

From: [Linguard, Christie](#)
Subject: Meeting Notice - The Commission of the SCDDSN - Policy Committee Meeting - September 6, 2022
Date: Sunday, September 4, 2022 12:20:27 PM
Attachments: [September 6, 2022 Policy Committee Public Packet \(090222\).pdf](#)

Everyone,

The South Carolina Commission on Disabilities and Special Needs will hold an in-person Policy Committee meeting on Tuesday, September 6, 2022, at 4:15 p.m. The Committee Meetings are held at the SC Department of Disabilities and Special Needs Central Administrative Office, 3440 Harden Street Extension, Columbia, SC. This meeting can also be viewed via a live audio stream at <https://ddsn.sc.gov>.

Please see the attached meeting material for the Policy Committee Meeting.

For further information or assistance, contact (803) 898-9769 or (803) 898-9600.

Thank you.

POLICY COMMITTEE AGENDA

DRAFT

**Commission of the South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Columbia, South Carolina**

September 6, 2022

4:15 p.m.

- 1. Call to Order** **Committee Chair Barry Malphrus**
- 2. Statement of Announcement** **Lori Manos on behalf of Chairman Malphrus**
- 3. Invocation** **Committee Chair Barry Malphrus**
- 4. Adoption of Agenda**
- 5. Approval of Summary Notes from August 9, 2022 Meeting**
- 6. Old Business:**
 - A. 700-09-DD: Determining Need for Residential Services
 - B. 700-03-DD: Informed Choice in Living Preference (Intermediate Care Facilities for Individuals with Intellectual Disabilities)
- 7. New Business:**
 - A. 505-02-DD: Death or Impending Death of Persons Receiving Services from DDSN
 - B. 275-04-DD: Procedures for Implementation of DDSN Audit Policy for DSN Boards
- 8. Adjournment – Next Meeting October 11, 2022**

MEETING SUMMARY OF THE POLICY COMMITTEE
Commission of the South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Columbia, South Carolina
August 9, 2022

IN ATTENDANCE: Chairman, Barry Malphrus; Commissioner David Thomas
Dr. Michelle Fry, Lori Manos, Erin Oehler, Harley Davis, Andrew Tharin, Janet Priest;
Nancy Rumbaugh, and Colleen Honey

1. Adoption of Agenda

Chairman Malphrus requested committee members to adopt the agenda.

As there were no objections, agenda was adopted.

2. Approval of Summary Notes from the July 12, 2022 Meeting

Chairman Malphrus requested committee members to adopt the summary notes.

As there were no objections, summary notes from the July 12, 2022 meeting were adopted.

3. Old Business:

- A. 300-05-DD: Maintenance Management Contract Requirements for Community Residential Homes

The directive was posted for external review. One comment was received and staff made additional changes. A copy of the draft version and final version (paperclipped) were included in the Committee packet. As there were no objections, the directive will be presented to the full Commission for approval and signing along with 300-04-DD: Maintenance of Physical Plant which was declared OBSOLETE at the August Policy meeting.

4. New Business:

- A. Selection of FY23 List of Directives/Standards for Policy Committee

According to 800-07-CP; Attachment D, a list of Directives/Standards to be considered by the Committee due for review during the fiscal year will be placed on the website. The list was vetted by the Chairman. As there were no objections, the list will be posted to the website.

5. Adjournment

The next meeting will take place on September 6, 2022.



Michelle G. Fry, J.D., Ph.D.

State Director

Janet Brock Priest

Associate State Director

Operations

Lori Manos

Associate State Director

Policy

Constance Holloway

General Counsel

Harley T. Davis, Ph.D.

Chief Administrative Officer

Nancy Rumbaugh

Interim Chief Financial Officer

Greg Meetze

Chief Information Officer

COMMISSION

Stephanie M. Rawlinson

Chairman

Barry D. Malphrus

Vice Chairman

Robin B. Blackwood

Secretary

Gary Kocher, M.D.

Eddie L. Miller

David L. Thomas

Michelle Woodhead

3440 Harden Street Extension
Columbia, South Carolina 29203

803/898-9600

Toll Free: 888/DSN-INFO

Home Page: www.ddsn.sc.gov

Reference Number:

700-09-DD

Title of Document:

Determining Need for Residential Services

Date of Issue:

~~August 18, 2022~~ September 15, 2022

Date of Last Revision:

~~August 18, 2022~~ September 15, 2022

(NEW)

Effective Date:

~~August 18, 2022~~ December 1, 2022

Applicability:

All DSN Boards and Contracted Service Providers

GENERAL:

The Department of Disabilities and Special Needs (DDSN) must ensure that those who are eligible for its services are provided with needed services and supports, including residential services, in the most timely and equitable manner possible. For the purpose of this document, the terms “DDSN-sponsored Residential Services” and “Residential Services” are used as collective terms for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services, Residential Habilitation services funded by the Intellectual Disabilities and Related Disability (ID/RD) Waiver or the Head and Spinal Cord Injury (HASCI) Waiver and/or Residential Habilitation services funded solely by DDSN.

The purpose of this Directive is to establish:

- Minimum criteria which must be met before DDSN-sponsored Residential Services may be offered.
- Definitions of the types Residential Services.
- A Committee responsible for reviewing requests for Residential Services.
- Procedures for evaluating requests and communicating the decisions.
- Procedures for requesting the need for Residential Services be determined.
- Procedures for requesting a change to an approved Residential Service.
- Procedure for notifying DDSN of the termination of Residential Habilitation or discharge from an ICF/IID.
- Procedure when seeking a different Residential Services provider.
- Procedure for notifying DDSN of an anticipated need for Residential Services.
- Repository of information about Residential Services options and Residential Services seekers.

MINIMUM CRITERIA FOR RESIDENTIAL SERVICES:

Only those who are eligible for DDSN services and are determined by DDSN to be experiencing circumstances that jeopardize their health and safety will be determined to need DDSN-sponsored Residential Services. Circumstances that jeopardize health and safety are defined as:

- Life-threatening situations that requires immediate action, and/or
- Situations that present imminent risk of jeopardizing the person’s health, safety and welfare.

Situations that are life threatening or pose an imminent risk of becoming life-threatening are typically limited to situations in which the person:

1. Has been recently abused/neglected/exploited by the primary caregiver;
2. Is homeless (to include situations where the individual is being discharged from an alternative placement and is unable to return to a family member’s home or live independently);
3. Has seriously injured self or others and continues to pose a threat to the health and safety of self or others;
4. Has been judicially admitted to DDSN;
5. Has recently lost a primary caregiver or is at imminent risk of losing a primary caregiver; or
6. Has a primary caregiver who is 80 years of age or older with diminished ability to provide care that is likely to continue indefinitely due to the caregiver’s physical or mental status and lack of an alternative caregiver. Care is being provided now, but it is clear that the need for services is imminent, because the caregiver will soon be unable to provide care and no other caregivers are available.

Additionally, to be determined by DDSN to be experiencing circumstances that jeopardize health and safety, when appropriate, all efforts to address the situation through the use of other services and supports, including Home and Community Based (HCB) Waiver services, must have been exhausted. The refusal of other supports and services may not necessarily constitute the presence of circumstances that jeopardize health and safety. Additionally, residing with relatives, friends, or alone with supports must be ruled out prior to someone being considered homeless.

TYPES OF DDSN-SPONSORED RESIDENTIAL SERVICES:

There are two (2) types of DDSN-sponsored Residential Services, Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) and Residential Habilitation. Each type is described below along with the settings and levels or tiers of service associated with each type.

1. Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID):

Facilities licensed by the state to provide comprehensive and individualized health care and habilitation services to individuals to promote their functional status and independence. ICF/IID services are available to those who need active treatment. Active treatment is the aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. ICF/IID services are not appropriate for those who are generally independent, able to function with little supervision and/or do not require a continuous program of habilitation services. ICF/IID services can be delivered in two (2) kinds of settings, a Regional Center setting or a community-based setting.

- Regional Centers are operated by DDSN and typically provide a campus-like environment with multiple ICF/IID living units, spaces/buildings for most professional resident services and spaces/buildings for most recreational pursuits such as gymnasiums, chapels, greenspace on the grounds of the campus.
- Community-based ICFs/IID are operated by some Disabilities and Special Needs (DSN) Boards. While more than one ICF/IID living unit may be located in close proximity to another, community-based ICFs/IID are typically located in neighborhoods or near community businesses. Community-based ICF/IID residents seek professional services from community businesses in locations away from the ICF/IID living unit.

2. Residential Habilitation:

Is a specifically defined service that must be provided in non-institutional settings that are licensed or certified by the state and chosen by the person. The setting may be owned by the person, rented by the person from a third party, or be a unit or physical space that is occupied under a legally enforceable agreement between the person and the Residential Habilitation provider.

Residential Habilitation does not include room and board. It is specifically defined as care (e.g., assistance with personal care, medication administration), supervision (oversight and guidance proportionate to the specific needs and preferences of the person) and skills training (e.g., adaptive skill building, activities of daily living, community inclusion, access and use of transportation, educational supports, social and leisure skill development) provided to support the person to live as independently as possible and exert positive control over his/her life.

Residential Habilitation is offered through different tiers of service. A tier of service is a combination of the model (see Appendix A) through which Residential Habilitation is delivered and the degree of support the person will require when Residential Habilitation is delivered in that model. There are nine (9) tiers of service which are described below.

- **High Management (Intensive Support Residential Habilitation)** is delivered through the Community Training Home II (CTH-II) model which is shared by up to three (3) people who have a brain injury, spinal cord injury or similar disability or those who have a diagnosis of intellectual disability/related disabilities and display extremely challenging behaviors.
- **Tier 4 (Intensive Support Residential Habilitation)** is delivered through the CTH-II model which is shared by up to four (4) people who may have been involved with the criminal justice system and individuals with severe behaviors requiring heightened staffing levels.
- **Tier 3 (Intensive Support Residential Habilitation)** is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people who have a diagnosis of brain injury, spinal cord injury or similar disability or those who have a diagnosis of intellectual disability/related disabilities and display extremely challenging behaviors. Includes people being discharged from a DDSN Regional Center (ICF/IID) or community ICF/IID. Also includes people who need additional supports to prevent or delay institutional placement and to participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform Activities of Daily Living without support from another.

- **Tier 2** is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need additional supports (greater than included in Tier 1) to prevent or delay institutional placement and to participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform Activities of Daily Living without support from another.
- **Tier 1** is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need support to live in and participate in their community. Those supports include a degree of care, supervision, and skills training provided throughout the day.
- **Supervised Living Program (SLP) II:** includes people who need support to live in and participate in their community. The supports delivered include a degree of care, supervision, and skills training provided throughout the day. SLP-II is delivered in a licensed SLP-II setting that is typically single or double-occupancy residence.
- **CTH Tier 2:** delivered to waiver participants who need additional supports (greater than included in CTH Tier) to enable them to live in the setting and participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform activities of daily living without support. Those additional supports are typically services/supports specifically intended to provide relief/assistance to the supports provider and are necessary due to the amount/intensity of supports the person requires. CTH Tier 2 services are delivered to up three (3) people in the CTH-I licensed home of the support provider.
- **CTH Tier 1:** delivered to waiver participants who need support to live in and participate in their community. CTH Tier 1 services are delivered to up three (3) people in the CTH-I licensed home of the support provider.
- **Supervised Living Program (SLP) I:** delivered to waiver participants who need support in their own apartment or home setting. Support is provided through a 15 minute-unit and support is available 24 hours per day by phone. An annual assessment is completed for each participation to verify support needs in their own setting.

RESIDENTIAL SERVICES REVIEW COMMITTEE:

To ensure appropriate consideration is given to all requests/notifications (~~requests~~) for Residential Services (both initial and requests for change), DDSN will empanel a Residential Services Review Committee (Committee) to review all thorough and complete requests submitted to the agency. The Committee will be comprised of DDSN staff who are appointed by the State Director. Committee members must have expertise at least one of the following areas: Case Management, Residential Habilitation, ICF/IID Services, or Fiscal. The Committee will meet as often as necessary in order to comply with the established deadlines.

At a minimum, three (3) Committee members must actively participate in the review of each request. Documentation of the date of the Committee's decision must be maintained and include the name of each person whose request is considered, the name of the case manager submitting the request, and the names of the Committee members reviewing the request. All Committee decisions must be made in

recognition of the mission, values and principles of DDSN. The Committee must determine the degree of support the person requires and consider those support needs in light of the model that is preferred by the person and most appropriate to deliver those supports.

INITIAL REQUEST FOR DETERMINATION OF NEED FOR RESIDENTIAL SERVICES:

When someone who is eligible for DDSN services has been assessed by his/her case manager to need support with housing, care, supervision and skills training and the person desires to receive DDSN – sponsored Residential Services, the case manager must make a request to DDSN. Requests must be submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.” All requests must be thorough and complete. DDSN will utilize information available in the person’s electronic health record and specific forms/information submitted to evaluate each request. At a minimum, the following information/completed forms must be available for review:

- Residential Services Request/Notification (form) (Attachment 1).
- Evidence that the case manager saw the person in his/her home or current location (e.g., hospital, homeless shelter, etc.).
- Evidence that the case manager explained the following to the person and/or his/her representative:
 - The minimum criteria for residential services (as defined in this document),
 - The process to be followed for a decision to be made,
 - The possible decisions that could be made by DDSN, and
 - The right the person has to request reconsideration of or appeal a decision with which he/she disagrees.
- Assessment of Need for Residential Services/Residential Habilitation (form) (Attachment 2)
- Evidence of continued contact with the person ~~during the pendency of the request~~ while the request is pending.

DDSN must complete a review and acknowledge receipt of requests /notifications submitted via Therap SComm to “DDSN, Residential Service Requests” within ~~five (5)~~ three (3) business days of submission. This review will be completed only to ensure the required information is available for evaluation. When acknowledging the submission, DDSN will indicate if the submission is:

- Thorough and complete and will be evaluated,
- Incomplete, is being returned/rejected and will not be evaluated, or
- Being held pending clarification.

As soon as possible, but no later than ~~ten (10)~~ five (5) business days of receipt of a thorough and complete request, the Residential Review Committee will evaluate the submitted and available documentation. The Committee may, at ~~their~~ its discretion, before making a decision, determine that a face-to-face visit with the person in his/her current residence/location or face-to-face visit with this person’s caregiver is needed to better understand the circumstances. These face-to-face visits will be conducted by DDSN staff with assistance, as needed, from the person’s case manager.

Following the evaluation, the Committee must, when determining if Residential Services are needed, decide if:

- a. The criteria for Residential Services has not been met (must explain why, and if appropriate, offer alternative solutions and /or designate as Priority 1), or

- b. The criteria for Residential Services has been met; and
 - i. The type Residential Services approved (ICF/IID or Residential Habilitation),
 1. If the type is ICF/IID, the setting (Regional Center or Community-based), or
 2. If the type is Residential Habilitation, the tier of service (see Appendix B).

DDSN must communicate the Committee's decision in writing within two (2) business days. The written communication must be transmitted via certified mail to the person and his/her representative (if appropriate) ~~and his/her case manager~~. The person's case manager will be copied. The communication must include written notice of the person's right to appeal or request reconsideration of the decision.

REQUEST FOR CHANGE TO RESIDENTIAL SERVICES (INCLUDING TYPE AND SETTING OR TIER):

Each person who is receiving a DDSN-sponsored Residential Service has been approved for a specific Residential Service type and setting or tier. As the agency in the state which has authority over all of the state's services and programs for people with intellectual disability, related disabilities, head injuries, and spinal cord injuries, including Residential Services, DDSN must approve or be notified of any change to the Residential Services being delivered prior to any change being made. Examples include:

- From one DDSN Regional Center to another DDSN Regional Center.
- From one ICF/IID to another ICF/IID within the same DDSN Regional Center.
- From a DDSN Regional Center to a Community-based ICF/IID.
- From a Community-based ICF/IID to another Community-based ICF/IID.
- From an ICF/IID (any setting) to Residential Habilitation (any tier).
- From any tier of service to another tier of service.
- From the current setting for Residential Habilitation (any tier) to another setting for Residential Habilitation (same tier) [e.g., from Tier 1 at Miles Rd. CTH-II to Tier 1 at Rose Circle CTH-II].
- From a model for a tier of service to a different model for the same tier of service (e.g., from Tier 2 at Delta CRCF to Tier 2 at Dixie Rd. CTH-II).

In order to receive prior approval for a change in Residential Services, the change must be requested. A request for a change must be submitted by the person's case manager or Qualified Intellectual Disabilities Professional (QIDP) and must only be submitted with the consent of the person, his/her legal guardian, or client representative.

Thorough and complete requests must be submitted to DDSN via Therap SComm to "DDSN, Residential Service Requests." All requests must explain the reason for the requested change (e.g., provider's request, person's request, person's desire for a less restrictive setting). Documentation that supports the reason for the change must be submitted or available. At a minimum, the following information must be submitted or available:

- Residential Services Request/Notification (form) (Attachment 1).
- Evidence the person has been informed of the request for change and consents to its submission.
- For anyone approved for Residential Habilitation, evidence supporting the person is aware of the terms his/her legally enforceable residential agreement (lease) and the how the change will impact it.

- When the Residential Habilitation provider owns/controls the residence/setting in which the person lives, evidence the provider has or will comply with the terms of the residential agreement.
- A thorough explanation of the reason the change is being requested.
- Evidence that the change is for good cause and is in the best interest of the person.
- Evidence supporting/demonstrating the reason for the change. Evidence must be current, specific to the person and specific to the circumstances necessitating the request for change. Examples of the kinds of evidence which, depending on the circumstances, could support a request for a change include but are limited to:
 - A statement of an ICF/IID resident's interest in and capacity for receiving needed services outside of an ICF/IID.
 - A statement of a Residential Habilitation recipient's interest in receiving Residential Habilitation through a different model.
 - Residential Habilitation plan(s) or Individual Program Plan(s) (IPPs) and amendments covering at least the last twelve (12) months. The plans must include the interventions implemented to address the circumstances necessitating the change.
 - Data showing the person's response to the planned interventions.
 - Behavior Support Plan(s) covering the past twelve (12) months and data showing the person's response to the implementation of its interventions.
 - Other data/information such as T-Logs, General Event Reports (GERs), Reports of Unusual Behavior (UBRs), etc.
 - Medical information, progress notes including changes to medications prescribed for behavior.
 - The level and pattern of staff support provided over the past twelve (12) months in the setting/model, including alternative levels or patterns tried and the outcome.
 - The level and/or pattern of staffing thought to be needed for the person and why.

Requests for change must be submitted to DDSN via Therap SComm to "DDSN, Residential Service Requests." All requests must be thorough and complete. DDSN will utilize information available in the person's electronic health record and specific forms/information submitted to DDSN to evaluate each request. Submitted requests will be acknowledged by DDSN within ~~three (3)~~ five (5) business days of submission and will include an initial review to ensure the required information is available. When acknowledging the submission, DDSN will indicate if the submission is complete and will be evaluated or if information or clarification will be needed.

Within ~~ten (10)~~ five (5) business days of the receipt, the Residential Review Committee will evaluate the submitted and available information. The Committee may at any time request additional information or clarification. Using the submitted and available information the Committee will decide to approve or deny the request. If approved, the Committee must document the **type** Residential Services (ICF/IID or Residential Habilitation) and either the ICF/IID **setting** or **tier of service**.

DDSN must communicate the Committee's decision in writing within two (2) business days. The written communication must be transmitted via certified mail to the person, and his/her representative (if appropriate) ~~and his/her case manager~~. The person's case manager will be copied. The communication must include written notice of the person's right to appeal or request reconsideration of the decision.

NOTIFICATION OF TERMINATION OF RESIDENTIAL HABILITATION OR DISCHARGE FROM ICF/IID:

Termination of Residential Habilitation by the residential services provider or discharge from the ICF/IID must be for good cause and, when possible, well planned. DDSN must be notified of all terminations or discharges. The “Residential Services Request/Notification” form (Attachment 1) must be used to notify DDSN of termination/discharges. Upon completion, this form must be submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.”

NOTIFICATION OF DESIRED CHANGE OR ANTICIPATED NEED:

People eligible for DDSN services must be supported, as appropriate, to exercise positive control over their lives especially as it relates to where and with whom they live. To that end, when a change to the person’s current living arrangement is desired or likely to be needed, DDSN must be notified. Examples of changes of which DDSN must be notified include:

- The person’s current living situation is sufficient but DDSN-sponsored residential supports will likely be needed within the next 24 months.
- The person lives in an ICF/IID and based on his/her annual assessment, ~~he~~ is interested in and has the capacity for receiving needed services outside of an ICF/IID.
- The person desires Residential Services from a different provider.
- The person desires Residential Services in a different city or county.
- The person desires a different type of ICF/IID Services.
- The person desires to receive Residential Habilitation through a different model.

When notification to DDSN is required and with the person’s consent, notification must be submitted by the person’s case manager or QIDP using the “Residential Services Request/Notification” (form). “Residential Services Request/Notification” form must be thoroughly completed and submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.” Within five (5) business days of receipt, DDSN will acknowledge receipt of the information and confirm that information about the person and his/her preferences has been included in the Residential Services Information Repository.

RESIDENTIAL SERVICES INFORMATION:

In order to facilitate the connection between those needing DDSN-sponsored Residential Services and providers of Residential Services who may be able to deliver those needed services, DDSN will maintain information about those determined by the agency to need residential services for the first time and those determined to need a different kind of residential service. Additionally, information about ICF/IID residents who wish to receive their needed services in community-based settings instead of the institutional setting will be maintained as well as information about anyone approved for DDSN Residential Services who may be seeking the same services in a different location or from a different provider. This information will be available in the “Portal Access Reports” application of the DDSN Application Portal. Confidentiality will be maintained with all person-specific data available. Until appropriate consent is obtained from the person, only non-specific information about the person will be shared (e.g., initials, age in years). Specific information such as full name, date of birth, current address will only be shared with specific provider(s) and only with appropriate consent.

In addition to information about people seeking Residential Services, DDSN will maintain information about the current and anticipated Residential Services openings or opportunities throughout the state. This information will be available in the “Portal Access Reports” application of the DDSN Application Portal. Information about openings or opportunities must be reported to DDSN by the Residential Services providers. Before posting the information about an actual opening, DDSN will verify the opening complies with the licensed capacity of the setting. Information about anticipated openings can be submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.” using the Notification of Anticipated Residential Availability form. Within three (3) business days of receipt of the completed form, DDSN will share the information.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

Appendix A: Description of Residential Habilitation Models
Appendix B: Residential Habilitation Tiers of Service

To access the following attachments, please see the agency website page “Current Directives” at: <https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives>

Attachment 1: Residential Services Request/Notification Form
Attachment 2: Assessment of Need for Residential Services
Attachment 3: Notification of Anticipated Residential Availability

Main document changes and comments

Page 1: Commented [HC1] **Honey, Colleen** **7/21/2022 10:23:00 AM**

Elizabeth Krauss – Georgetown DSN Board

I do think the conflicts created with Waiver requirements under the New HCBS Rule and state of SC’s CRCF regs need to be reconciled. Federal Law should take precedent vs State Fire Marshall rules

Page 1: Commented [ML2R1] **Manos, Lori** **9/1/2022 1:03:00 PM**

DDSN Response: DDSN consulted with SCDHHS. The CRCF regulations must be followed. While DDSN understands that this creates a perceived conflict, CRCF residents should be made aware of the requirements for living in the facility.

Page 1: Commented [HC3] **Honey, Colleen** **7/28/2022 4:41:00 PM**

Beth Franco – Disabilities Rights SC

See attached.

Page 1: Commented [HC4] **Honey, Colleen** **7/21/2022 10:30:00 AM**

Elizabeth Krauss – Georgetown DSN Board

What systems will be in place to ensure SC-DDSN is in compliance with the numerous timelines established in the directive?

Page 1: Commented [ML5R4] **Manos, Lori** **9/1/2022 1:04:00 PM**

DDSN Response: Metrics will be established to ensure compliance.

Page 2: Commented [HC6] **Honey, Colleen** **7/21/2022 10:25:00 AM**

Elizabeth Krauss – Georgetown DSN Board

Need to reconsider the criteria of 80 years old. You can be a primary care giver at any age and be experiencing diminishing ability to provide care.

Page 2: Commented [ML7R6] **Manos, Lori** **9/1/2022 1:06:00 PM**

DDSN Response: DDSN understands the stringency of the utilization control measures in place. Future consideration of changes to these measures will be given.

Page 2: Commented [HC8] **Honey, Colleen** **7/21/2022 10:40:00 AM**

Susan John – Horry DSN Board

Not sure if this was in the previous version, however sometimes this is just not an option. What type of documentation/information will be necessary??

Page 2: Commented [ML9R8] **Manos, Lori** **9/1/2022 1:08:00 PM**

DDSN Response: This is unchanged from current policy. While DDSN understands it is not always possible, it is there for exploration and consideration.

Page 4: Commented [HC10] **Honey, Colleen** **7/29/2022 11:35:00 AM**

Jason Tavenner – Laurens DSN Board

Committee needs to use a comprehensive assessment tool to make decisions. Using a narrative from the Case Manager may be biased by the Case Manager’s working knowledge of or lack of knowledge of the situation and their ability to articulate the needs of the person. Additionally, a comprehensive assessment tool may remove any perceived bias by the review committee.

Page 4: Commented [ML11R10] Manos, Lori 9/1/2022 1:10:00 PM

DDSN Response: DDSN is pursuing an assessment tool(s). Policy will be updated after an assessment tool(s) is established and implemented.

Page 4: Commented [HC12] Honey, Colleen 7/29/2022 11:20:00 AM

Ralph Courtney – Aiken DSN Board

This word string confuses me.

Page 4: Commented [ML13R12] Manos, Lori 9/1/2022 1:11:00 PM

DDSN Response: Addressed.

Page 5: Commented [HC14] Honey, Colleen 7/21/2022 10:42:00 AM

Susan John – Horry DSN Board

Without a comprehensive assessment tool, this is solely contingent on how well the Case Manager can articulate, and how well they may know the person to help committee members assess the needs and needed level of support. Providers need to push for a comprehensive assessment tool/method prior to implementation of this process. It is very subjective. Attachment #2 they reference is not an assessment tool but a fact-finding document. Again, not comprehensive enough to determine true level of need.

Page 5: Commented [ML15R14] Manos, Lori 9/1/2022 1:12:00 PM

DDSN Response: DDSN is pursuing an assessment tool(s). Policy will be updated after an assessment tool(s) is established and implemented.

Page 5: Commented [HC16] Honey, Colleen 7/29/2022 11:36:00 AM

Jason Tavenner – Laurens DSN Board

Timeframes need to be reduced. Recommend 3 days to authenticate the packet upon submission and no more than 5 days for committee to meet and make a decision once authenticated. Two pressure points here. One, these are usually crisis situations that cannot wait up to 15 days to vet. Two, as a Residential Provider, more time to get on the list will result in lost days before admission/billing.

What appeal rights does a person receiving services have to the decision of the committee?

Page 5: Commented [ML17R16] Manos, Lori 9/1/2022 1:15:00 PM

DDSN Response: Recommended changes incorporated. Directive 535-11-DD Appeal and Reconsideration of Decisions will be followed.

Page 5: Commented [HC18] Honey, Colleen 7/29/2022 11:22:00 AM

Ralph Courtney – Aiken DSN Board

I could not find this in Webster's Dictionary. I suggest using, ". . . during the period the request is pending."

Page 5: Commented [ML19R18] Manos, Lori 9/1/2022 1:16:00 PM

DDSN Response: Addressed.

Page 5: Commented [HC20] Honey, Colleen 7/21/2022 10:44:00 AM

Susan John – Horry DSN Board

This is for new persons requesting residential, however again, if the CM does not know the individual in question, this could present life safety factors to the consumer in question and the family/individual/entity that is currently supporting the person. (i.e. family member, aging caregiver, homeless shelter, hospital setting).

Page 5: Commented [ML21R20] Manos, Lori 9/1/2022 1:19:00 PM

DDSN Response: The Committee cannot make a decision without appropriate information.

Page 5: Commented [HC22] Honey, Colleen 7/29/2022 11:23:00 AM

Ralph Courtney – Aiken DSN Board

Committee is singular and, for agreement, the word, “their,” should be replaced by “its.”

Page 5: Commented [ML23R22] Manos, Lori 9/1/2022 1:21:00 PM

DDSN Response: Addressed.

Page 5: Commented [HC24] Honey, Colleen 7/29/2022 11:25:00 AM

Ralph Courtney – Aiken DSN Board

The following sentence is included twice, one time right after the other: “These face-to-face visits will be conducted by DDSN staff with assistance, as needed, from the person’s case manager.” The last sentence should simply be deleted.

Page 5: Commented [ML25R24] Manos, Lori 9/1/2022 1:23:00 PM

DDSN Response: No correction needed.

Page 5: Commented [HC26] Honey, Colleen 7/21/2022 10:27:00 AM

Elizabeth Krauss – Georgetown DSN Board

In my opinion it is SC-DDSN's responsibility to provide specific criteria of why Residential Services has not been met and alternative solutions.

Page 5: Commented [ML27R26] Manos, Lori 9/2/2022 10:06:00 AM

DDSN Response: Noted.

Page 6: Commented [HC28] Honey, Colleen 7/29/2022 11:25:00 AM

Ralph Courtney – Aiken DSN Board

This states that certified mail will be used to communicate the Committee’s decision with all parties listed. Does DDSN really intend to send notifications of these decisions to case managers by certified mail, or will regular mail or email be used?

Page 6: Commented [ML29R28] Manos, Lori 9/1/2022 1:24:00 PM

DDSN Response: Addressed

Page 6: Commented [HC30] Honey, Colleen 7/29/2022 11:37:00 AM

Jason Tavenner – Laurens DSN Board

Residential Providers should be added to the list of parties that can request a change. Residential Providers are directly affected by this process yet have no opportunity to initiate a need within their own programs. This is not a sound business practice.

In section outlining documents to provide, references to 12 months of data should state “up to” 12 months of data as available.

Timeframes need to be reduced. Recommend 3 days to authenticate the packet upon submission and no more than 5 days for committee to meet and make a decision once authenticated. These are usually crisis situations that cannot wait up to 15 days to vet.

What appeal rights does a person receiving services or a Residential Provider have to the decision of the committee?

Page 6: Commented [ML31R30] Manos, Lori 9/1/2022 1:42:00 PM

DDSN Response: When residential habilitation changed from a single daily service funded by funding bands to essentially 8 separate services (tiers) for which providers bill Medicaid directly, the involvement of the Case Manager when assessing the appropriate tier of service became pivotal. Just like Personal Care, which contains two levels of the service, the assessment of the appropriate level would never be at the discretion of the Personal Care provider. The determination of need for any service or level of service rests solely with the case manager. Granted, the residential habilitation provider should have a role in informing the assessment, as should other professionals with pertinent knowledge of the person. However, the case manager, as an independent party, should make a professional judgement based on all available information. As justified by the assessment, the Case Manager will update the Plan and issue the authorization.

These are examples.

Comment addressed.

Already addressed.

Page 6: Commented [HC32] **Honey, Colleen** **7/29/2022 11:26:00 AM**

Ralph Courtney – Aiken DSN Board

The word “in” needs to be inserted between “change and “Residential.”

Page 6: Commented [ML33R32] **Manos, Lori** **9/1/2022 1:43:00 PM**

DDSN Response: Corrected.

Page 6: Commented [HC34] **Honey, Colleen** **7/21/2022 10:45:00 AM**

Susan John – Horry DSN Board

This is problematic for the provider who is supporting the individual in question as the redetermination of need for residential services. The CM has no business requesting a change in a residential setting or tier reconsideration. This falls on the provider who is supporting the consumer. The CM should be involved, however the information that is essential in assuring accurate representation is coming from the current residential provider. This affects the business acumen and financial stability of the provider. The CM has no business being involved in the business decisions of that organization. If the CM does not know the person very well, if they are unable to articulate verbally and in writing the needs for re-evaluation and do not complete a comprehensive packet, then the provider is at the mercy of the CM who has 70 other cases to worry about. The sense of urgency in these cases is critical and should be completed by the residential service provider already providing the services.

Page 6: Commented [ML35R34] **Manos, Lori** **9/1/2022 1:44:00 PM**

DDSN Response: When residential habilitation changed from a single daily service funded by funding bands to essentially 8 separate services (tiers) for which providers bill Medicaid directly, the involvement of the Case Manager when assessing the appropriate tier of service became pivotal. Just like Personal Care, which contains two levels of the service, the assessment of the appropriate level would never be at the discretion of the Personal Care provider. The determination of need for any service or level of service rests solely with the case manager. Granted, the residential habilitation provider should have a role in informing the assessment, as should other professionals with pertinent knowledge of the person. However, the case manager, as an independent party, should make a professional judgement based on all available information. As justified by the assessment, the Case Manager will update the Plan and issue the authorization.

Page 7: Commented [HC36] **Honey, Colleen** **7/21/2022 10:47:00 AM**

Susan John – Horry DSN Board

The reference to 12 months of data showing the person’s response to BSP, staffing support provided, IPP, ISP information, etc. In some cases, the provider may not have supported the person for 12 months. What information will be required when that is the case?

Page 7: Commented [ML37R36] **Manos, Lori** **9/1/2022 1:43:00 PM**

DDSN Response: This is an example.

Page 7: Commented [HC38] **Honey, Colleen** **7/29/2022 11:31:00 AM**

Ralph Courtney – Aiken DSN Board

The same question as was raised in above applies here. Does DDSN really intend to send notifications of these decisions to case managers by certified mail, or will regular mail or email be used?

Page 7: Commented [ML39R38] **Manos, Lori** **9/1/2022 1:45:00 PM**

DDSN Response: Addressed

Page 8: Commented [HC40] **Honey, Colleen** **7/29/2022 11:38:00 AM**

Jason Tavenner – Laurens DSN Board

Add Residential Providers to the list of those that should notify DDSN of a need.

Page 8: Commented [ML41R40] **Manos, Lori** **9/1/2022 1:46:00 PM**

DDSN Response: See previous comment related to the role of the case manager.

Page 8: Commented [HC42] **Honey, Colleen** **7/29/2022 11:29:00 AM**

Ralph Courtney – Aiken DSN Board

I believe the writer’s intent was to put “is interested in.”

Page 8: Commented [ML43R42] Manos, Lori 9/1/2022 1:46:00 PM

DDSN Response: Addressed.

Page 8: Commented [HC44] Honey, Colleen 7/29/2022 11:38:00 AM

Jason Tavenner – Laurens DSN Board

Consent to share data needs to be obtained prior to name being put on the list. The current listing provided by DDSN is not helpful to Residential Providers as we seek placements for vacancies. It takes a significant amount of time to make calls to Case Managers or those with information on the person. Many times, we are not able to obtain necessary information either from lack of response or lack of knowledge, which prohibits us from properly considering a person for a vacancy. This could result in people remaining on the list longer than necessary due to the absence of information. Additionally, Residential Providers now carry the fiscal burden for vacant bed days. Any additional support of information to Residential Providers to expediate the process for admission is a support to the stability of the entire system of supports.

Page 8: Commented [ML45R44] Manos, Lori 9/1/2022 1:47:00 PM

DDSN Response: DDSN is pursuing better availability of information.

Page 8: Commented [HC46] Honey, Colleen 7/21/2022 10:49:00 AM

Susan John – Horry DSN Board

The current information available on the “Portal Access Reports” is not comprehensive enough for a provider to even screen a potential individual. Consent should be gotten immediately if a person is added to the residential waiting list so that the process does not slow down. I understand the need for consent, but information is necessary for a provider to screen in/out potential individuals based on some basic service needs that were assessed and determined by a “comprehensive assessment tool” and verified by the 3 person committee of DDSN representatives.

Page 8: Commented [ML47R46] Manos, Lori 9/1/2022 1:47:00 PM

DDSN Response: DDSN is pursuing better availability of information.

Page 9: Commented [HC48] Honey, Colleen 7/21/2022 10:29:00 AM

Elizabeth Krauss – Georgetown DSN Board

Will Case Managers be provided with specific training on completing the required Residential Service request forms/change of services forms on the Therap-SComm system?

Page 9: Commented [ML49R48] Manos, Lori 9/1/2022 1:48:00 PM

DDSN Response: Yes



**DISABILITY
RIGHTS**
SOUTH CAROLINA

July 27, 2022

VIA EMAIL (stephanie.rawlinson@ddsn.sc.gov; michelle.fry@ddsn.sc.gov; directivecomments@ddsn.sc.gov) AND U.S. MAIL

Ms. Stephanie Rawlinson
Chairman
S.C. Commission on Disabilities and Special Needs
3440 Harden Street Extension
Columbia, SC 29203

Dr. Michelle Gough Fry
State Director
S.C. Department of Disabilities and Special Needs
3440 Harden Street Extension
Columbia, SC 29203

Re: Public Comment on Proposed Directive 700-09-DD "Determining Need for Residential Services"

Dear Chairman Rawlinson and Director Fry:

Disability Rights South Carolina (DRSC) is submitting comments regarding proposed directive 700-09-DD "Determining Need for Residential Services". Overall, DRSC has serious concerns about the impact of these proposed criteria and procedures on the ability of individuals to access DDSN-sponsored Residential Services. DRSC submits the following comments addressing specific portions of the directive:

1. Minimum Criteria for Residential Services

The Directive notes at the outset that it intends to list "minimum criteria which must be met before DDSN-sponsored Residential Services may be offered." DDSN-sponsored Residential Services includes both Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and the Home and Community Based Services (HCBS) Waiver Residential Habilitation service.

The Directive specifically seeks to limit eligibility for DDSN-sponsored Residential Services to "only those who are eligible for DDSN services and are determined by DDSN to be experiencing circumstances that jeopardize their health and safety." The Directive limits critical needs to individuals experiencing recent abuse/neglect by a primary caregiver, homelessness, imminent danger or threat to

THE PROTECTION AND ADVOCACY SYSTEM FOR SOUTH CAROLINA

3710 Landmark Dr. Suite 208, Columbia, SC 29204

Office: 1-803-782-0639 | Help Line: 1-866-272-7273

TTY: 1-866-232-4525 | Fax: 1-803-790-1946

www.disabilityrightssc.org | info@disabilityrightssc.org

self or others, judicial admission to DDSN, and loss or imminent loss of a primary caregiver.

First, DDSN's continued reliance upon Directives for dictating ostensibly binding policy on Medicaid state plan services and Medicaid waiver services is problematic. For Medicaid state plan services (namely, ICF/IID services), the eligibility for and scope of services has minimum requirements within federal law and any limitations must be attested to within the State Plan. For Medicaid home and community based waiver services (namely, residential habilitation), the eligibility for and scope of services must be attested to within the Waiver Application. In addition, criteria for such vital services as DDSN-sponsored residential services should be promulgated as regulations.

Submission to any of these procedures ensures that policy regarding Medicaid services has been vetted by another entity (i.e., CMS) to ensure its compliance with federal law. For example, Appendix C-4 of an HCBS Waiver Application requires a state to justify proposed limitations on waiver services.¹ This type of oversight is not present through the issuing of a new directive by DDSN. To our knowledge, DDSN has not engaged DHHS to make any changes to the State Plan or Waiver Applications to effectuate proposals listed throughout the Directive or has pursued promulgating regulations. Thus, the Directive and any contradictory criteria within it fundamentally lacks the force of law and should not be implemented.

Additionally, the imposition of these criteria contravenes Medicaid law and circumvents the *Olmstead* mandate in several ways:

a. Medicaid – Sufficiency of Services

Federal law requires that a state provide its Medicaid beneficiaries services that are "sufficient in amount, duration, and scope to reasonably achieve its purpose."² Accordingly, in the interest of ensuring beneficiaries' access to sufficient services, Medicaid regulations limit permissible restrictions that a state may impose on a service to "criteria such as medical necessity or on utilization control procedures."³ Stated differently, the presumption is that a beneficiary should have "the opportunity for access to all needed services covered by the waiver and the Medicaid State plan."⁴ Only "reasonable and appropriate" limits centered on an

¹ The Waiver Application specifically requires consideration of: the basis of the limit, including historical expenditure/utilization patterns; procedures for making exceptions to the limit based on threats to an individual's health or welfare; safeguards for when the limit makes the service insufficient to meet the individual's need; and how notice is provided to individuals. See, e.g., South Carolina's ID/RD Waiver Application (Effective 07/01/19) Appendix C-4, available at <https://tinyurl.com/r5pjsdbw>.

² 42 U.S.C. § 1396a(a)(17), 42 C.F.R. § 440.230(b).

³ 42 C.F.R. § 440.230(d). "Utilization control" refers to efforts to control fraud, waste, or abuse, such as creating prior authorization requirements, and should not be utilized to categorically deny eligible individuals access to needed services. See 42 U.S.C. § 1396a(a)(30)(A); *Bontrager v. Indiana Fam. & Soc. Servs. Admin.*, 697 F.3d 604, 608 (7th Cir. 2012) (discussing the meaning of utilization control).

⁴ See HCFA, *Dear State Medicaid Director* (Jan. 10, 2001) (Olmstead Update No. 4), available at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf>.

assessment of the need for services constitutes a valid means of restricting services.⁵ In analyzing the requirements' applicability to HCBS waivers, CMS has stated that the overall sufficiency of a HCBS waiver merits consideration of several factors culminating in whether the waiver "meets its purpose, particularly its statutory purpose to service as a community alternative to institutionalization."⁶

The currently proposed minimum criteria for DDSN-sponsored residential services do not adequately assess whether an individual needs active treatment (ICF/IID) or "care, supervision, and skills training" (Residential Habilitation). This is particularly clear when reviewing Attachment 2 "Assessment of Need", which does not seek to identify functional needs for services outside of a critical needs context.⁷ The urgency of a need for residential services does not encapsulate an entire assessment of whether an individual requires the service at all. Rather, an individual without a critical need may require the service because of the nature of his disability.

For example, a young person with an intellectual or developmental disability upon reaching adulthood may need assistance with skills training in a supported living program, but not present with any critical need as defined by the directive. Yet, DDSN would deny him the opportunity to live as independently as possible in the least restrictive setting, instead required to access services in his family's home.

b. The ADA Community Integration Mandate, *Olmstead*, and the Medicaid Home and Community Based Services Final Rule

The Community Integration Mandate of the ADA (as interpreted by the Supreme Court in *Olmstead*) requires a state to "administer services, programs, and activities in the most integrated setting possible."⁸ The resolution behind *Olmstead* requires that states honors the right of individuals with disabilities to have freedom to choose where to live and be supported in their independence. The HCBS Final Rule incorporates and expands upon the *Olmstead* mandate in the context of Medicaid waiver services, including residential habilitation. These legal authorities together contradict the narrowness of DDSN's proposed minimum criteria.

The HCBS Final Rule particularly requires states to evaluate an individual's needs, goals, and preferences in a person-centered service plan.⁹ Specifically, the person-centered plan must include "clinical and support needs as identified through an assessment of functional need" and then reflect the services intended to meet

⁵ *Id.*

⁶ *Id.*

⁷ The Directive and Attachment 2 also imply that an individual must exhaust services delivered in a private home prior to being considered for DDSN-sponsored residential services, which imposes another impermissibly established criteria upon a Medicaid beneficiary.

⁸ 28 C.F.R. 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate"); *Olmstead v. L.C.*, 527 U.S. 581, 592 (1999).

⁹ 42 C.F.R. § 441.301(c)(2).

these needs.¹⁰ Additionally, the person-centered plan must “reflect that the setting in which the individual resides is chosen by the individual” and consider an individual’s preferences regarding “delivery of such services and supports.”¹¹ Moreover, the person-centered plan must include “individual identified goals and desired outcomes”, including supporting an individual’s desire and ability to live as independently as possible.¹²

Again, the currently proposed minimum criteria for DDSN-sponsored residential services do not adequately assess whether an individual needs “care, supervision, and skills training” in a residential habilitation setting. The urgency for services may constitute a portion of an assessment, but not the entirety. These criteria do not account for evaluation of any other needs, particularly functional needs, that an individual may have that requires this service. Moreover, these criteria also do not address the availability of the service when an individual without a critical need has identified independent living as a goal or preference. These exclusions are highlighted by a review of Attachment 2 “Assessment of Need for Residential Services”, which does not directly assess an individual’s need for residential services.¹³

Moreover, these restrictive criteria may have the unintended outcome of subjecting individuals without critical needs to the threat of unnecessary institutionalization in more restrictive settings. Practically, individuals residing in a family home may not be able to access certain other services due to provider shortages. For example, it is difficult for individuals currently residing in family homes to access to behavior support services. Without this service, individuals without specialized assistance provided by behavior supports face risk of psychiatric hospitalization or involvement in the criminal justice system.

Again, if these criteria apply, DDSN would deny a young person with an intellectual or developmental disability access to the opportunity to live as independently as possible in the least restrictive setting, instead requiring him to access services in his family’s home until he presents with a critical need, potentially subjecting him to an unnecessary risk of institutionalization.

c. Medicaid – Freedom of Choice

Similarly, federal law also requires that a state ensure its Medicaid beneficiaries are entitled to freedom of choice, meaning that an individual “may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.”¹⁴ Again, as long as an individual requires access to a service, that individual

¹⁰ 42 C.F.R. § 441.301(c)(2)(iii).

¹¹ 42 C.F.R. § 441.301(c)(2)(i).

¹² 42 C.F.R. § 441.301(c)(2)(iv).

¹³ Attachment 2 tangentially references services and supports, but only in consideration of whether services delivered in a private home have been exhausted. Again, implying that an individual must first exhaust services delivered in a private home imposes another impermissibly established criteria upon a waiver participant.

¹⁴ 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51; *Doe v. Kidd*, 419 F. App'x 411, 416 (4th Cir. 2011) (“In fact, § 1396a(a)(23) of the Medicaid Act ‘is clearly drawn to give Medicaid recipients the right to receive care from the

has the right to choose from amongst qualified providers of services.¹⁵ The currently proposed minimum criteria for DDSN-sponsored residential services do not account for an individual's right to access a waiver service, which certainly effects his ability to choose a provider of choice. Moreover, if an individual seeks a service that is currently only available from a provider serving only individuals in DDSN-sponsored residential settings (i.e., behavior support services), his choice to receive the service from that provider is restricted.

d. Medicaid – American Rescue Plan Section 9817 Funding

DHHS has committed to utilize the 10% FMAP increase authorized by Section 9817(b) of the American Rescue Plan to “build capacity for community transition services”, ostensibly including residential habilitation services available under the ID/RD and HASCI waivers.¹⁶ However, to comply with the ARP, a state must utilize the increased FMAP funds to “enhance, expand, or strengthen home and community-based services” and to “supplement, and not supplant” existing home and community based services.¹⁷ CMS has interpreted the latter requirement to disallow a state from “impos[ing] stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021” and requires a state to “preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021.”¹⁸

DDSN's effort to reduce eligibility for residential services through the directive establishes a stricter eligibility standard for a HCBS program than what was in effect April 1, 2021.¹⁹ If DHHS/DDSN intend to utilize the 10% FMAP to support residential habilitation, this directive violates CMS guidance to avoid imposing stricter standards.

Medicaid provider of their choice, rather than the government's choice', quoting *Silver v. Baggiano*, 804 F.2d 1211, 1217 (11th Cir.1986)). It is important to note that none of the listed exceptions for ensuring freedom of choice exist here. See CMS, *The State Medicaid Manual*, Section 2100 “Free Choice of Providers – General”, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927>.

¹⁵ *Id.*

¹⁶ SCDHHS, *South Carolina Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817* (Oct. 2021), available at <https://www.medicaid.gov/media/file/sc-quarterly-spending-plan-oct-21.pdf>. DDSN's initial proposal to DHHS included several programs for use in residential habilitation settings. See also SCDDSN, *10% FMAP Budget Proposal*, (June 2021), available at <https://ddsn.sc.gov/sites/ddsn/files/Documents/Executive%20Memos/06-30-21%2010%25%20FMAP%20Budget%20Proposal.pdf>

¹⁷ American Rescue Plan of 2021, Pub. L. No., § 9817, available at <https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf>.

¹⁸ CMS, *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency*, (May 2021), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>.

¹⁹ See South Carolina's ID/RD Waiver Application (Effective 07/01/19) Appendix A, available at <https://tinyurl.com/r5pjsdbw>. While not legally binding, the most recent version of DDSN's ID/RD manual effective prior to April 1, 2021 only provides for a) an assessment of need for the service and b) justification that needs cannot be met outside of an individual's current setting. SCDDSN, *ID/RD Waiver Manual Chapter 10* (July 2020) available at <https://tinyurl.com/5n7na4sa>.

2. Additional Criteria Throughout Directive

For the reasons already stated, DRSC disagrees with the addition of the more restrictive criteria for DDSN-sponsored residential habilitation through the issuance of a directive. First, DDSN seeks to empanel a Residential Services Review Committee with authority to issue binding decisions on initial requests for services and on transfer requests. Second, DDSN also seeks to impose more restrictive eligibility criteria for specific Residential Habilitation Tiers of Service (Appendix B of the proposed directive). Both criteria are not currently contained within the ID/RD Waiver Application and have not been promulgated as regulations.

3. Terminations and/or Discharges Initiated by Providers

To be clear, DRSC supports additional oversight by DDSN of its provider network regarding sudden termination of services and transfers. If a provider acts to either seek a transfer or terminate an individual's service, the provider should be required to notify DDSN's Central office of its intent per the section "Notification of Termination of Residential Habilitation or Discharge from ICF/IID". A provider should not have the ability to independently issue a binding termination notice without at least consideration of the factors outlined in the proposed directive, i.e., documentation of the services received by the individual in the setting and an analysis of its effectiveness. It is not clear whether a provider must submit to the procedures outlined in the section "Request for Change to Residential Services" which require these considerations. Nonetheless, any imposition of utilization controls that could affect the ability of an individual to access a service, particularly in light of the proposed minimum criteria, must go through the federal and/or state processes outlined previously.

4. Conclusion and Example

Ms. Sharon DeFelice provided public comment to the DDSN Commission on June 16.²⁰ Ms. DeFelice shared about the challenges she faces as the mother of a 35-year old daughter with disabilities, who assumedly is a client of DDSN. In her public comment, Ms. DeFelice advocated for greater access to residential habilitation services. She stated she would like her daughter to access a residential habilitation setting in her home community. However, she has faced challenges accessing updated information about the ID/RD waiver, especially as it relates to residential habilitation services. She also emotionally described how the lack of services available for her daughter affects her ability to care for her while she continues to reside with her at home.

²⁰ See https://www.youtube.com/watch?v=BB4PmmrIO_w at 19:00.

In response to her public comment, the Commissioners questioned why Ms. DeFelice's daughter could not access DDSN sponsored residential services. Ms. DeFelice that she has been told only a critical need would qualify her for the service. She also mentioned that she is unsure of whether her daughter has ever been truly placed on a residential waiting list. Ms. DeFelice noted she believes she will likely die prior to her daughter accessing residential habilitation in an HCBS setting.

This is a long standing wrong that DDSN now seeks to memorialize: the prioritization of resource allocation²¹ over a comprehensive assessment of whether an individual requires access to residential habilitation services to which he is entitled. In this case, this young woman will continue to wait for access to a needed service absent her parents passing away or another critical need arising, regardless of her desire to access the service, her desire to live as independently as possible, and her potential need for the service.

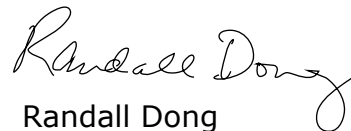
To conclude, while we appreciate DDSN's efforts to clarify its policies and procedures on DDSN-sponsored residential settings, we do not agree with the overall restriction of access to residential settings and with DDSN's actions in attempting to make this change through issuing a directive. We would be happy to discuss our concerns with you. Thank you for your attention to this matter.

Sincerely,

DISABILITY RIGHTS SOUTH CAROLINA



Beth Franco
Executive Director



Randall Dong
Legal Director

²¹ Lori Manos, Associate State Director of Policy, stated during the meeting, "You know, I don't think anybody in the room would want to justify why it is the way it is. But at the end of the day, it becomes allocation of resources to people who have the highest level of need for services at the time. That's really what it is about."



Anna Maria Conner
Senior Attorney



Rebekah D. Spannagel
Attorney

CC: Ms. Constance Holloway, SCDDSN, General Counsel
(constance.holloway@ddsn.sc.gov)
Mr. Byron Roberts, SCDHHS, General Counsel
(robertsb@scdhhs.gov)
Mr. Sherard McKie, CMS – Atlanta Regional Office, Regional Administrator
(sherard.mckie@cms.hhs.gov)

Michelle G. Fry, J.D., Ph.D.

State Director

Janet Brock Priest

Associate State Director

Operations

Lori Manos

Associate State Director

Policy

Constance Holloway

General Counsel

Harley T. Davis, Ph.D.

Chief Administrative Officer

Nancy Rumbaugh

Interim Chief Financial Officer

Greg Meetze

Chief Information Officer



3440 Harden Street Extension
Columbia, South Carolina 29203

803/898-9600

Toll Free: 888/DSN-INFO

Home Page: www.ddsn.sc.gov

COMMISSION

Stephanie M. Rawlinson

Chairman

Barry D. Malphrus

Vice Chairman

Robin B. Blackwood

Secretary

Gary Kocher, M.D.

Eddie L. Miller

David L. Thomas

Michelle Woodhead

September 2, 2022

Ms. Beth Franco

Executive Director

Disability Rights South Carolina

3710 Landmark Dr., Suite 208

Columbia, SC 29204

Mr. Randall Dong, Esq.

Legal Director

Disability Rights South Carolina

3710 Landmark Dr., Suite 208

Columbia, SC 29204

Re: Response to Public Comment on Proposed Directive 700-09-DD “Determining Need for Residential Services”

Dear Ms. Franco and Mr. Dong:

The Department of Disabilities and Special Needs (“DDSN”) is responding to the letter submitted by Disability Rights South Carolina (“DRSC”) regarding the Proposed Directive 700-09-DD “Determining Need for Residential Services.” DRSC made multiple, material inaccurate representations and omissions in their letter. Therefore, this letter is written to provide important corrections and clarifications regarding Proposed Directive 700-09-DD, as well as internal policies, laws, and cases cited by the DRSC.

I. Minimum Criteria for Residential Services

A. The Proposed Directive does not Narrow or limit eligibility from prior policy

DRSC inaccurately claims Directive 700-09-DD seeks to limit the eligibility for DDSN sponsored Residential Services by proposing a stricter standard and further suggests that “DDSN has not engaged the Department of Health and Human Services (“DHHS”) to make any changes to the State Plan or Waiver Applications to effectuate proposals listed throughout the Directive ...”. As the

agency designated in the Home and Community Based Services Waiver application and as the agency operating the Intellectual Disabilities/Related Disabilities (“ID/RD”) Waiver, all policies and procedures which impact the waiver, including Directive 700-09-DD, are approved by DHHS prior to implementation. The criterion included in Directive 700-09-DD has been approved by DHHS and followed since November 17, 2014 without any modifications. The criterion has previously been established in Directive 502-05-DD. A formal Assessment of Need for Residential Habilitation (“ANRH”) document, which is highlighted by DRSC as a concern, has been in place and utilized since 2016. The ANRH has been part of ID/RD waiver policy, as evidenced by its inclusion in the Waiver’s Operational Manual since its implementation. Therefore, Directive 700-09-DD makes no changes to current criteria, does not impose a stricter standard than what was in effect on April 1, 2021, and does not violate guidance from the Centers for Medicare and Medicaid Services (“CMS”) related to the American Rescue Plan Act (“ARPA”) section 9817.

B. DDSN properly involved DHHS regarding Residential Tiers

DRSC makes the claim that DDSN has not engaged DHHS with regards to the State Plan or Waiver Applications, and therefore Directive 700-09-DD lacks the force of law. This claim is false. As the Medicaid agency for the State and the administrative agency for all HCBS Waivers, DHHS alone may request changes to the Medicaid State Plan or HCBS Waiver applications. DHHS, in their role as the State Medicaid Agency, initiated the renewal of the ID/RD Waiver. In fact, DHHS worked collaboratively with DDSN on the addition of the Residential Habilitation Tiers in the ID/RD Waiver. The DHHS request for renewal of the ID/RD waiver was approved by the Centers for Medicare & Medicaid (“CMS”) on March 10, 2022 with an effective date of January 1, 2022. As required by CMS policy, prior to a request for approval, the public must be offered the opportunity to learn about and provide comment on any applications to CMS. DHHS received comments regarding the ID/RD Waiver proposed renewal beginning August 25, 2021, which continued for 30 days. A summary of the actions taken by DHHS to notify the public and the agency’s responses to the comments received are included in the approved ID/RD Waiver application. Accordingly, all appropriate steps were taken and Directive 700-09-DD has the full force of the law and must be followed.

II. Medicaid – Sufficiency of Services

A. Determination of Need

DRSC falsely wrote DDSN-sponsored Residential Services do not adequately assess whether an individual needs active treatment or “care, supervision, and skills training.” This seems to be based on a misunderstanding of efforts which must be undertaken. The ANRH is not the sole instrument used to determine the need for Residential Habilitation or Intermediate Care Facility for Individuals with Intellectual Disabilities (“ICF/IID”) services. The determination of the need for active treatment or for care, supervision, and skills training is assessed through the Case Management Annual Assessment (“CMAA”). The CMAA assesses the supports needed in multiple areas of the person’s life, including but not limited to, the supports required in the areas of personal care, daily living, behavioral and emotional health, physical health, supervision, community connections, and personal support networks. Information from the CMAA, the plan of supports created by the case manager, and the services notes created by the case manager are all considered along with information from the ANRH. As stated on the ANRH form “*Copies of South Carolina Annual Assessments [CMAA], Support Plans and Case Management Service Notes will be reviewed but copies need not be provided*”. All of the aforementioned information is considered by DDSN in order to determine whether the individual’s needs justify the authorization of ICF/IID services or Residential Habilitation services through the ID/RD waiver.

Furthermore, DRSC provides a vague and factually unsound example of a young person in need of assistance with skills training (“Skills Training Scenario”). The Skills Training Scenario illuminates an apparent fundamental misunderstanding by DRSC of how services are accessed by individuals and when various settings and services are appropriate. Specifically, if a young person needs assistance with “skills training” alone, by definition, this young person would not need ICF/IID services, nor would he/she need HCBS Waiver Residential Habilitation. Indeed, in order to be determined to qualify for ICF/IID services, the young person must need active treatment. In the Skills Training Scenario provided by DRSC, the need for “skills training” alone would not equate to the need for the consistent aggressive implementation of training and treatment services (i.e., active treatment). On the other hand, the need for Residential Habilitation is established when the need for care, supervision, and skills training is established. While the Skills Training Scenario does specifically indicate that this young person needs skills training, it fails to address the other criteria, *i.e.* it fails to indicate whether the young person has any need for care or supervision. Finally, Residential Habilitation, as defined in the waiver, does not include room and board. As such, if this young person needs a place to live, housing and food are not covered through the Residential Habilitation service. Thus, if this young person only required skills training, HCBS Waiver services such as adult companion, independent living skills, day activity, career preparation, or community services, could be authorized to address the need for skills training. And, if housing were also a concern, assistance to secure affordable housing would be provided by the person’s case manager as part of the waiver case management services. Conclusively, the most independent living option and the Least Restrictive Setting, for this young person would be to live in his/her own home, while receiving skills training through an appropriate HCBS waiver service that is chosen by the person after he/she was afforded the opportunity to choose among the waiver services available.

B. Access to Psychiatric Services

DRSC opines that the criteria in Directive 700-09-DD may have the unintended outcome of subjecting individuals without critical needs to the threat of unnecessary institutionalization. This opinion is based, practically, on provider shortages with the example given of the inability of waiver participants to access Behavior Support Services (“BSS”) services. In the example, it is noted that the inability to access BSS services could result in psychiatric hospitalization or involvement with the criminal justice system. To be admitted for psychiatric hospitalization, someone must have a psychiatric diagnosis and meet admissions criteria at the hospital. When someone has a psychiatric diagnosis, the best and most appropriate treatment for that condition is psychiatric care. Psychiatric care is covered by the Medicaid State Plan. Additionally, the South Carolina Department of Mental Health (“DMH”) is the agency in the state designated for the purpose of making psychiatric care readily available to all South Carolinians, including those eligible for DDSN services.

While BSS may sometimes be an appropriate adjunct to psychiatric care, it is not a substitute for it. Effective treatment for psychiatric conditions often includes, in addition to medication, evidence-based practices such as cognitive behavioral therapy (“CBT”), dialectic behavioral therapy (“DBT”), eye movement desensitization and reprocessing therapy (“EMDR”). These therapies are not BSS. DDSN actively advocates for individuals to receive psychiatric services when needed, and has even established an Interdisciplinary Technical Advisory Committee, (“ITAC”) which includes a Psychiatrist, internal medicine physician, policy expert, and behavioral expert, to offer professional advice regarding dually diagnosed individuals whose current services and plans are not sufficient to keep them out of crisis. DDSN formed the ITAC for multiple reasons, including but not limited to, the hope that receiving formal advice from such experts would bolster individuals’ ability to actually receive the mental health services they need by offering sophisticated and evidence-based opinions that distinguish between the mental health and ID/RD-related needs.

Again, BSS is not a substitute for appropriate psychiatric care. BSS are specifically tailored, in essence, to teach people how to get what they need or want in appropriate ways. When BSS are delivered, the specialist determines the function of the challenging behavior then devises strategies which can be used by those who support the person (family members, staff, etc.) to predict/avoid the challenging behavior, to teach appropriate ways to achieve the outcome historically achieved by the challenging behavior, and to appropriately respond when challenging behavior is displayed. BSS are only effective when those who support the person are willing to, as often as required, implement the strategies created by the specialist. Conversely, BSS are not effective, even when rigorously implemented, if the person is, for example, responding to internal stimuli. Thus, BSS and Psychiatric care are two very distinct services delivered by professionals with different areas of expertise. An individual may need neither, one, or both.

III. The ADA Community Integration Mandate, *Olmstead*, and the Medicaid Home and Community Based Services Final Rule

As DRSC points out, *Olmstead v. L.C.*, 527 US 581 (1999) requires a state to “administer services, programs, and activities in the most integrated setting possible.” DRSC’s concern that Directive 700-09-DD is in opposition to the *Olmstead* requirement is unfounded. The criteria expressed in Directive 700-09-DD does not impede those individuals currently receiving ICF/IID services from receiving HCBS waiver services. The ID/RD waiver (Appendix B – 3) reserves capacity for those leaving an ICF/IID in favor of community-based services. Reserved capacity means those who are discharged from ICF/IID services effectively bypass any waiting list and enroll directly in the HCBS waiver. Furthermore, those who choose to receive community-based services upon discharge from an ICF/IID will not be subjected to the process outlined in Directive 700-09-DD.

Also, as pointed out by DRSC, the Community Integration Mandate of the American with Disabilities Act (“ADA”) as established in *Olmstead* requires states to administer services, programs and activities in the most integrated setting possible. The process noted in Directive 700-09-DD requires the Residential Services Review Committee (“Committee”), using all available assessment data, to determine the least restrictive and most appropriate setting in which the person’s needs can be met. This effort enforces the *Olmstead* mandate.

IV. Medicaid – Freedom of Choice

Directive 700-09-DD in no way limits an individual’s freedom of choice. DRSC’s statements regarding freedom of choice are contradictory as to “any qualified Medicaid provider.” First, the specialized training delivered as part of Residential Habilitation and delivered by a Board-Certified Behavior Analyst (“BCBA”) are labeled Intensive Behavior Interventions (“IBI”). These interventions are delivered by a specialist as part of the Residential Habilitation service. Therefore, people who receive Residential Habilitation may not also receive BSS to address challenging behavior displayed in the residential setting. Second, the specialists who are employed by Residential Habilitation providers to deliver IBI services may or may not also be enrolled as a BSS provider. Third, if a specialist is both a Medicaid-enrolled BSS provider and employed by a Residential Habilitation provider to design specialized training to address challenging behavior (IBI), that provider has the freedom to undertake or not to undertake to provide services to anyone seeking BSS services from him/her, as long as the decision is not discriminatory. BSS and Residential Habilitation are not the same services. Residential Habilitation is generally defined as care, supervision, and skills training. The skills training delivered as part of Residential Habilitation may include skills training that is developed by a specialist and focused on teaching the person to manage his/her own behavior.

V. Additional Criteria Throughout Directive

DRSC indicates that empaneling a Residential Services Review Committee (“Committee”) will result in the addition of more restrictive criteria with the authority to issue binding decisions on initial requests for services and on transfer requests. While, as has been indicated, the criteria are not more restrictive, any adverse decision made by the Committee is accompanied by the offering of the opportunity to request a fair hearing as noted in the ID/RD Waiver (Appendix F-1). It is not clear what DRSC means by “transfers.” The Committee would not review requests by a waiver participant to move from one setting in which Residential Habilitation is being delivered to another nor would it review a request for someone seeking discharge from an ICF/IID in favor of receiving community-based services.

In addition, DRSC erroneously asserts that the Residential Habilitation Tiers of Service are not contained within the ID/RD Waiver Application. The ID/RD Waiver Application, which was approved by CMS on March 10, 2022, does, in Appendix C, include the Residential Habilitation Tiers of Service.

VI. Terminations and/or Discharges Initiated by Providers

The processes outlined in Directive 502-01-DD “Admissions/Discharges of Individuals to/from DDSN Funded Community Residential Settings” is, in part, captured in Directive 700-09-DD. The issue of provider-driven termination of Residential Habilitation services will be addressed, to a degree, through the DDSN Residential Habilitation Standards. For clarity, when the Residential Habilitation Standards are drafted by DDSN, DHHS approval will be required before implementation. However, it should be noted that neither DDSN nor DHHS can compel a Residential Habilitation provider to deliver services. Medicaid-enrolled providers, including those delivering Residential Habilitation services, may choose to not continue to undertake to deliver services to a Medicaid beneficiary as long as the decision is not discriminatory.

VII. Conclusion


In conclusion, DRSC’s letter is replete with inaccurate representations of DDSN’s directives and policies, whether due to fundamental misunderstandings of the policies or a result of a lack of due diligence. The severity and breadth of inaccuracies throughout DRSC’s letter is especially troubling given that DRSC letter falsely alleges violations of the ARPA requirement that access to services not be limited during the Public Health Emergency, thereby putting at risk South Carolina’s continued access to APRA funding.

DDSN’s mission is to assist people with disabilities and their families in meeting needs, pursuing possibilities, and achieving life goals. Since DRSC shares a similar mission, DDSN aims for DRSC and DDSN to work together to serve those most in need. Within the past several months, DDSN made significant efforts to work collaboratively with DRSC in the drafting of regulations that were ultimately passed with the support of DRSC. DDSN has also established monthly meetings to open up communication and strive for continued collaboration. Despite the preceding, the topics raised in the DRSC letter were not discussed with DDSN prior to sending to CMS even though the two entities had a regularly scheduled meeting set for the day following DRSC’s letter.

DDSN has already met with and explained the inaccurate information contained with the DRSC letter to DRSC leadership, as well as our disappointment that there was not an opportunity to discuss the concern prior to DRSC sending the errant information. DDSN thanks DRSC leadership for their time

and meaningful discussion. We are committed to working with DRSC to improve opportunities for those whom we serve, and we are optimistic regarding opportunities for DDSN and DRSC to increase collaboration and information sharing to help prevent a reoccurrence of inaccurate information being reported.

Sincerely,

A handwritten signature in blue ink that reads "Constance Holloway". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

Constance Holloway
General Counsel

cc: Dr. Michelle Gough Fry, State Director, DDSN

Michelle G. Fry, J.D., Ph.D.
State Director
Janet Brock Priest
Associate State Director
Operations
Lori Manos
Associate State Director
Policy
Constance Holloway
General Counsel
Harley T. Davis, Ph.D.
Chief Administrative Officer
Nancy Rumbaugh
Interim Chief Financial Officer
Greg Meetze
Chief Information Officer



3440 Harden Street Extension
Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

COMMISSION
Stephanie M. Rawlinson
Chairman
Barry D. Malphrus
Vice Chairman
Robin B. Blackwood
Secretary
Gary Kocher, M.D.
Eddie L. Miller
David L. Thomas
Michelle Woodhead

Reference Number: 700-09-DD

Title of Document: Determining Need for Residential Services

Date of Issue: September 15, 2022

Date of Last Revision: September 15, 2022 (NEW)

Effective Date: December 1, 2022

Applicability: All DSN Boards and Contracted Service Providers

GENERAL:

The Department of Disabilities and Special Needs (DDSN) must ensure that those who are eligible for its services are provided with needed services and supports, including residential services, in the most timely and equitable manner possible. For the purpose of this document, the terms “DDSN-sponsored Residential Services” and “Residential Services” are used as collective terms for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services, Residential Habilitation services funded by the Intellectual Disabilities and Related Disability (ID/RD) Waiver or the Head and Spinal Cord Injury (HASCI) Waiver and/or Residential Habilitation services funded solely by DDSN. The purpose of this Directive is to establish:

- Minimum criteria which must be met before DDSN-sponsored Residential Services may be offered.
- Definitions of the types Residential Services.
- A Committee responsible for reviewing requests for Residential Services.
- Procedures for evaluating requests and communicating the decisions.
- Procedures for requesting the need for Residential Services be determined.
- Procedures for requesting a change to an approved Residential Service.
- Procedure for notifying DDSN of the termination of Residential Habilitation or discharge from an ICF/IID.
- Procedure when seeking a different Residential Services provider.
- Procedure for notifying DDSN of an anticipated need for Residential Services.
- Repository of information about Residential Services options and Residential Services seekers.

MINIMUM CRITERIA FOR RESIDENTIAL SERVICES:

Only those who are eligible for DDSN services and are determined by DDSN to be experiencing circumstances that jeopardize their health and safety will be determined to need DDSN-sponsored Residential Services. Circumstances that jeopardize health and safety are defined as:

- Life-threatening situations that requires immediate action, and/or
- Situations that present imminent risk of jeopardizing the person’s health, safety and welfare.

Situations that are life threatening or pose an imminent risk of becoming life-threatening are typically limited to situations in which the person:

1. Has been recently abused/neglected/exploited by the primary caregiver;
2. Is homeless (to include situations where the individual is being discharged from an alternative placement and is unable to return to a family member’s home or live independently);
3. Has seriously injured self or others and continues to pose a threat to the health and safety of self or others;
4. Has been judicially admitted to DDSN;
5. Has recently lost a primary caregiver or is at imminent risk of losing a primary caregiver; or
6. Has a primary caregiver who is 80 years of age or older with diminished ability to provide care that is likely to continue indefinitely due to the caregiver’s physical or mental status and lack of an alternative caregiver. Care is being provided now, but it is clear that the need for services is imminent, because the caregiver will soon be unable to provide care and no other caregivers are available.

Additionally, to be determined by DDSN to be experiencing circumstances that jeopardize health and safety, when appropriate, all efforts to address the situation through the use of other services and supports, including Home and Community Based (HCB) Waiver services, must have been exhausted. The refusal of other supports and services may not necessarily constitute the presence of circumstances that jeopardize health and safety. Additionally, residing with relatives, friends, or alone with supports must be ruled out prior to someone being considered homeless.

TYPES OF DDSN-SPONSORED RESIDENTIAL SERVICES:

There are two (2) types of DDSN-sponsored Residential Services, Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) and Residential Habilitation. Each type is described below along with the settings and levels or tiers of service associated with each type.

1. Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID):

Facilities licensed by the state to provide comprehensive and individualized health care and habilitation services to individuals to promote their functional status and independence. ICF/IID services are available to those who need active treatment. Active treatment is the aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. ICF/IID services are not appropriate for those who are generally independent, able to function with little supervision and/or do not require a continuous program of habilitation services. ICF/IID services can be delivered in two (2) kinds of settings, a Regional Center setting or a community-based setting.

- Regional Centers are operated by DDSN and typically provide a campus-like environment with multiple ICF/IID living units, spaces/buildings for most professional resident services and spaces/buildings for most recreational pursuits such as gymnasiums, chapels, greenspace on the grounds of the campus.
- Community-based ICFs/IID are operated by some Disabilities and Special Needs (DSN) Boards. While more than one ICF/IID living unit may be located in close proximity to another, community-based ICFs/IID are typically located in neighborhoods or near community businesses. Community-based ICF/IID residents seek professional services from community businesses in locations away from the ICF/IID living unit.

2. Residential Habilitation:

Is a specifically defined service that must be provided in non-institutional settings that are licensed or certified by the state and chosen by the person. The setting may be owned by the person, rented by the person from a third party, or be a unit or physical space that is occupied under a legally enforceable agreement between the person and the Residential Habilitation provider.

Residential Habilitation does not include room and board. It is specifically defined as care (e.g., assistance with personal care, medication administration), supervision (oversight and guidance proportionate to the specific needs and preferences of the person) and skills training (e.g., adaptive skill building, activities of daily living, community inclusion, access and use of transportation, educational supports, social and leisure skill development) provided to support the person to live as independently as possible and exert positive control over his/her life.

Residential Habilitation is offered through different tiers of service. A tier of service is a combination of the model (see Appendix A) through which Residential Habilitation is delivered and the degree of support the person will require when Residential Habilitation is delivered in that model. There are nine (9) tiers of service which are described below.

- **High Management (Intensive Support Residential Habilitation)** is delivered through the Community Training Home II (CTH-II) model which is shared by up to three (3) people who have a brain injury, spinal cord injury or similar disability or those who have a diagnosis of intellectual disability/related disabilities and display extremely challenging behaviors.
- **Tier 4 (Intensive Support Residential Habilitation)** is delivered through the CTH-II model which is shared by up to four (4) people who may have been involved with the criminal justice system and individuals with severe behaviors requiring heightened staffing levels.
- **Tier 3 (Intensive Support Residential Habilitation)** is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people who have a diagnosis of brain injury, spinal cord injury or similar disability or those who have a diagnosis of intellectual disability/related disabilities and display extremely challenging behaviors. Includes people being discharged from a DDSN Regional Center (ICF/IID) or community ICF/IID. Also includes people who need additional supports to prevent or delay institutional placement and to participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform Activities of Daily Living without support from another.

- **Tier 2** is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need additional supports (greater than included in Tier 1) to prevent or delay institutional placement and to participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform Activities of Daily Living without support from another.
- **Tier 1** is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need support to live in and participate in their community. Those supports include a degree of care, supervision, and skills training provided throughout the day.
- **Supervised Living Program (SLP) II:** includes people who need support to live in and participate in their community. The supports delivered include a degree of care, supervision, and skills training provided throughout the day. SLP-II is delivered in a licensed SLP-II setting that is typically single or double-occupancy residence.
- **CTH Tier 2:** delivered to waiver participants who need additional supports (greater than included in CTH Tier) to enable them to live in the setting and participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform activities of daily living without support. Those additional supports are typically services/supports specifically intended to provide relief/assistance to the supports provider and are necessary due to the amount/intensity of supports the person requires. CTH Tier 2 services are delivered to up three (3) people in the CTH-I licensed home of the support provider.
- **CTH Tier 1:** delivered to waiver participants who need support to live in and participate in their community. CTH Tier 1 services are delivered to up three (3) people in the CTH-I licensed home of the support provider.
- **Supervised Living Program (SLP) I:** delivered to waiver participants who need support in their own apartment or home setting. Support is provided through a 15 minute-unit and support is available 24 hours per day by phone. An annual assessment is completed for each participation to verify support needs in their own setting.

RESIDENTIAL SERVICES REVIEW COMMITTEE:

To ensure appropriate consideration is given to all requests/notifications for Residential Services (both initial and requests for change), DDSN will empanel a Residential Services Review Committee (Committee) to review all thorough and complete requests submitted to the agency. The Committee will be comprised of DDSN staff who are appointed by the State Director. Committee members must have expertise at least one of the following areas: Case Management, Residential Habilitation, ICF/IID Services, or Fiscal. The Committee will meet as often as necessary in order to comply with the established deadlines.

At a minimum, three (3) Committee members must actively participate in the review of each request. Documentation of the date of the Committee's decision must be maintained and include the name of each person whose request is considered, the name of the case manager submitting the request, and the

names of the Committee members reviewing the request. All Committee decisions must be made in recognition of the mission, values and principles of DDSN. The Committee must determine the degree of support the person requires and consider those support needs in light of the model that is preferred by the person and most appropriate to deliver those supports.

INITIAL REQUEST FOR DETERMINATION OF NEED FOR RESIDENTIAL SERVICES:

When someone who is eligible for DDSN services has been assessed by his/her case manager to need support with housing, care, supervision and skills training and the person desires to receive DDSN – sponsored Residential Services, the case manager must make a request to DDSN. Requests must be submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.” All requests must be thorough and complete. DDSN will utilize information available in the person’s electronic health record and specific forms/information submitted to evaluate each request. At a minimum, the following information/completed forms must be available for review:

- Residential Services Request/Notification (form) (Attachment 1).
- Evidence that the case manager saw the person in his/her home or current location (e.g., hospital, homeless shelter, etc.).
- Evidence that the case manager explained the following to the person and/or his/her representative:
 - The minimum criteria for residential services (as defined in this document),
 - The process to be followed for a decision to be made,
 - The possible decisions that could be made by DDSN, and
 - The right the person has to request reconsideration of or appeal a decision with which he/she disagrees.
- Assessment of Need for Residential Services/Residential Habilitation (form) (Attachment 2)
- Evidence of continued contact with the person while the request is pending.

DDSN must complete a review and acknowledge receipt of requests /notifications submitted via Therap SComm to “DDSN, Residential Service Requests” within three (3) business days of submission. This review will be completed only to ensure the required information is available for evaluation. When acknowledging the submission, DDSN will indicate if the submission is:

- Thorough and complete and will be evaluated,
- Incomplete, is being returned/rejected and will not be evaluated, or
- Being held pending clarification.

As soon as possible, but no later than five (5) business days of receipt of a thorough and complete request, the Residential Review Committee will evaluate the submitted and available documentation. The Committee may, at its discretion, before making a decision, determine that a face-to-face visit with the person in his/her current residence/location or face-to-face visit with this person’s caregiver is needed to better understand the circumstances. These face-to-face visits will be conducted by DDSN staff with assistance, as needed, from the person’s case manager.

Following the evaluation, the Committee must, when determining if Residential Services are needed, decide if:

- a. The criteria for Residential Services has not been met (must explain why, and if appropriate, offer alternative solutions and /or designate as Priority 1), or
- b. The criteria for Residential Services has been met; and
 - i. The type Residential Services approved (ICF/IID or Residential Habilitation),
 1. If the type is ICF/IID, the setting (Regional Center or Community-based), or
 2. If the type is Residential Habilitation, the tier of service (see Appendix B).

DDSN must communicate the Committee’s decision in writing within two (2) business days. The written communication must be transmitted via certified mail to the person and his/her representative (if appropriate). The person’s case manager will be copied. The communication must include written notice of the person’s right to appeal or request reconsideration of the decision.

REQUEST FOR CHANGE TO RESIDENTIAL SERVICES (INCLUDING TYPE AND SETTING OR TIER):

Each person who is receiving a DDSN-sponsored Residential Service has been approved for a specific Residential Service type and setting or tier. As the agency in the state which has authority over all of the state’s services and programs for people with intellectual disability, related disabilities, head injuries, and spinal cord injuries, including Residential Services, DDSN must approve or be notified of any change to the Residential Services being delivered prior to any change being made. Examples include:

- From one DDSN Regional Center to another DDSN Regional Center.
- From one ICF/IID to another ICF/IID within the same DDSN Regional Center.
- From a DDSN Regional Center to a Community-based ICF/IID.
- From a Community-based ICF/IID to another Community-based ICF/IID.
- From an ICF/IID (any setting) to Residential Habilitation (any tier).
- From any tier of service to another tier of service.
- From the current setting for Residential Habilitation (any tier) to another setting for Residential Habilitation (same tier) [e.g., from Tier 1 at Miles Rd. CTH-II to Tier 1 at Rose Circle CTH-II].
- From a model for a tier of service to a different model for the same tier of service (e.g., from Tier 2 at Delta CRCF to Tier 2 at Dixie Rd. CTH-II).

In order to receive prior approval for a change in Residential Services, the change must be requested. A request for a change must be submitted by the person’s case manager or Qualified Intellectual Disabilities Professional (QIDP) and must only be submitted with the consent of the person, his/her legal guardian, or client representative.

Thorough and complete requests must be submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.” All requests must explain the reason for the requested change (e.g., provider’s request, person’s request, person’s desire for a less restrictive setting). Documentation that supports the reason for the change must be submitted or available. At a minimum, the following information must be submitted or available:

- Residential Services Request/Notification (form) (Attachment 1).
- Evidence the person has been informed of the request for change and consents to its submission.

- For anyone approved for Residential Habilitation, evidence supporting the person is aware of the terms his/her legally enforceable residential agreement (lease) and the how the change will impact it.
- When the Residential Habilitation provider owns/controls the residence/setting in which the person lives, evidence the provider has or will comply with the terms of the residential agreement.
- A thorough explanation of the reason the change is being requested.
- Evidence that the change is for good cause and is in the best interest of the person.
- Evidence supporting/demonstrating the reason for the change. Evidence must be current, specific to the person and specific to the circumstances necessitating the request for change. Examples of the kinds of evidence which, depending on the circumstances, could support a request for a change include but are limited to:
 - A statement of an ICF/IID resident's interest in and capacity for receiving needed services outside of an ICF/IID.
 - A statement of a Residential Habilitation recipient's interest in receiving Residential Habilitation through a different model.
 - Residential Habilitation plan(s) or Individual Program Plan(s) (IPPs) and amendments covering at least the last twelve (12) months. The plans must include the interventions implemented to address the circumstances necessitating the change.
 - Data showing the person's response to the planned interventions.
 - Behavior Support Plan(s) covering the past twelve (12) months and data showing the person's response to the implementation of its interventions.
 - Other data/information such as T-Logs, General Event Reports (GERs), Reports of Unusual Behavior (UBRs), etc.
 - Medical information, progress notes including changes to medications prescribed for behavior.
 - The level and pattern of staff support provided over the past twelve (12) months in the setting/model, including alternative levels or patterns tried and the outcome.
 - The level and/or pattern of staffing thought to be needed for the person and why.

Requests for change must be submitted to DDSN via Therap SComm to "DDSN, Residential Service Requests." All requests must be thorough and complete. DDSN will utilize information available in the person's electronic health record and specific forms/information submitted to DDSN to evaluate each request. Submitted requests will be acknowledged by DDSN within three (3) business days of submission and will include an initial review to ensure the required information is available. When acknowledging the submission, DDSN will indicate if the submission is complete and will be evaluated or if information or clarification will be needed.

Within five (5) business days of the receipt, the Residential Review Committee will evaluate the submitted and available information. The Committee may at any time request additional information or clarification. Using the submitted and available information the Committee will decide to approve or deny the request. If approved, the Committee must document the **type** Residential Services (ICF/IID or Residential Habilitation) and either the ICF/IID **setting** or **tier of service**.

DDSN must communicate the Committee's decision in writing within two (2) business days. The written communication must be transmitted via certified mail to the person, and his/her representative (if appropriate). The person's case manager will be copied. The communication must include written notice of the person's right to appeal or request reconsideration of the decision.

NOTIFICATION OF TERMINATION OF RESIDENTIAL HABILITATION OR DISCHARGE FROM ICF/IID:

Termination of Residential Habilitation by the residential services provider or discharge from the ICF/IID must be for good cause and, when possible, well planned. DDSN must be notified of all terminations or discharges. The “Residential Services Request/Notification” form (Attachment 1) must be used to notify DDSN of termination/discharges. Upon completion, this form must be submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.”

NOTIFICATION OF DESIRED CHANGE OR ANTICIPATED NEED:

People eligible for DDSN services must be supported, as appropriate, to exercise positive control over their lives especially as it relates to where and with whom they live. To that end, when a change to the person’s current living arrangement is desired or likely to be needed, DDSN must be notified. Examples of changes of which DDSN must be notified include:

- The person’s current living situation is sufficient but DDSN-sponsored residential supports will likely be needed within the next 24 months.
- The person lives in an ICF/IID and based on his/her annual assessment, is interested in and has the capacity for receiving needed services outside of an ICF/IID.
- The person desires Residential Services from a different provider.
- The person desires Residential Services in a different city or county.
- The person desires a different type of ICF/IID Services.
- The person desires to receive Residential Habilitation through a different model.

When notification to DDSN is required and with the person’s consent, notification must be submitted by the person’s case manager or QIDP using the “Residential Services Request/Notification” (form). “Residential Services Request/Notification” form must be thoroughly completed and submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.” Within five (5) business days of receipt, DDSN will acknowledge receipt of the information and confirm that information about the person and his/her preferences has been included in the Residential Services Information Repository.

RESIDENTIAL SERVICES INFORMATION:

In order to facilitate the connection between those needing DDSN-sponsored Residential Services and providers of Residential Services who may be able to deliver those needed services, DDSN will maintain information about those determined by the agency to need residential services for the first time and those determined to need a different kind of residential service. Additionally, information about ICF/IID residents who wish to receive their needed services in community-based settings instead of the institutional setting will be maintained as well as information about anyone approved for DDSN Residential Services who may be seeking the same services in a different location or from a different provider. This information will be available in the “Portal Access Reports” application of the DDSN Application Portal. Confidentiality will be maintained with all person-specific data available. Until appropriate consent is obtained from the person, only non-specific information about the person will be shared (e.g., initials, age in years). Specific information such as full name, date of birth, current address will only be shared with specific provider(s) and only with appropriate consent.

In addition to information about people seeking Residential Services, DDSN will maintain information about the current and anticipated Residential Services openings or opportunities throughout the state. This information will be available in the “Portal Access Reports” application of the DDSN Application Portal. Information about openings or opportunities must be reported to DDSN by the Residential Services providers. Before posting the information about an actual opening, DDSN will verify the opening complies with the licensed capacity of the setting. Information about anticipated openings can be submitted to DDSN via Therap SComm to “DDSN, Residential Service Requests.” using the Notification of Anticipated Residential Availability form. Within three (3) business days of receipt of the completed form, DDSN will share the information.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

Appendix A: Description of Residential Habilitation Models
Appendix B: Residential Habilitation Tiers of Service

To access the following attachments, please see the agency website page “Current Directives” at: <https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives>

Attachment 1: Residential Services Request/Notification Form
Attachment 2: Assessment of Need for Residential Services
Attachment 3: Notification of Anticipated Residential Availability

Constance Holloway
Interim State Director
Patrick Maley
Chief Financial Officer
Rufus Britt
Associate State Director
Operations
Lori Manos
Interim Associate State Director
Policy



3440 Harden Street Extension
Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

COMMISSION
Stephanie M. Rawlinson
Chairman
Barry D. Malphrus
Vice Chairman
Robin B. Blackwood
Secretary
Gary Kocher, M.D.
Gary C. Lemel
Eddie L. Miller
David L. Thomas

Reference Number: 700-03-DD

Title of Document: Informed Choice in Living Preference (Intermediate Care Facilities for Individuals with Intellectual Disabilities)

Date of Issue: November 1, 2006

Date of Last Revision: ~~September 16, 2021~~ XXXX, 2022 (REVISED)

Effective Date: ~~September 16, 2021~~ XXXX, 2022

Applicability: DDSN Regional Centers and DSN Board Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

PURPOSE

The purpose of this document is to ensure that residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) are informed of the service options available to them.

GENERAL

In accordance with the decision by the United States Supreme Court in the case of *Olmstead v. L.C.*, the South Carolina Department of Disabilities and Special Needs (DDSN) is committed to providing services in community-based settings which are not ICF/IIDs when it is appropriate and honors the wishes of those who desire to move from ICF/IIDs. In July 1999, the United States Supreme Court issued a decision in the case of *Olmstead v. L.C.* that required states to administer their services, programs, and activities in the most integrated setting appropriate to the need of qualified individuals with disabilities. Specifically it requires states to place persons with intellectual disabilities in community settings rather than in institutions (ICF/IIDs) when the state's treatment professionals (interdisciplinary teams) determine that community placement is

appropriate, the transfer is not opposed by the person, and the placement can be reasonably accommodated, taking into account the resources available to the state and needs of others with developmental disabilities. This decision is consistent with S.C. Code Ann. § 44-20-390 (2018) and § 44-20-20 (2018) ~~which and~~ requires ~~that~~ services be provided in the least restrictive environment.

In South Carolina, the Intellectual Disability/Related Disabilities (ID/RD) Waiver, operated by DDSN, allows services, similar to those provided in an ICF/IID, to be ~~paid for~~covered by Medicaid when provided outside of an ICF/IID. Therefore, ~~this~~ the Intellectual Disability and Related Disabilities (ID/RD) Waiver allows ICF/IID residents to move from the ICF/IID to a home of their own, a family member's home or to a Residential Habilitation setting ~~sponsored by DDSN~~ such as a Community Training Home or Supervised Living Program and receive needed services in that setting ~~which are funded by Medicaid~~.

POLICY

The decision of where to live and receive services cannot be made in a vacuum. It requires an awareness of available options and merits of each. To assure those who reside in ICFs/IID have such awareness, a thorough explanation of community living options, services, and the potential benefits of those options will be provided along with opportunities to visit options of interest and speak with qualified service providers. Since family members and ICF/IID staff are integral in assisting residents with the evaluation of options and decision-making, similar information regarding options and potential benefits should be provided to them as well.

Information regarding their right to choose between receiving services in an ICF/IID or in a non-ICF/IID setting with ID/RD Waiver funded services should be provided to all ICF/IID residents, ~~surrogate consent givers, and family members~~ the legal guardians of residents, and the client representatives of residents who may assist with decision-making. This information should be provided at the time of admission and at least annually thereafter. For this purpose, the two (2) page information sheet entitled "Medicaid Funded Service Options" (Attachment 1) may be used. Each resident's record should include documentation that the information was provided to all who may assist the resident with decision making.

~~All~~The ICF/IID ~~staff~~provider must ~~be taught about the~~ have staff who are knowledgeable of Medicaid funded service options ~~and~~ community living options and potential benefits. ~~This information must be part of the initial/pre-service training for all staff~~ of those options.

All ICF/IID residents must be evaluated at least annually to determine their interest in and capacity for receiving needed services outside of an ICF/IID. The results of each resident's evaluation must be discussed by his/her interdisciplinary team and documented in his/her record. The "Evaluation for Community Living" (Attachment 2) can be used for that purpose. If it is determined that a resident is interested in living outside of the ICF/IID, interventions to assist the resident toward that end must be added to his/her program plan and implemented accordingly. Such interventions may include requesting Case Management services from DDSN, assisting with visits to different ~~residential care~~ Residential Habilitation settings or with Residential Habilitation providers, ~~referrals to qualified residential service providers,~~ discussions with family

700-03-DD

~~September 16, 2021~~XXXX, 2022

Page 3

members including mediation with family members who may oppose a move, etc. If Case Management services are approved by DDSN, choice of Case Management Provider will be offered.

~~A listing of those individuals residing at the DDSN Regional Centers who desire to receive services in a community setting will be compiled on a regular basis. This listing will be shared with community service providers in a manner that preserves the confidentiality of protected health information to facilitate movement to a community service setting. DDSN must be notified when an ICF/IID resident has been identified as someone for whom community-based services are desired and appropriate. The ICF/IID provider is responsible for notifying DDSN. The process for notifying DDSN is outlined in DDSN Directive 700-09-DD: Determining Need for Residential Services.~~

Commented [HC1]: Ralph Courtney – Aiken Board

It is unclear as to what Case Management provider will deliver this service. Will it be community providers of Case Management or DDSN as a provider of Case Management? I feel that clarification of this could prove helpful in the future, as some confusion already exists among the provider network as to the roles of the recently added DDSN staff in the actual provision of Case Management services.

Commented [ML2R1]: DDSN Response: Clarified.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

To access the following attachments, please see the agency website page “Current Directives” at: <https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives>.

Attachment 1: Medicaid Funded Service Options

Attachment 2: Evaluation for Community Living

Attachment 3: Resource Information

Michelle G. Fry, J.D., Ph.D.
State Director
Janet Brock Priest
Associate State Director
Operations
Lori Manos
Associate State Director
Policy
Constance Holloway
General Counsel
Harley T. Davis, Ph.D.
Chief Administrative Officer
Nancy Rumbaugh
Interim Chief Financial Officer
Greg Meetze
Chief Information Officer



3440 Harden Street Extension
 Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

COMMISSION
Stephanie M. Rawlinson
Chairman
Barry D. Malphrus
Vice Chairman
Robin B. Blackwood
Secretary
Gary Kocher, M.D.
Eddie L. Miller
David L. Thomas
Michelle Woodhead

Reference Number: 700-03-DD

Title of Document: Informed Choice in Living Preference (Intermediate Care Facilities for Individuals with Intellectual Disabilities)

Date of Issue: November 1, 2006

Date of Last Revision: August 18, 2022 **(REVISED)**

Effective Date: August 18, 2022

Applicability: DDSN Regional Centers and DSN Board Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

PURPOSE

The purpose of this document is to ensure that residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) are informed of the service options available to them.

GENERAL

In accordance with the decision by the United States Supreme Court in the case of *Olmstead v. L.C.*, the South Carolina Department of Disabilities and Special Needs (DDSN) is committed to providing services in community-based settings which are not ICF/IIDs when it is appropriate and honors the wishes of those who desire to move from ICF/IIDs. In July 1999, the United States Supreme Court issued a decision in the case of *Olmstead v. L.C.* that required states to administer their services, programs, and activities in the most integrated setting appropriate to the need of qualified individuals with disabilities. Specifically it requires states to place persons with intellectual disabilities in community settings rather than in institutions (ICF/IIDs) when the state’s treatment professionals (interdisciplinary teams) determine that community placement is appropriate, the transfer is not opposed by the person, and the placement can be reasonably accommodated, taking into account the resources available to the state and needs of others with developmental disabilities. This decision is consistent with S.C. Code Ann. § 44-20-390 (2018) and § 44-20-20 (2018) and requires services be provided in the least restrictive environment.

In South Carolina, the Intellectual Disability/Related Disabilities (ID/RD) Waiver, operated by DDSN, allows services, similar to those provided in an ICF/IID, to be covered by Medicaid when provided outside of an ICF/IID. Therefore, the ID/RD Waiver allows ICF/IID residents to move from the

ICF/IID to a home of their own, a family member's home or to a Residential Habilitation setting such as a Community Training Home or Supervised Living Program and receive needed services in that setting.

POLICY

The decision of where to live and receive services cannot be made in a vacuum. It requires an awareness of available options and merits of each. To assure those who reside in ICFs/IID have such awareness, a thorough explanation of community living options, services, and the potential benefits of those options will be provided along with opportunities to visit options of interest and speak with qualified service providers. Since family members and ICF/IID staff are integral in assisting residents with the evaluation of options and decision-making, similar information regarding options and potential benefits should be provided to them as well.

Information regarding their right to choose between receiving services in an ICF/IID or in a non-ICF/IID setting with ID/RD Waiver funded services should be provided to all ICF/IID residents, the legal guardians of residents, and the client representatives of residents who may assist with decision-making. This information should be provided at the time of admission and at least annually thereafter. For this purpose, the two (2) page information sheet entitled "Medicaid Funded Service Options" (Attachment 1) may be used. Each resident's record should include documentation that the information was provided to all who may assist the resident with decision making.

The ICF/IID provider must have staff who are knowledgeable of Medicaid funded service options, community living options and potential benefits of those options.

All ICF/IID residents must be evaluated at least annually to determine their interest in and capacity for receiving needed services outside of an ICF/IID. The results of each resident's evaluation must be discussed by his/her interdisciplinary team and documented in his/her record. The "Evaluation for Community Living" (Attachment 2) can be used for that purpose. If it is determined that a resident is interested in living outside of the ICF/IID, interventions to assist the resident toward that end must be added to his/her program plan and implemented accordingly. Such interventions may include requesting Case Management services from DDSN, assisting with visits to different Residential Habilitation settings or with Residential Habilitation providers, discussions with family members including mediation with family members who may oppose a move, etc.

DDSN must be notified when an ICF/IID resident has been identified as someone for whom community-based services are desired and appropriate. The ICF/IID provider is responsible for notifying DDSN. The process for notifying DDSN is outlined in DDSN Directive 700-09-DD: Determining Need for Residential Services.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

To access the following attachments, please see the agency website page "Current Directives" at: <https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives>.

Attachment 1: Medicaid Funded Service Options
Attachment 2: Evaluation for Community Living
Attachment 3: Resource Information

Reference Number: 505-02-DD

Title of Document: ~~Death or Impending Death of Persons Receiving Services from DDSN~~ Reporting and Mortality Review Requirements

~~Effective Date: April 1, 1989~~
Date of Issue: April 1, 1989
~~Last Review Date: February 2, 2017~~
Date of Last Revision: February 2, 2017 XXXX, 2022 (REVISED)
Effective Date: ~~April 1, 1989~~ XXXX, 2022

Applicability: DDSN Regional Centers, DSN Boards, and Contracted Service Providers

I. Introduction

The purpose of this document is to establish procedures to be followed in the event of a ~~the impending death or death of persons receiving services from a Department of Disabilities and Special Needs (DDSN) sponsored program~~ individuals participating in a Department of Disabilities and Special Needs (DDSN) operated Home and Community Based (HCB) Waiver as well as individuals receiving DDSN contracted residential or day supports regardless of funding source.

Staff should always remain aware of the feelings and emotions of families whose loved one is critically ill or has just passed away. All contact with the family should be made in a sensitive and respectful manner. ~~If available, the physician should contact the family to answer questions and to assist them in understanding the person's medical condition or cause of death. If the physician is not available, the Facility Director/Executive Director/CEO should contact the family.~~ Residential Direct Service Provider or Case Management staff who have worked closely with the critically ill or deceased person and family are ~~also~~ important in assisting the family and are generally the primary contact for the family.

H. Impending Death

Should a person's death become imminent due to accident or serious illness, and the person is residing in a DDSN ~~sponsored-operated or contracted~~ residence, the physician or the ~~Facility Administrators/ Executive Directors/CEOs~~ DDSN Regional Center/Provider designee should inform the parents/next-of-kin of the critical nature of the ~~accident or serious~~ illness. The ~~residence social worker~~ residential staff or Case Manager, along with the physician will maintain contact with the family during the period the person remains in danger. If the family desires, a pastor or other religious person of their choice will be located to minister to the needs of the person and the family.

II. Definitions

Allegation of Abuse, Neglect, or Exploitation (ANE) – A person has reason to believe that another person has been or is at risk for abuse, neglect, or exploitation.

Administrative Review – The final step of the incident management process that reviews the circumstances of the incident; weighs evidence of policy or procedural violations or employee misconduct, and creates corrective action plans. The Administrative Review is intended to mitigate risks and prevent future incidents, where possible.

Case Manager - A person selected by the participant to coordinate assessment, planning, care coordination, evaluation, and services to meet a service recipient's needs. The Case Manager provides advocacy and information about available resources to ensure choice, satisfaction, and quality.

Corrective Actions – Actions implemented to increase protection to persons from similar future incidents. Corrective actions can be implemented for a single person and/or related to an organizational change to prevent similar incidents to all persons served.

Critical Incident – A type of incident that has been determined to be a sufficiently serious indicator of risk that it requires an administrative review.

Expected Death (Natural Causes) – Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. This includes a death that is medically determined, based on a death certificate and supporting documentation, to have resulted solely from a diagnosed degenerative condition or a death that occurs as the result of an undiagnosed condition resulting from an explained condition, such as the aging process.

Unexpected Death – An unexpected death is primarily attributed to an external unexpected force acting upon the person. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unexpected.

Unexplained Death – A death in which the cause of death noted on a person's death certificate is not supported by documentation found in the person's medical history and other documentation.

Incident Management- The response to an event, intended to ensure the adequate, appropriate, and effective protection and promotion of the health, safety, and rights for all people served.

III. Reporting the Death of Persons Supported by within DDSN Regional Centers or DDSN Contracted Service Providers

~~In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons who reside in DDSN sponsored residential services, or whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person. (e.g., individual rehabilitation supports).~~ In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons who reside in DDSN operated or contracted residential services, or whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person.

~~A. DEATHS OF PERSONS AGE 17 AND UNDER IN DDSN OPERATED HOMES OR THOSE HOMES CONTRACTED FOR OPERATION BY DDSN~~

- ~~1. Facility Administrators/Executive Directors/CEOs or their designee will report the death to DDSN using the Death Reporting function on the Incident Management System as soon as possible, but no later than 24 hours or the next business day.~~
- ~~2. A report must be made to DDSN, even if the child dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System.~~
- ~~3. If the death was unexpected or suspicious in nature, the Facility Administrator/Executive Director/CEO or their designee must call the DDSN District Director or their designee immediately. Immediately means within two (2) hours of the death. The DDSN District Director will then notify the Associate State Director Operations and the State Director. The Death Reporting function on the Incident Management System must be completed as soon as possible, but no later than 24 hours, or the next business day. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.~~
- ~~4. All child deaths in ICFs/IID facilities must be reported in writing by the Facility Administrator/Executive Director/CEO or their designee to the Health Licensing Division of DHEC at the same time a report is made to DDSN.~~
- ~~5. The physician, Facility Administrator/Executive Director/CEO or their designee shall notify the county coroner's office immediately of all child deaths unless the death occurred in a hospital setting.~~
- ~~6. An internal review by management will be conducted of all child deaths. However, **the review should never interfere with any outside investigation if applicable.** Results of all reviews must be submitted to DDSN and to DHEC, as applicable, within ten (10) working days of the death. The results of the review must be documented in the Report of Death Final Report, located within the Death Reporting function of the Incident Management System. The Facility Administrator/Executive Director/CEO or their designee will submit the final report.~~

A. Deaths of Persons Receiving Residential Services in a Home Operated by or Contracted for Operation by DDSN

1. The physician or DDSN Regional Center/Provider designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.
2. For deaths involving persons age 18 and above, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Vulnerable Adult Investigations Unit immediately using SLED's toll-free number: 1-866-200-6066.
3. For deaths involving persons age 17 and under, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Child Fatality Unit immediately using SLED's toll-free number: 1-866-200-6066. The death must also be reported to the SC DSS Out of Home Abuse and Neglect Investigation Unit (OHAN).
4. The Initial Report of Death Form located in the Death Reporting function of the Incident Management System, must be completed-within 24 hours. A report must be made to DDSN and SLED even if the person dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System. For persons recently discharged from a DDSN residential service location, SLED must be contacted by the former DDSN residential provider if the death occurs within 30 days of the discharge date.
5. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means within two (2) hours of the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.
6. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.
7. All deaths in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) and Community Residential Care Facilities (CRCF) must be reported in writing by the DDSN Regional Center/Provider designee to the Health Licensing Division of the South Carolina Department of Health and Environmental Control (DHEC) at the same time a report is made to DDSN.
8. An Administrative Review will be conducted for all deaths. **This review should never interfere with any outside investigation.** For ICF/IID and CRCF locations, the results of all Administrative Reviews must be submitted to DDSN and to DHEC, within five (5) calendar days of the death. For all other residential settings, the results of all Administrative Reviews must be submitted to DDSN within ten (10) business days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

~~B. — DEATHS OF PERSONS AGE 18 AND ABOVE IN DDSN OPERATED HOMES OR THOSE HOMES CONTRACTED FOR OPERATION BY DDSN~~

~~Facility Administrators/Executive Directors/CEOs or their designee will report the death to the South Carolina Law Enforcement Division (SLED) immediately using SLED's toll free number: 1-866-200-6066. In addition, the Initial Report of Death Form located in the Death Reporting function of the Incident Management System, must be completed as soon as possible, but no later than 24 hours, or the next business day.~~

- ~~1. — A report must be made to DDSN and SLED even if the person dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System. For persons recently discharged from a DDSN residential service location, SLED must be contacted by the former DDSN residential provider if the death occurs within 30 days of the discharge date.~~
- ~~2. — If the death was unexpected or suspicious in nature, the Facility Administrator/Executive Director/CEO or their designee must call the DDSN District Director or their designee and SLED immediately. Immediately means within two (2) hours of the death. The DDSN District Director will then notify the Associate State Director Operations and the State Director. The Report of Death function on the Incident Management System must be submitted to DDSN as soon as possible, but no later than 24 hours, or the next business day. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.~~
- ~~3. — All deaths in ICFs/IID and CRCFs must be reported in writing by the Facility Administrator/Executive Director/CEO or their designee to the Health Licensing Division of DHEC at the same time a report is made to DDSN.~~
- ~~4. — The physician, Facility Administrator/Executive Director/CEO or their designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.~~
- ~~5. — An internal review by management will be conducted of all deaths. However, the review should never interfere with the investigation of death conducted by SLED. Results of all reviews must be submitted to DDSN within ten (10) working days of the death. The results of the review must be documented in the Report of Death Final Report, located within the Death Reporting function of the Incident Management System. The Facility Administrator/Executive Director/CEO or their designee will submit the final report.~~

~~C. — DEATHS OF PERSONS OF ANY AGE OTHER THAN THOSE LIVING IN A RESIDENTIAL PROGRAM OPERATED BY OR CONTRACTED FOR OPERATION BY DDSN WHILE AT A DDSN REGIONAL CENTER OR PROVIDER LOCATION (E.G., DAY PROGRAM) OR WHILE UNDER THE SUPERVISION OF DDSN REGIONAL STAFF OR BOARD/PROVIDER STAFF PERSON (E.G., INDIVIDUAL REHABILITATION SUPPORTS)~~

- ~~1. — Facility Administrators/Executive Directors/CEOs or their designee will report the death to DDSN using the Death Reporting function of the Incident Management System as soon as possible, but no later than 24 hours, or the next business day.~~
- ~~2. — If the death was unexpected or suspicious in nature, the Facility Administrator/Executive Director/CEO or their designee must call the DDSN District Director or their designee immediately. Immediately means within two (2) hours of the death. The DDSN District Director will then notify the Associate Director Operations and the State Director. The Report of Death function on the Incident Management System must be sent to DDSN as soon as possible, but no later than 24 hours, or the next business day. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.~~
- ~~3. — The physician, Facility Administrator/Executive Director/CEO or their designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.~~
- ~~4. — An internal review by management will be conducted of all deaths. However, **the review should never interfere with any outside investigation if applicable.** Results of all reviews must be documented within ten (10) business days in the Report of Death Final Report, located within the Death Reporting function of the Incident Management System. The Facility Administrator/Executive Director/CEO or their designee will submit the final report.~~

B. Deaths of persons of any age, other than those living in a residential program operated by or contracted for operation by DDSN whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person (eg, respite, employment).

1. DDSN Regional Center/Provider designee will report the death to DDSN using the Death Reporting function of the Incident Management System within 24 hours.
2. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means within two (2) hours of the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.

3. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.
4. The physician or DDSN Regional Center/Provider designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.
5. An Administrative Review will be conducted of all child deaths. **This review should never interfere with any outside investigation.** Results of all Administrative Reviews must be submitted to DDSN and to DHEC, as applicable, within ten (10) working days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

IVC. Notification Procedures

For those persons living in a DDSN ~~sponsored~~operated or contracted residential setting, the family/guardian or primary correspondent will be notified of the death by the method they have identified in the person's plan such as by phone, personal visit or by notifying their minister who would then notify the family. If the family has made no prior arrangements, the attending physician will inform the family of the death of their family member ~~as soon as possible after the death~~per the physician's death notification policy. ~~The provider representative will seek Permission for an autopsy should be sought at that time as indicated by law. The Case Manager will also contact the family to help with funeral and burial arrangements.~~ The provider representative will seek When gathering information on the death of a DDSN consumer, care must be taken to respect the feelings of survivors. The ~~staff person~~provider representative should express condolences, indicate the importance of gathering key information for the benefit of other individuals with disabilities, and proceed to fill out the "Report of Death" ~~form~~by retrieving information from all appropriate sources~~the participant and staff records.~~ If family members are unwilling/unable to participate in filling out the ~~form report~~form, then the staff person should proceed with the form using information from other ~~sources~~approved participant records.

VD. Autopsy

An autopsy will be performed following the death of a person when requested by the coroner or SLED and should also be done when:

- a) death is an unexpected or unexplained outcome as determined by the attending physician and/or medical director, and/or Executive Director, or;
- b) requested by the family. (*Costs for an autopsy requested by the family, but not required by the Coroner or SLED, will be the financial responsibility of the family.*)

If the circumstances of the death do not require an autopsy (i.e., not ordered by the Coroner's Office or SLED), but one is sought, the attending physician will seek permission from the next of kin or correspondent. If permission is denied, this objection will be honored and the denial recorded in the chart by the requesting physician/medical director or ~~Executive Director~~DDSN Regional Center/Provider designee.

E. Disposition of Remains

The remains of the deceased will be released according to the wishes of the person as specified in a pre-need document or to the parents or other responsible relative or guardian of record. If no responsible person is known or if such person refuses to accept custody of the remains, the ~~Facility Administrators/Executive Directors/CEOs or their~~ DDSN Regional Center/Provider designee will arrange for burial or other appropriate disposition of the remains.

If possible, persons should be buried in accordance with their documented preferences or, if none, in their home community. If no family member or relative can be located to help make arrangements for the burial in the home community, the ~~Facility Administrators/Executive Directors/CEOs~~ DDSN Regional Center/Provider can arrange for the burial at an appropriate community or church cemetery. In these cases, burials will be the financial responsibility of the DDSN Regional Center or ~~board~~/provider responsible for previously supporting the person after all other resources have been utilized.

VHF. Personal Funds

At the time of death, all funds conserved for the person are frozen, and no disbursements will be made without legal authority of the Probate Court. Should this pose a problem for families needing immediate access to the person's funds for funeral expenses, the ~~provider~~ DDSN Regional Center/Provider will co-operate with the family to assure the burial is handled in a reasonable manner in accordance with the family's wishes.

The ~~Facility Administrators/Executive Directors/CEOs or~~ DDSN Regional Center/Provider designee will file the Affidavit for Collection of Personal Property Pursuant to Small Estate Proceeding available on the judicial website <http://www.judicial.state.sc.us/forms/> – quick links (Probate Court Form 420PC). The Probate Court will issue an order permitting payment to the proper persons.

IVG. Quality Management Mortality Reviews

~~All DDSN Regional Centers, DSN Boards and Contracted Service Providers must follow DDSN Directive 100-28-DD: Quality Assurance, to ensure continuous quality improvement in all services and supports provided to DDSN service recipients.~~ Providers are expected to promptly comply with any requests for information from the Vulnerable Adult Fatality Committee or from the SLED Vulnerable Adult Investigations Unit. In addition, DDSN will participate in the Vulnerable Adult Fatalities Review Committee and the Children's Fatalities Review Committee to improve service quality and to develop and implement measures to prevent future deaths from similar causes from occurring if at all possible.

Through the DDSN Regional Center/Provider Risk Management Committee, a Mortality Review Process should evaluate information gathered during the reporting process to identify the following:

1. Immediate and secondary causes of death;
2. If the deaths were:
 - a. Expected due to a known terminal illness;

- b. Associated with a known chronic illness;
 - c. A sudden, unexpected death;
 - d. Due to unknown cause
 - e. Due to an accident and, if so, the type of accident;
 - f. Due to self-inflicted injury or illness (e.g., suicide, serious self-injurious behavior);
 - g. Due to suspicious or unusual circumstances; and
 - h. Due to suspected or alleged neglect, abuse, or criminal activity.
3. Findings from any outside investigation (as available/applicable) such as SLED, law enforcement etc.
 4. Any trends and/or patterns in the deaths reported.
 5. Immediate and longer-term circumstances and events that contributed to or were associated with deaths.
 6. Actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths.

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

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

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

Related Directives or Laws:

Child Protection Reform Act, S.C. Code Ann. § 20-7-480, et seq.
 Omnibus Adult Protection Act, S.C. Code Ann. § 45-35-35, et seq.

~~100-28-DD: Quality Assurance and Management~~

200-02-DD: Financial Management of Personal Funds

200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs

Michelle G. Fry, J.D., Ph.D.
State Director
Janet Brock Priest
Associate State Director
Operations
Lori Manos
Associate State Director
Policy
Constance Holloway
General Counsel
Harley T. Davis, Ph.D.
Chief Administrative Officer
Nancy Rumbaugh
Interim Chief Financial Officer
Greg Meetze
Chief Information Officer



3440 Harden Street Extension
 Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

COMMISSION
Stephanie M. Rawlinson
Chairman
Barry D. Malphrus
Vice Chairman
Robin B. Blackwood
Secretary
Gary Kocher, M.D.
Eddie L. Miller
David L. Thomas
Michelle Woodhead

Reference Number: 275-04-DD

Title of Document: Procedures for Implementation of DDSN Audit Policy for DSN Boards

Date of Issuance: May 11, 1988

Date of Last Revision: ~~July 21, 2022~~ September 15, 2022 **(REVISED)**

Effective Date: ~~July 21, 2022~~ September 15, 2022

Applicability: DSN Boards

GENERAL PROVISIONS

Disabilities and Special Needs (DSN) Boards and entities grandfathered in as DSN Boards that fall into one of the following categories must obtain an audit of financial statements and a report on applying agreed-upon procedures (RoAAP) in accordance with this policy.

1. Those that receive financial assistance (program contracts, grants, subgrants, etc.) from the South Carolina Department of Disabilities and Special Needs (DDSN) during the State fiscal year ended June 30.
2. Those that receive DDSN funds and makes a sub-grant to another organization with the funds, then the sub-grantee would also be considered a recipient of DDSN funds. The sub-grantee must obtain an audit in accordance with this directive if the amount received exceeds \$250,000 during the State fiscal year ended June 30.

The audit is to be performed in accordance with Generally Accepted Governmental Auditing Standards (GAGAS or “Yellow Book”) by an independent Certified Public Accountant (CPA). If the entity expended over the threshold set by OMB Uniform Guidance (currently \$750,000) in federal awards

during the fiscal year, then it must obtain an audit in accordance with the Uniform Administration Requirements, Cost Principles, and Audit Requirements for Federal Awards, under 2 C.F.R., Subtitle A, Chapter II, Part 200 (“Uniform Guidance”). Please note that Medicaid funds received are not considered federal awards.

DSN Boards are required to: (1) engage an independent CPA to complete the agreed-upon procedures outlined in this directive and (2) submit a report on their results of applying the agreed-upon procedures.

If a DSN Board is recognized as part of county government, then the county audit, if it meets the requirements of the DDSN audit policy, will be accepted and a separate audit of the DSN Board is not necessary; however, DDSN requires the DSN Board to submit a RoAAP prepared by an independent CPA.

AUDIT REPORT AND PROCEDURES

The following applies:

1. The financial statements must be prepared in conformity with generally accepted accounting principles (GAAP). Effective implementation dates for recently issued and adopted accounting pronouncements must be followed. Early implementation of any standard must be approved by DDSN in advance of adoption. Requests for consideration of early implementation must be submitted in writing to the DDSN Chief Financial Officer (CFO) by July 31 of the applicable year. A written response will be provided to the requestor within 30 days of receipt of the request.
2. The Management Discussion and Analysis (MD&A), if applicable, must be written by the DSN Board’s staff.
3. The financial information outlined in this directive for the DDSN funding year ended June 30 must be included in the audit report. Failure to do so will make the report unacceptable.
4. The auditor must express an opinion on whether the information in the supplementary schedules is fairly stated in all material respects in relation to the financial statements taken as a whole.
5. DDSN required supplementary financial information:
 - a) Schedules of Revenues and Expenses
 - i) These schedules must be presented on the full accrual, economic resources basis and not on the modified accrual, current financial resources basis.
 - ii) These schedules must be developed using the same line item detail as illustrated on Attachment A. Use of additional line items not shown in the attachment are not permitted without written approval from the DDSN CFO.
 - iii) Schedules must be prepared for the following, if applicable:
 - (1) General fund;
 - (2) Capitated programs (utilizing the capitated services contract);

- (3) Non-capitated programs (utilizing the non-capitated services contract);
- (4) Special grant programs (utilizing special grant contracts);
- (5) Intermediate cost centers; and
- (6) Other programs.

iv) The auditor must present the revenues and expenses separately by program. Expenses for residential programs must also be presented in detail for each residence within the program. Additionally, residential programs must be clearly distinguished as being HUD or non-HUD home(s).

b) Room and Board Computation

Utilizing DDSN Directive 250-09-DD: Calculation of Room and Board for Non-ICF/IID Programs and Attachment C, prepare a computation of room and board utilizing the final audited trial balance. The auditor is not required to provide any additional assurance related to the contents of specific trial balance accounts comprising the room and board computation.

c) Schedule of Special Grant Revenues and Expenses

Utilizing Attachment D, prepare a schedule of special grants for all special grant revenues received and/or expended during the fiscal year.

d) Reconciliation of audited financial statements to Medicaid Cost Reports and Cost Statements.

When the audited financial statements and the cost reports/cost statements are both presented on the full accrual basis, but the program costs for Medicaid funded programs per the audited financial statements (AFS) do not equal the AFS program costs per the cost reports, the auditor must provide a reconciliation to explain the differences between the two documents.

e) Audit Directive Compliance Statement

The DSN Board must give a copy of this audit policy to the auditor prior to the start of the audit to ensure that DDSN's audit requirements are met. The auditor must include a signed statement with the audit report stating that he/she has read and complied with the requirements of the policy. The statement must indicate the revision date of the audit policy that was followed.

f) Supplementary Schedule of Questioned Costs

In performing the audit, the auditor must consider whether expenses are reasonable and necessary for the program to which they are charged. Limitations on costs for awards are detailed in DDSN Directive 250-05-DD: Cost Principles for Grants and Contracts with Community DSN Boards. Individual negotiations and reviews will occur between the DSN Board and DDSN on all questioned costs pertaining to DDSN programs. Final

resolution, use of audit information, and applicability resides with DDSN. A schedule of questioned costs must be provided by the auditor. See Attachment E for an example schedule.

6. Combining or Consolidation Schedules

If the audit report includes blended component units or subsidiaries, then combining or consolidation schedules must be provided to support the basic financial statements. For Governmental Accounting Standards Board (GASB) presentations, combining schedules are only required for the Statement of Net Position and the Statement of Activities.

REPORT ON APPLYING AGREED-UPON PROCEDURES (RoAAP):

DSN Boards will need to contract with an independent CPA to apply RoAAP for the procedures listed below.

A sample template of the required report on applying RoAAP can be found in Attachment B. CPAs must follow this template. The template will be provided in Word format if requested.

The CPA must follow AU-C 530 “Audit Sampling” in its sampling selection process and determination of the population and sample sizes required. DDSN is prescriptive in selecting audit sampling but will closely scrutinize the results for reasonableness. Attachment B contains a new chart to tease out specific number of Medicaid bills tested to permit both aggregating RoAAP data statewide to assess risk and crystalize CPA’s level of effort in sampling.

The procedures below are required to be completed and the results reported on by the CPA.

1. Test the DSN Board’s Control and Procedures for Medicaid Billings

a) Background Information

People may receive services provided either by the Board or a third-party vendor under the Medicaid program. Services must be authorized by the case manager and documented in the consumer’s plan. The DSN Board or the third-party vendor receives payments for the Medicaid billable services rendered to the individuals from either DDSN or the SC Department of Health and Human Services (DHHS). Medicaid billable programs include, but are not limited to, all Residential Habilitation Programs, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), Community Residential Care Facilities (CRCF), Community Training Home-I (CTH-I), Community Training Home-II (CTH-II), Community Integrated Residential Services (CIRS), Supervised Living Model-I and II (SLP-I) and (SLP-II), Adult Day Programs, Supported Employment, Home and Community Based Waiver Services (enhanced board and direct billed services), Head and Spinal Cord Injury Services Waiver (enhanced board and direct billed services), Community Supports Waiver (enhanced board and direct billed services), Case Management, and Early Intervention. The auditor should reference DDSN Standards and chapter 10 of the Finance Manual located on DDSN’s website for guidance related to these services and DDSN’s billing and reporting procedures.

b) Procedures

- i) The CPA must gain an understanding of the Medicaid billing process and controls over Medicaid billable services (enhanced board and direct billed services). In order to gain an accurate understanding of this process, the CPA should consult with the program staff and supervisors as these employees are directly responsible for Medicaid compliance and should be familiar with how Medicaid is billed. The CPA must perform sufficient work to determine if the DSN Board's policies and procedures are adequate to provide reasonable assurance that Medicaid billable services are properly supported.
- ii) The CPA must select a representative sample from all persons from each Medicaid billable service area for which the DSN Board or a third-party vendor is receiving payments for Medicaid billable services through DDSN or DHHS. For the sample selected, the CPA must perform sufficient work to determine the following:
 - Tests determine that the supporting documentation provides reasonable assurance that billings are supported by complete and accurate information.

Gain an understanding of the monitorship (scan service notes, phone contacts with family members and/or employers, visits to family members' homes and/or persons' job sites, etc.) procedures established by the DSN Board to monitor each program. Test monitorship is being provided and documented by supervisory staff on a continual basis to provide reasonable assurance to the DSN Board that the billable services are being provided to the persons and/or families as indicated by the documentation on file.

2. The auditor must select a representative sample in each provider residential Habilitation programs (ICF/ID, CRCF, CTH-I, CTH-II, CIRS, SLP-I and SLP-II). Test the DSN Board's management of the persons' personal funds and personal property for compliance with DDSN Directive 200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs and 604-01-DD: Individual Clothing and Personal Property.

a) Background Information

CPAs should familiarize themselves with the following directives: DDSN Directives 200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs and 604-01-DD: Individual Clothing and Personal Property, outline regulations related to DSN Board management of personal funds and property. Procedures may vary by residential program and will also vary based on whether funds are retained in individual checking accounts, savings accounts, burial accounts, Achieving a Better Life Experience (ABLE) accounts, or collective accounts. Care must be taken to gain an understanding of the unique characteristics of each and to ensure procedures are developed accordingly. Additionally, CPAs must understand eligibility, regulations, and resource limits established by Medicaid. Eligibility will vary by coverage group.

b) Procedures

The CPA must perform sufficient work to determine if the DSN Board's policies and procedures are adequate to safeguard the persons' personal funds and property, as well as remain in compliance with DDSN Directives. The CPA must select a representative sample of accounts and transactions to ensure proper coverage.

- i) Determine that the persons' personal funds are not borrowed, loaned, or co-mingled by the DSN Board or another person or entity for any purpose; or, combined or co-mingled in any way with the DSN Board's operating funds.
- ii) Determine that the person's accounts are established in the person's name and social security number, and that they indicate that the accounts are for the benefit of the person (fiduciary relationship).
- iii) Determine that bank signature cards are updated timely for changes in personnel and that a copy of the signature card is maintained.
- iv) Determine that bank reconciliations are being performed and documented within 20 business days of receipt of the bank statements by a staff member who is not a co-signer on the account.
- v) Determine, through a representative sample of all purchases, that receipts are on hand to support purchases made from the persons' personal funds.
- vi) Determine that the amount paid for by the person is properly charged to their personal funds. Consider if amounts should have been paid by the Waiver program, from residential program funds, or if items/services purchased are proper.
- vii) For any item purchased that is required to be inventoried, verify that the persons' personal property record is properly updated. Procedures used by the Provider should be evaluated to ensure they are adequate to ensure the item is properly marked in accordance with the directive. Actual observation of the items is not required but may be deemed necessary by the CPA to test the procedures used by the Provider.
- viii) Determine if checks written to the person cause them to exceed their cash on hand limit. Gift cards are also considered cash and must be included in the cash on hand limit. Funds written payable to the person and cashed are considered cash on hand until expended and should be considered in conjunction with other cash held by the person or by program staff.
- ix) Determine that actual counts of the persons' cash held by residential staff, and agreement of the counts to the records, are completed monthly by someone who does not have authority to receive or disburse cash. The count and agreement to the records must be documented. The CPA is only expected to test the procedures used by the Provider.

- x) Evaluated the controls over cash to ensure that the provider has adequate controls to identify and safeguard cash held by the provider and cash held by the person.
- xi) Determine that the persons' total countable resources do not exceed the established limits mandated by Medicaid (generally: \$2,000).
- xii) Determine that the DSN Board has a process established to identify those with recurring excess resources and have established a plan to eliminate risk of loss of benefits – for example, participation in the ABLE program, participation in a special needs trust (individual or pooled), spend down of resources, establishment of burial savings accounts, and/or establishment of prepaid burial arrangements.
- xiii) For collective accounts, determine that the account is being managed in accordance with the Social Security Organizational Representative Payee guide found on the Social Security Administration's website at <https://www.ssa.gov/payee>.

If the CPA becomes aware of a misappropriation involving DSN Board or persons' funds and/or any falsification of Medicaid billable services, then the CPA must promptly report that information to the DSN Board Executive Director and Financial Director, with a follow-up to DDSN Internal Audit.

3. Determine if the DSN Board is paying ALL direct care staff the established minimum hourly wage in accordance with the DDSN contract.

a) Background Information

DDSN is appropriated funds from the State to establish a minimum pay rate for direct care staff. These funds are passed to DSN Boards through an increase in rates and contract amounts. Direct support professionals are defined as people that are in a regular shift rotation and are directly involved in the care of persons' in residential or day program settings. Supervisors, House Managers, and other similar positions would qualify if they met the criteria above. Job classifications vary by service provider and the same job classification at different service providers may or may not involve the same level of hands-on care. As a result, DDSN did not take a prescriptive approach. Each DSN Board will have the responsibility of determining which employees qualify based on their unique circumstances. The minimum pay rate for direct support professionals will be \$13 per hour. DSN Boards are permitted to pay new hires a rate less than \$13 for staff training hours and for any on the job training hours where the direct support professional (DSP) is not permitted to work alone. If a DSP employee is able to work alone and has been cleared to work alone by their Manager but due to staffing patterns does not work alone in the home, then they must be paid \$13 per hour. In no case should a new hire direct support professional make less than \$13 per hour for a period to exceed 90 calendar days.

b) Procedures

The CPA must determine that the DSN Board is paying **ALL** direct care staff the established minimum hourly wage in accordance with DDSN requirements, for all hours worked.

- i) The CPA must test the minimum pay rate used by the Provider. A variety of testing procedures may be used. One such procedure could be selecting two (2) pay periods to test proper application of the pay rate.
- ii) The CPA must test the timing of disbursements when a pay increase has been instituted which in the past has been the first pay date in July. Retroactivity of the pay rate is permitted, but the CPA must perform sufficient work to ensure it was completed properly. If there was a retroactive payment to the employee, then the CPA is only expected to verify that the process used appears to be completed correctly to ensure compliance.
- iii) If direct care staff are paid less than \$13 per hour, verification is required that they meet the requirements noted in 3a. If this requirement has not been met there must be a written exception approved by DDSN.

4. Determine that the DSN Board has adopted a Board of Director approved room and board policy. Also, test that the provider has properly and timely implemented the DDSN approved room and board rate, in accordance with their policy.

a) Background Information

DSN Boards are required to adopt a fee for services policy in accordance with DDSN Directive 250-09-DD: Calculation of Room and Board for Non-ICF/IID Programs. Additionally, they are to obtain DDSN approval at least annually on the room and board rates to be charged to persons' in residential programs.

b) Procedures

- i) The CPA must determine that the DSN Board has established a room and board policy for persons' fees that has been reviewed and approved by the Board of Directors.
- ii) The CPA must obtain the DDSN approved room and board rates utilized during the fiscal year.
- iii) The CPA must familiarize themselves with the policy and the approved rates.
- iv) Test actual charges made to persons to ensure that they comply with the policy and do not exceed the approved room and board rates.
- v) Test individuals' move-ins and move-outs and verify that room and board charges were properly applied. The CPA is testing the proper proration of the room and board charge.

5. Determine that the DSN Board has adopted a cost allocation plan and costs charged to intermediate cost centers are in accordance with DDSN Directives.

a) Background Information

All DSN Boards are required to submit cost allocation plans to DDSN. The cost allocation plan submitted by the DSN Board must be appropriate and comply with DDSN Directive 250-05-DD: Cost Principles for Grants and Contracts with Community Providers. DSN Boards are to ensure that costs are properly accumulated and allocated to final cost centers.

b) Procedures

- i) The CPA must determine if the cost allocation plan used was submitted and approved by DDSN.
- ii) The CPA must determine if the approved cost allocation plan is implemented as designed and note any material exceptions.

6. Determine if DSN Board complies with DDSN Directive 250-08-DD: Procurement Requirements for Local DSN Boards and Contracted Service Providers.

a) Background Information

DSN Boards are required to establish procurement policies and procedures in accordance with the requirements contained in DDSN Directive 250-08-DD: Procurement Requirements for Local DSN Boards and Contracted Service Providers. The policies and procedures can be more, but not less restrictive than the requirements in the Directive.

b) Procedures

- i) The CPA must determine that the DSN Board has established a procurement policy that has been reviewed and approved by the Board of Directors.
- ii) The CPA must perform tests to determine if the DSN Board's procurement policies and procedures are in compliance with the Directive.
- iii) When standards of conduct are included which require the members of the Board of Directors, Executive Director, President/CEO, finance staff, procurement staff, and staff directly reporting to the Executive Director/President/CEO to provide sign statements to disclose potential conflicts of interest and to acknowledge/prevent potential conflicts of interest, the CPA firm is required to ensure these statements have been provided and are on file.
- iv) A sample of purchase transactions must be selected to test compliance with the DSN Board's procurement policy.

7. The CPA must select a representative sample of financial transactions made by or on behalf of the Executive Director and top administrative staff (i.e., travel, credit cards, personal use of agency owned vehicles). Determine if transactions are proper and any tax reporting is properly reported.

AUDIT REPORT, COST REPORT, AND RoAAP DUE DATES AND EXTENSIONS

The audit report, separate letter to management (if issued), cost report, and RoAAP are to be filed with DDSN by September 30th of each year for fiscal year ending June 30th according to the Distribution section listed below. If this due date falls on a weekend, or any due date, then the due date is the next workday.

A request for an extension of time to file the audit, cost, and/or RoAAP reports must be submitted to DDSN Internal Audit by the DSN Board in writing on the DSN Board's letterhead stationery and signed by the Executive Director and must be approved by DDSN Internal Audit. The request for an extension must be received by DDSN Internal Audit ~~by October 10th of the applicable year~~ at least 15 calendar days prior to the due date of the report. Such requests will only be approved in extreme circumstances that are beyond the control of the DSN Board or the Auditor or when approval would be to the benefit of DDSN.

If the audit, cost, and RoAAP reports are not received within five (5) business days of the due date, including approved extensions, then a financial sanction of \$100 per calendar day will be assessed on each report until each of the reports are received by DDSN or up to a maximum of \$2,500 per report has been assessed. The total amount of the financial sanction will be invoiced. If a DSN Board incurs a contract reduction in consecutive years for not meeting a reporting deadline subject to a financial sanction for the same report, then the financial sanction for the missed deadline(s) for the second year will be doubled.

AMENDMENTS TO AUDIT REPORTS

Where additional explanations or corrections are necessary after a report has been filed, supplements must be prepared by the audit firm for all copies and distributed as noted in "Distribution" below.

CORRECTIVE ACTION PLANS (CAP) AND EXTENSIONS

When the auditor's report, separate letter to management (if issued), or the RoAAP identify material weaknesses, any deficiencies, findings or questioned costs, then the DSN Board must submit a CAP to address and resolve the problem identified by the auditor/CPA, or submit a statement of reasons why no corrective action is necessary. The CAP must be prepared on DSN Board's letterhead stationery and signed by the Executive Director. The CAP must be submitted to DDSN Internal Audit within 20 business days after issuance of the audit report or RoAAP. If the CAP is not received within 20 business days of the issuance date, then a financial sanction of \$100 per calendar day for financials and/or RoAAP will be assessed until the CAP is received by DDSN or a maximum of \$2,500 per cap has been assessed. The total amount of the financial sanction will be invoiced. Any invoices not paid within 60 days will be subject to additional collection efforts including, but not limited to, deductions from future contract payments. Invoices not able to be resolved after such efforts will be reviewed by the State Director and/or the DDSN Commission for potential additional action. It is recommended that the CAP be submitted with or be included as part of the audit report and RoAAP when issued.

The CAP must include the specific dates when deficiencies will be corrected. Copies of documents that clarify the resolution of deficiencies must be included with the CAP.

A request for an extension of time to file a CAP must be submitted to DDSN Internal Audit by the DSN Board in writing on the **DSN Board's letterhead stationery and signed by the Executive Director and must be approved by DDSN Internal Audit. The request for an extension must be filed at least 15 business days prior to the due date for the CAP.** Such requests will only be approved in extreme circumstances that are beyond the control of the DSN Board or its auditor, or when approval would be to the benefit of DDSN.

ADDRESSEE

The audit, cost, and RoAAP reports are to be addressed to the governing boards.

DISTRIBUTION

Copies of the audit, cost, and RoAAP reports, management letters, and internal control reports shall be filed as follows:

1. Executive Director of the DSN Board.
2. Chairperson of the DSN Board's governing board.
3. Hard copy of audit report and cost report to:

DDSN Director of Cost Analysis
3440 Harden Street Extension
Columbia, S.C. 29203

4. Electronic pdf copies of all reports are required to be sent to financial.reports@DDSN.sc.gov.

The audit firm must present the final audit report, any management letter comments, the RoAAP, and all deficiencies noted, at a scheduled meeting of the DSN Board's Board of Directors. If this is not done prior to the due date for submitting the documents to DDSN, the auditor must ensure that management is aware of the contents of the final report, management letter comments, the RoAAP, and deficiencies noted.

DISCLOSURE OF THREATS TO INDEPENDENCE

When the audit reports are filed with DDSN, DSN Boards must also submit a statement on letterhead stationery and signed by the Executive Director disclosing all identified threats to independence. The letter must outline the type and extent of all attestation, consulting, bookkeeping, and/or other services performed under contract or agreement with the audit firm. Examples that must be considered include: maintenance of the depreciation schedule, preparation of the financial statements, preparation of the SEFA (Schedule of Expenditures of Federal Awards), completion of the Federal Audit Clearinghouse Data Collection Form, preparation of the MD&A, preparation of income tax returns, preparation of Medicaid Cost Reports/Cost Statements, individual or aggregate material adjustments, payroll services, bookkeeping services, budget preparation, and software selection/implementation.

Reference must be made to the Government Auditing Standards 2018 Revision for those services that present threats to independence. The DSN Board is responsible for being aware of independence threats and ensuring they are addressed by the auditor to ensure they remain independent.

INSPECTION/ACCEPTANCE

Final inspection and acceptance of audit documents shall be the responsibility of DDSN Internal Audit.

AUDIT QUALITY

To verify that the responsibility of quality audits is accomplished, DDSN Internal Audit will work with other DDSN staff, as well as other state agencies, to:

1. Ensure that all audit reports of DSN Boards are received, reviewed, and distributed to appropriate DDSN officials.
2. Ensure that if significant inadequacies relating to the professional performance of the audit are discovered, the DSN Board will be advised and the auditor will be required to take corrective action. If corrective action is not taken, DDSN shall notify the DSN Board and other state agencies of the facts. Major inadequacies or repetitive substandard performance of auditors shall be referred to the appropriate professional bodies.
3. Ensure that satisfactory audit coverage is provided in a timely manner in accordance with DDSN audit requirements.
4. Maintain a follow-up system on audit findings and investigative matters.

The State Board of Accountancy may review all or a sample of DSN Board Audit Reports for compliance with professional standards.

Audit firms that receive a peer review report of other than pass must notify the DSN Board client and DDSN Internal Audit of the peer review results.

WORKING PAPERS

Working papers are to be retained by the audit firm for six (6) years following the end of the fiscal year being audited. Retention of working papers beyond six (6) years is required for audits of DSN Boards where questioned costs and/or practices have not been resolved with DDSN.

Working papers must be available, upon request, for examination by representatives of DDSN or its designee as well as successor auditors who may perform audits of the DSN Board. Availability of working papers must be provided at no additional cost to the representatives of DDSN or the successor auditor.

The auditor may be required to provide copies of any specific portions of working papers requested by DDSN personnel.

CONTRACTS

While DSN Boards are not required to obtain bids for audit services, DDSN believes that obtaining such bids is a good practice. DDSN, therefore, encourages DSN Boards to obtain bids for audit services. Additionally, in-charge auditor rotation, as well as, audit engagement team member rotation is highly recommended.

OUT-OF-STATE (CPA FIRM) REGISTRATION

CPAs and firms that operate out-of-state must comply with the requirements of the SC Board of Accountancy regarding “mobility” guidelines and/or out-of-state firm registration. Please contact the SC Board of Accountancy for more information. DDSN may verify with the SC Board of Accountancy that mobility guidelines and/or out-of-state firm registration requirements are being met.

CONFIRMATIONS - DDSN PAYMENTS

The independent auditor’s confirmation of DDSN payments made to a DSN Board is to be secured from DDSN’s Director of Finance. Requests for confirmations must be emailed to confirmations@ddsn.sc.gov. If electronic responses are desired, then please indicate such in the request along with the email address or other method of remitting the information. The auditor must reconcile DDSN payments per the confirmation with revenue per the DSN Board’s books. Questions concerning confirmations should be addressed to DDSN’s Accounting Manager at (803) 898-9682 or by email at confirmations@ddsn.sc.gov.

AMENDMENTS TO AUDIT POLICY

This document is subject to alteration or change as needed. Any changes will be made at the discretion of DDSN.

Barry D. Malphrus
Vice-Chairman

Stephanie M. Rawlinson
Chairman

To access the following attachments, please see the agency website page “Current Directives” at:
<https://DDSN.sc.gov/providers/DDSN-directives-standards-and-manuals/current-directives>

Attachment A: Sample - Financial Statements
Attachment B: Sample - Independent Accountant’s Report on Applying Agreed-Upon Procedures
Attachment C: Sample - Supplementary Room and Board Computation
Attachment D: Sample - Supplementary Schedule of Special Grants
Attachment E: Sample - Supplementary Schedule of Questioned Costs

Michelle G. Fry, J.D., Ph.D.

State Director

Janet Brock Priest

Associate State Director

Operations

Lori Manos

Associate State Director

Policy

Constance Holloway

General Counsel

Harley T. Davis, Ph.D.

Chief Administrative Officer

Nancy Rumbaugh

Interim Chief Financial Officer

Greg Meetze

Chief Information Officer



3440 Harden Street Extension
Columbia, South Carolina 29203

803/898-9600

Toll Free: 888/DSN-INFO

Home Page: www.ddsn.sc.gov

COMMISSION

Stephanie M. Rawlinson

Chairman

Barry D. Malphrus

Vice Chairman

Robin B. Blackwood

Secretary

Gary Kocher, M.D.

Eddie L. Miller

David L. Thomas

Michelle Woodhead

Reference Number: 275-04-DD

Title of Document: Procedures for Implementation of DDSN Audit Policy
for DSN Boards

Date of Issuance: May 11, 1988

Date of Last Revision: September 15, 2022

Effective Date: September 15, 2022

(REVISED)

Applicability: DSN Boards

GENERAL PROVISIONS

Disabilities and Special Needs (DSN) Boards and entities grandfathered in as DSN Boards that fall into one of the following categories must obtain an audit of financial statements and a report on applying agreed-upon procedures (RoAAP) in accordance with this policy.

1. Those that receive financial assistance (program contracts, grants, subgrants, etc.) from the South Carolina Department of Disabilities and Special Needs (DDSN) during the State fiscal year ended June 30.
2. Those that receive DDSN funds and makes a sub-grant to another organization with the funds, then the sub-grantee would also be considered a recipient of DDSN funds. The sub-grantee must obtain an audit in accordance with this directive if the amount received exceeds \$250,000 during the State fiscal year ended June 30.

The audit is to be performed in accordance with Generally Accepted Governmental Auditing Standards (GAGAS or “Yellow Book”) by an independent Certified Public Accountant (CPA). If the entity expended over the threshold set by OMB Uniform Guidance (currently \$750,000) in federal awards

during the fiscal year, then it must obtain an audit in accordance with the Uniform Administration Requirements, Cost Principles, and Audit Requirements for Federal Awards, under 2 C.F.R., Subtitle A, Chapter II, Part 200 (“Uniform Guidance”). Please note that Medicaid funds received are not considered federal awards.

DSN Boards are required to: (1) engage an independent CPA to complete the agreed-upon procedures outlined in this directive and (2) submit a report on their results of applying the agreed-upon procedures.

If a DSN Board is recognized as part of county government, then the county audit, if it meets the requirements of the DDSN audit policy, will be accepted and a separate audit of the DSN Board is not necessary; however, DDSN requires the DSN Board to submit a RoAAP prepared by an independent CPA.

AUDIT REPORT AND PROCEDURES

The following applies:

1. The financial statements must be prepared in conformity with generally accepted accounting principles (GAAP). Effective implementation dates for recently issued and adopted accounting pronouncements must be followed. Early implementation of any standard must be approved by DDSN in advance of adoption. Requests for consideration of early implementation must be submitted in writing to the DDSN Chief Financial Officer (CFO) by July 31 of the applicable year. A written response will be provided to the requestor within 30 days of receipt of the request.
2. The Management Discussion and Analysis (MD&A), if applicable, must be written by the DSN Board’s staff.
3. The financial information outlined in this directive for the DDSN funding year ended June 30 must be included in the audit report. Failure to do so will make the report unacceptable.
4. The auditor must express an opinion on whether the information in the supplementary schedules is fairly stated in all material respects in relation to the financial statements taken as a whole.
5. DDSN required supplementary financial information:
 - a) Schedules of Revenues and Expenses
 - i) These schedules must be presented on the full accrual, economic resources basis and not on the modified accrual, current financial resources basis.
 - ii) These schedules must be developed using the same line item detail as illustrated on Attachment A. Use of additional line items not shown in the attachment are not permitted without written approval from the DDSN CFO.
 - iii) Schedules must be prepared for the following, if applicable:
 - (1) General fund;
 - (2) Capitated programs (utilizing the capitated services contract);

- (3) Non-capitated programs (utilizing the non-capitated services contract);
- (4) Special grant programs (utilizing special grant contracts);
- (5) Intermediate cost centers; and
- (6) Other programs.

iv) The auditor must present the revenues and expenses separately by program. Expenses for residential programs must also be presented in detail for each residence within the program. Additionally, residential programs must be clearly distinguished as being HUD or non-HUD home(s).

b) Room and Board Computation

Utilizing DDSN Directive 250-09-DD: Calculation of Room and Board for Non-ICF/IID Programs and Attachment C, prepare a computation of room and board utilizing the final audited trial balance. The auditor is not required to provide any additional assurance related to the contents of specific trial balance accounts comprising the room and board computation.

c) Schedule of Special Grant Revenues and Expenses

Utilizing Attachment D, prepare a schedule of special grants for all special grant revenues received and/or expended during the fiscal year.

d) Reconciliation of audited financial statements to Medicaid Cost Reports and Cost Statements.

When the audited financial statements and the cost reports/cost statements are both presented on the full accrual basis, but the program costs for Medicaid funded programs per the audited financial statements (AFS) do not equal the AFS program costs per the cost reports, the auditor must provide a reconciliation to explain the differences between the two documents.

e) Audit Directive Compliance Statement

The DSN Board must give a copy of this audit policy to the auditor prior to the start of the audit to ensure that DDSN's audit requirements are met. The auditor must include a signed statement with the audit report stating that he/she has read and complied with the requirements of the policy. The statement must indicate the revision date of the audit policy that was followed.

f) Supplementary Schedule of Questioned Costs

In performing the audit, the auditor must consider whether expenses are reasonable and necessary for the program to which they are charged. Limitations on costs for awards are detailed in DDSN Directive 250-05-DD: Cost Principles for Grants and Contracts with Community DSN Boards. Individual negotiations and reviews will occur between the DSN Board and DDSN on all questioned costs pertaining to DDSN programs. Final

resolution, use of audit information, and applicability resides with DDSN. A schedule of questioned costs must be provided by the auditor. See Attachment E for an example schedule.

6. Combining or Consolidation Schedules

If the audit report includes blended component units or subsidiaries, then combining or consolidation schedules must be provided to support the basic financial statements. For Governmental Accounting Standards Board (GASB) presentations, combining schedules are only required for the Statement of Net Position and the Statement of Activities.

REPORT ON APPLYING AGREED-UPON PROCEDURES (RoAAP):

DSN Boards will need to contract with an independent CPA to apply RoAAP for the procedures listed below.

A sample template of the required report on applying RoAAP can be found in Attachment B. CPAs must follow this template. The template will be provided in Word format if requested.

The CPA must follow AU-C 530 “Audit Sampling” in its sampling selection process and determination of the population and sample sizes required. DDSN is prescriptive in selecting audit sampling but will closely scrutinize the results for reasonableness. Attachment B contains a new chart to tease out specific number of Medicaid bills tested to permit both aggregating RoAAP data statewide to assess risk and crystalize CPA’s level of effort in sampling.

The procedures below are required to be completed and the results reported on by the CPA.

1. Test the DSN Board’s Control and Procedures for Medicaid Billings

a) Background Information

People may receive services provided either by the Board or a third-party vendor under the Medicaid program. Services must be authorized by the case manager and documented in the consumer’s plan. The DSN Board or the third-party vendor receives payments for the Medicaid billable services rendered to the individuals from either DDSN or the SC Department of Health and Human Services (DHHS). Medicaid billable programs include, but are not limited to, all Residential Habilitation Programs, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), Community Residential Care Facilities (CRCF), Community Training Home-I (CTH-I), Community Training Home-II (CTH-II), Community Integrated Residential Services (CIRS), Supervised Living Model-I and II (SLP-I) and (SLP-II), Adult Day Programs, Supported Employment, Home and Community Based Waiver Services (enhanced board and direct billed services), Head and Spinal Cord Injury Services Waiver (enhanced board and direct billed services), Community Supports Waiver (enhanced board and direct billed services), Case Management, and Early Intervention. The auditor should reference DDSN Standards and chapter 10 of the Finance Manual located on DDSN’s website for guidance related to these services and DDSN’s billing and reporting procedures.

b) Procedures

- i) The CPA must gain an understanding of the Medicaid billing process and controls over Medicaid billable services (enhanced board and direct billed services). In order to gain an accurate understanding of this process, the CPA should consult with the program staff and supervisors as these employees are directly responsible for Medicaid compliance and should be familiar with how Medicaid is billed. The CPA must perform sufficient work to determine if the DSN Board's policies and procedures are adequate to provide reasonable assurance that Medicaid billable services are properly supported.
- ii) The CPA must select a representative sample from all persons from each Medicaid billable service area for which the DSN Board or a third-party vendor is receiving payments for Medicaid billable services through DDSN or DHHS. For the sample selected, the CPA must perform sufficient work to determine the following:
 - Tests determine that the supporting documentation provides reasonable assurance that billings are supported by complete and accurate information.

Gain an understanding of the monitorship (scan service notes, phone contacts with family members and/or employers, visits to family members' homes and/or persons' job sites, etc.) procedures established by the DSN Board to monitor each program. Test monitorship is being provided and documented by supervisory staff on a continual basis to provide reasonable assurance to the DSN Board that the billable services are being provided to the persons and/or families as indicated by the documentation on file.

2. The auditor must select a representative sample in each provider residential Habilitation programs (ICF/ID, CRCF, CTH-I, CTH-II, CIRS, SLP-I and SLP-II). Test the DSN Board's management of the persons' personal funds and personal property for compliance with DDSN Directive 200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs and 604-01-DD: Individual Clothing and Personal Property.

a) Background Information

CPAs should familiarize themselves with the following directives: DDSN Directives 200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs and 604-01-DD: Individual Clothing and Personal Property, outline regulations related to DSN Board management of personal funds and property. Procedures may vary by residential program and will also vary based on whether funds are retained in individual checking accounts, savings accounts, burial accounts, Achieving a Better Life Experience (ABLE) accounts, or collective accounts. Care must be taken to gain an understanding of the unique characteristics of each and to ensure procedures are developed accordingly. Additionally, CPAs must understand eligibility, regulations, and resource limits established by Medicaid. Eligibility will vary by coverage group.

b) Procedures

The CPA must perform sufficient work to determine if the DSN Board's policies and procedures are adequate to safeguard the persons' personal funds and property, as well as remain in compliance with DDSN Directives. The CPA must select a representative sample of accounts and transactions to ensure proper coverage.

- i) Determine that the persons' personal funds are not borrowed, loaned, or co-mingled by the DSN Board or another person or entity for any purpose; or, combined or co-mingled in any way with the DSN Board's operating funds.
- ii) Determine that the person's accounts are established in the person's name and social security number, and that they indicate that the accounts are for the benefit of the person (fiduciary relationship).
- iii) Determine that bank signature cards are updated timely for changes in personnel and that a copy of the signature card is maintained.
- iv) Determine that bank reconciliations are being performed and documented within 20 business days of receipt of the bank statements by a staff member who is not a co-signer on the account.
- v) Determine, through a representative sample of all purchases, that receipts are on hand to support purchases made from the persons' personal funds.
- vi) Determine that the amount paid for by the person is properly charged to their personal funds. Consider if amounts should have been paid by the Waiver program, from residential program funds, or if items/services purchased are proper.
- vii) For any item purchased that is required to be inventoried, verify that the persons' personal property record is properly updated. Procedures used by the Provider should be evaluated to ensure they are adequate to ensure the item is properly marked in accordance with the directive. Actual observation of the items is not required but may be deemed necessary by the CPA to test the procedures used by the Provider.
- viii) Determine if checks written to the person cause them to exceed their cash on hand limit. Gift cards are also considered cash and must be included in the cash on hand limit. Funds written payable to the person and cashed are considered cash on hand until expended and should be considered in conjunction with other cash held by the person or by program staff.
- ix) Determine that actual counts of the persons' cash held by residential staff, and agreement of the counts to the records, are completed monthly by someone who does not have authority to receive or disburse cash. The count and agreement to the records must be documented. The CPA is only expected to test the procedures used by the Provider.

- x) Evaluated the controls over cash to ensure that the provider has adequate controls to identify and safeguard cash held by the provider and cash held by the person.
- xi) Determine that the persons' total countable resources do not exceed the established limits mandated by Medicaid (generally: \$2,000).
- xii) Determine that the DSN Board has a process established to identify those with recurring excess resources and have established a plan to eliminate risk of loss of benefits – for example, participation in the ABLÉ program, participation in a special needs trust (individual or pooled), spend down of resources, establishment of burial savings accounts, and/or establishment of prepaid burial arrangements.
- xiii) For collective accounts, determine that the account is being managed in accordance with the Social Security Organizational Representative Payee guide found on the Social Security Administration's website at <https://www.ssa.gov/payee>.

If the CPA becomes aware of a misappropriation involving DSN Board or persons' funds and/or any falsification of Medicaid billable services, then the CPA must promptly report that information to the DSN Board Executive Director and Financial Director, with a follow-up to DDSN Internal Audit.

3. Determine if the DSN Board is paying ALL direct care staff the established minimum hourly wage in accordance with the DDSN contract.

a) Background Information

DDSN is appropriated funds from the State to establish a minimum pay rate for direct care staff. These funds are passed to DSN Boards through an increase in rates and contract amounts. Direct support professionals are defined as people that are in a regular shift rotation and are directly involved in the care of persons' in residential or day program settings. Supervisors, House Managers, and other similar positions would qualify if they met the criteria above. Job classifications vary by service provider and the same job classification at different service providers may or may not involve the same level of hands-on care. As a result, DDSN did not take a prescriptive approach. Each DSN Board will have the responsibility of determining which employees qualify based on their unique circumstances. The minimum pay rate for direct support professionals will be \$13 per hour. DSN Boards are permitted to pay new hires a rate less than \$13 for staff training hours and for any on the job training hours where the direct support professional (DSP) is not permitted to work alone. If a DSP employee is able to work alone and has been cleared to work alone by their Manager but due to staffing patterns does not work alone in the home, then they must be paid \$13 per hour. In no case should a new hire direct support professional make less than \$13 per hour for a period to exceed 90 calendar days.

b) Procedures

The CPA must determine that the DSN Board is paying **ALL** direct care staff the established minimum hourly wage in accordance with DDSN requirements, for all hours worked.

- i) The CPA must test the minimum pay rate used by the Provider. A variety of testing procedures may be used. One such procedure could be selecting two (2) pay periods to test proper application of the pay rate.
- ii) The CPA must test the timing of disbursements when a pay increase has been instituted which in the past has been the first pay date in July. Retroactivity of the pay rate is permitted, but the CPA must perform sufficient work to ensure it was completed properly. If there was a retroactive payment to the employee, then the CPA is only expected to verify that the process used appears to be completed correctly to ensure compliance.
- iii) If direct care staff are paid less than \$13 per hour, verification is required that they meet the requirements noted in 3a. If this requirement has not been met there must be a written exception approved by DDSN.

4. Determine that the DSN Board has adopted a Board of Director approved room and board policy. Also, test that the provider has properly and timely implemented the DDSN approved room and board rate, in accordance with their policy.

a) Background Information

DSN Boards are required to adopt a fee for services policy in accordance with DDSN Directive 250-09-DD: Calculation of Room and Board for Non-ICF/IID Programs. Additionally, they are to obtain DDSN approval at least annually on the room and board rates to be charged to persons' in residential programs.

b) Procedures

- i) The CPA must determine that the DSN Board has established a room and board policy for persons' fees that has been reviewed and approved by the Board of Directors.
- ii) The CPA must obtain the DDSN approved room and board rates utilized during the fiscal year.
- iii) The CPA must familiarize themselves with the policy and the approved rates.
- iv) Test actual charges made to persons to ensure that they comply with the policy and do not exceed the approved room and board rates.
- v) Test individuals' move-ins and move-outs and verify that room and board charges were properly applied. The CPA is testing the proper proration of the room and board charge.

5. Determine that the DSN Board has adopted a cost allocation plan and costs charged to intermediate cost centers are in accordance with DDSN Directives.

a) Background Information

All DSN Boards are required to submit cost allocation plans to DDSN. The cost allocation plan submitted by the DSN Board must be appropriate and comply with DDSN Directive 250-05-DD: Cost Principles for Grants and Contracts with Community Providers. DSN Boards are to ensure that costs are properly accumulated and allocated to final cost centers.

b) Procedures

- i) The CPA must determine if the cost allocation plan used was submitted and approved by DDSN.
- ii) The CPA must determine if the approved cost allocation plan is implemented as designed and note any material exceptions.

6. Determine if DSN Board complies with DDSN Directive 250-08-DD: Procurement Requirements for Local DSN Boards and Contracted Service Providers.

a) Background Information

DSN Boards are required to establish procurement policies and procedures in accordance with the requirements contained in DDSN Directive 250-08-DD: Procurement Requirements for Local DSN Boards and Contracted Service Providers. The policies and procedures can be more, but not less restrictive than the requirements in the Directive.

b) Procedures

- i) The CPA must determine that the DSN Board has established a procurement policy that has been reviewed and approved by the Board of Directors.
- ii) The CPA must perform tests to determine if the DSN Board's procurement policies and procedures are in compliance with the Directive.
- iii) When standards of conduct are included which require the members of the Board of Directors, Executive Director, President/CEO, finance staff, procurement staff, and staff directly reporting to the Executive Director/President/CEO to provide sign statements to disclose potential conflicts of interest and to acknowledge/prevent potential conflicts of interest, the CPA firm is required to ensure these statements have been provided and are on file.
- iv) A sample of purchase transactions must be selected to test compliance with the DSN Board's procurement policy.

7. The CPA must select a representative sample of financial transactions made by or on behalf of the Executive Director and top administrative staff (i.e., travel, credit cards, personal use of agency owned vehicles). Determine if transactions are proper and any tax reporting is properly reported.

AUDIT REPORT, COST REPORT, AND RoAAP DUE DATES AND EXTENSIONS

The audit report, separate letter to management (if issued), cost report, and RoAAP are to be filed with DDSN by September 30th of each year for fiscal year ending June 30th according to the Distribution section listed below. If this due date falls on a weekend, or any due date, then the due date is the next workday.

A request for an extension of time to file the audit, cost, and/or RoAAP reports must be submitted to DDSN Internal Audit by the DSN Board in writing on the DSN Board's letterhead stationery and signed by the Executive Director and must be approved by DDSN Internal Audit. The request for an extension must be received by DDSN Internal Audit at least 15 calendar days prior to the due date of the report. Such requests will only be approved in extreme circumstances that are beyond the control of the DSN Board or the Auditor or when approval would be to the benefit of DDSN.

If the audit, cost, and RoAAP reports are not received within five (5) business days of the due date, including approved extensions, then a financial sanction of \$100 per calendar day will be assessed on each report until each of the reports are received by DDSN or up to a maximum of \$2,500 per report has been assessed. The total amount of the financial sanction will be invoiced. If a DSN Board incurs a contract reduction in consecutive years for not meeting a reporting deadline subject to a financial sanction for the same report, then the financial sanction for the missed deadline(s) for the second year will be doubled.

AMENDMENTS TO AUDIT REPORTS

Where additional explanations or corrections are necessary after a report has been filed, supplements must be prepared by the audit firm for all copies and distributed as noted in "Distribution" below.

CORRECTIVE ACTION PLANS (CAP) AND EXTENSIONS

When the auditor's report, separate letter to management (if issued), or the RoAAP identify material weaknesses, any deficiencies, findings or questioned costs, then the DSN Board must submit a CAP to address and resolve the problem identified by the auditor/CPA, or submit a statement of reasons why no corrective action is necessary. The CAP must be prepared on DSN Board's letterhead stationery and signed by the Executive Director. The CAP must be submitted to DDSN Internal Audit within 20 business days after issuance of the audit report or RoAAP. If the CAP is not received within 20 business days of the issuance date, then a financial sanction of \$100 per calendar day for financials and/or RoAAP will be assessed until the CAP is received by DDSN or a maximum of \$2,500 per cap has been assessed. The total amount of the financial sanction will be invoiced. Any invoices not paid within 60 days will be subject to additional collection efforts including, but not limited to, deductions from future contract payments. Invoices not able to be resolved after such efforts will be reviewed by the State Director and/or the DDSN Commission for potential additional action. It is recommended that the CAP be submitted with or be included as part of the audit report and RoAAP when issued. The CAP must include the specific dates when deficiencies will be corrected. Copies of documents that clarify the resolution of deficiencies must be included with the CAP.

A request for an extension of time to file a CAP must be submitted to DDSN Internal Audit by the DSN Board in writing on the **DSN Board's letterhead stationery and signed by the Executive Director and must be approved by DDSN Internal Audit. The request for an extension must be filed at least 15 business days prior to the due date for the CAP.** Such requests will only be approved in extreme circumstances that are beyond the control of the DSN Board or its auditor, or when approval would be to the benefit of DDSN.

ADDRESSEE

The audit, cost, and RoAAP reports are to be addressed to the governing boards.

DISTRIBUTION

Copies of the audit, cost, and RoAAP reports, management letters, and internal control reports shall be filed as follows:

1. Executive Director of the DSN Board.
2. Chairperson of the DSN Board's governing board.
3. Hard copy of audit report and cost report to:

DDSN Director of Cost Analysis
3440 Harden Street Extension
Columbia, S.C. 29203

4. Electronic pdf copies of all reports are required to be sent to financial.reports@DDSN.sc.gov.

The audit firm must present the final audit report, any management letter comments, the RoAAP, and all deficiencies noted, at a scheduled meeting of the DSN Board's Board of Directors. If this is not done prior to the due date for submitting the documents to DDSN, the auditor must ensure that management is aware of the contents of the final report, management letter comments, the RoAAP, and deficiencies noted.

DISCLOSURE OF THREATS TO INDEPENDENCE

When the audit reports are filed with DDSN, DSN Boards must also submit a statement on letterhead stationery and signed by the Executive Director disclosing all identified threats to independence. The letter must outline the type and extent of all attestation, consulting, bookkeeping, and/or other services performed under contract or agreement with the audit firm. Examples that must be considered include: maintenance of the depreciation schedule, preparation of the financial statements, preparation of the SEFA (Schedule of Expenditures of Federal Awards), completion of the Federal Audit Clearinghouse Data Collection Form, preparation of the MD&A, preparation of income tax returns, preparation of Medicaid Cost Reports/Cost Statements, individual or aggregate material adjustments, payroll services, bookkeeping services, budget preparation, and software selection/implementation.

Reference must be made to the Government Auditing Standards 2018 Revision for those services that present threats to independence. The DSN Board is responsible for being aware of independence threats and ensuring they are addressed by the auditor to ensure they remain independent.

INSPECTION/ACCEPTANCE

Final inspection and acceptance of audit documents shall be the responsibility of DDSN Internal Audit.

AUDIT QUALITY

To verify that the responsibility of quality audits is accomplished, DDSN Internal Audit will work with other DDSN staff, as well as other state agencies, to:

1. Ensure that all audit reports of DSN Boards are received, reviewed, and distributed to appropriate DDSN officials.
2. Ensure that if significant inadequacies relating to the professional performance of the audit are discovered, the DSN Board will be advised and the auditor will be required to take corrective action. If corrective action is not taken, DDSN shall notify the DSN Board and other state agencies of the facts. Major inadequacies or repetitive substandard performance of auditors shall be referred to the appropriate professional bodies.
3. Ensure that satisfactory audit coverage is provided in a timely manner in accordance with DDSN audit requirements.
4. Maintain a follow-up system on audit findings and investigative matters.

The State Board of Accountancy may review all or a sample of DSN Board Audit Reports for compliance with professional standards.

Audit firms that receive a peer review report of other than pass must notify the DSN Board client and DDSN Internal Audit of the peer review results.

WORKING PAPERS

Working papers are to be retained by the audit firm for six (6) years following the end of the fiscal year being audited. Retention of working papers beyond six (6) years is required for audits of DSN Boards where questioned costs and/or practices have not been resolved with DDSN.

Working papers must be available, upon request, for examination by representatives of DDSN or its designee as well as successor auditors who may perform audits of the DSN Board. Availability of working papers must be provided at no additional cost to the representatives of DDSN or the successor auditor.

The auditor may be required to provide copies of any specific portions of working papers requested by DDSN personnel.

CONTRACTS

While DSN Boards are not required to obtain bids for audit services, DDSN believes that obtaining such bids is a good practice. DDSN, therefore, encourages DSN Boards to obtain bids for audit services. Additionally, in-charge auditor rotation, as well as, audit engagement team member rotation is highly recommended.

OUT-OF-STATE (CPA FIRM) REGISTRATION

CPAs and firms that operate out-of-state must comply with the requirements of the SC Board of Accountancy regarding “mobility” guidelines and/or out-of-state firm registration. Please contact the SC Board of Accountancy for more information. DDSN may verify with the SC Board of Accountancy that mobility guidelines and/or out-of-state firm registration requirements are being met.

CONFIRMATIONS - DDSN PAYMENTS

The independent auditor’s confirmation of DDSN payments made to a DSN Board is to be secured from DDSN’s Director of Finance. Requests for confirmations must be emailed to confirmations@ddsn.sc.gov. If electronic responses are desired, then please indicate such in the request along with the email address or other method of remitting the information. The auditor must reconcile DDSN payments per the confirmation with revenue per the DSN Board’s books. Questions concerning confirmations should be addressed to DDSN’s Accounting Manager at (803) 898-9682 or by email at confirmations@ddsn.sc.gov.

AMENDMENTS TO AUDIT POLICY

This document is subject to alteration or change as needed. Any changes will be made at the discretion of DDSN.

Barry D. Malphrus
Vice-Chairman

Stephanie M. Rawlinson
Chairman

To access the following attachments, please see the agency website page “Current Directives” at:
<https://DDSN.sc.gov/providers/DDSN-directives-standards-and-manuals/current-directives>

Attachment A: Sample - Financial Statements
Attachment B: Sample - Independent Accountant’s Report on Applying Agreed-Upon Procedures
Attachment C: Sample - Supplementary Room and Board Computation
Attachment D: Sample - Supplementary Schedule of Special Grants
Attachment E: Sample - Supplementary Schedule of Questioned Costs