 543,164	
TOTAL MIRCI CONTRACT		**12**	**$ 1,037,556**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	12	$ 1,037,556	Lexington, Richland

NEWBERRY	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	25	$ 324,750	
Band I - At-Home CSW	37	$ 503,644	
Band C - Residential	6	$ 189,996	
Band D - Residential	7	$ 136,976	
Band G - Residential	39	$ 2,400,957	
Band H - Residential	17	$ 1,400,766	
Total Capitated Contract	**131**	**$ 4,957,089**	
Special Contracts			
Early Intervention	24	$ 62,309	
Family Support	-	$ 9,648	
Total Special Contracts	**24**	**$ 71,957**	
TOTAL NEWBERRY CONTRACTS	**155**	**$ 5,029,046**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	119	$ 195,550	Newberry
Early Intervention	24	$ 62,309	
Day	99	$ 1,179,882	
Residential	69	$ 3,520,877	
At-Home Services	62	$ 265,978	

OCONEE	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	54	$ 701,460	
Band I - At-Home CSW	51	$ 694,212	
Band C - Residential	17	$ 538,322	
Band D - Residential	17	$ 332,656	
Band G - Residential	22	$ 1,354,386	
Band H - Residential	26	$ 2,142,348	
Band W - Residential	11	$ 441,848	
Total Capitated Contract	**198**	**$ 6,205,232**	
Special Contracts			
HASCI Residential	2	$ 143,961	
Early Intervention	73	$ 249,234	
Family Support	-	$ 14,756	
State Funded Community Supports	4	$ 56,888	
Total Special Contracts	**79**	**$ 464,839**	
TOTAL OCONEE CONTRACTS	**277**	**$ 6,670,071**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	311	$ 346,732	Statewide
Early Intervention	73	$ 249,234	
Day	160	$ 1,916,096	Oconee
Residential	95	$ 3,892,819	
At-Home Services	105	$ 611,922	

ORANGEBURG	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	97	$ 1,399,741	
Band I - At-Home CSW	66	$ 898,392	
Band C - Residential	18	$ 569,988	
Band G - Residential	41	$ 2,524,083	
Band H - Residential	63	$ 5,220,304	
Total Capitated Contract	**285**	**$ 10,612,508**	
Special Contracts			
HASCI Residential	5	$ 320,118	
Early Intervention	56	$ 276,389	
Family Support	-	$ 46,184	
State Funded Community Supports	5	$ 71,110	
Total Special Contracts	**66**	**$ 713,801**	
TOTAL ORANGEBURG CONTRACTS	**351**	**$ 11,326,309**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	323	$ 537,767	Allendale, Bamberg, Barnwell, Berkeley, Calhoun, Dorchester, Lexington, Orangeburg
Early Intervention	56	$ 276,389	Orangeburg
Day	208	$ 2,490,464	Orangeburg
Residential	127	$ 7,621,463	
At-Home Services	163	$ 937,993	

PADD		#	$	
	CRCF - Low Needs	6	$ 369,387	
TOTAL PADD CONTRACT		**6**	**$ 369,387**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	6	$ 369,387	Florence

PICKENS	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	33	$ 428,670	
Band I - At-Home CSW	60	$ 816,720	
Band C - Residential	16	$ 506,656	
Band D - Residential	12	$ 234,816	
Band G - Residential	19	$ 1,169,697	
Band H - Residential	41	$ 3,872,123	
Total Capitated Contract	**181**	**$ 7,028,682**	
Special Contracts			
Early Intervention	10	$ 62,309	
Family Support	-	$ 27,171	
State Funded Community Supports	6	$ 85,332	
Total Special Contracts	**16**	**$ 174,812**	
TOTAL PICKENS CONTRACTS	**197**	**$ 7,203,494**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	196	$ 325,651	
Early Intervention	10	$ 62,309	
Day	142	$ 1,706,180	Pickens
Residential	88	$ 4,806,016	
At-Home Services	93	$ 628,989	

PINE GROVE		#	$	
	CTH 2 - High Needs	12	$ 1,000,085	
TOTAL PINE GROVE CONTRACT		**12**	**$ 1,000,085**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	12	$ 1,000,085	Statewide

RICHLAND/LEXEXINGTON			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	1	$ 12,990	
		Band F - Residential	26	$ 990,704	
	Total Capitated Contract		**27**	**$ 1,003,694**	
	Special Contracts				
		Early Intervention	127	$ 582,598	
		Family Support	-	$ 112,799	
		Special Supports - ID/RD Individual	-	$ 12,000	
*		Rent Expenses	-	$ 124,000	
		BEAP Program	-	$ 26,000	
		TFH - Level 2	1	$ 37,686	
		TFH - Level 3	1	$ 52,071	
		Day Service Add-Ons	-	$ 23,837	
	Total Special Contracts		**129**	**$ 970,991**	
TOTAL RICHLAND/LEXINGTON CONTRACTS			**156**	**$ 1,974,685**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	1,600	$ 2,783,430	Statewide
		Early Intervention	127	$ 582,598	
		Day	22	$ 262,196	Lexington, Richland
		Residential	28	$ 854,102	
		At-Home Services		$ 151,789	Statewide
		Program Expenses		$ 124,000	Richland

SAFY	#	$	
TFH - Level 2	3	$ 113,059	
TFH - Level 3	5	$ 260,355	
Day Service Add-Ons	-	$ 47,674	
TOTAL SAFY CONTRACT	**8**	**$ 421,087**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Residential	8	$ 421,087	Berkeley, Calhoun, Charleston, Colleton, Dorchester, Greenville, Laurens, Lexington, Orangeburg, Pickens, Richland, Spartanburg, Sumter, Union

	SC AUTISM	#	$	
	Family Support	-	$ 109,535	
*	Support Project	-	$ 20,000	
*	Teaching Toy Box	-	$ 25,000	
TOTAL SC AUTISM CONTRACTS		**-**	**$ 154,535**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.			
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Case Management	612	$ 1,005,687	Statewide
	At-Home Services		$ 154,535	

SC MENTOR	#	$	
CTH 1	1	$ 29,413	
Low Needs CTH 2	4	$ 246,258	
High Needs CTH 2	62	$ 5,108,723	
HASCI Residential - CTH 2	10	$ 833,405	
High Management Homes - CTH 2	95	$ 9,867,837	
Band R - CTH 2	4	$ 362,109	
TFH - Level 1	3	$ 75,851	
TFH - Level 2	2	$ 75,373	
THH - Level 3	8	$ 416,567	
Day Service Add-Ons	-	$ 35,755	
TOTAL SC MENTOR CONTRACTS	**189**	**$ 17,051,290**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Residential	189	$ 17,051,290	Statewide

SUMTER	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	38	$ 493,620	
Band I - At-Home CSW	73	$ 993,676	
Band C - Residential	12	$ 379,992	
Band G - Residential	42	$ 2,585,646	
Band H - Residential	45	$ 3,707,910	
Band R - Residential	1	$ 90,529	
Total Capitated Contract	**211**	**$ 8,251,373**	
Special Contracts			
Early Intervention	22	$ 124,618	
Family Support	-	$ 30,576	
State Funded Community Supports	8	$ 113,776	
Total Special Contracts	**30**	**$ 268,970**	
TOTAL SUMTER CONTRACTS	**241**	**$ 8,520,343**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	188	$ 308,937	Sumter
Early Intervention	22	$ 124,618	
Day	156	$ 1,877,640	
Residential	100	$ 5,894,063	
At-Home Services	111	$ 624,022	

TRI-DEVELOPMENT CENTER			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	148	$ 1,922,520	
		Band I - At-Home CSW	166	$ 2,259,592	
		Band C - Residential	20	$ 633,320	
		Band D - Residential	15	$ 293,520	
		Band F - Residential	10	$ 381,040	
		Band G - Residential	56	$ 3,447,528	
		Band H - Residential	88	$ 7,298,105	
	Total Capitated Contract		**503**	**$ 16,235,625**	
	Special Contracts				
		HASCI Residential	2	$ 101,966	
		State Funded Community Supports	12	$ 170,664	
*		Healthy Outcomes	-	$ 50,000	
	Total Special Contracts		**14**	**$ 322,630**	
TOTAL TRI-DEVELOPMENT CENTER CONTRACTS			**517**	**$ 16,558,255**	
*	Denotes Contract amount does not fluctuate as a result of consumers exercising choice of service provider or utilization of authorized service.				
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Day	378	$ 4,532,652	
		Residential	190	$ 10,439,287	Aiken
		At-Home Services	314	$ 1,586,316	

UCP		#	$	
	CTH 1	4	$ 117,654	
	SLP 1	8	$ 158,475	
	SLP 2	9	$ 306,370	
	Low Needs CTH 2	14	$ 861,904	
	High Needs CTH 2	48	$ 3,955,140	
	HASCI Residential - CTH 2	3	$ 250,021	
	High Needs CTH 2 with Outliers	3	$ 559,797	
	Band R - CTH 2	1	$ 90,527	
	Day Services	2	$ 23,837	
	Final Rule Initiative - Day Service Add-On	-	$ 84,474	
TOTAL UCP CONTRACTS		**92**	**$ 6,408,199**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Day	27	$ 108,311	Statewide
	Residential	90	$ 6,299,888	

UNION			#	$	
	Capitated Contract				
		Band B - At-home ID/RD Waiver	22	$ 285,780	
		Band I - At-Home CSW	28	$ 381,136	
		Band D - Residential	4	$ 78,272	
		Band G - Residential	17	$ 1,046,571	
		Band H - Residential	21	$ 1,753,876	
	Total Capitated Contract		**92**	**$ 3,545,635**	
	Special Contracts				
		Early Intervention	-	$ 93,464	
		Family Support	-	$ 14,827	
		State Funded Community Supports	2	$ 28,444	
	Total Special Contracts		**2**	**$ 136,735**	
TOTAL UNION CONTRACTS			**94**	**$ 3,682,370**	
		SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
		Case Management	88	$ 144,609	Union
		Early Intervention	20	$ 93,464	
		Day	67	$ 803,114	
		Residential	42	$ 2,521,179	
		At-Home Services	50	$ 264,613	

WILLIAMSBURG	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	23	$ 323,126	
Band I - At-Home CSW	46	$ 626,152	
Band D - Residential	1	$ 19,568	
Band E - Residential	1	$ 24,297	
Band F - Residential	6	$ 228,624	
Band G - Residential	17	$ 1,046,571	
Band H - Residential	11	$ 906,378	
Total Capitated Contract	**105**	**$ 3,174,716**	
Special Contracts			
Early Intervention	24	$ 93,464	
Family Support	-	$ 14,330	
Caregiver Relief	-	$ 40,000	
State Funded Community Supports	4	$ 56,888	
Total Special Contracts	**28**	**$ 204,682**	
TOTAL WILLIAMSBURG CONTRACTS	**133**	**$ 3,379,398**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	110	$ 180,761	
Early Intervention	24	$ 93,464	
Day	97	$ 1,165,262	Williamsburg
Residential	36	$ 1,796,390	
At-Home Services	69	$ 324,282	

WILLOWGLEN ACADEMY		#	$	
	High Needs CTH 2	16	$ 1,318,380	
TOTAL WILLOWGLEN ACADEMY CONTRACT		**16**	**$ 1,318,380**	
	SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
	Residential	16	$ 1,318,380	Statewide

MAX ABILITIES OF YORK	#	$	
Capitated Contract			
Band B - At-home ID/RD Waiver	164	$ 2,175,611	
Band I - At-Home CSW	101	$ 1,374,812	
Band C - Residential	19	$ 601,654	
Band D - Residential	13	$ 254,384	
Band G - Residential	45	$ 2,770,335	
Band H - Residential	74	$ 6,289,320	
Total Capitated Contract	**416**	**$ 13,466,116**	
Special Contracts			
HASCI Residential	1	$ 39,412	
HASCI - Individual Rehab Supports	1	$ 11,250	
Early Intervention	77	$ 276,389	
Family Support	-	$ 45,545	
State Funded Community Supports	4	$ 56,888	
Total Special Contracts	**83**	**$ 429,484**	
TOTAL MAX ABILITIES OF YORK CONTRACTS	**499**	**$ 13,895,600**	
SERVICES	**# OF CONSUMERS**	**CONTRACT AWARD AS OF 2018**	**COUNTIES SERVED**
Case Management	428	$ 709,271	Cherokee, Chester, Lancaster, spartanburg, Union, York
Early Intervention	77	$ 276,389	
Day	237	$ 2,833,114	York
Residential	152	$ 8,310,421	
At-Home Services	265	$ 2,475,676	

Administrative Costs

Agency

Local Board

SC Department of Disabilities and Special Needs			
Administration Program Expenditures to Total Agency Expenditures			
September 13, 2017			
	Admin		Total
Fiscal Year	Totals	% of Total	Expenditures
2012	$7,426,284	1.58%	$468,890,174
2013	$7,274,128	1.51%	$480,615,564
2014	$7,159,375	1.34%	$533,511,342
2015	$7,640,917	1.30%	$588,162,190
2016	$7,915,654	1.29%	$611,683,916
2017	$8,623,289	1.33%	$648,844,004

		Total Expenses		Administration Allocation	%
Marlboro	$	1,486,533.00	$	206,396.00	13.88%
Hampton	$	1,766,486.00	$	248,445.00	14.06%
Jasper	$	2,894,557.00	$	350,883.00	12.12%
Bamberg	$	2,902,884.00	$	347,785.00	11.98%
Kershaw	$	3,028,208.00	$	309,378.00	10.22%
Williamsburg	$	3,785,131.00	$	289,717.00	7.65%
Cherokee	$	3,946,601.00	$	446,984.00	11.33%
Union	$	4,134,441.00	$	449,543.00	10.87%
Fairfield	$	4,604,352.00	$	479,193.00	10.41%
Georgetown	$	4,651,787.00	$	465,352.00	10.00%
Darlington	$	4,955,548.00	$	571,559.00	11.53%
Less than $5 million subtotal	**$**	**38,156,528.00**	**$**	**4,165,235.00**	**10.92%**
Richland/Lexington	$	5,067,806.00	$	309,101.00	6.10%
Colleton	$	5,183,256.00	$	454,856.00	8.78%
Lee	$	5,190,806.00	$	435,387.00	8.39%
Calhoun	$	5,375,854.00	$	374,322.00	6.96%
Newberry	$	5,434,967.00	$	553,914.00	10.19%
Chester-Lancaster	$	6,270,803.00	$	547,239.00	8.73%
Clarendon	$	6,323,401.00	$	440,363.00	6.96%
Marion-Dillon	$	6,675,790.00	$	896,240.00	13.43%
Allendale/Barnwell	$	6,900,496.00	$	570,571.00	8.27%
Pickens	$	7,255,107.00	$	607,057.00	8.37%
Oconee	$	7,481,848.00	$	815,923.00	10.91%
Sumter	$	8,887,090.00	$	693,521.00	7.80%
Horry	$	9,700,477.00	$	722,116.00	7.44%
Anderson	$	9,707,701.00	$	662,532.00	6.82%
Dorchester	$	10,588,946.00	$	651,152.00	6.15%
Laurens	$	10,683,870.00	$	624,769.00	5.85%
Berkeley	$	10,767,963.00	$	491,628.00	4.57%
MaxAbilities of York County	$	13,199,243.00	$	1,018,795.00	7.72%
Florence	$	13,245,573.00	$	1,050,235.00	7.93%
Orangeburg	$	13,533,056.00	$	575,681.00	4.25%
Between $5 and $15 million subtotal	**$**	**167,474,053.00**	**$**	**12,495,402.00**	**7.46%**
Tri-Development	$	16,377,259.00	$	1,066,033.00	6.51%
Burton Center	$	16,711,219.00	$	1,458,794.00	8.73%
CHESCO	$	22,711,038.00	$	872,586.00	3.84%
Charleston	$	25,372,187.00	$	1,203,457.00	4.74%
Thrive Upstate	$	25,767,332.00	$	1,441,527.00	5.59%
Charles Lea	$	28,302,525.00	$	2,901,674.00	10.25%
Babcock	$	32,062,185.00	$	2,640,407.00	8.24%
Over $15 million subtotal	**$**	**167,303,745.00**	**$**	**11,584,478.00**	**6.92%**
Overall Statewide Total	**$**	**372,934,326.00**	**$**	**28,245,115.00**	**7.57%**

Innovations Related to Potential Medicaid Changes

NASUAD
National Association of States
United for Aging and Disabilities

1201 15th Street NW
Suite 350
Washington, DC 20005
Phone 202-898-2578
Fax 202-898-2583
www.nasuad.org

September 21, 2017

Hon. Mitch McConnell
Majority Leader
U.S. Senate

Hon. Orrin Hatch
Chairman
Senate Finance Committee

Dear Majority Leader McConnell and Chairman Hatch:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to you in regards to the current efforts to repeal and replace the Affordable Care Act. NASUAD is a nonpartisan association of state government agencies and represents the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and individuals with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including Medicaid long-term services and supports (LTSS), the Older Americans Act (OAA), and a variety of other health and human services programs. Together with our members, we work to design, improve, and sustain state systems delivering home and community-based services and supports for people who are older or have a disability and for their caregivers.

We have reviewed the text of the legislation released on September 13th by Senators Cassidy (R-LA), Graham (R-SC), Heller (R-NV), and Johnson (R-WI). As you know, the legislation would transform the ACA coverage expansions, including the Medicaid Childless Adult Group, the Advance Premium Tax Credits, the Cost Sharing Reductions, and the Basic Health Plan, into a block grant to states. The legislation would also provide the opportunity for states to apply for waivers of ACA insurance regulations, such as community rating and essential health benefits. Additionally, the legislation would make significant changes to the core Medicaid program by establishing a per capita limitation on total federal funding for each state. As a nonpartisan organization, we are not taking a stance on the efforts to repeal and replace the Affordable Care Act. However, as administrators of Medicaid long-term services and supports, as well as other programs for older adults and persons with disabilities, we have concerns about several of the policies included in the bill text. We specifically have concerns that this legislation seeks to impose a per capita cap on Medicaid expenditures, which is outside the scope of ACA's coverage expansion and insurance regulations. Below, we provide a summary of our concerns and, where appropriate, provide recommendations for improving these provisions.

Establishment of Per Capita Caps

Section 124 of the legislation sets an upper limit of Federal match that a state may receive based on the number enrollees in Medicaid. The per capita caps are established using state FY2016 expenditures for four groups:

- Individuals age 65 or older;
- Individuals who are blind or have a disability;
- Children under the age of 19 without disabilities who are not eligible via CHIP; and
- Adults who are not included in the prior groups.

An aggregate cap is then placed on total Medicaid spending by multiplying the per capita spending limits for each of the groups by the average number of monthly enrollees within the group. As we have previously discussed in our comments on prior ACA repeal and replace proposals, this policy will create a number of challenges to states, including:

- It prevents states from targeting Medicaid to individuals with the highest level of need: Under this policy, states do not have the ability to target individuals with the highest need because the spending caps are based upon historical spending for all individuals within each enrollee category without any risk-adjustment provisions. This will create challenges if states experience budget pressure and look to restrict eligibility in a way that preserves services for individuals with the highest level of need. For example, if a state experiencing a budget shortfall increases the level of care requirements for LTSS eligibility, the new eligibility policy would ensure that services remain available for individuals with the highest level of need. However, the resulting higher acuity of individuals who remain in the program would result in a higher per-person cost of care which would likely create challenges with the per capita caps. In short, the policy creates incentives to serve a larger number of individuals with lower care requirements instead of focusing supports on those with the most significant health and LTSS needs.
- The policy limits states' ability to expand benefits: States without optional benefits would find it difficult to add additional services that could be valuable for participants, such as adult dental care; expanded rehabilitation benefits; or enhanced HCBS programming. Many states have made efforts to broaden benefits in order to improve the overall health and well-being of their Medicaid beneficiaries while simultaneously reducing the need for institutional LTSS and reducing hospitalization. Since these high-cost services are often financed by Medicare, any savings generated from the expanded Medicaid benefits would not be reflected in the cap calculations. Thus, benefit enhancements that result in improved health and reduced overall expenditures would be unworkable under this bill;
- The policy forces states to freeze or reduce provider rates: Freezing spending based on historic levels undermines efforts to increase provider rates, as provider payments constitute the vast majority of Medicaid spending. Thus, increases to payment rates will violate the spending caps. Additionally, states that were forced to implement payment rate reductions or benefit restrictions during economic downturns would be prevented from restoring those cuts once state finances rebound. CMS has been working with states to promote access to services, which has included review of state reimbursement rates

compared to other health insurance programs.[1] Implementation of these caps on spending will undermine these efforts and prevent states from any upward adjustment of provider rates;

- It limits the ability of states to respond to new requirements: Medicaid spending is often driven by factors beyond state control, such as new and costly treatments and technology, increases to provider payments due to wage growth and staffing changes, or changes to federal requirements. For example, complying with the 2014 Home and Community-Based Services final rule[2] is likely to require increased staffing ratios at various LTSS providers, which requires increased spending that results in a violation of the caps. Similarly, the Department of Labor has modified FLSA rules in a manner that continues to increase LTSS expenditures and will likely exacerbate the challenges to remain compliant with the caps;[3]
- It creates competition between spending for different populations in Medicaid: The per capita caps are calculated independently for each population, but they are applied in an aggregate manner. Thus, increased spending for one category of enrollees would need to be offset by other groups. Given that older adults, people with disabilities, and LTSS participants represent a disproportionate portion of the total Medicaid spend, they are likely to be places where spending constraints are applied and felt most acutely.
- It uses a base-year that is already completed: The calculation is based upon prior state expenditures for these populations, allowing states to select baseline expenditures from fiscal year quarters that fall between the first fiscal quarter of 2014 and the third fiscal quarter of 2017. This policy would not be responsive to changes that have been made since that date, nor would it account for mid-year modifications that could have altered expenditures for a period of less than the entire fiscal year. States would effectively be limited to policies in place during a previous period, and any improvements to services, reimbursement increases, or other policies with a fiscal impact would need to be undone. For example, states that have aggressively moved to address the opioid epidemic through in calendar year 2017 their Medicaid program would need to either roll-back any of those increased expenditures or find offsetting reductions in other parts of the program.

Due to all of these challenges, we recommend that Congress remove the per capita cap policies included in this legislation. States have a vested interest in the fiscal sustainability of the program and must ensure that they have balanced budgets each year. The existing financing arrangement where states establish the appropriate eligibility, benefits, and reimbursement policies based upon their unique characteristics and available finances should be maintained.

Lack of Flexibility for States

The legislation includes significant new restrictions to Federal financing for states but does not offer any corresponding state flexibility. When discussing the value of Medicaid reform proposals, state flexibility is the most significant benefit that policymakers propose to give state agencies in exchange for limitations in Federal funds. Yet this legislation leaves the major Medicaid

[1] https://www.federalregister.gov/documents/2015/11/02/2015-27697/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services

[2] https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

[3] https://www.dol.gov/whd/homecare/agencies-what-are-requirements.htm

requirements that drive state spending intact. This includes retaining all mandatory Medicaid eligibility categories, mandatory services, the early and periodic screening, diagnostic, and treatment (EPSDT) benefit, and the Medicaid drug rebate coverage requirements. We specifically note that in the LTSS space the legislation does not address Medicaid's institutional bias or provide opportunities to reduce expenditures by rebalancing LTSS towards home and community-based services. In fact, some of the policies, as discussed below, actually reduce the ability of states to provide HCBS in their Medicaid programs.

We note that the Flexible Block Grant option does provide some greater ability of states to modify their programs; however, in some cases it actually includes more expansive benefit requirements than the 1905(a) services. Similarly, it maintains all mandatory Medicaid populations without including much opportunity to adjust for enrollment changes. This creates a challenging dynamic that may make it challenging for states to effectively leverage the flexibilities that a block grant could otherwise provide.

All of these requirements place significant responsibilities on states regarding the individuals and services that must be covered. Thus, keeping them in place will severely limit the ability of states to respond to the bill's funding limitation by implementing flexible, innovative, and targeted reforms that reduce the spending growth in Medicaid while maintaining the health of individuals covered. Without corresponding flexibility to accompany the limitation in Federal funding, the legislation will simply serve as a cost-shift from the Federal government to states rather than a reform that strengthens the program.

Repeal of the Community First Choice Matching Increase

The legislation repeals the six percent increase in matching funds provided to state programs established under 1915(k) of the Social Security Act. These programs, called "Community First Choice" or "CFC," provide valuable and necessary attendant care services to older adults and individuals with significant disabilities that enable them to live in the community. The most beneficial parts of the CFC program are that the program does not include limitations on the number of individuals served and the increased Federal matching funds. These increased funds are one of the major factors that enable states to use CFC as a mechanism to reduce waiting lists for home and community-based services (HCBS). Repealing this increased funding will likely result in states needing to re-establish waiting lists for HCBS due to the reduction in available resources.

Several other important programs that promote the use of HCBS in lieu of institutional services have lapsed during the past several years, including the Balancing Incentives Program (BIP) and the Money Follows the Person Program (MFP). The expiration of MFP and BIP are already reducing the Federal government's support of deinstitutionalization activities, and the repeal of enhanced funding for these important CFC services will further exacerbate the lack of funding. Ultimately, this will be detrimental to both the states and the people served in LTSS programs. We encourage Congress to maintain this important program and the enhanced funding that it provides.

HCBS Provider Payment Adjustment Grant

We appreciate that the legislation includes $8 billion in funding to address HCBS quality and access

issues. We request clarification regarding how the payment adjustments will be calculated, as well as the limitation on individual providers. Lastly, we note that the legislation does not appear to specifically exclude these payment adjustments from the calculation of 1903A per capita caps. In the event that the per capita cap policy is retained, we request clarification regarding how the increased payments under this provision would interact with the aggregate limit on expenditures.

Medicaid Expansion and Market-Based Health Care Grant Program

We note that the legislation creates a new block grant using funding derived from repealing the ACA's Medicaid expansion, advance premium tax credits, cost sharing reduction payments, and Basic Health Plan. While we appreciate the way that these programs focus on state flexibility, we are concerned with the long-term sustainability of the fund. Current ACA provisions are responsive to growth in population, medical inflation, and increased eligibility due to economic downturns. In contrast, the block grants grow at a defined rate without regard to these factors. The block grants also do not take into account regional in cost of living and health care expenses. Lastly, the block grants would necessitate transitioning individuals from Medicaid into the private marketplace, which historically has higher per-person costs. Since the grant allocations are based upon current spending under the ACA, this shift could increase expenses beyond what the grants are funded to cover. We are concerned that, without appropriate funding, these programs will have the unintended consequences of reducing coverage for individuals while increasing out of pocket costs.

This concern is particularly relevant to individuals with disabilities and health conditions who may struggle to secure affordable care in the private marketplace. A study published in Health Affairs[4] found a significant number of individuals eligible under the ACA expansion to have chronic health conditions and/or disabilities. We believe that any ACA replacement should provide states with the funding needed to protect and preserve the health, welfare, and services for individuals with significant health needs and disabilities.

Repeal of the Public Health Prevention Fund

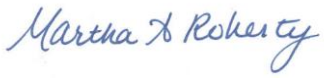
While we recognize and understand Congress' concerns with the broad scope of activities that can be included in this fund, we wish to highlight the value of some of its activities. The public health and prevention fund has been used to support a number of programs that are crucial to assisting older adults with chronic conditions and other health needs. The Administration for Community Living has used resources from this fund to support several important activities, including chronic disease self-management, falls prevention, and Alzheimer's education and outreach. Other programs through this fund have focused on diabetes and stroke prevention, which are significant for older adults. Repealing the bill would represent a step backwards for preventive care, research, and health promotion of older adults. We believe that some of Congress' concerns could be alleviated through stringent monitoring and evaluation of grant activities, instead of repealing the fund completely.

[4] http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/

Concluding Thoughts
As noted earlier, NASUAD is a nonpartisan organization and will not be taking a stance on the efforts to repeal and replace the Affordable Care Act nor will we be endorsing or opposing any specific pieces of legislation. However, we have serious concerns about the impact the bill may have on state governments, on LTSS programs, as well as on older adults, persons with disabilities, and their caregivers. We would be pleased to work with Congress to find ways to improve the legislation in a manner that supports and promotes the health, welfare, and community living of the individuals we serve.

If you have any questions regarding this letter, please feel free to contact Damon Terzaghi of my staff at dterzaghi@nasuad.org or (202) 898-2578.

Sincerely,



Martha A. Roherty
Executive Director
NASUAD

Cc:

Members of the U.S. Senate

FOR IMMEDIATE RELEASE

September 21, 2017

contact: Matt Salo
matt.salo@medicaiddirectors.org

NAMD Statement on Graham-Cassidy

The Board of Directors of the National Association of Medicaid Directors (NAMD) urges Congress to carefully consider the significant challenges posed by the Graham-Cassidy legislation. State Medicaid Directors are strong proponents of state innovation in the drive towards health care system transformation. Our members are committed to ensuring that the programs we operate improve health outcomes while also being fiscally responsible to state and federal taxpayers. In order to succeed, however, these efforts must be undertaken in a thoughtful, deliberative, and responsible way. We are concerned that this legislation would undermine these efforts in many states and fail to deliver on our collective goal of an improved health care system.

1. Graham-Cassidy would completely restructure the Medicaid program's financing, which by itself is three percent of the nation's Gross Domestic Product and 25 percent of the average state budget. Like BCRA, the legislation would convert the traditional Medicaid program into a per-capita cap financing system. All states will be impacted by this change, regardless of their decisions to leverage the Medicaid expansion option under the ACA. It would also incorporate Medicaid expansion funding and other ACA health funds into a block grant, made available to all states. How these block grants will be utilized, what programs they may fund, and the overall impact they will have on state budgets, operations, and citizens are all uncertain. Taken together, the per-capita caps and the envisioned block grant would constitute the largest intergovernmental transfer of financial risk from the federal government to the states in our country's history. While the block grant portion is intended to create maximum flexibility, the legislation does not provide clear and powerful statutory reforms within the underlying Medicaid program commensurate with proposed funding reductions of the per capita cap.

2. The Graham-Cassidy legislation would require states to operationalize the block grant component by January 1, 2020. The scope of this work, and the resources required to support state planning and implementation activities, cannot be overstated. States will need to develop overall strategies, invest in infrastructure development, systems changes, provider and managed care plan contracting, and perform a host of other activities. The vast majority of states will not be able to do so within the two-year timeframe envisioned here, especially considering the apparent lack of federal funding in the bill to support these critical activities.

3. Any effort of this magnitude needs thorough discussion, examination and analysis, and should not be rushed through without proper deliberation. The legislative proposal would not even have a full CBO score until after its scheduled passage, which should be the bare minimum required for beginning consideration. With only a few legislative days left for the entire process to conclude, there clearly is not sufficient time for policymakers, Governors, Medicaid Directors, or other critical stakeholders to engage in the thoughtful deliberation necessary to ensure successful long-term reforms.

For these reasons, we encourage Congress to revisit the topic of comprehensive Medicaid reform when it can be addressed with the careful consideration merited by such a complex undertaking – as we articulated in our June 26 statement on BCRA.

# # #

NASDDDS

National Association of State Directors of Developmental Disabilities Services

NASDDDS Statement Opposing Proposed Graham-Cassidy-Heller-Johnson Legislation

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) is a non-profit membership organization of state developmental disabilities agency directors. Our members are the 51 state agencies that oversee Long-Term Supports and Services (LTSS) systems for individuals with intellectual and developmental disabilities, which are predominantly funded by Medicaid. The principal mission of NASDDDS is to assist state agencies in building person-centered systems of services and supports for people with developmental disabilities and their families.

Medicaid is our nation's largest payer of long-term services and supports (LTSS), which includes home and community-based services (HCBS) and institutional services such as nursing facilities and institutions for individuals with intellectual disabilities (ICF/IID). These services maintain the health, function, independence, and well-being of millions of people with intellectual and developmental disabilities, elderly people, and individuals with physical disabilities, behavioral health diagnoses, spinal cord or traumatic brain injuries, and/or disabling chronic conditions. Total Medicaid LTSS expenditures were $158 billion in FY 2015—nearly a third of all Medicaid spending for the year.

NASDDDS strongly believes that as a nation we must have a clear and honest conversation about how best to address and fund the LTSS needs of the people we support. This conversation must be thoughtful and deliberate, bipartisan, and informed by accurate data. The process Congress has engaged in this year to develop health care reform to meet reconciliation instructions in the 2017 congressional budget resolution has included significant alterations to Medicaid without meeting any of these criteria. State I/DD agency directors are particularly concerned with provisions in the Graham-Cassidy-Heller-Johnson legislation, similar to those in the House-passed American Health Care Act (AHCA) and in the Senate's previous bill, the Better Care Reconciliation Act (BCRA), which would dramatically reduce funding for Medicaid and for our nation's LTSS system.

While the Congressional Budget Office (CBO) has not yet had a chance to weigh in on the impact of Graham-Cassidy, reputable analysts estimate that the per capita cap provisions in the bill will cut approximately $1 trillion from Medicaid over the next twenty years. These cuts would undermine the ability of states to meet the LTSS needs of

individuals with developmental disabilities. NASDDDS firmly opposes this or any legislative package that includes Medicaid cuts of this magnitude.

NASDDDS and its members are prepared and willing to participate in thoughtful and deliberate discussions that would consider sustainable funding of LTSS. We urge Congress to halt the rush to massive cuts in LTSS funding and engage in a process that takes a broad and inclusive look at LTSS in the United States, acknowledges Medicaid's current role as the de facto LTSS system in our nation, and seeks real bipartisan solutions to meeting the support needs of our elderly and individuals with disabilities across the nation.

NASMHPD

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 (703) 739-9333 Fax (703) 548-9517

September 19, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
104 Hart Senate Office Bldg.
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The National Association of State Mental Health Program Directors writes to express our serious concerns regarding the provisions of the Senate Amendment to H.R. 1628 known as "Graham-Cassidy-Heller-Johnson (GCHJ)". We must again, as we did last July, voice our opposition to the restructuring of the Medicaid program into a per capita cap block grant program and the termination of Medicaid expansion. Medicaid is the major source of Federal funding in every state for mental health and substance use services, and expansion has been a significant driver in the treatment of substance use disorders within Medicaid, including treatment of the epidemic of opioid dependence.

NASMHPD is the organization representing the state executives responsible for the $41 billion public mental health service delivery systems serving 7.5 million people annually in 50 states, 4 territories, and the District of Columbia.

We recognize that the GCHJ proposal would require coverage of mental health and substance use disorder treatment consistent with the Health Parity and Addiction Equity Act (§ 2726 of the Public Health Service Act). However, the parity law does not require that those services be covered, only that once covered they be provided at parity. And other changes in the proposal would reduce access to substance use disorder and mental health treatment, including not only the cap on Federal funding for Medicaid and the end to Medicaid expansion, but also the potential elimination through state "flexibility" of mental health and substance use disorder benefit protections for Americans covered by Medicaid and insured through the small group and individual markets.

The elimination of Medicaid expansion under the amendment would leave without coverage the 1.3 million childless, non-pregnant adults with serious mental illness who were able, for the first time, to gain coverage under Medicaid expansion. It would also leave uncovered the 2.8 million childless, non-pregnant adults with substance use disorders who gained coverage under expansion for the first time. These are populations that Congress promised and worked to serve with the passage of 21st Century Cures and the Comprehensive Addiction and Recovery Act (CARA) of 2016, respectively.

Medicaid is the single largest payer for behavioral health services in the

United States, accounting for about 27 percent of behavioral health spending. It covers a broad range of behavioral health services at low or no cost, including psychiatric hospital care, case management, day treatment, evaluation and testing, psychosocial rehabilitation, medication management, as well as individual, group and family therapy. In 43 states, Medicaid covers essential peer support services to help sustain recovery. In states that have expanded Medicaid and which have been particularly hard hit by the opioid crisis, Medicaid has paid between 35 to 50 percent of the costs of medication-assisted treatment for substance use disorders.

Additionally, because people with behavioral health disorders experience a higher rate of chronic physical conditions than the general population, Medicaid's coverage of primary care is critical to helping this population receive needed treatment for both their behavioral health and physical medical conditions. It is also important to remember that untreated mental health and substance use disorders intensify and serve to increase the number of co-morbid medical conditions in those populations, thereby multiplying total Medicaid program and private insurance costs.

As you are aware, converting Medicaid into a per capita cap block grant program or a simple block grant program will shift significant costs to states over time. Capping Medicaid funding will force states to determine which Medicaid services should be covered, and could very well leave many low-income Americans with mental illness and substance use disorders without access to medically necessary prevention and treatment services. Ultimately, states will be forced to reduce their Medicaid rolls, benefits, and already low payments to an already scarce workforce of behavioral health providers. Mental health and substance use disorder treatments and programs will be at high risk of state budget cuts, even though they are cost-effective, because they are intensive and expensive. The long-term reduction of real funding dollars will leave states and plans no alternative but to reduce or eliminate services in order to balance state Medicaid budgets and operate within managed care organizations' capitated rates. Similar pressures will reduce coverage in the private insurance market over the long term.

NASMHPD looks forward to continuing to work with Congress to make both the insurance marketplace and the Medicaid program more accessible and cost-effective for individuals with mental illness and substance use disorders to ensure they are on their way to recovery. We support the current bipartisan efforts to stabilize the health insurance marketplaces, create competition among insurers, and lower the costs of health care.

We urge you to continue to protect vulnerable Americans' access to and coverage of vital mental health and substance use care and services, and not reverse the recent progress made with the enactment of key mental health and substance use disorder prevention and treatment reforms under the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act.

Please feel free to reach out to me by email or by phone at 703-682-5181 or to NASMHPD's Director of Policy and Communications, Stuart Yael Gordon, by email or by phone at 703-682-7552 with any questions regarding this letter.

Sincerely,

Brian Hepburn, M.D.
Executive Director
National Association of State Mental Health Program Directors (NASMHPD)

RESPONSES TO SEPTEMBER 18, 2017 MEETING FOLLOW UP LETTER

Local Board Governance

During the September 18, 2017 meeting, Subcommittee members asked a question related to Disability and Special Needs local board governance. That question was:

- For each recognized county board, please provide the following information in a tabular format:
    - Board name, counties served as the statutory county board, appointment ordinance, and appointing authority.

Agency Response

South Carolina Department of Disabilities and Special Needs

Board Governance

October 3, 2017

County	Board Name	Appointment Ordinance	Appointing Authority
Aiken	Aiken County Board of Disabilities and Special Needs (Tri-Development Center of Aiken Co., Inc.)	Ordinance No. 92-3-12 (1992)	Governor
Allendale/Barnwell	Allendale/Barnwell Counties Disabilities and Special Needs Board	Ordinance No. 92-63 (1992); 1992-55 (1992)	Governor
Anderson	Anderson County DSN Board	Ordinance No. 343 (1992)	Governor
Bamberg	Bamberg County DSN Board	Ordinance No. 1-93-1 (1993)	Governor
Beaufort	Beaufort County DSN Board	Ordinance No. 89-9 (1989)	Governor
Berkeley	Berkeley Citizens, Inc.	Ordinance No. 88-8-12 (1988)	County Council
Calhoun	Calhoun County DSN	Act 1127 (1974) (approved 1974)	Governor
Charleston	Disabilities Board of Charleston County	Ordinance No. 805 (1991)	County Council
Cherokee	Cherokee County DSN Board	Ordinance of 2-21-1995 (Unnumbered)	Governor
Chester/Lancaster	Chester-Lancaster Disabilities and Special Needs Board, Inc.	Ordinance No. 5-1-89 (1989) (Chester); 311 (1998) (Chester-Lancaster)	Governor
Chesterfield	Chesterfield County DSNB (CHESCO Services)	Ordinance No. 90-91-06 (1991)	County Council
Clarendon	Clarendon County DSN Board	Ordinance No. 11-7 (1991)	County Council
Colleton	Colleton County Board of Disabilities and Special Needs	Ordinance No. 83-0-23 (1983); 93-0-29 (1993)	County Council
Darlington	Darlington County DSN Board	Ordinance No. 91-16 (1991)	Governor
Dorchester	Dorchester County Board of Disabilities and Special Needs	Ordinance No. 90-05 (1990)	Governor
Multi-County Board (Emerald City)	Emerald City (Burton Center For Disabilities and Special Needs)	Ordinance No. 95-96-329 (1995)	Governor
Abbeville	Emerald City (Burton Center For Disabilities and Special Needs)	Ordinance No. 91-11 (1992)	Governor
Edgefield	Emerald City (Burton Center For Disabilities and Special Needs)	Ordinance No. 93-94-314 (1994)	Governor
Greenwood	Emerald City (Burton Center For Disabilities and Special Needs)	Ordinance No. 11-91 (1991)	Governor
McCormick	Emerald City (Burton Center For Disabilities and Special Needs)	Ordinance No. 94-03 (1994)	Governor
Saluda	Emerald City (Burton Center For Disabilities and Special Needs)	Ordinance 79-91 (1991)	Governor
Fairfield	Fairfield DSN Board	Ordinance No. 61 (1983)	County Council
Florence	Florence County DSN Board	Ordinance No. 15-93/94 (1993)	Governor

South Carolina Department of Disabilities and Special Needs

Board Governance

October 3, 2017

County	Board Name	Appointment Ordinance	Appointing Authority
Georgetown	Georgetown DSN Board	Ordinance No. 94-21 (1994)	Governor
Greenville	Greenville County DSN Board (Thrive Upstate)	Ordinance No. 2378 (2013)	Governor
Hampton	Hampton DSN Board	Ordinance of 12-22-1981 (Unnumbered)	Governor
Horry	Horry DSN Board	Ordinance No. 81-91 (1991)	Governor
Jasper	Jasper DSN Board	Ordinance of 10-6-1986 (Unnumbered)	Governor
Kershaw	Kershaw DSN Board	Ordinance of 7-1-1992 (Unnumbered)	Governor
Lancaster	Chester-Lancaster Disabilities and Special Needs Board, Inc.	Ordinance No. 311 (1998)	Governor
Laurens	Laurens County Disabilities & Special Needs Board	Ordinance No. 360 (1992)	Governor
Lee	Lee County Disabilities and Special Needs Board	Ordinance of 7-10-1984 (Unnumbered)	County Council
Marion/Dillon	Marion-Dillon County Board of Disabilities and Special Needs	Ordinance No. 92-1-23; 94-6-23B (1994)	Governor
Marlboro	Marlboro County DSN Board	Ordinance No. 284 (1990)	Governor
Newberry	Newberry County Disabilities and Special Needs Board	Ordinance No. 57 (1988)	County Council
Oconee	Oconee DSN Board	Ordinance No. 95-5 (1995)	Governor
Orangeburg	Orangeburg County Disabilities and Special Needs Board	Ordinance No. 88-4-7 (1988)	County Council
Pickens	Pickens County DSN Board	Ordinance No. 111 (1986)	Governor
Richland/Lexington	Richland-Lexington DSN Board	Ordinance No. 92HR (1992)	Governor
Sumter	Sumter County Disabilities and Special Needs Board, Inc.	Ordinance No. 95-288 (1995)	Governor
Spartanburg	Spartanburg DSN Board	Ordinance No. 122 (1979)	County Council
Union	Union Disabilities and Special Needs Board	Ordinance No. 102 (1993)	Governor
Williamsburg	Williamsburg DSN Board	Ordinance No. 1994-6 (1994)	Governor
York	York County Board of Disabilities and Special Needs (dba Maxabilities of York County)	Ordinance No. 917 (2017)*	Governor

*Most recent revision

CHAPTER 21
Department of Disabilities and Special Needs Family Support Services

SECTION 44-21-10. Legislative intent; intent of program; guiding principles.

(A) It is the intent of the General Assembly that individuals with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities and their families be afforded supports that emphasize community living and enable them to enjoy typical lifestyles. One way to do this is to recognize that families are the greatest resource available to individuals with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities and that families must be supported in their role as primary caregivers. The General Assembly finds that supporting individuals and families in their effort to care for themselves or their family members at home is more efficient, cost-effective, and sensitive than maintaining people with intellectual disability or related disabilities in out-of-home residential settings.

(B) The intent of the Family Support Services Program provided for in this chapter is to assist individuals with disabilities and their families who desire or choose to support a family member with intellectual disability or a related disability or head injury, spinal cord injury, or similar disability in their home. The program is not meant to create a hardship on a family by supplanting or diverting access from other appropriate or necessary services. It is recognized that persons with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities have the right to receive services from public and other agencies that provide services to South Carolina citizens and to have those services coordinated with the services needed because of their disabilities. It is the position of this State that children and adults have the right to live with their families. The individual's and family's circumstances and desires must be taken into account when considering the appropriate types of services or supports which can best meet the needs of the individual and family.

(C) In recognition of the importance of families, the following principles must be used as guidelines in developing services to support families:

(1) Families and individuals with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities are best able to determine their own needs and should be able to make decisions concerning necessary, desirable, and appropriate services.

(2) Individuals and families should receive the support necessary to care for themselves or their family member at home.

(3) Family support is needed throughout the lifespan of an individual with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities.

(4) Family support services should be sensitive to the unique needs, strengths, and values of the individuals and the family and should be responsive to the needs of the entire family.

(5) Family support should build on existing social networks and natural sources of support and should encourage community integration.

(6) Family support services should be provided in a manner that develop comprehensive, responsive, and flexible support to individuals and families as their needs evolve over time.

(7) Family support services should be coordinated across the numerous agencies likely to provide resources and services to individuals and families and should be provided equitably across the State.

(8) Family, individual, and community-based services should be based on the principles of sharing ordinary places, developing meaningful relationships, learning things that are useful, making choices, as well as promoting an individual's self-esteem.

(9) Family support services should be sufficient to enable families to keep their family members with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities at home or be sufficient to enable the individual with a disability to remain at home.

(10) Services provided through the Family Support Program must be coordinated closely with services received from public and other agencies and shall foster collaboration and cooperation with all agencies providing services to individuals with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities.

(D) The General Assembly recognizes that the South Carolina Department of Disabilities and Special Needs for several years has developed and maintained a family support program that provides support services to some families with members with intellectual disability. The success of this program demonstrates the need and value of family support services. More families in the State should be able to receive appropriate services and assistance needed to stabilize the family unit.

HISTORY: 1993 Act No. 38, Section 1; 1994 Act No. 344, Section 2; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment substituted "intellectual disability" for "mental retardation" throughout; in subsection (A), substituted "with intellectual disability" for "who have mental retardation"; in subsection (C)(3) substituted "with intellectual disability" for "who has mental retardation"; and in subsection (D) substituted "with intellectual disability" for "who have mental retardation".

SECTION 44-21-20. Definitions.

As used in this chapter:

(1) "Department" means the Department of Disabilities and Special Needs.

(2) "Family support" means goods and services needed by individuals or families to care for themselves or their family members with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities and to enjoy a quality of life comparable to other community members.

(3) "Family Support Program" means a coordinated system of family support services administered by the department directly or through contracts with private nonprofit or governmental agencies across the State, or both.

HISTORY: 1993 Act No. 38, Section 1; 1994 Act No. 344, Section 2; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment substituted "intellectual disability" for "mental retardation" in subsection (2).

SECTION 44-21-30. Authority to contract or make grants.

The department may contract with or make grants to agencies or individuals to provide for a Family Support Program in accordance with this chapter. Services and supports developed must be flexible to address individual and family needs.

HISTORY: 1993 Act No. 38, Section 1; 1994 Act No. 344, Section 2; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."

Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-21-40. Focus of Family Support Program.

The focus of the Family Support Program is supporting:

(1) families with children with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities, twenty-one years of age and younger;

(2) persons older than twenty-one years of age with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities who choose to live with their families;

(3) persons older than twenty-one years of age with intellectual disability or related disabilities or head injuries, spinal cord injuries, or similar disabilities who are residing in the community in an unsupported setting, not a state or federally funded program.

HISTORY: 1993 Act No. 38, Section 1; 1994 Act No. 344, Section 2; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment substituted "intellectual disability" for "mental retardation" throughout.

SECTION 44-21-50. Contracted agency to assist families in assessing needs and preparing plan.

The contracted agency shall assist each individual or family for whom services will be provided in assessing its needs and shall prepare a written plan with the person and family. The needs and preferences of the individual and family will be the basis for determining what goods and services will be provided within the resources available.

HISTORY: 1993 Act No. 38, Section 1; 1994 Act No. 344, Section 2; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-21-60. Services included in Family Support Program.

The services in the Family Support Program include, but are not limited to, family support services coordination, information, referral, advocacy, educational materials, emergency and outreach services, and other individual and family-centered assistance services such as:

(1) respite care;

(2) personal assistance services;

(3) child care;

(4) homemaker services;

(5) minor home and work site modifications and vehicular modifications;

(6) specialized equipment and maintenance and repair;

(7) specialized nutrition and clothing and supplies;

(8) transportation services;

(9) health-related costs not otherwise covered;
(10) licensed nursing and nurses' aid services;
(11) family counseling, training, and support groups;
(12) financial assistance;
(13) emergency services;
(14) recreation and leisure needs.

HISTORY: 1993 Act No. 38, Section 1; 1994 Act No. 344, Section 2; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-21-70. Implementation contingent upon annual appropriations.

Implementation of this chapter and the Family Support Program is contingent upon annual appropriation of sufficient funding for the program and benefits. This chapter does not establish or authorize creation of an entitlement program or benefit.

HISTORY: 1993 Act No. 38, Section 1; 1994 Act No. 344, Section 2; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-21-80. Regional tertiary level developmental evaluation centers.

(A) The Department of Pediatrics of the Medical University of South Carolina, the University Pediatrics of the University Affiliated Program of the University of South Carolina, and the Children's Hospital of the Greenville Hospital System, are each hereby authorized, as agents of the State of South Carolina, to fulfill the role of Regional Tertiary Level Developmental Evaluation Centers providing comprehensive developmental assessment and treatment services for children with developmental disabilities, significant developmental delays, or behavioral or learning disorders.

(B) As developmental evaluation centers, the above named institutions shall provide a seamless continuum of developmental services, including medically necessary diagnostic and treatment services for the purpose of correcting or ameliorating physical or mental illnesses and conditions which, left untreated, would negatively impact the health and quality of life of South Carolina's children. Further, these centers shall work collectively with the teaching, training, and research entities of each institution, extending the state's efforts to prepare professionals to work in the field of developmental medicine, while lending expertise to the research efforts in this field.

(C) The developmental evaluation centers shall be involved in research, planning, and needs assessment of issues related to developmental disabilities and shall be committed to develop a regionalized system of community-based, family-centered care for children with developmental and behavioral disabilities. In so doing, the centers shall serve as primary points of entry for developmental evaluation services and as

regional coordinators for the delivery of the services and are encouraged to affiliate with other providers thus enhancing the availability of high quality services for the children of South Carolina.

HISTORY: 1996 Act No. 458, Part II, Section 86; 2011 Act No. 47, Section 3, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

DDSN Organizational Structure

During the September 18, 2017 meeting, Subcommittee members asked a question related to the agency's organizational structure. That question was:

- Could changes to the Department of Disabilities and Special Needs (DDSN) organizational structure allow the agency to better serve its clients? If so, please provide potential options to do this.

Agency Response

A response will be provided during subsequent meetings.

Services (DDSN and Provider Network)

During the September 18, 2017 meeting, Subcommittee members asked questions about services provided to DDSN consumers. Those questions were:

- Has a service needs assessment been conducted for each county? How does the agency ensure appropriate services are available in each county?
- What services are not covered by Medicaid? For each listed service, was the decision to provide the service based on statute? If not, what was it based on?
- What services would DDSN offer if there were infinite resources?
- What other states exemplify service to populations served by DDSN? Why are those states successful?
- How many people are housed at the regional centers? What are the mean and median lengths of residence for consumers at the regional centers?

Agency Response

The agency provided the documents on pages _____ and will provide more information during subsequent meetings.

Program	Intellectual Disabilities & Related Disabilities (ID/RD) Waiver	Head & Spinal Cord Injuries (HASCI Waiver)	Pervasive Developmental Disorder (PDD) Waiver*	Community Supports Waiver
Group Served	Medicaid eligible, all ages, with intellectual disabilities or related disabilities and Autism Spectrum Disorder	Medicaid eligible, age 0-65, with head and/or spinal cord injuries or similar disabilities	Medicaid eligible children age 3-10 who have been diagnosed with PDD including Autism Spectrum Disorder meet level of care criteria	Medicaid eligible, all ages, with intellectual disabilities or related disabilities and Autism Spectrum Disorder
Contact Agency	DDSN Single Point of Entry 1-800-289-7012 (toll-free)	DDSN - HASCI Info. & Referral Service 1-866-867-3864 (toll free)	DDSN - PDD Intake & Referral 1-888-576-4658 (toll free)	DDSN Single Point of Entry 1-800-289-7012 (toll-free)
Level of Care	Intermediate Care Facility/Individuals with Intellectual Disability	Nursing Facility or Intermediate Care Facility/Individuals with Intellectual Disability	Intermediate Care Facility/Individuals with Intellectual Disability	Intermediate Care Facility/Individuals with Intellectual Disability
Available Servs	Personal Care I Personal Care II Residential Habilitation Evironmental Modifications Private Vehicle Modifications Durable Medical Equipment/Assistive Technology Prescription Drugs Respite Care Audiology Services Adult Companion Services Nursing Services Adult Dental Adult Vision Adult Day Health Care (ADHC) ADHC Nursing	Prevocational Services Day Habilitation Supported Employment Attendant Care Health Education for Consumer Directed Care Peer Guidance for Consumer Directed Care Residential Habilitation Medical Supplies, Equipment & Assistive Technology Prescription Drugs Respite Care Personal Emergency Response System (PERS) Physical Therapy Occupational Therapy	Case Management Early Intensive Behavioral Intervention	Personal Care I Personal Care II Adult Day Health Care (ADHC) ADHC Nursing ADHC Transportation Respite Care Environmental Modifications Specialized Medical Equipment, Supplies, Assistive Technology & Appliances Incontinence Supplies Private Vehicle Modifications Behavior Support Services Day Activity Services Career Preparation Services Community Services Employment Services

Program	Intellectual Disabilities & Related Disabilities (ID/RD) Waiver	Head & Spinal Cord Injuries (HASCI Waiver)	Pervasive Developmental Disorder (PDD) Waiver*	Community Supports Waiver
	ADHC Transportation Adult Attendant Care Behavior Support Services Career Preparation Employment Services Day Activity Community Services Support Center Services Personal Emergency Response System (PERS) Pest Control	Psychological Services Behavior Support Services Nursing Services Speech, Hearing & Language Services Private Vehicle Modifications Environmental Modifications	** Sunsetting Dec 2017*	Support Center Services In-Home Support Personal Emergency Response System (PERS)
Waiting List	YES	NO	YES	YES

South Carolina Department of Disabilities and Special Needs

FY 2017 State Funded Expenditures

July 26, 2017

Area	Amount
State Funded Family Support	$ 1,454,800
State Funded Community Supports	$ 3,443,012
State Funded Follow Along	$ 113,992
Early Intervention (40% is State Funded)	$ 10,269,976
Case Management (10% is State Funded)	$ 2,049,866
State Funded Case Management	$ 1,173,924
PDD - State Funded	$ 4,700,813
Caregiver Relief	$ 380,298
Post Acute TBI / SCI	$ 3,100,000
Bed Fees	$ 3,565,109
Correct Care, Just Care, Alt Placement	$ 4,238,019
Child Day	$ 317,594
State Funded Residential (Non-HASCI)	$ 2,734,895
Greenwood Genetics - Autism Research	$ 200,000
Head & Spinal Cord (Residential, Community Opportunities)	$ 1,081,496
GRAND TOTAL - STATE FUNDED	**$ 38,823,794**

State Funded Expenditures
Brief Descriptions

State Funded Family Support: When no other assistance is available**,** financial assistance for families who care for those with a disability to provide relief from direct, hands-on caregiving or improve an unsafe, risky or dangerous situation.

State Funded Community Supports: Available to those not eligible for a Medicaid HCBS Waiver for which services are needed to avoid out-of-home placement.

State Funded Follow Along: Available to those who are not enrolled in a Medicaid HCBS Waiver who have secured integrated, individual employment and require on-going supports to maintain employment.

Early Intervention: Family training provided in-home by trained staff intended to increase family's ability to promote the developmental growth of children ages birth to three (3).

Case Management: Ongoing assistance provided to gain access to needed medical, social, educational and other services.

State Funded Case Management: Services available to those who are not Medicaid eligible to gain access to needed medical, social, educational and other services.

PDD- State Funded: Services provided per the 2006-2007 General Appropriations Act to include applied behavior analytic and case management services paid with 100% state dollars for non-Medicaid recipients. These individuals meet all program requirements to receive the 1915c HCBS Pervasive Developmental Disorder Waiver service with the exception of Medicaid eligibility.

Caregiver Relief: Group respite provided on an alternate schedule (e.g., Saturday) to those without other available funding sources for respite.

Post Acute TBI/SCI: Rehabilitation services provided for uninsured or under-insured individuals to address needs as soon as possible post-injury.

Bed Fees: The federal government allows states to charge a per bed tax for hospital and nursing home beds that are provided to Medicaid recipients. The bed tax/fee covers some of the cost of administering the Medicaid program within the state.

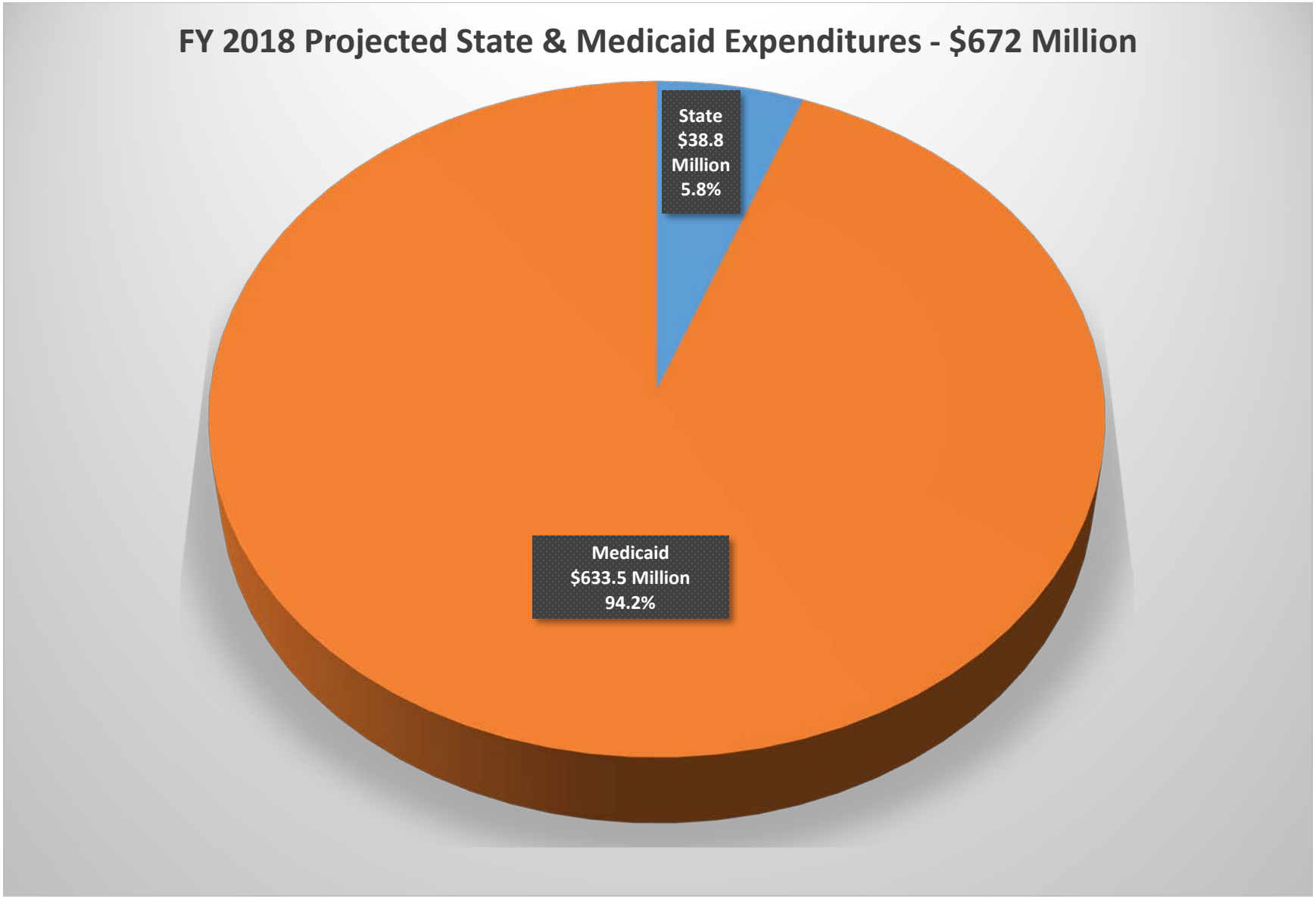
Correct Care, Just Care, Alt. Placement: Specialized residential service provided to individuals involved in the criminal justice system.

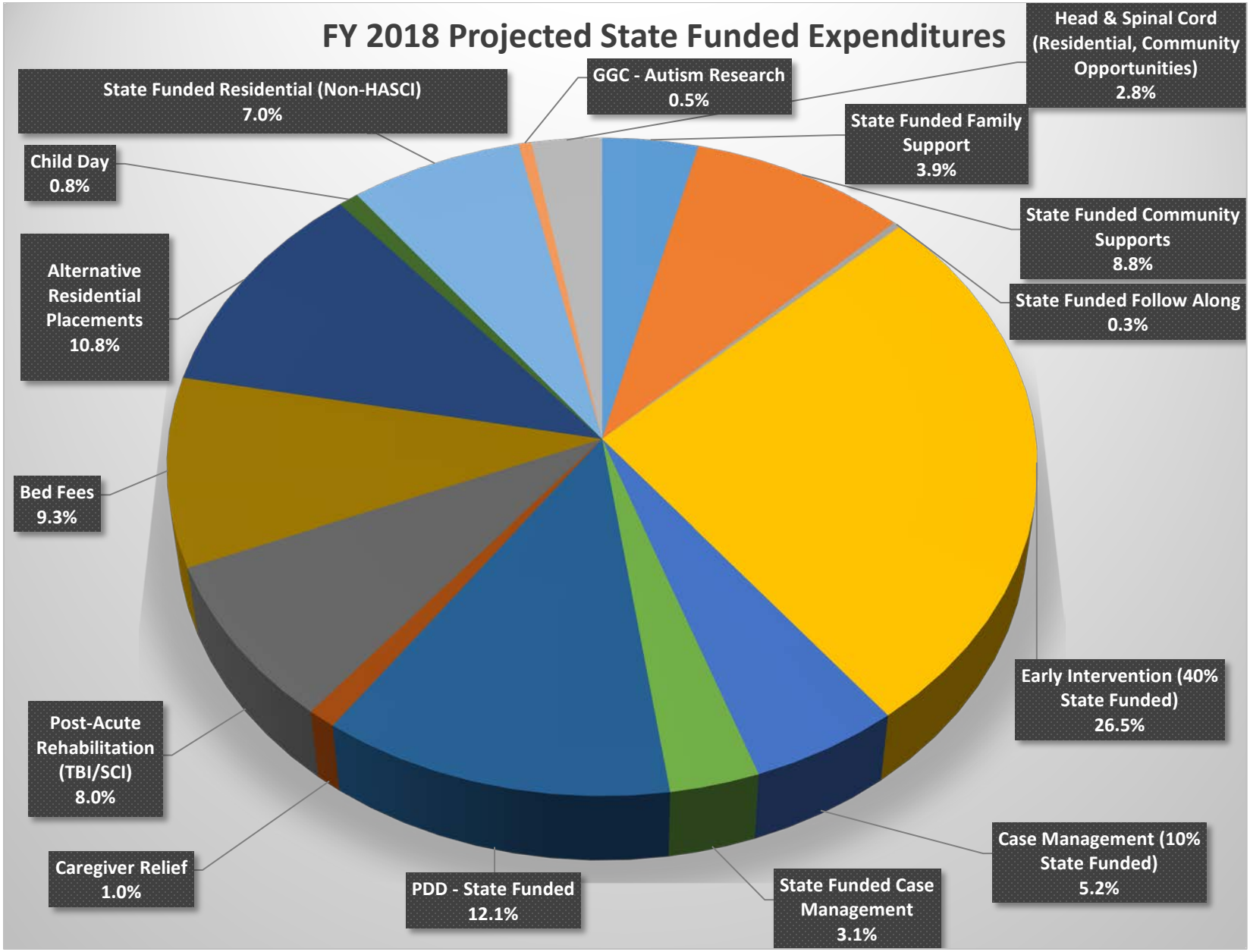
Child Day: Limited, specialized daytime activity program for children with intensive needs.

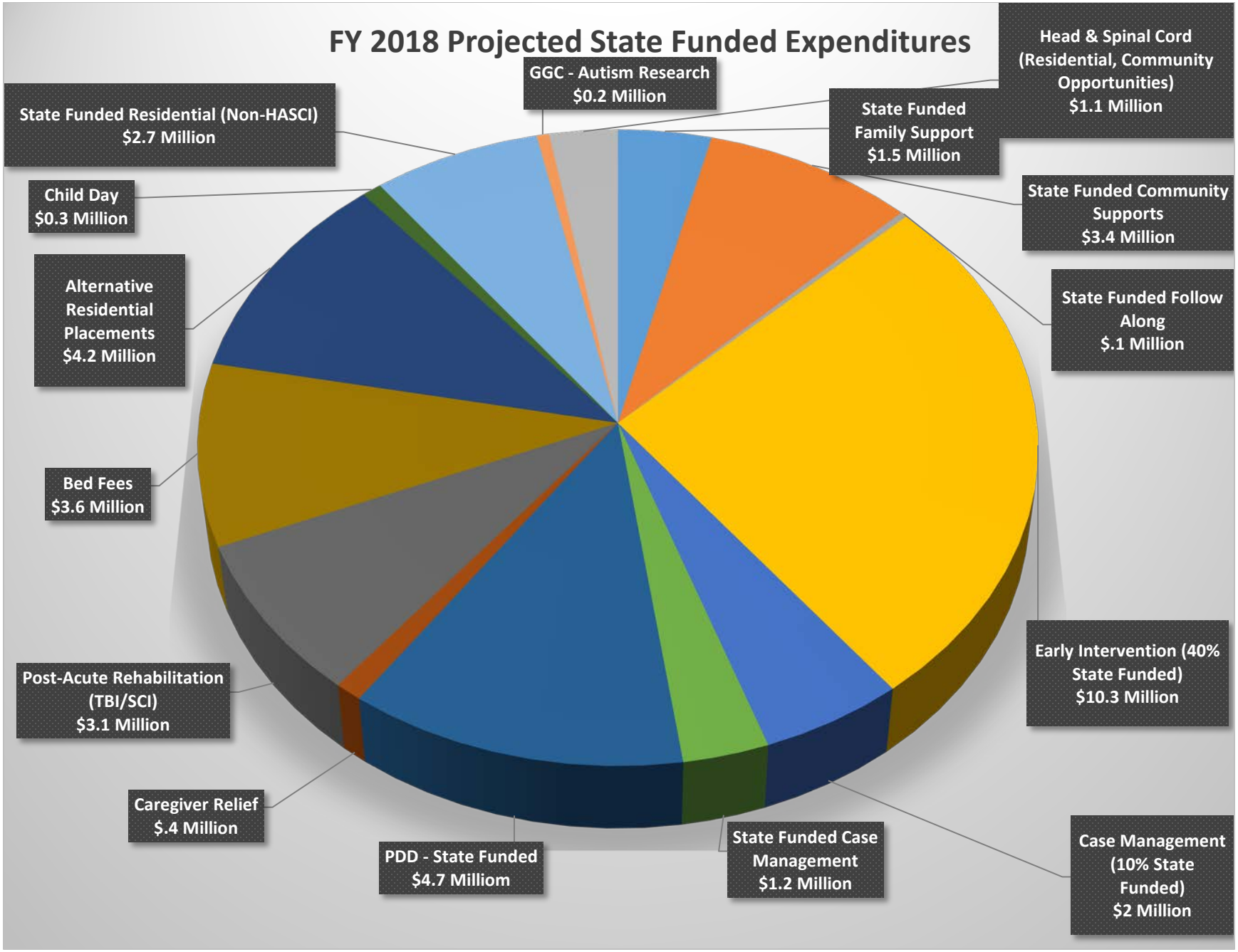
State Funded Residential (Non-HASCI): Residential Habilitation provided to those who are not Medicaid eligible.

Greenwood Genetics – Autism Research: Research addressing the causes and prevention of Autism Spectrum Disorder.

Head & Spinal Cord (Residential, Community Opportunities): State-funded Residential Habilitation services for individuals who do not meet Medicaid eligibility requirements. This category also includes community drop-in centers people with brain and spinal cord injury attend for socialization experiences.


FY 2018 Projected State & Medicaid Expenditures - $672 Million
State
$38.8
Million
5.8%
Medicaid
$633.5 Million
94.2%


FY 2018 Projected State Funded Expenditures
Head & Spinal Cord (Residential, Community Opportunities) 2.8%
GGC - Autism Research 0.5%
State Funded Residential (Non-HASCI) 7.0%
State Funded Family Support 3.9%
Child Day 0.8%
State Funded Community Supports 8.8%
Alternative Residential Placements 10.8%
State Funded Follow Along 0.3%
Bed Fees 9.3%
Early Intervention (40% State Funded) 26.5%
Post-Acute Rehabilitation (TBI/SCI) 8.0%
Case Management (10% State Funded) 5.2%
Caregiver Relief 1.0%
PDD - State Funded 12.1%
State Funded Case Management 3.1%


FY 2018 Projected State Funded Expenditures
GGC - Autism Research $0.2 Million
Head & Spinal Cord (Residential, Community Opportunities) $1.1 Million
State Funded Residential (Non-HASCI) $2.7 Million
State Funded Family Support $1.5 Million
Child Day $0.3 Million
State Funded Community Supports $3.4 Million
Alternative Residential Placements $4.2 Million
State Funded Follow Along $.1 Million
Bed Fees $3.6 Million
Early Intervention (40% State Funded) $10.3 Million
Post-Acute Rehabilitation (TBI/SCI) $3.1 Million
Caregiver Relief $.4 Million
PDD - State Funded $4.7 Milliom
State Funded Case Management $1.2 Million
Case Management (10% State Funded) $2 Million

Turnover Rates

During the September 18, 2017 meeting, Subcommittee members asked a question regarding turnover rates. That question was:

- Please provide a chart of Turnover by Reason for FY 14-15, FY 15-16, and FY 16-17. Include all reasons for turnover applicable to DDSN. Also, do providers (boards and private providers) maintain data on the reasons why employees conclude their employment with the organization?

Agency Response

A response will be provided during subsequent meetings.

Provider Oversight

During the September 18, 2017 meeting, Subcommittee members asked a question about the agency's oversight of providers. That question was:

- Provide the policy that explains the management/administrative review processes that occurs in cases of alleged abuse, neglect, or exploitation. If the provider requests to reinstate an employee as a result of the provider's review but prior to the conclusion of an investigating agency's review, what authority does DDSN have to refuse to allow reinstatement of the employee?

Agency Response

The agency provided the documents on pages _____ and will provide more information during subsequent meetings.

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

SOUTH CAROLINA Department OF Disabilities AND Special Needs

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Katherine W. Davis
Katherine Llamas Finley
Harvey E. Shiver

Reference Number:	534-02-DD
Title of Document:	Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a DSN Board or Contracted Service Provider
Date of Issue:	March 31, 1988
Effective Date:	November 13, 2014
Last Review Date:	January 26, 2015
Date of Last Revisions:	January 26, 2015 **(REVISED)**
Applicability:	DDSN Regional Centers, DSN Boards and Contracted Service Providers

I. PURPOSE

This directive establishes the system for preventing and reporting abuse, neglect, or exploitation of people receiving services and supports from the South Carolina Department of Disabilities and Special Needs (DDSN) or from service providers under contract with DDSN.

This directive sets forth the reporting requirements of state law and also identifies DDSN and its contract provider agencies legal responsibility for reporting abuse, neglect, or exploitation. The directive also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected abuse, neglect, or exploitation and identifies the administrative and management functions of DDSN and its network of contracted service providers.

The directive shall apply to all employees, volunteers, caregivers and other persons responsible for the welfare of any person receiving services and supports from DDSN or one of its contracted service providers.

II. POLICY

People with disabilities and special needs have a right to be treated with dignity and respect and to receive services and supports in an environment that is safe and free of abuse, neglect, or exploitation. Abuse, neglect, or exploitation, as defined by this policy, is strictly prohibited.

Employees and volunteers of DDSN and its network of contracted service providers are all mandated reporters and are required to report any suspected abuse, neglect, or exploitation in accordance with agency policy and state law. Failure to report may constitute abuse and may result in termination of employment and prosecution.

Employees who abuse, neglect, or exploit any person receiving services/supports as determined by State Law Enforcement Division (SLED), local law enforcement, the Attorney General's Office, or DSS (either APS or CPS) will be terminated and may be subject to prosecution. An employee terminated for abuse, neglect, or exploitation as determined by SLED, local law enforcement, the Attorney General's Office, or DSS (either APS or CPS) will not be eligible for employment in any program, facility, service, or supports operated by DDSN or its contract service providers. Likewise, if under an Administrative or Management Review, the employee has been found to violate Written Rules, Regulations or Policies, employee disciplinary action will be taken based upon the nature and extent of the policy violation.

NOTE: When SLED vets a case to the Long Term Care (LTC) Ombudsman Office, there are separate policy and procedures to follow. Please see DDSN Directive 534-03-DD: The Long Term Care Ombudsman Program.

To ensure that people receiving services/supports are assured of equal protection and a uniform system of reporting suspected abuse, neglect, or exploitation, DDSN and its network of providers shall develop written policies and procedures consistent with this policy and in accordance with state law.

III. ABUSE PREVENTION

Quality Assurance

As part of an effective system of quality assurance each DDSN operated service and support, DDSN Regional Center, and contracted service provider shall establish and implement an abuse prevention program. The prevention program should be proactive in developing a system of identifying at-risk situations, preventive actions, analyzing incident trends and taking appropriate steps to address any negative trends, employee training and assistance, and corrective actions that lead to abuse prevention. An abuse prevention program shall include but is not limited to:

A. Employee Training

All employees, volunteers, and caregivers shall receive training in their legal responsibilities to report suspected abuse, neglect, or exploitation and prevention of abuse. To ensure statewide consistency in the overall content of training, DDSN requires the use of training materials

developed by the USC Children's Law Center and the Adult Protection Coordinating Council (APCC), in addition to this Directive. The USC Children's Law Center training and the APCC Omnibus Adult Protection Act training Power Point presentations may be accessed through the DDSN Website http://www.ddsn.sc.gov/providers/Pages/ANEReportingTools.aspx. Additional resources may include resources from the National Center on Elder Abuse: http://www.ncea.aoa.gov/Resources/Publication/docs/NCEA_LTCF_ResearchBrief_2013.pdf and http://www.ncea.aoa.gov/Resources/Publication/docs/NCEA_WhatYouMustKnow2013_508.pdf Providers may supplement training with their own materials, but may not exclude any of the training described above. Comprehension based training shall be provided as a part of new employee orientation and at least every 12 months thereafter. Staff should be able to define and give examples of different types of abuse, including physical, financial, sexual and psychological abuse, and neglect. [Staff training is also an important element in the prevention of abuse. Such training should address interpersonal skills, managing difficult situations, problem solving, cultural issues that affect staff–consumer relationships, conflict resolution, stress reduction and information about dementia when applicable]. Each employee shall participate in comprehension based training as indicated by DDSN. Providers may supplement the Comprehension Test and alter the formatting based on provider needs, but the minimum content provided by DDSN must not be changed. A copy of the employee's test shall be placed in the human resources file each year as evidence of the training.

B. Employee Assistance

Resources will be made available for employees to seek assistance for themselves or co-workers who may exhibit potential problems or risk indicators for committing abuse, neglect, or exploitation. DDSN operated services and supports, DDSN Regional Centers, and contract provider agencies will designate a staff person for employees to talk to about preventing and reporting abuse, neglect, or exploitation.

C. Identification of Risk Situations

Procedures to identify situations or people that may be at risk for abuse, neglect, or exploitation should be a part of any provider's quality management system. For example:

- Identify workplace contexts (e.g., staffing and oversight) that create a risky climate for mistreatment.

- Identify worker attitudes and behaviors that create a risky climate, such as unintentional rough handling, carrying stress or inappropriate disciplinary habits from home.

- Identify resident vulnerabilities that increase the risk of their being mistreated such as those who are quiet, disoriented, unable to communicate or isolated from family support.

Increased monitorship, prevention strategies, and resources must be developed to address these situations.

D. Consumer Training

Training for people receiving services/supports in reporting abuse, neglect or exploitation and how to recognize and avoid dangerous situations must be provided and documented in the consumer's file at least annually by the case management provider and/or by the residential services provider. A copy of the documentation must exist in both files.

E. Positive Behavior Support

Positive behavior support recognizes that consumers with disabilities exhibit problem behavior because it serves a useful purpose for them in their current situation. Therefore, the focus of behavioral supports must begin with understanding the structure and function of the problem behavior in order to teach and promote effective alternatives and not just to eliminate the undesirable behavior. It is the philosophy of DDSN that during the development of Behavior Support Plans, people receiving services/support will be free from any serious and immediate threat to physical and psychological health and safety. It is also important to note that procedures used to ensure safety are not misunderstood and/or substitute for procedures to provide positive behavioral supports.

F. Administrative and Management Reviews

The review of incidents/allegations of abuse, neglect, or exploitation will be used as a management tool to assist in identifying preventive and corrective actions that may lead to prevention of abuse, neglect, or exploitation, but also to determine if an employee's conduct toward a consumer was improper or violates agency policy.

G. Abuse Prevention Coordinator

As a part of quality assurance, the Facility Administer/Executive Director/CEO may designate a staff person to serve as the abuse prevention coordinator. This person would have responsibility for ensuring that corrective/preventive actions are taken to prevent a recurrence of a similar incident, identify at-risk situations, and develop initiatives and employee training on abuse prevention. Resources are made available on the DDSN web-site, including a presentation for reporting Abuse, Neglect, and Exploitation of Children and Elderly and Vulnerable Adults in South Carolina and additional resources made available through the APCC based on the Omnibus Adult Protection Act (OAPA). Providers may supplement training with their own materials, but may not exclude any of the training described above.

H. Reporting Reasonable Suspicion of a Crime in ICF/IID Residences

Section 1150B of the Social Security Act, established by section 6703(b)(3) of the Affordable Care Act requires ICFs/IID to report any reasonable suspicion of a crime against a resident to at least one law enforcement agency and to DHEC – Bureau of Certification. In the case of Abuse, Neglect, or Exploitation, suspicion of a crime should be reported to the State Law Enforcement Division (SLED). Reasonable suspicion of other crimes should be reported to local law enforcement. The report to should be made within two (2) hours if serious bodily injury

occurred and within 24 hours for all other incidents. Notification can be made to DHEC – Bureau of Certification 24 hours a day via fax (803) 545-4292 or via the 24 hour complaint line 1-800-922-6735.

IV. STATE LAWS

South Carolina state law requires the reporting of any suspected abuse, neglect, or exploitation. **The Child Protection Reform Act** requires the reporting of any suspected abuse or neglect occurring to a child, age 17 and under. **The Omnibus Adult Protection Act** requires the reporting of suspected abuse, neglect, or exploitation of a vulnerable adult, age 18 and above.

Vulnerable Adult is defined as any person, age 18 and above, who has a physical or mental condition that substantially impairs the person from adequately providing for his/her own care or protection. A resident of a facility or a person, age 18 and above receiving services from DDSN or its contract provider agencies is a vulnerable adult.

The appropriate reporting agency is determined by the age of the victim, suspected perpetrator, and the location of the alleged incident.

A. Child Protection Reform Act – Age 17 and Under

1. Definitions

S.C. Code Ann. § 63-7-20 (Supp. 2014), et seq., Child Protection Reform Act

Child abuse or neglect or harm occurs when the parent, guardian, or other person responsible for the child's welfare:

(a) inflicts or allows to be inflicted upon the child physical or mental injury or engages in acts or omissions which present a substantial risk of physical or mental injury to the child, including injuries sustained as a result of excessive corporal punishment, but excluding corporal punishment or physical discipline which:

  (i) Is administered by a parent or person in loco parentis;
  (ii) Is perpetrated for the sole purpose of restraining or correcting the child;
  (iii) Is reasonable in manner and moderate in degree;
  (iv) Has not brought about permanent or lasting damage to the child, and;
  (v) Is not reckless or grossly negligent behavior by the parents.

(b) commits or allows to be committed against the child a sexual offense as defined by the laws of this State or engages in acts or omissions that present a substantial risk that a sexual offense as defined in the laws of this State would be committed against the child;

(c) fails to supply the child with adequate food, clothing, shelter, supervision appropriate to the child's age and development, or health care though financially able to do so or offered financial or other reasonable means to do so and the failure to do so has caused or presents

a substantial risk of causing physical or mental injury. However, a child's absences from school may not be considered abuse or neglect unless the school has made efforts to bring about the child's attendance, and those efforts were unsuccessful because of the parents' refusal to cooperate. For the purpose if this chapter "adequate health care" includes any medical or non-medical remedial healthcare permitted or authorized under state law;

(d) Abandons the child;

(e) Encourages, condones, or approves the commission of delinquent acts by the child and the commission of the acts are shown to be the result of the encouragement, disregard, or approval; or

(f) Has committed abuse or neglect as described in subsections (a) through (e) such that a child who subsequently becomes part of the person's household is at substantial risk of one of those forms of abuse or neglect.

Physical injury means death or permanent or temporary disfigurement or impairment of any bodily organ or function.

Mental injury means an injury to the intellectual, emotional, or psychological capacity or functioning of a child as evidenced by a discernible and substantial impairment of the child's ability to function when the existence of that impairment is supported by the opinion of a mental health professional or medical professional.

Institutional child abuse and neglect means situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is the employee of a public or private residential home, institution, or agency.

2. **Penalties for not reporting**

Any person required to report child abuse or neglect or any other person required to forward a report who knowingly fails to do so, or any person who threatens or intimidates the victim or any witnesses shall be subject to prosecution. Upon conviction, the person is guilty of a misdemeanor and shall be fined not more than $2,500.00 or imprisoned for not more than six (6) months, or both. An employer cannot dismiss, demote or suspend an employee who is required by statute to report abuse or neglect based on the fact the person made a report of child abuse and neglect. Employees shall file a report to the appropriate State Investigative Agencies, as outlined in this directive.

Penalties if found guilty of abuse, neglect or exploitation

A person who abuses a child is guilty of a felony and upon conviction can be imprisoned for up to ten (10) years. Cruelty to a child is a misdemeanor with up to 30 days imprisonment and a fine up to $200.00.

3. Negligence

The State Attorney General's Office, upon referral, may bring an action for negligence against a person, corporation, or other business entity if, through pattern or practice, the entity fails to exercise reasonable care in hiring, training, or supervising staff, or in operating a facility or services and this failure results in the commission of abuse, neglect, or exploitation. This is a civil action in Circuit Court and may result in a fine or other relief the Court feels is needed.

B. Omnibus Adult Protection Act – Age 18 and Above

Definitions – S.C. Code Ann. § 43-35-5 (Supp. 2014), et seq., S.C. Code Ann. §43-35-10 (Supp. 2014)

Physical abuse means intentionally inflicting or allowing to be inflicted physical injury on a vulnerable adult by an act or failure to act. Physical abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery, use of medication outside the standards of reasonable medical practice for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment except that a therapeutic procedure prescribed by a licensed physician or other qualified professional or that is part of a written plan of care by a licensed physician or other qualified professional is not considered physical abuse. Physical abuse does not include altercations or acts of assault between vulnerable adults.

Psychological abuse means deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

Neglect means the failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Neglect may be repeated conduct or a single incident which has produced or can be proven to result in serious physical or psychological harm or substantial risk of death. Noncompliance with regulatory standards alone does not constitute neglect. Neglect includes the inability of a vulnerable adult, in the absence of a caretaker, to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death.

Exploitation means:

- Causing or requiring a vulnerable adult to engage in activity or labor which is improper, unlawful, or against the reasonable and rational wishes of the vulnerable adult. Exploitation does not include requiring a vulnerable adult to participate in an activity or labor which is a part of a written plan of care or which is prescribed or authorized by a licensed physician attending the patient;

- An improper, unlawful, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a vulnerable adult by a person for the profit or advantage of that person or another person; or

- Causing a vulnerable adult to purchase goods or services for the profit or advantage of the seller or another person through:

    - Undue influence,
    - Harassment,
    - Duress,
    - Force,
    - Coercion, or
    - Swindling by overreaching, cheating, or defrauding the vulnerable adult through cunning arts or devices that delude the vulnerable adult and cause them to lose money or other property.

Penalties for not reporting

Any person required to report abuse or neglect of a vulnerable adult or any other person required to forward a report, who knowingly fails to do so, or any person who threatens or intimidates the victim or any witnesses shall be subject to prosecution. Upon conviction, the person is guilty of a misdemeanor and shall be fined not more than $2,500.00 and imprisoned for up to one (1) year. An employer cannot dismiss, demote or suspend an employee who is required by statute to report abuse or neglect based on the fact the person made a report of abuse and neglect. Employees shall file a report to the appropriate State Investigative Agencies as outlined in this directive.

Penalties if found guilty of abuse, neglect or exploitation

A person who knowingly and willfully abuses, neglects, or exploits a vulnerable adult is guilty of a felony and upon conviction will receive the following:

- Simple Abuse (no serious injury): Punishment: Up to 5 years
- Abuse great bodily injury: Punishment: Up to 15 years
- Abuse resulting in death: Punishment: Up to 30 years
- Neglect: Punishment depends on seriousness of injury
- Exploitation: Punishment: Up to 5 years and a fine up to $5,000 plus restitution

It is against the public policy of South Carolina to change an employee's employment status solely because a person reports abuse, neglect and exploitation.

Negligence

The State Attorney General's Office, upon referral, may bring an action for negligence against a person, corporation, or other business entity if, through pattern or practice, the entity fails to exercise reasonable care in hiring, training, or supervising staff, or in operating a facility or

services and this failure results in the commission of abuse, neglect, or exploitation. This is a civil action in Circuit Court and may result in a fine or other relief the Court feels is needed.

Posting Notices under Omnibus Adult Protection Act (OAPA)

All programs operated or contracted for operation by DDSN shall prominently display notices stating the duties of its personnel and contact information, the text of which must be provided by the Long Term Care Ombudsman Program in consultation with SLED Vulnerable Adults Investigations Unit.

V. REPORTING REQUIREMENTS AND PROCEDURES

Children Age 17 and Under

1. STEP ONE – Make a Direct Report to the Appropriate State Investigative Authority

Employees and volunteers of DDSN or its contracted service providers are required to report directly to the appropriate state investigative agency, immediately but no later than 24 hours, except as noted below when they have reason to believe that a child has been or is at risk for abuse, neglect, or exploitation.

If anyone other than an employee or volunteer of DDSN or its contracted service providers makes a direct report to the appropriate state investigative agency the Facility Administrator/Executive Director/CEO or higher authority, once notified, must immediately initiate activities beginning at STEP 3. The alleged perpetrator must immediately be placed on administrative leave without pay[1] and the initial report must be sent to the DDSN Director of Quality Management within 24 hours or the next business day. This requirement applies to all allegations of ANE, regardless of the intake status with the State Investigative Agency.

NOTE: In cases of an emergency, serious injury, or suspected sexual assault, the victim's health and welfare takes priority to STEP ONE. If medical attention is needed, the reporter must call 911 prior to calling law enforcement or DSS. Serious is defined as "needing immediate medical attention or hospitalization." Once 911 is contacted, the person making the report must contact law enforcement or DSS immediately.

Serious consumer injuries of unknown or unexplainable origin must be reported to the appropriate state investigative agency according to the procedures outlined herein.

[1] When an employee of a DSN Board/Qualified Provider (not a DDSN Regional Center or DDSN employee) is placed on leave without pay, the Board/Qualified Provider may allow the employee to use their annual/sick leave while the case is being investigated, if the Board/Qualified Provider's HR policy allows for such action. However, if and when, the employee is cleared of the allegation against them and returns to work, the Board/Qualified Provider must reinstate the employee's hours of leave used.

State DSS Out of Home Abuse and Neglect Investigation Unit (OHAN)

State DSS has established an Out of Home Abuse and Neglect Investigation Unit (OHAN) to investigate all out of home allegations of abuse and neglect of children. This includes alleged abuse or neglect occurring to a child in facilities operated by or contracted for operation by DDSN to include DDSN Regional Centers, ICF/IID and Community Training Homes I and II. In these facilities, staff are required to report immediately, but no later than, the end of the reporter's shift.

DSS-Child Protective Service-County Offices

When the suspected abuse or neglect of a child occurs in any location other than those defined above, a report must be made to county DSS immediately, but no later than 24 hours. Reports of suspected abuse in locations other than those defined above are not required to be reported to DDSN. The report and final outcome must be documented in the vulnerable child's and appropriate agency files.

Local Law Enforcement

In addition to notifying the investigative agency above, local law enforcement must be contacted immediately if any of the following condition(s) exist:

- All sexual assaults between consumers and staff, volunteers, or other persons responsible for their care.
- There is serious physical injury (such as fractures, burns, serious lacerations, death, etc.) and there is reason to believe the injury was caused by possible abuse or neglect, or when a physician documents that the injury was due to abuse or neglect.
- There are multiple victims.
- Abuse or neglect was inflicted on a child by a person who is not a parent or a childcare worker.
- Serious abuse, neglect, or exploitation occurred and there is a cover up or failure to report when clearly an obligation existed to report.
- Intimidation of the victim or witness, or impediment to an investigation.
- Time sensitive evidence.
- When the victim or victim's family requests a referral to law enforcement.

2. STEP TWO – REPORT TO SUPERVISOR OR HIGHER AUTHORITY

After the report to the appropriate investigative agency is made, the employee is obligated to report the suspected abuse, neglect, or exploitation to their supervisor or the Facility Administrator/Executive Director/CEO immediately following the report to the appropriate state investigative agency. Immediately means within one (1) hour. The person making the report must assure the alleged victim is safe.

3. STEP THREE – INITIAL RESPONSE

Once the supervisor, Facility Administrator/Executive Director/CEO or higher authority is notified, the following actions must be initiated when the allegation of abuse occurs in a residential or other facility operated or contracted for operation by DDSN:

Initial Response is the initial brief immediate action taken by the first response person who is called to the scene of the alleged abuse, neglect, or exploitation and should be conducted concurrently with reporting requirements. Because of the seriousness of any allegation of abuse, neglect, or exploitation, the first response person is usually a supervisory/administrative level staff person. This decision is made by the supervisor in STEP 2.

The focus of the initial response is to ensure:

- The victim is safe;
- Needed medical treatment is sought;
- Evidence is preserved; and
- The victim, witnesses, and alleged perpetrator(s) are identified.

(a) Safety Plan

Ensure the victim is safe, free from harm and intimidation.

- An assessment should be made as to the safety of the victim and others who may be at risk.
- The alleged perpetrator must be separated from the victim.
- The alleged perpetrator must be placed on administrative leave without pay pending the outcome of the investigation[2].

[2] When an employee of a DSN Board/Qualified Provider (not a DDSN Regional Center or DDSN employee) is placed on leave without pay, the Board/Qualified Provider may allow the employee to use their annual/sick leave while the case is being investigated, if the Board/Qualified Provider's HR policy allows for such action. However, if and when, the employee is cleared of the allegation against them and returns to work, the Board/Qualified Provider must reinstate the employee's hours of leave used.

(b) **Determine if alleged victim requires medical assistance**

The alleged victim should be taken/referred for a medical exam if needed.

(c) **Secure the scene-preserve evidence**

The scene should be secured if there is physical evidence of a disturbance or crime, (e.g., overturned chairs, blood on floor, evidence of sexual assaults, etc.)

For Administrative Review purposes only, the Receipt for Property should be completed.

(d) **Identify Victim, witnesses, and perpetrator**

Identify victim, alleged perpetrator and all potential witnesses. It is essential to identify all potential witnesses, including people receiving services, employees, volunteers, or others who may have information.

4. STEP FOUR – NOTIFICATION

Based on the contact information in the consumer's plan, the parent/guardian or primary correspondent will be notified of the allegation, as soon as possible, in the most expeditious manner possible and will be kept informed of the results of the review to the extent possible, while maintaining confidentiality for all parties involved. The parent/guardian or primary correspondent will be informed of any injuries as well as action taken to ensure the consumer's safety. There may be situations in which family members of other residents may need to be contacted regarding concern for their own family member's status and safety. The circumstances requiring contact would be specified in the annual service plan. The parent/guardian or primary correspondent will also be informed of their right to contact the state investigative agency if they have any questions or concerns. If the Case Manager/Qualified Intellectual Disability Professional/Early Interventionist is not the person notifying the family, then DDSN will assure that the Case Manager/Qualified Intellectual Disability Professional/Early Interventionist is aware of the allegation within three (3) working days of the incident, if applicable.

Adult consumers who may legally consent may also choose not to disclose individual incidents. At least annually, the adult consumer, with input from those important to him/her will specify who will be contacted should an incident occur. This information will be documented and readily available in the person's file.

NOTE: The state investigative agency may also contact the alleged victim's parent/guardian or primary correspondent directly.

5. STEP FIVE – INITIAL REPORT OF ALLEGED ABUSE, NEGLECT, EXPLOITATION

A report of the allegation must be submitted on the DDSN Incident Management System within 24 hours or the next business day in which the suspected abuse, neglect or exploitation is discovered.

6. STEP SIX – INITIATE A REVIEW OF THE ALLEGATION

DDSN Regional Centers, DSN Boards and contracted service providers shall cooperate with external investigations to insure the Administrative/Management review as described below does not jeopardize the investigation by law enforcement or the state investigative agency. The Administrative/Management Review will be completed on the DDSN Incident Management System.

A. Application of Review

An Administrative or Management Review should be done when the following conditions apply:

Administrative Review

An ICF/IID (Community or DDSN Regional Center) resident is allegedly abused, including when resident is at a day program.

Management Review

(1) An alleged abuse occurs while a child resides in any other home operated or contracted for operation by DDSN, or

(2) An alleged abuse occurs while a child is under the direct supervision of an agency employee or contracted employee, to include respite services, early intervention, and support centers.

While conducting an Administrative or Management Review, system-oriented information that warrants further review may be received. The recommendation for such review along with recommendation for personnel action (e.g., staff training, reassignments, environmental modifications, procedural changes, etc.) and other recommendations should be noted.

Any risk situations should be identified and appropriate action taken. If negligent situations are identified through the review process, this should be brought to the immediate attention of the Facility Administrator/Executive Director/CEO or their designee for prompt corrective/preventive action.

B. Types of Reviews

Administrative Review

DDSN Regional Centers and ICF/IID providers will conduct an Administrative Review immediately upon receiving an allegation of abuse, neglect, or exploitation.

For non ICF/IID facilities/consumers, the provider is permitted to conduct an Administrative Review for Improper Conduct Toward a Consumer if the state investigative agency (i.e., DSS(CPS)) does not notify the provider of their acceptance or otherwise of the initial report of an allegation. Once the review is complete providers may take appropriate personnel action as policies dictate, including bringing the employee back to work if the review did not indicate improper conduct.

Purpose

The Administrative Review is the systematic review of all information, witness statements, and evidence related to the allegation in order to make a determination, based on facts, if:

- An employee has violated a written rule, regulation or policy and related to improper conduct toward a consumer; and

- What actions management might take in order to reduce the likelihood that abuse would occur in the future.

This Administrative Review will be completed by a person assigned by the Facility Administrator/Executive Director/CEO. The assigned staff member will determine if an employee has violated any written rule, regulation or policy related to improper conduct toward consumer. When the credible, relevant facts support violation of the provider's written rules, regulations or policies related to improper conduct toward a consumer, the provider will follow its personnel policy of disciplinary action.

The Administrative Review along with the report of the initial response fulfills the requirements of CFR §483.420(d)(3) which requires the thorough investigation of all allegations of improper conduct toward a consumer.

Administrative Review Functions

The following activities must be conducted, as applicable, during the Administrative Review; however, they should never interfere with the investigation of the allegation of abuse, neglect or exploitation conducted by the state investigative agency.

- Collecting witness statements.
- Interviewing witnesses.

- Chronology of events – This section shall include in paragraph form, the recreation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.
- Discussion – This section will list all facts.
- Conclusion.
- Supporting documents to be included:

    - Signed and dated statements from each person involved
    - Unusual occurrence form
    - Photographs
    - Officer of the day report
    - Injury report
    - Other documents, if needed during the Administrative Review, such as:

        - Body check report
        - Doctor/nurse reports
        - Work schedule
        - Security report

Reporting to DDSN

Administrative Review

The ICF/IID Administrative Review must be submitted on the DDSN Incident Management System, within five (5) working days, excluding state and federal holidays of discovery of the suspected abuse, neglect or exploitation.

The non ICF/IID Administrative Review, conducted for improper conduct toward a consumer, must be submitted on the DDSN Incident Management System within five (5) working days excluding state and federal holidays of discovery of the suspected abuse, neglect or exploitation.

If the outcome of the Administrative Review results in "no findings" meaning the employee did not violate a written rule, regulation or policy related to improper conduct toward a consumer, the provider should document the results of their review and note their intention of bringing the employee back to work. If the date the employee will return is known, the date may be included in the Administrative Review. If the date is not known, the provider will need to submit an Addendum once established, to notify DDSN of the date of the employee's return to work.

Management Review

Non ICF/IID providers will conduct a Management Review when the state investigative agency actively investigates or refers the allegation to be investigated, the investigative agency may be DSS(CPS), local law enforcement, or Attorney General's Office. If DSS(CPS) does not notify

the provider of their acceptance or otherwise of the initial report of an allegation - in these cases, the provider may conduct an Administrative Review.

Purpose

The purpose of the Management Review is to determine if:

- An employee has violated a written rule, regulation or policy related to improper conduct toward a consumer; and

- Whether corrective actions regarding the employee (such as disciplinary action), management or practice/service changes need to occur.

Management Review Functions

The following activities may be conducted during the Management Review; however, they should never interfere with the investigation of the allegation of abuse, neglect or exploitation conducted by the state investigative agency. During the Management Review process, which is conducted when DSS(CPS), local law enforcement, or the Attorney General's Office accepts a case for investigation, reviewers are not permitted to interview the consumer or staff and cannot collect witness statements. Staff can write a statement to share with the state investigative agency, but staff cannot share the information with providers during an active investigation.

- Chronology of events – This section shall include in paragraph form, the recreation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.
- Discussion – This section will list all facts.
- Conclusion.
- Supporting documents to be included:
    - unusual occurrence form
    - photographs
    - officer of the day reports
    - injury reports
    - other documents, if needed during the Management Review, such as:
        - body check report
        - doctor/nurse reports
        - work schedule
        - security report

Reporting to DDSN

The Management Review must be completed and the results reported to the DDSN Director of Quality Management, within ten (10) working days, excluding state and federal holidays, in which the suspected abuse, neglect or exploitation are discovered.

If the outcome of the Management Review results in "no findings," meaning the employee did not violate a written rule, regulation or policy related to improper conduct toward a consumer, the provider may request to the DDSN Director of Quality Management to reinstate the employee with back pay, prior to the completion and/or receipt of the state investigative agency's final report from DSS(CPS), local law enforcement, or the Attorney General's Office. This request must be submitted using the DDSN Incident Management System. Request for Reinstatement of Employee Form. DDSN will review the request and inform the provider of the results. If the employee is recommended for reinstatement, the provider will submit the Addendum to Administrative/Management Review Report to notify DDSN of its action. All forms/correspondence regarding ANE Reports must be submitted on the IMS.

7. STEP SEVEN – CONFIDENTIALITY

The Administrative/Management Review is an internal, confidential document and may not be released except to law enforcement and/or state investigative agencies. The report shall not be filed in the victim or alleged perpetrator/employee's file. The results of the Review, including actions taken to ensure the victim's safety, must be shared with the parent/guardian or primary correspondent. However, the Review may not be released.

The Facility Administrator/Executive Director/CEO or their designee may share information from the Review or a copy of the Review with their staff on a need to know basis.

8. STEP EIGHT-OUTCOME OF THE EXTERNAL ABUSE INVESTIGATION AND/OR INTERNAL REVIEW

Investigation

Only DSS(CPS), local law enforcement, or the Attorney General's Office, can make a determination of abuse, neglect, or exploitation. Once written notification from one of the aforementioned agencies is received concerning the outcome of the investigation, the following action must be taken by the Facility Administrator/Executive Director/CEO or their designee:

Founded/Substantiated, Perpetrator Known

Founded abuse, neglect, or exploitation by DSS(CPS), local law enforcement, or the Attorney General's Office, will result in termination of the perpetrator within 24 hours of receiving the results of the investigation.

In cases of financial exploitation by an employee, the Facility Administrator/Executive Director/CEO or their designee shall ensure that the victim's misappropriated funds are reimbursed to the victim.

Under statutory authority, State DSS maintains a statewide Central Registry of Child Abuse and Neglect. Initial reports of suspected child abuse and neglect reported to DSS(CPS) will be entered in the registry. Indicated reports (i.e., founded), including the name of the perpetrator, will be maintained on the registry for seven (7) years. State DSS has established due process procedures for appeal of indicated reports.

Founded/Substantiated, Perpetrator Unknown

When the investigation determines that abuse, neglect, or exploitation occurred, but the perpetrator cannot be identified, the Facility Administrator/Executive Director/CEO or their designee shall ensure that the victim is safe and free from harm. Corrective/preventive action shall be taken to prevent a recurrence.

Unfounded/Unsubstantiated

If the allegation is unsubstantiated, the alleged perpetrator will be reinstated without prejudice, including any back wages, unless the employee has violated the provider's rules, regulations or policies and the provider has followed its personnel policy of progressive discipline.

ADMINISTRATIVE/MANAGEMENT REVIEW

Once the Administrative/Management Review is completed, the following action must be taken by the Facility Administrator/Executive Director/CEO or their designee:

Employee Violation of Rules, Regulations or Policies

If an employee has been found to have violated the provider's written rules, regulations or policies, the provider must follow its personnel policy of disciplinary action.

Staff Training/Policy Procedural Change

Staff training issues or policy procedural changes identified during the Review shall be addressed to determine whether or not a violation of agency rules, regulations or policies is discovered. Training issues and/or policy procedural changes must be submitted to the DDSN Director of Quality Management along with corrective action planned or taken to address the issues identified.

Environmental Modifications

Issues regarding structural accommodations or safety devices identified during the Review shall be addressed whether or not a violation of agency rules, regulations or policies is discovered. All changes identified to be made must be submitted to the DDSN Director of Quality Management.

Notification of Licensure/Certification Boards

DHEC, Division of Health Licensing shall be notified within ten (10) days of any suspected abuse, neglect, or exploitation occurring within a Habilitation Center (e.g., regional and community-based ICF/IIDs, Community Residential Care Facilities, Hospitals and Day Care Facilities for adults).

The appropriate state licensure or state accreditation board (e.g., State Board of Nursing, State Board of Medical Examiners, Long Term Care Nurse Aide Registry), will be notified in writing by the provider whenever an allegation of abuse, neglect, or exploitation, including failure to report, has been substantiated against a licensed/accredited employee. The employee may be subject to disciplinary action by the licensing/accreditation board.

Addendum to Administrative/Management Review Report:

If the disposition of the Administrative/Management Review changes, or if there is additional information after the Review, (e.g., the results from external agency investigation/review are received, or if upon approval from DDSN the employee is reinstated prior to the completion of a state investigative agency's final report), the Addendum to Administrative/Management Review Report must be completed and sent to the DDSN Director of Quality Management within 24 hours or the next business day of the change.

9. **STEP NINE - EMPLOYEE GRIEVANCE APPEAL PROCEDURES**

If an employee is reinstated during the Employee Grievance Appeal, an addendum must be completed stating the reason for reinstatement and sent to the DDSN Director of Quality Management.

REPORTING REQUIREMENTS CONTINUED:

B. **Vulnerable Adults Age 18 and Above**

1. **STEP ONE**

Make a Direct Report to the Appropriate State Investigative Authority SLED, local law enforcement, or DSS(APS) depending on where abuse is alleged and type of alleged abuse.

Employees and volunteers of DDSN or its contracted service providers are mandated to report directly to the appropriate state investigative agency immediately, but no later than 24 hours, except as noted below, when they have reason to believe that a vulnerable adult has been or is at risk for abuse, neglect, or exploitation.

If anyone other than an employee or volunteer of DDSN or its contracted service providers makes a direct report to SLED, local law enforcement, or DSS(APS), the Facility Administrator/Executive Director/CEO or higher authority, once notified, must immediately initiate activities beginning at STEP 3. The alleged perpetrator must immediately be placed on

administrative leave without pay[3] and the initial report must be sent to the DDSN Director of Quality Management within 24 hours or the next business day. This requirement applies to all allegations of ANE, regardless of the intake status with the State Investigative Agency.

NOTE: In cases of an emergency, serious injury, or suspected sexual assault, the victim's health and welfare takes priority to STEP ONE. If medical attention is needed, the reporter must call 911 prior to calling SLED or DSS(APS). Serious is defined as "needing immediate medical attention or hospitalization." Once 911 is contacted, the person making the report must contact SLED or DSS(APS) immediately.

Serious consumer injuries of unknown or unexplainable origin must be reported to the state investigative agency according to the procedures outlined herein.

SLED-Special Victims Unit

Alleged abuse, neglect, or exploitation occurring to a vulnerable adult in any residential program operated by or contracted for operation by DDSN shall be reported to SLED's toll free number by the person who has actual knowledge, or reason to believe, that a vulnerable adult has been or is likely to be abused, neglected, or exploited. In these facilities, staff is required to report immediately, but no later than the end of the reporter's shift.

DSS - Adult Protective Services – County Offices

Alleged abuse, neglect, or exploitation occurring to a vulnerable adult in settings other than a home operated or contracted for operation by DDSN, shall be reported to DSS in the county where the alleged incident occurred. This includes suspected abuse that may have occurred while a person is living at home or on a home visit. Reports of suspected abuse in locations other than those defined above are not required to be reported to DDSN. The report, and final outcome, must be documented in the vulnerable adult's and appropriate agency files.

Local Law enforcement

In addition to reporting to DSS(APS), local law enforcement must be notified immediately when the following conditions apply (note, if report is made to SLED, local law enforcement does not need to be contacted by the provider).

- All sexual assaults between consumers and staff, volunteers, or other persons responsible for their care.

[3] When an employee of a DSN Board/Qualified Provider (not a DDSN Regional Center or DDSN employee) is placed on leave without pay, the Board/Qualified Provider may allow the employee to use their annual/sick leave while the case is being investigated, if the Board/Qualified Provider's HR policy allows for such action. However, if and when, the employee is cleared of the allegation against them and returns to work, the Board/Qualified Provider must reinstate the employee's hours of leave used.

- There is serious physical injury (such as fractures, burns, serious lacerations, death, etc.) and there is reason to believe the injury was caused by possible abuse or neglect, or when a physician documents that the injury was due to abuse or neglect.

- There are multiple victims.

- Serious abuse, neglect, or exploitation occurred and there is a cover up or failure to report when clearly an obligation existed to report.

- Intimidation of the victim or witness, or impediment to an investigation.

- Time sensitive evidence.

- When the victim or victim's family requests a referral to law enforcement.

2. STEP TWO – REPORT TO SUPERVISOR OR HIGHER AUTHORITY

After the required report by phone is made, the person making the report must make a report immediately to his/her supervisor or Facility Administrator/Executive Director/CEO. Immediately means within one (1) hour. The person making the report must assure the alleged victim is safe.

3. STEP THREE – INITIAL RESPONSE

Once the supervisor, Facility Administrator/Executive Director/CEO or higher authority is notified, the following actions must be initiated when the allegation of abuse occurs in a residential or other facility operated or contracted for operation by DDSN.

Initial Response is the initial brief immediate action taken by the first response person who is called to the scene of the alleged abuse, neglect, or exploitation and should be conducted concurrently with the reporting requirements. Because of the seriousness of any allegation of abuse, neglect, or exploitation, the first response person is usually a supervisory/administrative level staff person. This decision is made by the supervisor in STEP 2.

The focus of the initial response is to ensure:

- The victim is safe;
- Needed medical treatment is sought;
- Evidence is preserved; and
- The victim, witnesses, and alleged perpetrator(s) are identified.

Safety Plan

Ensure the victim is safe, free from harm and intimidation.

- An assessment should be made as to the safety of the victim and others who may be at risk.

- The alleged perpetrator must be separated from the victim.
- The alleged perpetrator must be placed on administrative leave without pay pending the outcome of the investigation.

Determine if alleged victim requires medical assistance

The alleged victim should be taken/referred for a medical exam if needed. Talk with the victim/assess degree of injury, functional level, etc.

Secure the scene - Preserve Evidence

The scene should be secured if there is physical evidence of a disturbance or crime, (e.g., overturned chairs, blood on floor, evidence of sexual assaults, etc.). For Administrative Review purposes only, a Receipt for Property should be completed.

Identify Victim, Witnesses, and Perpetrator

Identify victim, alleged perpetrator and all potential witnesses. It is essential to identify all potential witnesses, including people receiving services, employees, volunteers, or others who may have information.

4. STEP FOUR – NOTIFICATION

Based on the contact information in the consumer's plan, the parent/guardian or primary correspondent will be notified of the allegation, as soon as possible, in the most expeditious manner possible and will be kept informed of the results of the review to the extent possible, while maintaining confidentiality for all parties involved. The parent/guardian or primary correspondent will be informed of any injuries as well as action taken to ensure the consumer's safety. There may be situations in which family members of other residents may need to be contacted regarding concern for their own family member's status and safety. The circumstances requiring contact would be specified in the annual service plan. The parent/guardian or primary correspondent will also be informed of their right to contact the state investigative agency if they have any questions or concerns. If the Case Manager/Qualified Intellectual Disability Professional/Early Interventionist is not the person notifying the family, then DDSN will assure that the Case Manager/Qualified Intellectual Disability Professional/Early Interventionist is aware of the allegation within three (3) working days of the incident, if applicable.

Adult consumers who may legally consent may also choose not to disclose individual incidents. At least annually, the adult consumer, with input from those important to him/her will specify who will be contacted should an incident occur. This information will be documented and readily available in the person's file.

NOTE: The state investigative agencies may contact the alleged victim's parent/guardian or primary correspondent directly.

5. STEP FIVE – INITIAL WRITTEN REPORT

A report of the allegation must be submitted on the DDSN Incident Management System and SLED within 24 hours or the next business day in which the suspected abuse, neglect or exploitation is discovered using the Initial Report of Alleged Abuse, Neglect or Exploitation.

6. STEP SIX – INITIATE A REVIEW OF THE ALLEGATION

DDSN Regional Centers, DSN Boards and contracted service providers shall cooperate with external investigations to insure the Administrative/Management Review does not jeopardize the investigation by law enforcement or the state investigative agency.

A. Application of Review

An Administrative or Management Review should be done when the following conditions apply:

Administrative Review

(1) An ICF/IID (community or DDSN Regional Center) resident is allegedly abused, including when resident is at a day program, or

(2) When SLED vets the case to the Long Term Care Ombudsman Office.

Management Review

(1) An alleged abuse occurs while consumer resides in any other homes operated or contracted for operation by DDSN, or

(2) An alleged abuse occurs when a consumer is under direct supervision of agency employee or contracted employee, to include day services, rehabilitation supports, companion, respite, etc.

While conducting an Administrative or Management Review, system-oriented information that warrants further review may be received. The recommendation for such review along with recommendation for personnel action (e.g., staff training, reassignments, environmental modifications, procedural changes, etc.) and any other recommendations should be noted.

Any risk situations should be identified and appropriate action taken. If negligent situations are identified through the Review process, this should be brought to the immediate attention of the Facility Administrator/Executive Director/CEO or their designee for prompt corrective/preventive action.

B. Types of Reviews

Please see DDSN Directive 534-03-DD: The Long Term Care Ombudsman Program, in cases where SLED vets to the Long Term Care Ombudsman Office.

Administrative Review

DDSN Regional Centers and ICF/IID providers must conduct an Administrative Review immediately upon receiving an allegation of abuse, neglect, or exploitation.

For non ICF/IID facilities/consumers, the provider is permitted to conduct an Administrative Review for Improper Conduct towards a consumer upon receiving the SLED intake form, which indicates the case has been vetted to the Long Term Care Ombudsman or DSS(APS). Once the Review is complete, providers may take appropriate personnel action as policies dictate, including bringing the employee back to work if the review did not indicate improper conduct.

Purpose

The Administrative Review is the systematic review of all information, witness statements, and evidence related to the allegation in order to make a determination, based on facts, if:

- An employee has violated a written rule, regulation or policy related to improper conduct toward a consumer; and
- What actions management might take in order to reduce the likelihood that abuse would occur in the future.

The Administrative Review will be completed by a person assigned by the Facility Administrator/Executive Director/CEO. The assigned staff member will determine if an employee has violated any written rule, regulation or policy related to improper conduct toward consumer. When the credible, relevant facts support violation of the provider's written rules, regulations or policies related to improper conduct toward a consumer, the provider will follow its personnel policy of disciplinary action.

The Administrative Review along with the report of the initial response (STEP 3) fulfills the requirements of CFR §483.420(d) (3) which requires the thorough investigation of all allegations of improper conduct toward a consumer.

Administrative Review Functions

The following activities must be conducted during the Administrative Review, as applicable; however, they should never interfere with the investigation of the allegation of abuse, neglect or exploitation conducted by the state investigative agency.

- Collecting witness statements.
- Interviewing witness.
- Chronology of events – this section shall include in paragraph from the recreation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.
- Discussion – This section will list all facts.

- Conclusion.
- Supporting documents to be included:

    - signed and dated statements from each person involved
    - unusual occurrence form
    - photographs
    - officer of the day reports
    - injury of the report
    - other documents, if needed during the Administrative Review, such as:

        - body check report
        - doctor/nurse reports
        - work schedule
        - security report

Reporting to DDSN

The ICF/IID Administrative Review conducted by DDSN Regional Centers and ICF/IID must be submitted on the DDSN Incident Management System, within five (5) working days, excluding state and federal holidays, of discovery of the suspected abuse, neglect or exploitation.

If SLED vets the investigation to the State Long-Term Care Ombudsman and the outcome of the ICF/IID Administrative Review results in "no findings" meaning the employee did not violate a written rule, regulation or policy related to improper conduct toward a consumer, the provider should document the results of their review and note their intention of bringing the employee back to work. If the date the employee will return is known, the date may be included in the Administrative Review. If the date is not known, the provider will need to submit an Addendum, once established, to notify DDSN of the date of the employee's return to work.

If SLED accepts the case for investigation (ICF/IID only) and the outcome of the ICF/IID Administrative Review results in "no findings" meaning the employee did not violate a written rule, regulation or policy related to improper conduct toward a consumer, the provider should document the results of their review and may request to reinstate the employee, with back pay, prior to the completion and/or receipt of the state investigative agency's report. This request must be submitted on the DDSN Incident Management System, using the Request for Reinstatement of Employee Form. DDSN will review the request and inform the provider of the results. If the employee is recommended for reinstatement the provider will send in the Addendum to Administrative/Management Review Report to notify DDSN of its action. All forms are to be completed using the Incident Management System.

The Administrative Review conducted for improper conduct toward a consumer (Non-ICF/IID) must be completed and the results reported to the DDSN Director of Quality Management, within ten (10) working days excluding state and federal holidays.

If the outcome of the Administrative Review for Improper Conduct results in "no findings" meaning the employee did not violate a written rule, regulation or policy related to improper

conduct toward a consumer, the provider should document the results of their review and note their intention of bringing the employee back to work. If the date the employee will return is known, the date may be included in the Administrative Review. If the date is not known, the provider will need to submit an Addendum, once established, to notify DDSN of the date of the employee's return to work.

Management Review

Non ICF/IID providers will conduct a Management Review when SLED actively investigates or refers the allegation to local law enforcement or the Attorney General's Office.

Purpose

The purpose of the Management Review is to determine if:

- An employee has violated a written rule, regulation or policy related to improper conduct toward a consumer, and

- Whether corrective actions regarding the employee (such as disciplinary action), management or practice/service changes need to occur.

Management Review Functions

The following activities may be conducted during the Management Review; however, they should never interfere with the investigation of the allegation of abuse, neglect or exploitation by the state investigative agency. During the Management Review process, which is conducted when SLED or local law enforcement accepts a case for investigation, reviewers are not permitted to interview the consumer or staff and cannot collect witness statements. Staff can write a statement to share with the state investigative agency, but cannot share the information with providers during an active investigation.

- Chronology of events – this section shall include in paragraph form, the recreation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.

- Discussion – this section will list all facts.

- Conclusion.

- Supporting documents to be included:

    - unusual occurrence form
    - photographs
    - officer of the day report

- injury reports
- other documents, if needed during the Management Review, such as:

  - body check report
  - doctor/nurse reports
  - work schedule
  - security report

Reporting to DDSN

The Management Review must be completed and the results reported to the DDSN Director of Quality Management, within ten (10) working days, excluding state and federal holidays, in which the suspected abuse, neglect or exploitation is discovered.

If the outcome of the Management Review results in "no findings," meaning the employee did not violate a written rule, regulation or policy related to improper conduct toward a consumer, the provider may request to the DDSN Director of Quality Management to reinstate the employee with back pay, prior to the completion and/or receipt of the state investigative agency's report. This request must be submitted on the DDSN Incident Management System, using the Request for Reinstatement of Employee Form. DDSN will review the request and inform the provider of the results. If the employee is recommended for reinstatement the provider will send in the Addendum to Administrative/Management Review Report to notify DDSN of its action. All forms are to be completed using the DDSN Incident Management System.

7. STEP SEVEN – CONFIDENTIALITY

The Administrative/Management Review is an internal, confidential document and may not be released except to law enforcement and/or state investigative agencies. The report shall not be filed in the victim or alleged perpetrator/employee's file. The results of the Review, including actions taken to ensure the victim's safety, must be shared with the parent/guardian or primary correspondent. However, the Review may not be released.

The Facility Administrator/Executive Director/CEO or their designee may share information from the Review or a copy of the Review with their staff on a need to know basis.

8. STEP EIGHT – Outcome of the External Investigation and/or Internal Review

A. Investigation

Only the state investigative agency (SLED, local law enforcement agency, the Attorney General's Office, or DSS(APS) can determine abuse, neglect, or exploitation. Once written notification from the state investigative agency is received concerning the outcome of the investigation, the following action must be taken by the Facility Administrator/Executive Director/CEO or their designee:

- Founded/Substantiated, Perpetrator Known

  Founded abuse, neglect, or exploitation will result in termination of the perpetrator, within 24 hours of receiving the results of the investigation. In cases of financial exploitation by an employee, the Facility Administrator/Executive Director/CEO or their designee shall ensure that the victim's misappropriated funds are reimbursed to the victim.

- Founded/Substantiated, Perpetrator Unknown

  When the investigation determines that abuse, neglect, or exploitation occurred, but the perpetrator cannot be identified, the Facility Administrator/Executive Director/CEO or their designee shall ensure that the victim is safe and free from harm. Corrective/preventive action shall be taken to prevent a recurrence.

- Unfounded/Unsubstantiated

  If the allegation is unsubstantiated, the alleged perpetrator will be reinstated without prejudice, including any back wages, unless the employee has violated the provider's rules, regulations or policies and the provider has followed its personnel policy of progressive discipline.

B. Administrative/Management Review

Once the Administrative/Management Review is completed, the following action must be taken by the Facility Administrator/Executive Director/CEO or their designee.

Employee Violation of Rules, Regulations or Policies

If an employee has been found to have violated the provider's written rules, regulations or policies, the provider must follow its personnel policy of disciplinary action.

Staff Training/Policy Procedural Change

Staff training issues or policy procedural changes identified during the Review shall be addressed whether or not a violation of agency rules, regulations or policies is discovered. Training issues and/or policy procedural changes must be submitted to the DDSN Director of Quality Management along with corrective action planned or taken to address the issues identified.

Environmental Modifications

Issues regarding structural accommodations or safety devices identified during the Review shall be addressed whether or not a violation of agency rules, regulations or policies is discovered. All changes identified to be made must be submitted to the DDSN Director of Quality Management.

Notification of Licensure/Certification Boards

DHEC, Division of Health Licensing shall be notified within ten (10) days of any suspected abuse, neglect, or exploitation occurring within a Habilitation Center (e.g., DDSN Regional and community-based ICF/IIDs, Community Residential Care Facilities, Hospitals and Day Care Facilities for adults).

The appropriate state licensure or state accreditation board (e.g., State Board of Nursing, State Board of Medical Examiners, Long Term Care Nurse Aide Registry), will be notified in writing by the provider whenever an allegation of abuse, neglect, or exploitation, including failure to report, has been substantiated against a licensed/accredited employee. The employee may be subject to disciplinary action by the licensing/accreditation board.

Addendum to Administrative/Management Review Report

If the disposition of the Administrative/Management Review changes or if there is additional information after the Review, (e.g., the results from external agency investigation/review are received, or if upon approval from DDSN the employee is reinstated prior to the completion of a state investigative agency's final report), the Addendum to Administrative/Management Review Report must be submitted to DDSN on the Incident Management System within 24 hours or the next business day of the change.

9. STEP NINE - EMPLOYEE GRIEVANCE APPEAL PROCEDURES

If an employee is reinstated during the Employee Grievance Appeal, an addendum must be completed stating the reason for reinstatement and sent to the DDSN Director of Quality Management. The Addendum must be completed on the IMS.

VI. MISCELLANOUS INFORMATION

Provider agencies will assure that the person's Case Manager/QIDP/Early Interventionist is aware of the allegation and is informed of the investigative findings. The Case Manager/QIDP/Early Interventionist will monitor to make sure that adequate services and supports recommended are in place to prevent future occurrences of abuse, neglect, or exploitation.

Human Rights Committee

The agency's Human Rights Committee shall be notified at the next regularly scheduled meeting of all allegations of abuse, neglect, or exploitation and the results of the state investigative agency.

Legal Action

If legal pleadings are served which resulted from an incident of abuse, neglect, or exploitation, the Facility Administrator/Executive Director/CEO or their designee shall notify the DDSN Associate State Director of Operations and DDSN General Counsel immediately.

Media Inquiries

In situations where media attention has been generated about an incident of abuse, neglect, or exploitation, DDSN and provider agencies should cooperate with providing information as required under the Freedom of Information Act. Consistent with the provisions of South Carolina Law and Health Insurance Portability and Accountability Act (HIPAA), the Facility Administrator/Executive Director/CEO or their designee must notify the DDSN Associate State Director of Operations when media attention is generated about an incident of abuse, neglect, or exploitation.

The Director of Community Relations is available to provide assistance to DDSN and contract providers in responding to media inquiries.

VII. OTHER INVESTIGATIVE AGENCIES

DDSN and contract providers shall cooperate with external investigations. In addition to investigations by SLED, local law enforcement, Attorney General's Office or DSS (either CPS or APS), other state agencies have jurisdiction to make inquiry into incidents of abuse, neglect, or exploitation and may conduct their own investigation. These agencies include, but are not limited to:

Long Term Care Ombudsman

The Long Term Care Ombudsman's Office investigates those cases vetted by SLED when there is no reasonable suspicion of criminal conduct. Please see DDSN Directive 534-03-DD: The Long Term Care Ombudsman Program.

SC Code Ann § 43-38-10 also allows the Ombudsman to investigate complaints in facilities including intermediate care facilities, residential care facilities and facilities for persons with developmental disabilities.

The Long Term Care Ombudsman Program is authorized to investigate any problem or complaint on behalf of any interested party or any client, patient, or resident of any of the DDSN facilities. In carrying out the investigation, the Long Term Care Ombudsman Program may request and receive written statements, documents, exhibits, and other items pertinent to the investigation. Following the investigation, the Long Term Care Ombudsman Program may issue such report and recommendations as in its opinion will assist in improving the facility under investigation.

All departments, officers, agencies and employees of the state shall cooperate with the Long Term Care Ombudsman's Office in carrying out their duties.

Child Fatalities Review Office

The Child Fatalities Review Office of SLED will investigate all deaths involving abuse, physical and sexual trauma as well as suspicious and questionable deaths of children. The State Child Fatalities Review Office will also review the involvement that various agencies may have had with the child prior to death. DDSN is an active member of this committee.

Vulnerable Adult Fatalities Review Office

The Vulnerable Adult Fatalities Review Office of SLED will investigate all deaths involving a vulnerable adult in any residential program operated or contracted for operation by DDSN. DDSN is an active member of this committee.

Attorney General - Office of Medicaid Fraud

The Medicaid Fraud Division of the State Attorney General's Office may also investigate allegations of financial exploitation in Medicaid facilities and programs.

Protection and Advocacy for People with Disabilities, Inc.

Protection and Advocacy for People with Disabilities (P&A) has statutory authority to investigate abuse and neglect of people with disabilities upon receipt of a complaint.

VIII. QUALITY ASSURANCE

In order to effect and/or maintain a comprehensive system to ensure the timely reporting, as well as preventive/corrective actions, DDSN shall implement and evaluate its quality assurance program which monitors all allegations of abuse, neglect, or exploitation and other violations of rules, regulations or policies occurring in DDSN operated services and supports, Regional Centers, and contract provider agencies.

Susan Kreh Beck, Ed.S. NCSP
Associate State Director-Policy
(Originator)

Beverly A.H. Buscemi, Ph.D.
State Director
(Approved)

Related Directives:

100-09-DD	Critical Incident Reporting
100-28-DD	Quality Assurance and Management
413-01-DD	Standards of Disciplinary Action
505-02-DD	Death or Impending Death of Person Residing in a Residential Program Sponsored by DDSN
533-02-DD	Sexual Assault Prevention and Incident Procedure Follow-up
534-03-DD	The Long Term Care Ombudsman Program

Attachment: Comprehension Test

All forms are to be completed using the Incident Management System

DDSN Training for Abuse, Neglect and Exploitation Comprehension Test

Employee Name: _____ Date of training: _____

Date of Test: _____ Score: _____
(*Must score 80% or re-test*)

Provider Agency: _____

Section 1- True or False

1. A resident of any DDSN facility is a Vulnerable Adult.
   ☐True ☐False

2. After the report to the appropriate investigating agency is made, the employee is obligated to report the suspected abuse, neglect, or exploitation to their supervisor or other management staff within their organization.
   ☐True ☐False

3. Punishing a vulnerable adult by using a restrictive or physically intrusive procedure to control behavior may be considered physical abuse unless the procedure is included as a part of a therapeutic plan developed by a qualified professional.
   ☐True ☐False

4. Failure to properly follow a behavior support plan may result in an allegation of abuse.
   ☐True ☐False

5. If an employee does not think an allegation of abuse is true, they do not have to report.
   ☐True ☐False

6. An employee terminated for abuse, neglect, or exploitation as determined by SLED, local law enforcement, the Attorney General's Office, or DSS (either APS or CPS) will not be eligible for employment in any program, facility, service, or supports operated by DDSN or its contract service providers.
   ☐True ☐False

7. Employees may contact consumers/ coworkers while they are on Administrative Leave without Pay.
   ☐True ☐False

8. If a family member makes an allegation of abuse, neglect, or exploitation, staff must follow-up to ensure the allegation is reported to the appropriate state investigative agency.
   ☐True ☐False

Section 2- Multiple Choice

9. The following persons are mandated reporters and shall report when they believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited:

   A) Medical Professionals (physician, nurse, dentist, etc.)
   B) Teacher, Counselor, psychologist
   C) Caregiver, staff, supervisors and volunteers of day and residential facilities
   D) All of the above.

10. Employees and volunteers of DDSN and its network of contracted service providers are all mandated reporters and are required to report the following in accordance with agency policy and state law:

    A) Abuse
    B) Neglect
    C) Exploitation
    D) All of the above.

11. The following action must take place when an alleged perpetrator has been identified:

    A) The staff is assigned to work with another consumer or in another location.
    B) The staff receives a written warning and placed back on the schedule.
    C) The staff must be placed on administrative leave without pay pending the outcome of the investigation.
    D) The staff is terminated without any internal review.

12. If under an Administrative or Management Review, the employee has been found to violate Written Rules, Regulations or Policies, employee disciplinary action will be taken based upon the nature and extent of the policy violation. This disciplinary action may include:

    A) Written Warning
    B) Additional training
    C) Termination
    D) Any of the above, depending on the nature of the violation.

13. Allegations of abuse, neglect or exploitation may be investigated by:

    A) Department of Social Services (Child Protective Services or Adult Protective Services)
    B) Attorney General- Medicaid Fraud Control Unit
    C) Law Enforcement
    D) Any of the above

Section 3- Please fill in the blank using the word list below

Psychological Abuse	Misdemeanor	Exploitation
Supervisor	Long Term Care Ombudsman (LTCO)	Law Enforcement
Department of Social Services (DSS)		

14. _____may include threatening, harassing or intimidating a vulnerable adult or committing other acts of intimidation that cause fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

15. _____may include causing a vulnerable adult to purchase goods or services for the profit or advantage of the seller or another person.

16. _____investigates or cause to be investigated noncriminal reports of alleged abuse, neglect, and exploitation of vulnerable adults occurring in facilities other than those handled by SLED.

17. The Adult Protective Services Program (APS) or Child Protective Services Program (CPS) of the ____ _____ investigates or causes to be investigated noncriminal reports of alleged abuse, neglect, and exploitation of vulnerable adults occurring in all settings other than facilities.

18. A mandated reporter who knowingly and willfully fails to report is guilty of a _____ ___and, upon conviction, must be fined not more than twenty-five hundred dollars or imprisoned not more than one year.

19. Provided the mandatory reporting requirements are met, a reporter can also make direct contact with _ _____, and in cases of an emergency, serious injury, or suspected sexual assault law enforcement must be contacted immediately.

20. After the report to the appropriate investigative agency is made, the employee is obligated to report the suspected abuse, neglect, or exploitation to their _____or the Facility Administrator/Executive Director/CEO immediately following the report to the appropriate state investigative agency. Immediately means within one (1) hour. The person making the report must assure the alleged victim is safe.

I have completed this Comprehension Test independently after receiving training on Abuse, Neglect and Exploitation and DDSN Directive 534-02-DD: Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Organization.

_____ Date: _____

Employee Signature

Training staff responsible for providing correction for any missed questions to ensure the employee understands the correct procedures: (*Employee must score 80% or re-test*)

_____ Date: _____

Training Staff/ Supervisor Signature

SC Department of Disabilities & Special Needs

Reporting Procedures for Allegations of Abuse, Neglect and Exploitation 534-02-DD

What to Report: Any observed or suspected allegations of abuse, neglect or exploitation.

- *Physical Abuse* includes hitting, slapping, Burning, kicking, biting, pinching, actual or attempted sexual assault; use of meds outside the standards of reasonable medical practice; use of a restrictive method or procedure to control behavior except those prescribed by a physician or part of a BSP.
- *Psychological Abuse* includes making threats of harm; intimidation causing embarrassment, fear, humiliation, agitation or other forms of emotional stress.
- *Exploitation* includes causing or requiring participation in activity or labor that is improper or against the will/wishes of consumer; unlawful use of consumer funds, assets or property of the consumer; improper use of consumer Power of Attorney, guardianship for advantage or profit; causing consumer to make purchases for profit or advantage of the seller or another person through undue influence, coercion or swindling.

- NOTE: The DDSN policy for Abuse, Neglect, and Exploitation does not include any incident referred to as "verbal abuse". These incidents are reported as a Critical Incident. Please refer to Critical Incident policy regarding use of profane and disrespectful language towards a consumer.

Where do you make reports of ANE Allegations?

Adults

- If incident occurs while consumer is at the Day Program, make the report to DSS.
- If incident involving an ICF/ID consumer occurs on the agency van en route to the Day Program, make the report to SLED except as noted below.
- All other incidents of possible ANE should be reported **directly to SLED.**
- **Do not make any reports directly to the Ombudsman—SLED will decide if a case should be referred/vetted to the Ombudsman.**
- If an incident of possible ANE occurs while the consumer is on a home visit or out in the community not under direct supervision by DDSN staff, make the report to DSS and no reports to DDSN are required.

Children

- For children in residential services, report any possible ANE of consumers age 17 and under to OHAN.
- For suspected ANE in other locations, report to the local DSS Child Protective Services Office.

REPORTS MADE TO SLED:

SLED is the "gatekeeper" and will decide whether they will accept a report, issue an Intake Report and whether the case will be referred to another investigative agency.

TO MAKE A REPORT TO SLED: CALL TOLL FREE 1-866-200-6066 *If SLED accepts a case and issues an Intake report, they will usually fax it to DDSN and the Provider within 24-36 hours.*

CRIMINAL CASES

- SLED may vet a case to a Local Law Enforcement agency, to the Attorney General's Office or SLED may conduct the investigation.
- If a report is made to SLED and SLED vets a case to DSS **and** advises the caller to also report the case to LLE, proceed as a criminal case.

NON-CRIMINAL CASES

- SLED may vet(refer) a case to the Ombudsman.
- SLED may accept the report For Information only or For Assessment and issue an Intake report. (All required ANE reports must still be submitted in these instances.)

REPORTS MADE TO DSS:

CRIMINAL CASES:

- In some instances a report is made by the Provider to DSS and simultaneously to Local Law Enforcement, or DSS advises the Provider at the time the report is made that they will also contact LLE. When either of these occurs, proceed as a criminal case.

NON-CRIMINAL CASES:

- Most of the time, cases reported to DSS will be Non-criminal in nature and LLE will not be involved in the case.

INITIAL ANE REPORTS

- Include all required consumer information in the IMS report
- Be sure the residential setting listed is correct
- Include names of all alleged perpetrators and the required personnel action of Administrative Leave Without Pay (date and time)
- Include the required Safety Plan for the victim to include any referral for medical exam if indicated
- The Description of Incident should include all information from the SLED Intake Report narrative (if reported to SLED)
- Initial Reports are due within 24 hours of Incident Date or Date of Discovery

TYPES OF REVIEWS CONDUCTED/SUBMITTED:

- If the consumer is an ICF/IID resident, the ***only*** Review conducted will be the *Administrative Review for ICF/IID.*
- For Non ICF/IID consumers, a *Management Review* will be conducted on **criminal** cases.
- For Non-ICF/IID consumers, an *Administrative Review for Improper Conduct* will be conducted on **Non-criminal** cases.

Administrative Reviews for ICF/ID:

ADMINSTRATIVE REVIEW FOR ICF/IID IS DUE WITHIN 5 BUSINESS DAYS OF INCIDENT DATE OR DATE REPORTED; ALL OTHER REVIEWS ARE DUE WITHIN 10 BUINESS DAYS OF DATE OF INCIDENT OR DATE OF DISCOVERY.

The Purpose of the Review (whether case is criminal or non-criminal) is to determine if staff violated any of your agency policy or engaged in inappropriate conduct towards the consumer

- Can we collect written/signed statements? Yes--required
- Can we conduct interviews Yes--required
- Can we take photographs of injuries? Yes--optional
- Can we review shift notes, logs, etc.? Yes--if indicated
- Can we include a report from the OD? Yes--if one was done
- Can we review accident/injury reports? Yes—as indicated
- All of the above may be done as long as it does not interfere with the investigation by LLE , SLED, DSS or the Ombudsman.

Management Reviews:

- Can we collect written statements? No-- investigating agency does this
- Can we conduct interviews? No— investigating agency does this
- Can we take photographs of injuries? Yes— to give to investigating agency
- Can we review shift notes, nursing notes? Yes
- Can we review accident/injury reports? Yes

Administrative Review for Improper Conduct

- Can we collect written statements? Yes--required
- Can we conduct interviews? Yes—required
- Can we take photographs of injuries? Yes
- Can we review shift notes, logs, etc.? Yes
- Can we include a report from the OD? Yes
- Can we review accident/injury reports? Yes
- If consumer/victim can provide his/her written statement, please obtain. If unable to provide a written statement, staff should take victim's verbatim statement and victim can initial statement; if unable to do either, please address in Discussion section of Outline of Report
- A written, signed/dated statement must be obtained from the alleged perpetrator(s)

Returning Staff to Work:

Criminal cases:

- If the provider has not received a written Case Status Report from the investigative agency (SLED or LLE), then a Request for Reinstatement must be submitted and approved in advance of the employee's return to work. The provider may document any verbal findings on the Request for Reinstatement, noting the name of the investigator providing the information and the date given.

- If the provider has received written Case Status report from SLED or LLE indicating case closed as Unfounded or Unsubstantiated and completed Management Review, then the date the date staff will return to work may be indicated on the Management Review (or in an Addendum) and any applicable disciplinary actions or staff training noted.

Non-criminal Cases:

- The employee may return to work once the Administrative Review is completed to determine if there was any improper conduct or if there were any policy/ procedural violations. The date the date staff will return to work may be indicated on the Administrative Review (or in an Addendum) and any applicable disciplinary actions or staff training noted.

Final Case Disposition:

- **ANE REVIEWS SUBMITTED:** The Disposition in the section on Alleged Perpetrators should remain " *Other Agency Investigating"* unless we have received a Case Status Report from SLED or LLE, or a Written Report from DSS or the Ombudsman.

- **DISPOSITIONS CONFIRMED SUBSEQUENT TO REVIEW SUBMISSION:** If the Case Status report from SLED or LLE or Written report from DSS or the Ombudsman is received after the review has been submitted, an Addendum should be submitted to include the Final determination by the investigative agency. The Disposition in the section of the Addendum on Allegations should be added/updated to reflect the final case determination.

Other Reasons to submit an Addendum:

- When additional information is received after the Review has been submitted and approved
- When a case determination or status changes
- To indicate final personnel action and date for alleged perpetrators
- Within 24 hours after a reinstatement request has been approved

COMMITTEE CONTACT INFORMATION

Legislative Oversight Committee

South Carolina House of Representatives

- Website - http://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee.php
- Phone Number - 803-212-6810
- Email - HCommLegOv@schouse.gov
- Location - Blatt Building, Room 228