Healthcare and Regulatory Subcommittee Meeting

Thursday, February 1, 2018

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AGENDA

South Carolina House of Representatives

Legislative Oversight Committee

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

Thursday, February 1, 2018
30 minutes after the House adjourns
Room 110 - Blatt Building

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

AGENDA

I. Approval of Minutes

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

III. Adjournment

MEETING MINUTES

Legislative Oversight Committee

South Carolina House of Representatives

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Columbia, South Carolina 29211
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Healthcare and Regulatory Subcommittee Meeting

Monday, November 30, 2017, at 10:00 am
Blatt Building Room 321

Archived Video Available

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

Attendance

I. The Healthcare and Regulatory Subcommittee is called to order by Chair Phyllis J. Henderson on Monday, November 30, 2017, in Room 321 of the Blatt Building. All members of the Subcommittee are present for all or a portion of the meeting, except Representative Bill Bowers.

Minutes

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

II. Representative Douglas moves to approve the meeting minutes from the November 6, 2017, meeting.

Representative Douglas moves to approve the meeting minutes from the November 6, 2017 meetings	Yea	Nay	Not Voting (Absent)	Not Voting (Present)
Rep. William K. Bowers	✓			
Rep. MaryGail Douglas	✓			
Rep. Henderson	✓			
Rep. Taylor			✓	

Meeting

I. Chair Henderson explains that this is the fifth meeting with the Department of Disabilities and Special Need (DDSN).

II. Chair Henderson explains that the purpose of today's meeting is to hear testimony from two of DDSN's partner agencies, Department of Health and Hunan Services and the Department of Vocational Rehab, and from a panel of executive directors of entities that provide services to DDSN clients.

III. Chair Henderson explains that all testimony given to this subcommittee, which is an investigating committee, must be under oath. She reminds those sworn in during prior meetings that they remain under oath. Chair Henderson swears in the following individuals:

a. Joshua Baker, Interim Director, South Carolina Department of Health and Human Services
b. Peter Liggett, Deputy Director, Long Term Care and Behavioral Health Services
c. Laura Spears, Transition Services Coordinator, Department of Vocational Rehab.
d. Mark Wade, Assistant Commissioner, Department of Vocational Rehab.
e. Margaret Alewine Director of Planning and Program Evaluation, Department of Vocational Rehab.
f. Gerald Bernard, Charles Lea Center
g. Ralph Courtney, Tri-Development Center
h. Susan John, Horry County Disabilities and Special Needs
i. Judy Johnson, Babcock Center
j. Mary Poole, MaxAbilities
k. Tyler Rex, Thrive Upstate
l. Thoyd Warren, Sumter County Disabilities and Special Needs

IV. Joshua Baker, Interim Director of the South Carolina Department of Health and Human Services, provides testimony about Medicaid in general and DDSN's provider payment system options.

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

a. Fee-for-Service & Coordinated Care

b. Waiver Services Billing
c. Band System Payments
d. Direct Billing

V. Laura Spears, Transition Services Coordinator, Mark Wade, Assistant Commissioner, and Margaret Alewine Director of Planning and Program Evaluation, from the Department of Vocational Rehab, provide testimony about the transition of DDSN-eligible youth out of school and into the workforce.

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

a. Sub-Minimum Wage
b. Youth Enrollment

V. Seven provider executive directors provide testimony about their relationship with the agency and their concerns. Executive directors presented in the following order:

a. Thoyd Warren, Sumter County Disabilities and Special Needs
b. Mary Poole, MaxAbilities
c. Ralph Courtney, Tri-Development Center
d. Gerald Bernard, Charles Lea Center
e. Susan John, Horry County Disabilities and Special Needs
f. Judy Johnson, Babcock Center
g. Tyler Rex, Thrive Upstate

Subcommittee members ask questions, which different provider executive directors answer. Topics questioned include:

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

STUDY TIMELINE

Study Update - Department of Disabilities and Special Needs

- March 2015 - Agency submits its **Annual Restructuring and Seven-Year Plan Report**, which is available online.
- January 11, 2016 - Agency submits its **2016 Annual Restructuring Report**, which is available online.
- January 10, 2017 - **Full committee votes to schedule the Department of Disabilities and Special Needs for study**. Video of the meeting is available online.
- February 9, 2017-March 13, 2017 - Committee solicits input from the public about the agency in the form of an **online public survey.** The results of the public survey are available online.
- March 2, 2017 - Committee holds **public input meeting** (Meeting #1) about Department of Archives and History; DDSN; and John de la Howe School. Video of the meeting is available online.
- May 1, 2017 - Agency submits its **Program Evaluation Report**, which is available online.
- September 18, 2017 - Subcommittee holds meeting #2 to discuss agency **history, governance, services, and customers**.
- October 10, 2017 - Subcommittee holds meeting #3 to discuss **agency finances and responses to questions** from September 18, 2017 meeting.
- October 24, 2017 - Subcommittee holds meeting #4 to continue to discuss **agency finances and responses to questions** from the September 18, 2017, and October 10, 2017 meetings.
- Novermber 6, 2017 - Subcommittee holds meeting #5 to discuss **human resources and responses to questions** from the October 24, 2017 meeting.
- November 30, 2017 - Subcommittee holds meeting #6 to receive testimony from the **Department of Health and Human Services, Vocational Rehabilitation Department, and directors of Disabilities and Special Needs Boards and other providers**.
- Ongoing - Public may submit written comments on the Oversight Committee's webpage on the General Assembly's website (www.scstatehouse.gov).

AGENCY OVERVIEW

Snapshot

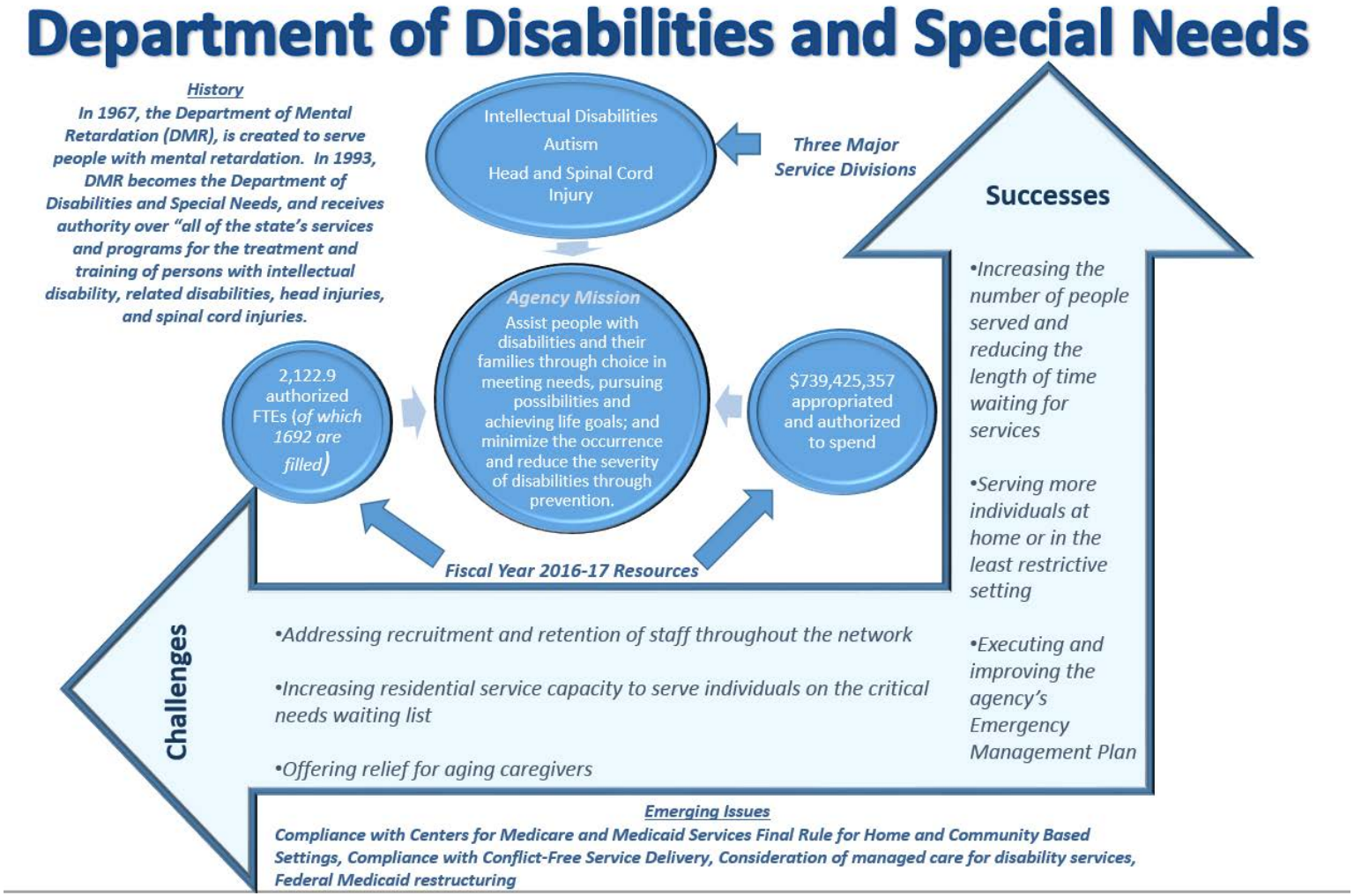
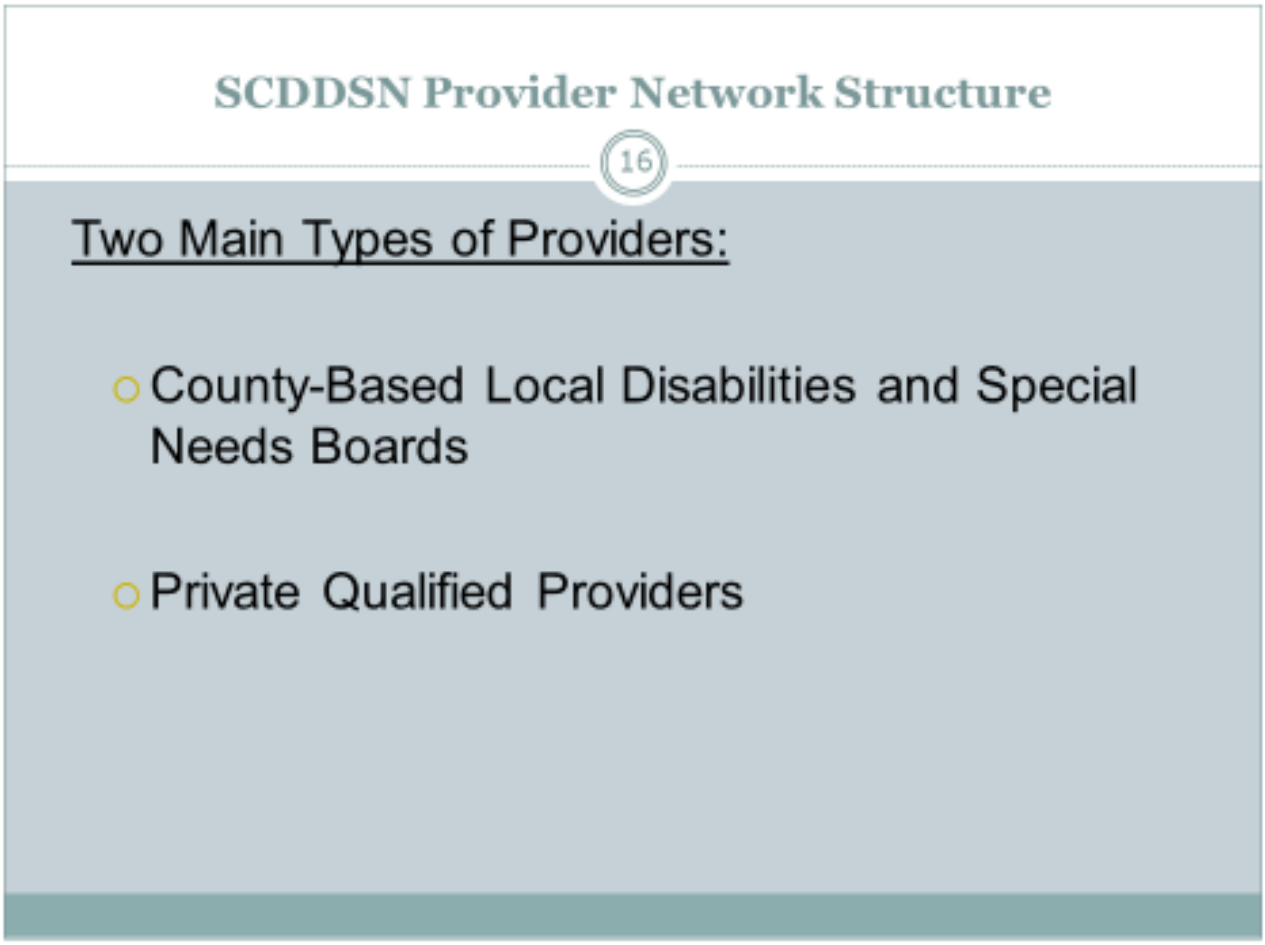


Figure 1. Snapshot of agency that includes its history, mission, resources, successes, challenges, and emerging issues. Source: Agency PER

PROVIDER PAYMENTS

During the Healthcare and Regulatory Subcommittee's September 18, 2017, and October 24, 2017, meetings, payment to providers was discussed. What follows are the related meeting packet and agency presentation sections.

DDSN Provider Network Structure[1]



[1] DDSN Agency Presentation, September 18, 2017 - Slides 16-26

SCDDSN Provider Network Structure

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Creation

County-Based Local Disabilities and Special Needs Boards

- Each is created by state statute and individual local county ordinance
- Most community DSN Boards have a Board of Directors (BOD) that is recommended by the local delegation and appointed by the Governor
- Some BOD are appointed by the County Council and one County Board is a part of the local county government
- Some County Boards serve the SCDDSN population in multiple counties

Private Qualified Providers

- Private Entity
- Contracted through State Procurement Request for Proposal process
- Provides additional choice of available providers to individuals and families

SCDDSN Provider Network Structure

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Public vs. Private

County-Based Local Disabilities and Special Needs Boards

- Public Entities
  - Combine the best aspects of public accountability with local control and pride of ownership
  - Must comply with FOIA and other aspect of local government

Private Qualified Providers

- Private Entities
  - For Profit
  - Not for Profit

SCDDSN Provider Network Structure

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Accountability

County-Based Local Disabilities and Special Needs Boards

- Accountable through public board appointments and through contracts, standards and state law with state level oversight provided by the Department of Disabilities and Special Needs
- Through contractual arrangements, quality assurance reviews, and licensing inspections to ensure quality and strict compliance with standards

Private Qualified Providers

- Accountable through contracts, standards, directives, and state law with state level oversight provided by the Department of Disabilities and Special Needs
- Through contractual arrangements, quality assurance reviews, and licensing inspections to ensure quality and strict compliance with standards

SCDDSN Provider Network Structure

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Employees

County-Based Local Disabilities and Special Needs Boards

- Employees are not considered state employees
- The State Director of DDSN does not have direct hiring authority over any of the local DSN Board employees or Board of Directors
- The County-Based DSN Boards are separate independent entities from the State Agency
- The County-Based Boards can participate in the State Retirement System and in State Insurance Plans

Private Qualified Providers

- Employees are not considered state employees
- The State Director of DDSN does not have direct hiring authority over any of the private provider employees
- The private providers are separate independent entities from the State Agency

SCDDSN Provider Network Structure

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Services

County-Based Local Disabilities and Special Needs Boards

- Provide case management, direct and indirect services and supports to individuals with disabilities

Private Qualified Providers

- Currently a private entity cannot provide both direct services and case management
- Entities must choose

SCDDSN Provider Network Structure

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State Service Area Coverage

County-Based Local Disabilities and Special Needs Boards

- Provide a fixed local point of initial and continuing contact that is well known to all people with disabilities and their families
- Ensure services are available to individuals and families across all 46 counties in South Carolina

Private Qualified Providers

- Determined by the individual provider
- Compliant with State Procurement policies and procedures

SCDDSN Provider Network Structure

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Funding and Payment from SCDDSN

County-Based Local Disabilities and Special Needs Boards

- Receive funds from the Disabilities and Special Needs agency in a prospective per person per month payment to provide or purchase services
- The per person per month payment is based on the services needed by the service recipient and is paid in a prospective band payment to the County Board

Private Qualified Providers

- Receive funds from the Disabilities and Special Needs agency in a retrospective payment after services are rendered
- The rate paid is equivalent to the payment rate for the DSN County Boards
- There is no cost settlement process for the retrospective payment
- Funds may be recouped if services are not provided in accordance with contractual requirements

SCDDSN Provider Network Structure

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Fiscal Agent

County-Based Local Disabilities and Special Needs Boards

- Serve as the fiscal agent for all service recipients that live in the family home in their county
  - Pays other providers for services rendered out of the per member, per month band payment
  - Funds up to a certain percentage not expended on services are returned to the Agency

Private Qualified Providers

- Receive funds from Department of Disabilities and Special Needs in a retrospective payment after services are rendered
- The rate paid is equivalent to the payment rate for the DSN County Boards
- There is no cost settlement process for the retrospective payment
- Funds may be recouped if services are not provided in accordance with contractual requirements

SCDDSN Provider Network Structure

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All DDSN Service Providers

- Contract with existing public and private organizations to provide services for people with disabilities
- Develop and support affiliated consumer and family organizations who monitor service quality and ensure appropriateness of services

SCDDSN Provider Network Structure

25

All DDSN Service Providers

- Contract with existing public and private organizations to provide services for people with disabilities
- Develop and support affiliated consumer and family organizations who monitor service quality and ensure appropriateness of services

Overview of DDSN Provider Funding[2]

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

Funding for Services (Directive 250-10-DD)

[2] Meeting Packet, October 10, 2017 - Pages 23-32

DDSN Funding Bands[3]

[3] Agency Presentation, October 24, 2017 - Slides 5-14 and attachment

DDSN Funding Bands – only applies to DSN Boards

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- The Band payment system for the local DSN Boards (Boards) originated in 1999.
- Individuals receiving services are assigned to a specific band payment based on their individual needs.
- This band payment is paid in advance of services delivers and equates to a per member per month payment.
- Cost settled at the end of the year.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- Band System Benefits:
  - All Boards are paid the same equitable rate.
  - Flexibility to move resources within operations to meet consumers' unique needs.
  - Improved financial stability through prospective payment coupled with fiscal discipline of finite bands.
  - Consumer flexibility though policies of residential and day program attendance.
  - Simplifies administration through DDSN's centralize administrative process of billing Medicaid.
    - DDSN bares responsibility for Medicaid ineligibles and audit risks from Federal Medicaid Audits.
  - DDSN is the "provider of record" for DDSN Medicaid services.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- Using historical cost and reporting statistics DDSN develops the average band payments.
- Band payments are lower than the Medicaid Fee for Service rates paid to DDSN from DHHS.
  - DDSN's overhead
  - Statewide system costs
  - System policies (i.e. 80 % residential and day program attendance)
  - Providers historical pattern of generating billable Medicaid service units

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- Ten band categories
- Three are for in-home services (Bands A, B, and I)
- Seven are for residential services (Bands C through H and R).
- Each band contains the average cost for consumers (much like a managed care capitated model).
- From these band payments Boards are expected to pay for all consumer needs.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- Boards function as the fiscal agent for individual consumers.
- This means that charges for some services that are directly billed to Medicaid by private providers will be taken out of the Board band payment.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Current Funding Bands

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		Funding Bands effective 7/1/17
Band A	State Funded Community Supports	14,607
Band B	At Home –IDRD Waiver	13,328
Band C	Supported Residential – SLP II	33,520
Band D	Supported Residential – SLP I	20,312
Band E	Supported Residential – CTH I	24,954
Band F	Supported Residential-Enhanced CTH I	38,870
Band G	Residential Low Needs	66,267
Band H	Residential High Needs	86,755
Band I	At Home – Community Supports Waiver	14,086
Band R	Residential Placement from Regional Centers	95,459

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- There is an expectation consumers' needs will vary within each band, but will "average out" for total actual costs paid.
- DDSN has an "outlier" process, which provides additional revenue to a band if the costs for a specific consumer are inordinately high based on the needs of that individual.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- After the end of the fiscal year, DDSN requires Boards to submit audited annual financial statements and cost data for services provided.
- DDSN performs test of each Board's annual financial statements to ensure 98 % of band funds (95 % for non-band funds) are expended.
- Proviso 36.15 allows the 98 % to be adjusted to 90%, if the department can validate that the certified public expenditures support the Medicaid allowable costs.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- If Medicaid cost reimbursements exceed Boards' and DDSN's associated costs, DDSN must repay DHHS the Medicaid reimbursed cost difference
  - Approximately 71 % of each dollar
- If Medicaid cost reimbursement fall short of Boards' and DDSN's associated costs, DDSN cannot seek additional funds from DHHS.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Funding Bands – only applies to DSN Boards

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- June 2017 DSN Commission authorized review of the band system for potential modifications or restructuring.
- Band system is in need of "rebasing" at a minimum.
- Boards functioning as the fiscal agent is becoming more administratively burdensome and potentially conflicts with CMS rules.

Overview of DDSN's Band Payment System available in today's notebooks.

DDSN Payment System Study[4]

[4] DDSN interim director Pat Maley executed a review of DDSN's provider payment system, finalized in November of 2017. His data sources included DDSN providers, DDSN employees, other state ID/DD officials, and national experts.

November 21, 2017

To: State Director Dr. Beverly Buscemi

From: Program Manager Pat Maley

Re: Background Data Collection Regarding DDSN's Current Provider Payment System Review

This project's background collection phase developed data from four areas: interviews of other states' ID/DD officials along with their state reports of major payment system changes; interviews with national subject matter experts (SME) hired by states for these major payment system changes; interviews and surveys of South Carolina providers; and analysis of the band system's "as is" state, to include DDSN employee interviews.

This memo will not make recommendations; it provides background data for a stakeholder group to start the formal process to address this critical issue for all involved. A key element in any successful major organizational change requires the support of those impacted by the change. The best way to get stakeholder support is embed them in the process, so all are fully aware of issues, options, constraints, and are part of the problem solving process. How DDSN and its stakeholders move forward to develop payment system changes to be accepted is as important as what changes we make.

To assist decision makers, I will also identify key facts/issues surfaced in this background phase to be considered as stakeholders start their evidence collection and deliberative process to develop a plan to improve the current provider payment system.

I. Other States & Subject Matter Experts Input from Similar Reviews

Input from other states and SMEs was consistent. Similar reviews from other states generally started due to a level of dissatisfaction with the state ID/DD agency's current payment system, often noting inadequate provider payments and complexity from the aggregate rules/policies compiled over many years. The main change driver, inadequate provider payments, can be addressed by a rate methodology review ranging from simple (cheap) to comprehensive (expensive). A simple rate update can be drawn from rates from surrounding or comparative states. A little more effort adds cost index adjustments or independent market conditions, such as data from the Bureau of Labor Statistics. These two types of rate methodology updates may not be applicable to South Carolina's situation, which has bundled service bands not rebased/revalidated in over a decade and broad provider dissatisfaction with various aspects of the band payment system.

States with system-wide dissatisfaction indicators looked for comprehensive solutions, which included improvements to policies; consumer needs (acuity) assessments; service array; and, ultimately, payment rate methodology often incorporating consumer acuity assessments. These comprehensive solutions sometimes impacted a state's current payment system model, most notably going from a single rate fee-for-service (FFS) with a cost settlement model to another FFS model with some differing rates based on acuity categories with no cost settlement. Some states have moved their ID/DD Medicaid consumers into a managed care organization (MCO), which has much broader implications than a change in payment systems. Yet, these states' MCOs, which received a capitated rate from the state, still provided a FFS rate to providers. Some SMEs offered more sophisticated actuarial based capitated payment model to providers; however, no state was identified during this background phase using any new model for providers other than FFS with no cost settlement.

The overarching principles of these comprehensive payment system reviews focused on fairness, simplicity, and understandability by governing bodies and consumers. Fairness had the dual benefit to identify an "independent" cost based payment rate schedule for providers, but consumers and the state also benefitted from clearer service

expectations with corresponding increased accountability, such as direct care & supervision staffing level requirements--a key ingredient in quality consumer care.

Every state initiating a comprehensive review hired a SME. SMEs provided expertise from prior similar projects; work products were readily accepted by CMS for waiver amendments; and generally accepted by providers as an honest broker establishing fair "independent" cost based payment rates. States' SME project cost ranged from $500,000 to over a $1,000,000. Projects' timelines included the following components: initial problem identification phase to determine if issues significant enough to warrant a comprehensive review using a SME; RFP develop, solicitation, and SME selection; SME work phase; and implementation phase. Project lengths ranged from 3-4 years prior to full implementation. South Carolina's situation likely will have more complexity if the current band payment system model is completely replaced by another payment model. Such a decision would include understanding the risks and estimated costs for another payment model, such as FFS, in terms of personnel, process, technology, and training.

SMEs' level of effort is a function of a state's current "as is" state. Even though the primary impetus for similar reviews may have been the real or perceived inadequate provider payments, these reviews inherently expand to also consider reflection on the state's current policies, service array, and needs (acuity) assessment process inasmuch as having consistency among these operational components improves overall effectiveness. For example, a SME suggested policy reconsiderations when conducting a rate review for such circumstances as high spending levels for waiver enrollees while simultaneously having years-long waiting lists; anticipate budget cuts and/or pressure for containing costs; weak needs assessment relationship between individuals' needs and the amount of supports received; increased demand for integration & self-direction; and payment approaches not differentiating between individuals' needs resulting in a 'one size fits all' approach.

SMEs' rigor in analyzing provider costs can build fair "independent" cost based payment rates. This same rigor also identifies improvement areas for the state agency to specify service requirements clearer to avoid paying for unneeded current service tasks or better target task requirements to improve service. A fair payment system prevents both unnecessary overpayments and corrosive underpayments eroding the long-term health of the service delivery system. Equally important, a fair payment system deploys business controls to prevent over-serving (i.e., need/acuity categories) and underserving consumers (i.e., staffing level standards). Such substantial business risk controls built into the provider payment system creates opportunities to consider reducing other existing state agency business controls. One SME persuasively described a comprehensive payment system approach as building a new transparent business partnership model between providers and the state, which both improves overall effectiveness and rebuilds trust often frayed from the system being replaced.

SMEs' emphasized a high level of engagement with providers to use their costs and identify comparative factors to arrive fair "independent" payment rates for the cost of services provided. SMEs emphasized drilling down to collect consumer direct cost data from providers through examining their general ledger accounts, rather than solely relying on providers' cost reports generated by a variety of accounting systems and overhead allocation methods. The emphasis on direct costs kept resources focused on consumers. Overhead rates developed by the SME were specifically itemized as percentages of direct care costs. These direct and overhead cost itemizations established provider expectations in using rate resources, which guided providers to restrain overhead expenses from encroaching upon rate dollars dedicated to direct care. This focus on direct and overhead aspects of rates was considered a critical provider accountability control to protect consumers from being underserved in residential and adult day settings.

New FFS rates were a combination of multiple needs (acuity) based rates for shared services (i.e., residential and day) and single service rates (i.e., transportation). It should be noted, a reliable needs (acuity) assessment process is required for this payment system. SMEs also can review for potential payment adjustment factors, such as higher urban area costs or the scale of provider operations. The rates and underlying assumptions are transparently published, which creates an efficient mechanism to modify in the future, such as for inflation or specific variables (i.e., transportation).

SMEs and states were careful to advise the community and stakeholders that new rates will not necessarily create new money for the service delivery system. Funded percentages less than 100% of the new rates were typical. Therefore, funding percentages of less than 100% were usually addressed prospectively through advocacy or through the state's annual budget process, or potentially adjustments to policies, service array, and waiting lists. With a variety of stakeholders not necessarily with the same perspectives, all must realize operating an ID/DD waiver delivery system is a "zero sum game" requiring tradeoffs between policies, services, rates, and number of consumers served, absent adding more appropriated resources.

States reported high satisfaction with SMEs; providers appeared satisfied with SMEs; and the process to arrive at final payment rates was perceived as fair. Most every state, but not all, realized higher rates than existing funding would permit, yet providers understood the state agency's current inability to fully raise all rates. Having a true cost rate created the foundation for the potential to obtain future appropriations and restored a sense of fairness and trust in the delivery system. Given new rates generally exceeded existing resources, SMEs' worked with states to develop an implementation plan to minimize the level of decrease in any provider's income to a tolerable change.

States reported challenges with the SMEs analyzing providers' cost data due to differing levels of provider sophistication in maintaining cost data; time to full implementation took a bit longer than expected; and the new payment process clarity on service provision/expectations increased the state agency's ability to hold providers accountable for actual service levels provided.

A review of five states surrounding South Carolina (North Carolina, Tennessee; Georgia; Florida; and Virginia) determined all use a "front-end" consumer needs assessment to establish an individual consumer budget or budget tier (upper limit cap), along with paying providers FFS (no cost settlement) including multiple acuity based rates for some services (i.e., residential and adult day). Even though two of these states use a Manage Care Organization (MCO) model, MCO payments to providers were still through FFS.

To illustrate how similar projects were conducted, five recent states' reports conducted by three different SMEs can be reviewed using the below Internet links:

- Georgia subject matter expert (Burns) PowerPoint overview
  (https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/ProposedRateModels_July%209%202015_OverviewHandout.pdf)
  Georgia's proposed rates after the review
  (https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/ProposedRateModels_July%209%202015.pdf)

- Virginia subject matter expert (Burns) PowerPoint overview (http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/my-life-my-community-waiver-redesign ; click on "My Life My Community Training Slides")
  Virginia's proposed rates after the review
  (http://www.dbhds.virginia.gov/library/developmental%20services/va%20dbhds%20ratemodels_final_rev1_2016_03-22.pdf)

- New Jersey subject matter expert (JVGA) final report
  (http://www.state.nj.us/humanservices/ddd/documents/Documents%20for%20Web/JVGA%20NJ%20Final%20Report.pdf)
  New Jersey's proposed rates after the review
  (http://www.nj.gov/humanservices/ddd/documents/ffs_rate_schedule_quick_reference_guide.pdf)

- Mississippi PowerPoint overview [slides 59-62]
  (https://www.eiseverywhere.com/file_uploads/e9649cbe7c681d8c47a4c3dc44a6684b_EstabliahingPersonalSupports.pdf)

- Wyoming subject matter expert (Navagant) final report & proposed rates
  (http://legisweb.state.wy.us/InterimCommittee/2015/10-0107APPENDIXK.PDF)

II. Provider Input

A. Interviews

Fifteen providers were interviewed (12 county Boards; 3 QPLs). The interviews emphasized open ended questions with appropriate follow-up to identify the strengths/weaknesses of the current DDSN provider payment system and areas to improve. Data collected is presented below in order of significance:

- Of the 15 providers interviewed, two fully endorsed bands citing the prospective payment, adequate funding, flexibility, streamlined Medicaid billing, and accepted the inherent fluctuations in actual band costs which, on averaged, even out over time. On the other end of the spectrum, three providers strongly preferred moving away from the bands toward direct FFS billing to SC DHHS to minimize DDSN's role in carving out partial rates for overhead, simplicity, and, to a lesser extent, minimize general DDSN oversight into providers' operations. Of these three, two reported the current bands provided sufficient overall funding, although some bands (i.e., ICF) needed upward adjustments, and one opined bands were substantially insufficient causing eroded service levels, particularly excessive direct care staffing shortages/turnover and delayed maintenance/capital projects. The majority of providers (10) were not extreme towards high satisfaction with the bands, nor urgent in moving to another unknown payment model, such as FFS. This group had a general appreciation for the prospective payments and other supportive policies of the band system, yet all in this group still had varying levels of dissatisfaction with aspects of the bands. Despite these varying levels of dissatisfaction, this group had a pragmatic, if not cautious approach, to the potential consequences of a new payment system. Concerns included a retrospective payment, capacity to bill Medicaid direct, liability risks with direct Medicaid billing, or impact on DDSN's current system's capacity building funding tools (30 day residential vacancies; 80% adult day & residential attendance; assume Medicaid ineligible risk; annual grants; and residential capital funding).

- The majority of providers cited frustration in discussing unique cost issues (i.e., transportation; unfunded cost of new administrative requirements; supported employment; unique consumer with unique needs) with DDSN, because these conversations can stall with DDSN responding the cost issue raised is "in the bands." Providers challenged this lack of transparency because they have not been provided the detail cost and utilization assumptions in the bands to verify the cost issue is actually "in the bands," as well as it has been over a decade since the bands have been rebased/revalidated. Many cited DDSN promised when the band system was originally rolled out, the bands would be rebased/revalidated on a frequent basis, which has not occurred. Even one of the two providers satisfied with the bands noted the bands are not itemized to understand the cost or assumptions underpinning the band rate, but this provider was satisfied because the total band payment was sufficiently healthy enough to meet consumers' needs.

- Several providers had deep seated trust issues with DDSN based on a long history of events, while the majority's trust issues appear associated with process issues, to include the lack of transparency in the band system; perceived inconsistent decisions within the band process; clarity in policy and responding to questions; and a perceived lack understanding of local community service delivery by DDSN central office. The trust issues were driven much more by process issues than issues with individual DDSN employees.

- The concept of the current band funding averaging out within a band or potentially between bands was viewed as flawed by the majority of providers because several specific band's payment revenue, most notably ICF residential beds (combination of bands G, H & R) and ID/RD at-home (band B), were perceived to be systemically less than the actual cost of services. The CS Waiver (Band I) was often cited as having a pattern of excess funds compared to actual costs. Placing the burden on providers to reduce funding/services from other bands to continually infuse funds into known underfunded bands was viewed as a flaw in the band

system; “robbing Peter to pay Paul” was cited several times by providers who had to recalibrate their internal budgets at the beginning of each fiscal year to account for this predictable imbalance in band funding.

- A sizable majority cited frustration with the perceived increasing problems associated with being the band financial manager for consumers’ purchasing services from third party providers, which appears to be increasing in frequency. These service purchases can occur unsystematically resulting in large fluctuations in monthly billings from third parties or waiver credits when providers bill SC DHHS direct. Providers’ description of these fluctuations’ impact on operations (i.e., budgeting, administrative costs, and cash flow) varied from significant to having no issue at all.

- Providers’ views on the band providing adequate level of funds to meet service needs ranged from nearing a financial crisis to being fully satisfied. Most providers asserted a level of inadequate funding impinging services, to include some describing only serving at a basic/minimal level; however, providers were hesitant to assert services were provided at an overall inadequate level. Given providers’ perceptions of some level of deficient band funding levels, providers were asked how they balance their annual budgets, which generated the following answers: delayed maintenance; delayed capital projects; and erosion of both direct and administrative service levels. At the end of FY 2014, the Boards had a collective cash balance of $8 million dollars equating to cash reserves of about a week for the system. At the end of FY 2015, these cash reserves escalated to $45 million, or seven weeks of cash reserves, due to a DDSN payback of a prior year(s) rate adjustment issue. These somewhat high cash balances convolutes understanding providers’ sense of being underfunded. When queried about these cash reserves, providers cited these funds as unrelated to their current annual situation due to their one-time payback nature and desire to maintain reserves to mitigate risk in future years given their experiences from the difficulties faced during the 2009-2011 recession years.

- Most every provider with an ICF asserted costs exceeded band payments (combination of G, H & R bands) every year. Many providers, but certainly not all, asserted Band B (ID/RD at-home) costs exceeded band payments in recent years. However, providers made a distinction that ICF excess costs were more a function of consumer need, while Band B excess costs were suspected of being both a function of consumer need and an inability to control over-serving some consumers.

- Some providers were frustrated with consumers’ annual needs based waiver budgets as exceeding actual needs, which leads to over-serving consumers. Technically, providers serving as the financial manager for a consumer’s band can deny a budget request. However, the historical experience with prior denial decisions being overturned by SC DHHS and DDSN have created an environment to just approve these perceived excessive budgets. Two providers made compelling cases to address this risk of excessive budgets by aggressively managing these annual budget requests through training and personal engagement with case managers to be more rigorous in justifying needs. Some providers felt at-home consumers/guardians sometimes were looking for the state to become entirely responsible for consumers rather than support within a consumer’s natural support environment. Fortunately, these perceived excessive budgets yielded actual costs that were less than the budget. Still, this is indicative of a level of an inflated nature of the annual needs based budgets, which creates a challenge for some providers budgeting given each approved annual budget creates an equal provider liability if the consumer fully utilizes the entire budget.

- A single rate band payment appears to impact providers differently, such as urban versus rural personnel costs; providers vary in health & retirement benefits offered; operational scale (small vs. large Boards); legacy financial management liabilities; and lack of standardized indirect overhead expectations/allocations. The single rate also seems to be, at least at the margin, influencing providers to avoid serving high need consumers.

- Case management rates were generally described as insufficient to cover many providers' case management costs.

- Providers generally described current band funding levels leading to some level of eroding services, but were hesitant to clearly assert band funding was inadequate to meet basic consumer needs. However, providers were certain current band funding levels were insufficient to meet additional costs required to be compliant with CMS HCBS final rule expectations.

- Providers appeared generally uncomfortable with their experience or base of knowledge to accurately predict staffing, technology, and cash flow impact if the current payment system changes from a prospective band payment to a retrospective FFS reimbursement.

- Many providers cited frustration with DDSN's lack of financial training, lack of financial manuals, problematic return of phone calls, and lack of clarity when responding to financial related questions. New provider financial managers had a high level of frustration and even experienced provider financial managers relayed difficulty in training new entry level financial personnel on the band system. Several providers noticed DDSN Central Office's financial staff has had turnover challenging its ability to keep the band system operating smoothly.

- Several of the providers positively viewed DDSN's payment system as protecting the statewide service delivery system by pragmatically creating a safety net for providers to smooth/mitigate financial risks (30 day residential vacancy; 80% adult day attendance; Medicaid billing; Medicaid audit risk; one-time grants; capital funding for residential housing). However, an approximately equal number negatively viewed DDSN's payment system as enabling and catering to assist poorly managed providers.

- Finite band funding could create some potential risks of incentivizing under-serving band consumers, particularly if a consumer may desire to purchase services from third party vendors. Through survey, band financial managers opined they generally operated in a conflict free manner (17 agree; 3 disagree; 5 neither/uncertain), while QPLs had a less positive view of Boards yet without a consensus (7 agree; 11 disagree; 9 neither/uncertain). This conflict of interest issue seems almost negated by the fact most Boards appear more than willing to jettison the band financial management function.

- The state funded at-home band (band A) was mildly commented on pertaining to being over-funded with some mild dissatisfaction why the excess band funds need to be returned when other bands were consistently underfunded. In general, the state funded nature of band A was understood.

B. Survey

Based on the qualitative data collected during interviews, a survey instrument was developed to quantitatively measure providers' input on key issues surfaced. The survey summarize the providers' spectrum of positions and intensity of key issues identified.

Boards (85% provider revenue) and QPLs (15% provider revenue) were surveyed on the same general topics, but each with a separate survey tailored to their separate payment systems of bands and FFS, respectively. Attachments A and B to this memo are the survey to Boards and QPLs, respectively (questions tabulated and all comments). Both surveys' electronic files can be located at: DDSN's Application Portal (https://app.ddsn.sc.gov/ddsnportal/ddsnlogin.jsp); after logging in, click Application Listings/Business Tools/Band Project Literature Search.

Three survey questions provide a high level insight into the Boards' views on bands and payment system change:

- For FY 2017, did your total annual prospective band payments provide adequate funding to meet the service needs of your consumers?

  37% Yes
  21% No--marginally inadequate
  19% No--moderately inadequate
  11% No--grossly inadequate
  12% Uncertain

- Describe your satisfaction with the current band system for providers.

  11% Very Satisfied
  15% Satisfied
  26% Marginally Satisfied
  3% Neither Satisfied/Dissatisfied or Uncertain
  19% Marginally Dissatisfied
  19% Dissatisfied
  7% Very Dissatisfied

- How would you characterize the level of change, if any, needed for the current band provider payment system to perform at an effective level?

  11% No change; currently operating effectively
  19% Minor change
  22% Moderate change
  22% Substantial change
  19% Total replacement with a new provider payment system
  7% Uncertain

These questions indicate providers, in general, have a wide variation on their assessment of the problems and satisfaction/dissatisfaction levels with the band payment system. During interviews and surveys, providers all had some issues with varying aspects of the band system and there was a general consensus on many of the issues (i.e., specific bands underfunded; reluctance to continue as band financial managers; transparency). However, providers did not weigh these problems and benefits of the band's benefits the same; this resulted in the wide variations on their overall views of the band system and the need for change.

Given the predominant payment system issue pertains to bands impacting Boards, the Board survey results directly address the band issue. Inasmuch as the 90 QPL providers surveyed spanned a wide variety of specialized services (i.e., case management, Early Interventionist, supported employment, residential services), many QPL providers did not have observations or experience with bands preventing responses. However, the two questions below asked to both Boards and QPLs provide insight into the satisfaction levels of providers using different payment systems:

- The band (FFS) system promotes a trusting business relationship between Boards (QPLs) and DDSN.

Scaled Response	Boards (Bands)		QPLs (FFS)	
Strongly Agree	7%	37%	7%	57%
Agree	30%		50%	
Neither Agree/Disagree or Uncertain	22%		31%	
Disagree	26%	41%	7%	12%
Strongly Disagree	15%		5%	
Total	**100%**		**100%**	

- Describe your satisfaction with DDSN's current band (FFS) provider payment system used by Boards (QPLs).

Scaled Response	Boards (Bands)		QPLs (FFS)	
Very Satisfied	11%	52%	3%	68%
Satisfied	15%		47%	
Marginally Satisfied	26%		18%	
Neither Satisfied/Dissatisfied; Uncertain	3%		5%	
Marginally Dissatisfied	19%	45%	11%	27%
Dissatisfied	19%		11%	
Very Dissatisfied	7%		5%	
Total	**100%**		**100%**	

In the section II-A, I provided my analysis of responses from 15 EDs (12 Boards; 3 QPLs), which covered the topics assessed in both surveys. The survey responses appeared consistent, in the main, with my interviews with a few mild differences. Rather than analyze the survey responses, it is best to let the survey responses "speak for themselves" and permit the reader to draw their independent conclusions from the data. The Board and QPL payment system surveys (tabulated scaled responses and verbatim comments) are contained in Attachments A (Board) and B (QPL).

III. DDSN's Provider Payment System "As Is" State

To understand the "band" methodology, the most recent DDSN fiscal year (FY) with a completed cost settlement with SC DHHS was selected for review, which was FY 12 (7/1/2011 - 6/30/2012). This section (pages 8-14) likely has too much detail for most readers, but it is presented to satisfy a sizable group of providers who have voiced frustrated of the lack of transparency in band funding. During FY 12, DDSN operated 10 programs totaling $471,763,171 in costs, which were:

Program	Costs
Regional ICF Centers	$99,694,737
Community ICFs	$46,982,992
ID/RD Waiver	$221,442,535
HASCI Waiver	$7,200,300
Community Supports Waiver	$16,855,125
Pervasive Developmental Disorder Waiver	$75,862
Service Coordination	$18,887,217
Early Intervention	$21,070,349
Greenwood Genetics Center	$9,729,000
100% State Funded Services	$25,825,053
Total	**$471,763,171**

Note: DDSN's 2.8% overhead (admin & program) included

Of the 10 DDSN programs, nine involved Medicaid matching funds requiring a cost settlement with SC DHHS. The cost settlement process with SC DHHS is a key element in understanding how DDSN sets rates with providers, as well as represents a major component in explaining the difference, sometimes sizable, between SC DHHS rates to DDSN and DDSN's corresponding rates to providers.

The ID/RD Waiver, representing 90% of all waiver dollars, was analyzed in detail. This analysis started with the SC DHHS rates to DDSN at the beginning of the FY and ending with a DDSN cost settlement with SC DHHS after the FY. Then, the residual eight programs with Medicaid cost settlement data (12 different cost settlements in total) will be incorporated to present the "big picture" of the complex funding streams running through DDSN. Also, comparing FY 12 band payment revenue to providers with their associated costs (ID/RD; CS Waiver; and ICF-Community) will help understand the net effect on the provider of the somewhat complex band payment system.

A. Analysis of the IR/RD Waiver Flow of Funds

1. FY 12 SC DHHS Waiver Service Rates to DDSN Compared to Corresponding DDSN Rates to Providers

The SC DHHS contracts with DDSN to administer the ID/RD waiver services. The FY 12 ID/RD Waiver contained 15 specific services with corresponding contractual service rates from SC DHHS to DDSN. DDSN then established corresponding provider payment rates, which were often lower, to account for DDSN's overhead (2.8%) and providers' historical pattern of generating billable Medicaid service units. These 15 service rates were:

Waiver Service	SC DHHS Rate to DDSN	DDSN Rate to Providers	% Difference	% of total Waiver Billing
Residential habilitation-by day	$161.99/day	Various	n/a	80.0%
Day activity services	$22.07/half day	$15.90/half day	(28.0%)	16.2% (Day Program)
Career preparation services	$22.07/half day	$15.90/half day	(28.0%)	
Community services	$22.07/half day	$15.90/half day	(28.0%)	
Employment services-group	$22.07/half day	$15.90/half day	(28.0%)	
Support center services	$22.07/half day	$15.90/half day	(28.0%)	
Respite care – hourly	$11.07/hour	$8.30/hour	(25%)	2.2%
Respite care – at ICF	$261.90/day	$270/day	3.0%	1.6% (all other)
Residential habilitation-by hour	$53.35/hour	$55.00/hour	2.7%	
Adult companion care	$10.26/hour	$10.26/hour	0%	
Environmental/vehicle modifications	Per claim	Per claim	0%	
Psychological services	$27.00/30 minutes	$27.00/30 minutes	0%	
Behavior support services	$27.00/30 minutes	$27.00/30 minutes	0%	
Adult attendant care	$11.69/hour	$11.10/hour	(5.0%)	
Employment services-individual	$77.60/hour	$48.78/hour	(37.1%)	

Despite receiving only one SC DHHS residential habilitation rate ($161.99/day), DDSN established 5 residential services to meet consumers varying needs, which were: high residential (Band H--$196.34/day); low residential (Band G--$141.71/day); supported residential/enhanced CTH I (Band F--$92.71/day); supported residential/CTH I (Band E--$55.50/day); and supported residential SLP II (Band C--$72.06/day). DDSN's calculations of these five provider rates ranged from $55.50/day to $196.34/day, which have no equivalent SC DHHS residential service rate. However, a weighted average of the five bands revenue, minus each band's adult day allocations, yielded $155.96/day weighted average and $158.29/day including outliers, which were 3.72% and 2.28% less, respectively, than SC DHHS's single $161.99/day rate to DDSN.

These "band" rates were developed at the inception of the band payment system in 1999 using historical cost data; since that time, changes appear to be incremental due to legislative appropriation increases, year-to-year internal cost data analysis, and DDSN judgment. There appears to have never been a cost analysis of a specific service mix, utilization estimates, or cost assumptions. As a result, each service "band" does not have a current documented itemization of the cost factors supporting the bundled rate.

2. DDSN FY 12 Band Rates

The FY 12 prospective band rates were:

Band Name	Description	At Home or Residential	Annual Band Amount	Daily Band Rate for Residential
Band A	Day Supports Only—primarily state $s	At Home	$8,269	n/a
Band B	At Home Waiver-ID/RD	At Home	$10,042	n/a
Band C	Supported Residential-SLP II	Residential	$26,305	$72.06
Band D	Supported Residential-SLP I	Residential	$16,136	n/a ($55.00/hour)
Band E	Supported Residential-CTH I	Residential	$20,259	$55.50
Band F	Supported Residential-Enhanced CTH I	Residential	$33,841	$92.71
Band G	Residential Low Needs	Residential	$51,725	$141.71
Band H	Residential High Needs	Residential	$71,666	$196.34
Band I	At Home-Community Supports Waiver	At Home	$9,960	n/a

*Band R did not exist in FY 12

3. Overview of the Flow of Funds in the Band Payment System

Each consumer approved for an ID/RD and CS waiver are assigned a prospective band payment. There are two "at home" bands (B & I) and six residential bands (C-H) [Note: Band A was primarily state dollars]. Each consumer establishes an annual waiver budget with their respective case manager based on needs. Consumers assigned to the same funding band will have annual waiver budgets that vary in estimated cost and actual utilization. A prospective band payment is designed to be the "average" cost to serve members of the band, so during an average year, higher budgets (costs) over the band payment average will be offset by lower budgets (costs) to arrive at total band revenue approximating total costs of consumers in the band.

Waiver "at home" consumers choose one of the 39 county disability Boards to be their "financial manager." Waiver "residential" consumers can choose the 39 county disability Boards to be their "financial manager," but also can choose from approximately five QPL residential providers with the same band amount. The only difference is Boards are paid prospectively and QPLs are paid retrospectively.

A Board receives a consumer's band payments paid bi-monthly (24/year) to serve all of a consumer's needs, much like actuarially based capitated funding model in managed care organizations. Boards provide many of the waiver services, so the financial manager tends to be the primary service provider to their consumers. Despite the lengthy menu of ID/RD services denoted above, two services, residential (80%) and day program (16.2%), generated 96.2% of total ID/RD billing costs in FY 12.

4. Compare Providers' Total Actual ID/RD Costs by Service to Corresponding DDSN Medicaid Billings

The best way to understand the band process is to "follow the money" using the most recent FY DDSN cost settlement with SC DHHS (FY 12). The ID/RD waiver was analyzed in detail below:

Analysis of FY 12 (7/1/2011-6/30/2012) ID/RD Waiver to Illustrate Cost Settlement Process with Emphasis on Understanding Impact of the Rate Differentials Between SC DHHS & DDSN

Description	Residential Services	Day Program	Hourly Respite	SLP I Supported Residential	Supported Employment	Assist Tech	Institution Respite	Companion Cost	Environ. Mods	Home Maker	Total	Admin Overhead - Central Office & Program *	Cost Settlement between DDSN & SCDHHS
Cost-provider books ***	$174,799,150	$37,612,667	$5,203,612	$1,827,452	$717,083	$238,818	$328,926	$471,437	$242,284	$1,105	$221,442,534	($6,463,237)	$214,979,297
DDSN Medicaid billings	$182,095,397	$36,858,494	$5,090,502	$2,231,934	$194,254	$159,285	$322,398	$373,788	$197,532	$0	$227,523,584		$227,523,584
cost difference	$7,296,247	($754,173)	($113,110)	$404,482	($522,829)	($79,533)	($6,528)	($97,649)	($44,752)	($1105)	$6,081,050		($12,544,287)
(% difference)	4.0%	(2.0%)	(2.2%)	18.1%	(73.0%)	(33.3%)	(2.0%)	(20.7%)	(18.5%)	n/a (%)	(2.6%)		(5.5%)
													x .7019
													$8,804,836
Comparision of SC DHHS Rates with DDSN Rates to Providers:											50% of $6,463,237 overhead		($3,231,618)
Description	Residential Services	Day Program	Hourly Respite	SLP I Supp. Res.	Supported Employment	Assist Tech	Institution Respite	Companion Cost	Environ. Mods	Home Maker	DDSN repays SC DHHS		$5,573,218
SC DHHS rate to DDSN	$161.99	$22.07	$11.07	$53.50	$77.60 indiv	none	$280.00	companion $10.26	none	$11.69 **			
DDSN rate to provider	$155.96; $158.29 (w/outlier)	$15.90	$8.30	$55.00	$48.78 indiv	none	$270.00	companion $10.26	none	$11.10			
% difference	3.72%; 2.28% (w/outlier)	28.0%	25.0%	2.70%	37.1%	n/a	3.6%	companion 0%	n/a	5.0%			

* $6,463,237 total overhead: $2,987,954 (45%) general admin & $3,475,283 (55%) program specific overhead; reduction to calculate due to 50% reimburse on overhead differs from 70.19% service rate

** closest waiver service to "home maker" appeared to be attendant service

*** Includes pro-rata share of $6,463,237 in program & general overhead allocated to each Medicaid waiver service

Using provider FY 12 cost reports, allowable Medicaid costs were aggregated into four separate DDSN cost reports based on the four DDSN regions (Midlands; Piedmont; Coastal; and Pee Dee). Each cost report established 10 Medicaid cost categories, which required combining costs from several similar services into one category (i.e., five different services associated with a Day Program). DDSN then allocated statewide direct costs (i.e., autism residential; self-directed care paid centrally by DDSN), statewide system indirect costs (i.e., USC training/SIS/intake), DDSN program specific administration, and DDSN general overhead (i.e., Central Office costs). The four regions' ID/RD cost data were then integrated into one DDSN-wide schedule to aggregate total ID/RD waiver Medicaid allowable costs of $221,442,534, to include DDSN overhead allocations [$6,463,237; 2.91% of waiver costs (1.61% program admin & 1.30% Central Office general admin)]. The $221,442,534 in total ID/RD Medicaid allowable waiver costs compared to DDSN Medicaid billings of $227,523,584 resulted in a difference of $6,081,050 (2.6%) [SEE green cell above] to be cost settled. The cost settlement calculation requires calculating the Medicaid match on DDSN overhead at a 50% rate and allowable service costs at a 70.19% rate leaving a DDSN payback to SC DHHS of $5,573,218.

From a provider perspective, this $6,081,050 Medicaid billings (2.6%) in excess of provider costs could be viewed as their rate dollars "left on the table." If DDSN gave providers a higher rate along with having the 29.81% state match available, providers could have used funds to increase consumer services and potentially generate more Medicaid allowable costs to exactly match billings. From a DDSN perspective, the 2.6% excess allowed it to repay SC DHHS with SC DHHS's own funds. If DDSN gave a higher rate to providers which did not generate sufficient Medicaid allowable costs, then DDSN would have to repay SC DHHS with unmatched state funds creating a significant financial risk to the agency. The "art" of setting the provider rate is to find that sweet spot of optimizing the providers' rate, yet hedge to ensure DDSN Medicaid billings are slightly greater than providers' generated Medicaid allowable costs. Regardless, the fact DDSN has to estimate these rate differentials to meet several financial objectives can manufacture suspicion between partners operating a service delivery system.

Three service categories had a substantial difference in SC DHHS rate compared to the DDSN rate to providers [SEE gold cells above]:

- DDSN's Day Program $15.90 rate to providers was 28% less than SC DHHS's $22.07 rate to DDSN. Yet, with only a $15.90 reimbursement rate, the providers' were still able to generate costs 2% higher ($37,612,667) than the corresponding Medicaid billings ($36,858,494) calculated at the higher rate of $22.07 per provider service unit. A major factor in this difference pertains to providers being paid $15.90 for every day a consumer is registered

full-time, yet a consumer only has to attend a minimum of 80%. In short, providers are paid $15.90/day rate for days consumers don't attend up to a 20% vacancy rate, while DDSN can only bill Medicaid for days consumer actually attends at the $22.07 higher rate. Further, DDSN allows providers to count "non-Medicaid" consumers attending the Day Program for free, which also counts towards its 80% minimum attendance, yet DDSN cannot bill Medicaid for these days either. It also appears the DDSN rate to providers for FY 12 may have been just too low and additional costs in Adult Day came from other band revenue.

- Two other service rates appear to have a disproportionate higher SC DHHS rate than DDSN's corresponding rate to providers:

    - SC DHHS's hourly respite rate of $11.07 was 25% higher than DDSN's $8.30 rate to providers. Yet, with only an $8.30 reimbursement rate, the providers' were still able to generate costs 2% higher ($5,203,667) than the corresponding Medicaid billings ($5,090,502) calculated at the higher rate of $11.07 per provider service unit.

    - SC DHHS's hourly supported employment rate of $77.60 was 37.1% higher than DDSN's $48.78 rate to providers. However, this lower $48.78 reimbursement rate generated Medicaid allowable costs of $717,083, yet these costs only generated Medicaid service billable units at a $77.60 rate of $194,254 in Medicaid billings.

  These unusual variances could be the result of a number of situations, such as the DDSN rate too low requiring a provider to pull resources from other bands; high provider overhead allocated to these service costs; providers are not efficiently using its costs to correlate with generating Medicaid billable services; or providers are not reporting billable Medicaid service units.

Regardless for the reasons for the initial wide gap between SC DHHS and DDSN rates and narrow/unusual variances in individual service cost settlements, the ID/RD as a whole generated Medicaid billings 2.6% above providers' Medicaid allowable costs. Medicaid allowable costs certainly included DDSN ID/RD program and general overhead of 2.91% and there were DDSN system-wide direct costs (i.e., self-directed care and Autism residential direct service) and in-direct costs (i.e., USC training/intake/SIS) estimated at 6%.

B. Analysis of Board Band Payments Compared to Associated Medicaid Eligible Costs

Analyzing how the various services within the ID/RD waiver were cost settled (positive or negative) is an indicator if band payments were insufficient or yielded a surplus on each service. However, the best way to understand how band payments impacted Boards is by reconciling band payment revenues with associated Medicaid costs to see if band revenue was less than or exceeded providers' reported Medicaid costs.

Board band payments are used for Boards' costs in the ID/RD waiver, CS waiver, and Community ICFs (non-waiver), which equates to 60% of annual DDSN expenditures. Inasmuch as QPL residential and day providers' costs are co-mingled with Boards in DDSN's cost settlement process with SC DHHS, the QPLs revenue must also be added to the Board band revenue for an accurate comparison of revenue and costs for ID/RD, CSW, and Community ICFs. It should be noted QPLs operate on a FFS basis where DDSN payments to QPLs are immediately considered an allowable Medicaid cost at the same rate. So any difference between QPL/Board revenues and their associated costs directly has to do with the difference between Board band revenues and associated Medicaid allowable expenses aggregated from 39 Boards cost reports. The below table compares QPL & Board band revenue for ID/RD waiver, CS waiver, and Community ICFs with associated Medicaid allowable costs:

Compare QPL Provider & Board Band Revenue in Medicaid Programs (ID/RD, CSW, ICF-Comm; No State) with Associated Medicaid Allowable Costs				
Revenue/Cost Categories	QPL Residential & Board Band **REVENUE** in ID/RD, CSW & ICF-Comm (No State)	QPL Residential & Board Medicaid Eligible **COSTS** in ID/RD, CSW & ICF-Comm (No State)	$ difference	% difference
All Residential	$176,746,557 (Bands $150,034,609; QPL $26,711,948)	$170,983,645	$5,762,912	3.26%
ICF-Community	$43,341,256	$44,014,691	-$2,505,415	-5.69%
ICF-Comm Bed Fees	-$1,831,980			
subtotal	$218,255,833	$214,998,336	$3,257,497	1.49%
Band B-in home (w/o Day)	$15,279,534	$6,752,688	$8,526,846	55.80%
Band I-CSW (w/o Day)*	$4,819,426	$1,239,931	$3,579,495	74.28%
subtotal	$20,098,960	$7,992,619	$12,106,341	60.23%
Adult Day Program	$45,381,954	$52,076,559	-$6,694,605	-12.85%
Supported Employment	$242,434		$242,434	n/a
One-Time Contracts	$281,803		$281,803	n/a
Total	$284,260,984	$275,067,514	$9,193,470	3.23%

QPL/Board band revenue totaled $284,260,984 with $275,067,514 in associated Medicaid allowable costs, resulting in a difference of $9,193,470 (3.23%) [SEE yellow cells above]. This $9,193,470 (3.23%) difference is the net result of differences in primarily five revenue/cost categories: $5,762,912 ID/RD Residential; -$2,505,415 Community ICFs; $8,526,846 Band B ID/RD In-Home without Adult Day; $3,579,495 Band I CSW In-Home without Adult Day; and -$6,694,605 Adult Day (ID/RD & CSW) [SEE orange cells above]. In short, DDSN band payments exceeded Boards' associated Medicaid allowable expenses by $9,193,470, from which Boards used to pay for $2,012,773 Medicaid ineligible residential consumers, leaving a net of $7,180,697.

The level of effort and the risk of calculation errors in the above analysis should give pause to any organization considering such a model; it certainly makes me nervous that even an objective analytical effort to calculate may miss relevant data. Then, why does DDSN do this complex math? It solved the previous payment system's problems.

The bands originated in 1999. The prior payment system was a fee-for-service (FFS) model with individual rates for each provider and each community residence, which were all annually cost settled. The prior system problems included provider cost overruns, perceived inequity, and administrative burden caused by individual rates and individual residential cost settlements. The band system was designed to have all Boards be paid the same equitable rate; Board flexibility to move resources within operations to meet consumers' unique needs; improve financial stability through prospective payments coupled with the fiscal discipline to operate within its fixed pooled band payments; consumer flexibility through liberal policies of residential and day program attendance; and simplify administration through DDSN's centralized administrative process of billing Medicaid, to include responsibility for Medicaid ineligibles and audit risks from Federal Medicaid audits.

These band system benefits are still valued today by Board providers as evidence by a Board survey question assessing these benefits as follows:

Band Benefit Description	Not Beneficial	Beneficial	Very Beneficial	Uncertain
30 day residential vacancy payment	23.08%	46.15%	30.77%	0.00%
80% residential attendance allowance	3.85%	69.23%	26.92%	0.00%
80% day service attendance allowance	4.00%	52.00%	32.00%	12.00%
One-time grants	3.85%	30.77%	57.69%	7.69%
Capital for new residences	7.69%	30.77%	50.00%	11.54%
Prospective payments	7.69%	26.92%	57.69%	7.69%
DDSN bills Medicaid on behalf of providers	23.08%	26.92%	38.46%	11.54%
DDSN assumes Medicaid audit financial risk	7.69%	38.46%	38.46%	15.38%
DDSN assumes Medicaid ineligibles	0.00%	42.31%	38.46%	19.23%
Average	**9.00%**	**40.39%**	**41.16%**	**9.45%**

It should be noted band payments in excess of associated Medicaid costs and one-time capital allocations are Medicaid unmatched, which is a fiscal weakness. Band payments have inherent Medicaid allowable cost slippage/error risk in the complex cost recapture cost settlement process of 39 Boards' individual cost reports, which never occur in a FFS model where Medicaid provider payments are immediately 100% recognized as Medicaid allowable costs without using cost settlements.

C. Cost Settling DDSN's Medicaid Programs with SC DHHS

Section I-A-4 above cost settled the ID/RD waiver, which is only one of 12 Medicaid cost settlements with SC DHHS. The details of all 12 cost settlements is contained in the below table:

Description	ID/RD Waiver	ICF-Community	ICF-Regional Centers	Community Supports Waiver	HASCI Waiver	PDD Waiver	Service Coordination (Case Management)	Early Intervention	Greenwood Genetics Metabolic	Greenwood Genetics NTD & Metabolic Admin	Greenwood Genetics Service Coordination	Rehabilitate Support Services	Total	Medicaid Reimbursed Home Office Costs	DDSN payback to SC DHHS
Allowable Medicaid service costs	$214,979,297	$46,804,414	$98,412,857	$16,322,323	$6,990,144	$890,390	$17,248,658	$15,053,790	$2,037,554	$2,457,894	$1,834,570	$547,847	$423,579,738		
DDSN Medicaid billing revenue	$227,523,584	$50,591,205	$87,066,638	$16,821,344	$4,967,093	$763,470	$20,683,754	$15,652,243	$2,064,536	$2,378,600	$1,237,707	$408,172	$430,158,346		
cost difference	($12,544,287)	($3,786,791)	$11,346,219	($499,021)	$2,023,051	$126,920	($3,435,096)	($598,453)	($26,982)	$79,294	$596,863	$139,675	($6,718,283)		
% difference	5.5.%	7.5%	11.5%	3.0%	29.0%	14.3%	16.6%	3.8%	1.3%	3.2%	32.5%	25.5%	1.5%		
Mediciad reimbursement rate	x .7019	x .7019	x .7019	x .7019	x .7019	x .7019	x .7019	x .7019	x .7019	x .50	x .7019	x .7019	(differing rates;n/a		
Medicaid payback or due from Med.	-$8,804,835	($2,657,948)	$7,963,911	($350,262)	$1,419,979	$89,085	($2,411,093)	($420,054)	($18,938)	$39,647	$418,937	$98,037	($4,633,534)	$3,583,778	($1,049,756)

The 12 Medicaid cost settlements had $423,579,738 in allowable Medicaid costs from providers, to include DDSN system-wide and overhead costs. These costs generated billable services to Medicaid totaling $430,158,346, yielding a difference of $6,718,283 (1.5%). This difference represented net Medicaid reimbursements in excess of associated allowable Medicaid costs, which then triggered a repayment by DDSN to SC DHHS. Only Medicaid's reimbursed portion of the $6,718,283 had to be repaid, which was $4,633,534. This repayment was offset by Medicaid's reimbursement due to DDSN for its administrative overhead of $3,583,778, leaving a net payable to SC DHHS of $1,049,756. It should be noted that of DDSN's 12 Medicaid cost settlements; six had costs in excess of Medicaid billable services and six had Medicaid billable services in excess of costs.

IV. Other Key Factors

A. Medicaid Requirement of Direct Payment to Providers

DDSN has used the band system since 1999 to fund a "per person, per month" capitated fee model to Boards. This system is considered an "alternate payment methodology" designed to improve the service delivery system. This may be efficient and effective, but DDSN's intermediary role as an Organized Health Care Delivery System (OHCDS) does not negate the state from making provisions for direct payment of claims by providers who choose not to use this alternative payment methodology. Currently, DDSN Boards and QPL providers do not have access to bill or receive Medicaid reimbursements directly. Further, providers using an alternative payment methodology must do so voluntarily; the State cannot mandate a provider reassign its rights to receive its Medicaid payment directly (42 CFR §447.10).

The first step to address this Medicaid issue is establishing an administrative contract between SC DHHS and DDSN to separate its overhead and statewide delivery system costs from provider service rates, which is nearing completion. After implementation, the separated SC DHHS service rates would be available to providers without adjustment by DDSN inasmuch as DDSN would be able to fund its mission through the SC DHHS administrative contract. This will then permit providers to direct bill SC DHHS or voluntarily use an alternative payment methodology, such as DDSN's band payment system. However, SC DHHS's current Medicaid Management Information System (MMIS) does not have the capabilities or development resources to accommodate DDSN providers to bill directly for ID/DD Medicaid services at the current time.

B. SC DHHS's New Medicaid Management Information System (MMIS)

SC DHHS estimates in the next 3-5 years it will have the MMIS capabilities to effectively accommodate DDSN providers to bill direct. As a result, DDSN should factor any current payment system change decision to be postured, to include possibly being mandated, to obtain the cost and effectiveness benefits from SC DHHS's new MMIS in 3-5 years. The MMIS should allow DDSN to better leverage other statewide Medicaid data sets and applications, as well as enhances SC DHHS's capabilities to manage and monitor the statewide use of all Medicaid resources and consumers.

C. DDSN's Capabilities to Process a FFS Payment Model

This project's background phase did not conduct a feasibility study of DDSN's financial and technological capabilities to support a FFS payment model prior to SC DHHS delivering its new MMIS to address this need. However, given the aforementioned Medicaid requirement and the SC DHHS administrative contract with DDSN in motion, the background phase data suggested DDSN potentially could convert to a FFS model as an interim step prior to SC DHHS new MMIS. DDSN already processes FFS for QPLs and its current residential and day data system used to bill Medicaid services (90+% of provider dollars) could be easily converted to a FFS bundled rate. The challenge would be eliminating 39 Boards' band financial management role and re-direct those transactions to a central DDSN processing function. Interviews at DDSN assessed this option as feasible. The administrative cost savings from 39 Boards currently handling this function almost certainly would be more than enough resources to offset any additional DDSN costs.

V. Way Forward

A key element in any successful major organizational change requires the support of those impacted by the change. From a DDSN financial personnel perspective, they recognize the statewide stability benefits of the band system, but can also appreciate the simplicity of a FFS model. However, let there be no misunderstanding to the provider community, there is no DDSN resistance in changing the band payment system, in whole or part. Quite frankly, the vast majority of DDSN financial personnel are tired of the friction with providers over both the legitimate and perceived issues in the band system. From a provider perspective, Boards identified a pattern of problem areas within the current band system needing improvement, but the majority were cautious to leave the band system for an unknown new payment model, most likely FFS. The good news is two key stakeholders have a forward leaning "readiness" posture for some change. The challenge is how to go about making positive change in an evidence based manner where all stakeholders are fully aware of issues, options, and are part of the problem solving process, so whatever change occurs will be accepted. How we all move forward for change to be accepted is as important as what changes we make.

To assist the decision makers with their evidenced based process, rather than over-relying on their individual preferences, key issues identified in the background phase will be itemized for future decision makers to start their deliberative process and stimulate future data collection efforts. The ultimate way forward will be how decision makers weigh these issues, as well as refine and add/subtract to them, which all lead to generating a strategy and tactical plans to improve. These issues are:

- The band amounts have been established and adjusted over the years through analysis of historical provider costs, incremental adjustments from specific appropriations, and DDSN judgments based on experience. The band amounts have not been verified as actuarially sound or calibrated through a bottom up cost study to arrive at an evidenced based band needed to meet consumers' needs. However, despite the lack of precision in establishing the band funding, there is data to suggest the total band funding is not far off from the current consumer populations' total needs.

- The current payment bands are perceived by many providers as not balanced; providers know at the beginning of a FY that some specific bands generate excess revenue while others require revenue from other bands to address consumers' needs. This is not consistent with the band model where each band, on its own, should fund, on average, the costs of consumers in that specific band. These systemic imbalanced bands breeds dissatisfaction and manufactures unnecessary trust issues.

- Boards funded with bands surveyed were asked if their total band payments met the "needs of their consumers." Those responding covered a wide spectrum of "yes" (35%); "marginally inadequate" (23%); "substantially inadequate" (19%); "grossly inadequate" (11%); and "uncertain" (12%). Each respondent certainly relied on their experience which generated a wide variation in responses, but what standard should we use to make this determination? An ID/DD industry best practice uses the ratio of direct care expenses in relation to overhead (indirect program and general overhead). The current band system allows each provider to independently decide on its overhead percentages, so it is difficult to discern if operational losses are from insufficient DDSN bands or degrees of mismanagement unnecessarily absorbing direct care resources into overhead. Given the challenges of outcome measures to finely discern level of provider performance, a focus on the industry generally accepted standard most correlating with consumer needs, direct care expenditures compared to overhead, should be considered.

- The DDSN payment system does not use a best practice of first evaluating consumers' needs through standard, objective, and preferably independent evaluation process to establish consumer budget ranges. This establishes equitable and rationale cost controls based on needs, yet provides consumers flexibility in designing service plans to meet their individual needs. DDSN currently relies on consumer case managers developing an initial budget with weak standard protocols, followed by DDSN's new centralized process of approving proposed case manager budgets. The absence of this "front end" best practice undermines developing a payment system which includes a range of rates for shared services based on consumer acuity to increase providers' willingness to serve higher needs consumers. Additionally, a front end evaluation process lessens the volume of outlier requests throughout the system, which can generate unnecessary friction in the system. There is evidence DDSN's current single rate for shared services, at least at the margins, has caused providers to avoid serving higher need consumers.

- The band systems' use of Boards as band financial managers is increasingly causing both frustration with Boards and creating unhealthy financial accountability dynamics. Boards are financially responsible for consumers with fixed funded bands, yet lack the authority to reign in perceived unnecessary high consumer budgets or paying third party providers for services of questionable value. DDSN's new central budget review/approval process sets consumers' budgets, yet Boards assume the financial risk of over-utilization without an actuarially sound fixed funding band. This dynamic appears certain to have worsen as historical excessive revenue "cushion" in the in-home bands shrinks (i.e., band Bs) and the increasing frequency of third party providers serving band consumers increases. This issue almost negates the Board conflict of interest risk issue serving as a band financial manager, because it appears most Boards seem willing to jettison this band financial management function.

- Boards serving as financial managers over fixed band resources creates a cost containment dynamic, which would not be present if this band financial management role was eliminated.

- The band payment system is based on participants' trust that band revenue in total will be sufficient to meet consumers' needs. Currently, a majority of providers have a level of distrust in this assumption. It is creating a hyper-sensitive environment where both system-wide policy decisions and any real or perceived inequitable band impact on a provider's operation is highly scrutinized without necessarily factoring in other operational areas bands positively impact operations.

- Compliance with Medicaid's requirement for an Organized Health Care Delivery System to also permit providers to direct bill should be a major factor in any changes to the current payment system. Further, any changes should posture DDSN to be able to obtain cost and effectiveness benefits from SC DHHS's new MMIS in 3-5 years. It should also be noted that the FFS model still offers many opportunities to customize provider payments to account for current system policies to meet consumers' needs in South Carolina (residential/day attendance rate; vacancy allowance; provider size/metropolitan costs adjustments; capital rate components; bundled rates versus bands; and other variables in rate setting to fit the needs of South Carolina).

- The current band benefits of prospective payments and DDSN Medicaid administrative billing services are most at risk if bands are completely replaced by FFS; other band benefits can be integrated into FFS rates.

- Given DDSN's existing financial capabilities in bands and FFS, DDSN may have the **potential** capabilities to process a FFS model as an interim step to SC DHHS's MMIS, as well as potentially even a long-term niche service to providers in need if economically feasible. It is important to understand the cash flow risk when shifting from a prospective payment to a retrospective payment is twofold. First, the turn-around time from billing to receiving reimbursement; second, the risk of an error (i.e., automated computer edit) "hanging up" the reimbursement payment for an extended period to work out. DDSN's mitigation of the first risk is illustrated by its processing FFS for QPLs, where it pays within a week and QPLs appear quite satisfied. The second risk is completely mitigated by DDSN because it "owns" the administrative risk of submitting Medicaid billing.

- Under the current conditions where DDSN's financial intermediary role requires providing different rates to providers, DDSN must continue its annual labor intensive cost settlement process with SC DHHS. If providers access SC DHHS rates with direct billing, the opportunity to set rates without the need to cost settle can be an option, but it would likely require a rigorous initial cost study to validate rates as fair.

- DDSN and SC DHHS are in the final phase of approving an administrative contract, which will separate out funds necessary for DDSN to operate its mission from SC DHHS service rates directly available to providers. When this occurs and if SC DHHS or DDSN does not have a mechanism in place to permit direct billing, it could dramatically increase the pressure to change in a compressed time frame. This risk should be factored into the operational tempo in addressing and implementing any changes to the band payment system.

- Case management capabilities is an operational risk to the entire ID/DD delivery system due to perceived insufficient rates, questionable capacity to meet system demands, weak criteria in establishing consumer budgets, and overall uncertainty from conflict free case management.

- A significant operational risk in the band system is the length of time to train and develop financial personnel to operate the system. The variety of timing differences in financial transactions (i.e., band payment contract modification; waiver credits; 3rd party billings to bands; cost settlements; error adjustments) negatively impacted a majority of providers, often in cash flow, planning, and unnecessary reconciling to ensure accuracy.

- A major criteria for success in other states' payment system improvement efforts was to maximize transparency and simplicity. The band system in its current state falls far short of this criteria.

- A single rate band payment appears to impact providers differently, such as urban versus rural personnel costs; providers vary in health & retirement benefits offered; operational scale (small vs. large Boards); legacy financial management liabilities; and lack of standardized indirect overhead expectations/allocations.

- There is a perception from some that DDSN has unnecessary overhead depriving both providers of higher service rates or funds to decrease the waiver waiting list. These two issues should absolutely be DDSN priorities. However, reality is addressing these two issues is more a function of changing DDSN policies to reprioritize funds for both needs, rather than a simplistic notion of cutting general DDSN overhead to address these issues. DDSN expenditures during FY 12 were 84.8% to direct services (providers & regional centers), 6.4% state funds (primarily direct services for Medicaid ineligible ID/DD consumers), 2.8% DDSN program & administrative overhead (currently 2.2% for FY 17) and 6.0% for statewide direct and indirect system costs. Possible data collection to identify funds for resource reprioritization include:

    - Examine every dollar of state funds to consider reprioritizing to a Medicaid service obtaining a 70.19% federal match where $1 converts to $3.35 [i.e., address residential Medicaid ineligibles to become Medicaid eligible (2% of residential consumers; $5 million state funds; potentially $11 million Medicaid match missed); adopt best practices from other states in Early Intervention to maximize Medicaid/private insurance; challenge preventative state dollar use compared to real-time needs on waiver waiting list].

    - Examine every dollar of the 6.0% statewide <u>direct</u> (i.e., self-directed care & Autism residential paid centrally by DDSN) and <u>indirect</u> (i.e., USC training, SIS, intake) system-wide cost allocations by reviewing adjusting allocation entries for the most recently completed FY. It may yield some reallocations, but it will also address the perception of DDSN waste or hidden overhead costs. It should be noted these expenses are already considered Medicaid eligible expenses, so there will be no match benefit. The majority of these allocations will be for direct service cost paid for by DDSN and allocated to a waiver. Certainly, the indirect system costs have the greatest potential of reprioritization, but having personally reviewed all, I would not anticipate easy reallocation decisions nor discovery of the perceived "hidden" DDSN overhead costs in this category

    - The band system has positive attributes, but financial weaknesses include:

        - The band payments in excess of associated Medicaid costs and one-time capital allocations are Medicaid unmatched;

        - Bands incur the inherent Medicaid allowable cost slippage/error risk in the complex cost recapture cost settlement process versus 100% immediate Medicaid cost recognition in a FFS model; and

        - Band policies of liberal 80% residential/day attendance and 30 day vacancy reimbursement are essentially paid for through reduction of providers' rates from SC DHHS, which could be lessened similar to other state models, such as 90-95% attendance and no vacancy rate reimbursement.

    - DDSN overhead should always be under scrutiny. However, from my perch, the greatest opportunity to save DDSN overhead is not piecemeal overhead cuts to 2.2% overhead expenses. To both conserve overhead resources and reduce the current risk of every anecdote (i.e., un-litigated civil suit filing, a single ANE incident, and regurgitated old audit findings) being spooled up to a crisis diluting operational focus, DDSN should refine its enterprise performance management system to rigorously include risk based indicators approved by the Commission. Oversight, public input, and media scrutiny all make any

organization better, as long as there is general agreement on the risk based indicators of success and the organization collects the corresponding data. This both increases assurance to all stakeholders, while preventing the public from misinterpreting performance data. An integrated view of risk has the likelihood of better understanding how to place risk based performance indicators within the organization to maximize assurance, while being very conscious of the need to minimize DDSN's administrative footprint, both internally and on contract providers.

VI. Final Thoughts

After having the opportunity and time to process data collected in this review, I am drawn towards the wisdom of other states reporting they started similar reviews by first establishing overarching principles, which were in the direction of fairness, simplicity, and understandability by governing bodies and consumers. As we look forward, we must face the current reality that:

- DDSN's current band system's bands are not actuarially sound or calibrated to assure fair provider compensation; although, there is sufficient data to suggest the total funding is not far off from the current consumer populations' total needs;

- DDSN's current band system is not transparent;

- DDSN's current band system is a mandatory alternative payment system which appears not in compliance with Medicaid guidance; and

- 45% of providers are dissatisfied (52% satisfied; 3% uncertain) with the band system.

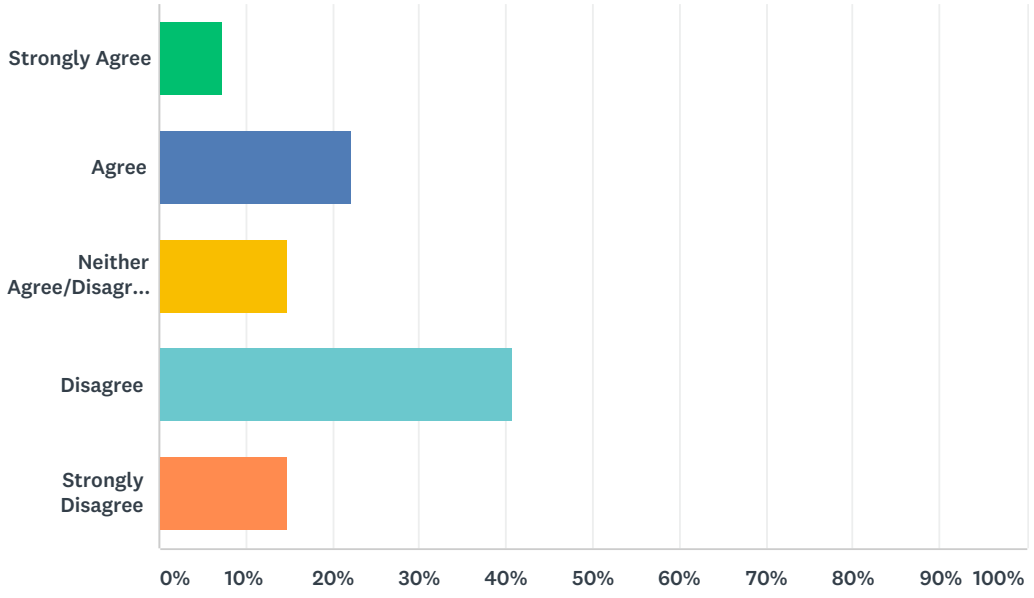
Inaction or tweaking around the margins should no longer be considered a viable option. We need to robustly engage this issue.

I suggest we not start with a natural temptation of adversarially comparing the pros/cons of the band system and FFS. It may lead us down a false path thinking we have a binary choice of an upgraded band system or FFS. Rather than a narrow focus of comparing two known payment systems, we should think bigger to establish a **cost based provider payment (compensation) system that is fair and sustainable to providers, consumers, and taxpayers**. To do this, we should consider starting with a principle approach and then select the best parts of any model to meet our needs. I have learned a state has many options/tools to modify any model to meets its unique needs. Further, we need to look at this problem from both short-term improvements and long-term solutions inasmuch as a robust rate study and completion of the SC DHHS MMIS are many years away. There seems to be too much pressure in the current system to just sit back and wait for a long-term solution.

The band review project is an opportunity to rebuild some frayed trust with many stakeholders. However, all stakeholders need to be reminded not all stakeholders have the same perspectives/experiences/priorities, and the government funded ID/DD service delivery system is a "zero sum game" requiring tradeoffs between policies, services, rates, and number of consumers served, absent adding more appropriated resources. If a robust cost survey is initiated, it should restore a sense of fairness and equity in the provider payment system, but it may not result in more near-term appropriated resources.

Q1 I have adequate direct care staffing levels in my Day Program to meet my consumers' needs.

Answered: 27 Skipped: 1



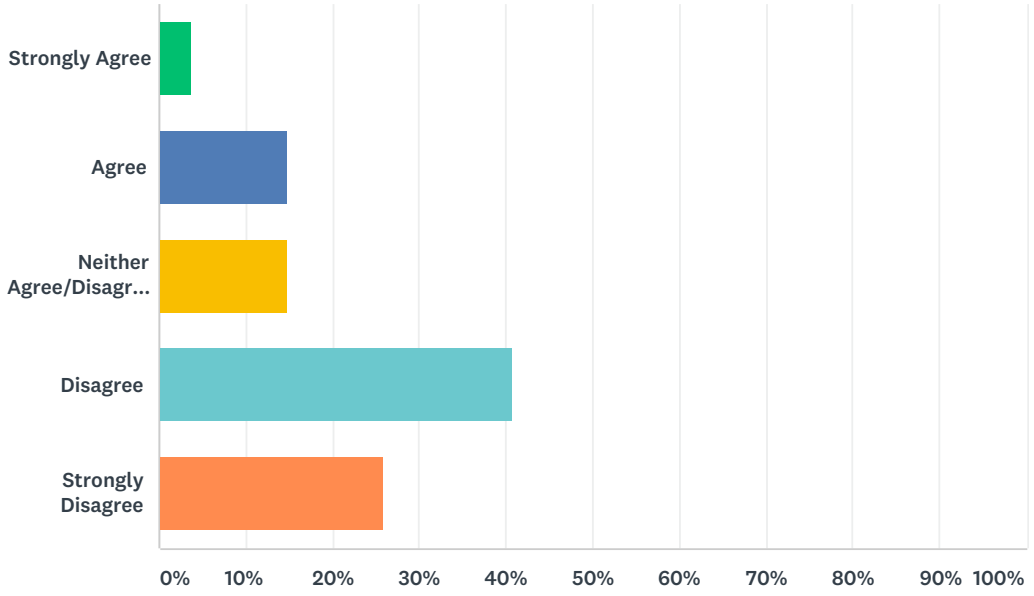
ANSWER CHOICES	RESPONSES	
Strongly Agree	7.41%	2
Agree	22.22%	6
Neither Agree/Disagree or Uncertain	14.81%	4
Disagree	40.74%	11
Strongly Disagree	14.81%	4
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	With upcoming changes in Day Program requirement resulting from CMS Final Rule, staffing ratios will need to increase significantly in order to provide a more individualized approach to services. Direct Support staff have been difficult to recruit and maintain at current pay rates.	10/18/2017 12:04 PM
2	At this time, yes. In the future, with CMS final rule issues, we are very concerned.	10/17/2017 11:55 AM
3	Day program rates which are in the band do not adequately cover transportation nor do they cover the lower ratios to take care of the needs of the consumers. Local QPL day program provider can pick and choose who they will serve – and they choose not to serve individuals with behavioral issues. We serve those folks and for exactly the same rate. We have adequate staffing at our day programs because we choose to make sure the individual has what they need to ensure quality care – NOT because DDSN funds us properly for it. Ultimately when someone walks through the door of our day program and we agree to serve them – their needs dictate the staffing ratio not what some artificially contrived band says it will be.	10/16/2017 5:28 PM
4	1. As the level of needs increase for those we serve more individualized supports are needed. 2.The turnover rate is high due the lack of funding and support from the state level for adequate salaries. We are training people and they moving on to better paying jobs with lower stress levels.	10/16/2017 2:49 PM

5	Our staff ratio is only capable of doing day to day functions. There is not enough staff to do extra things or projects with and for individuals.	10/16/2017 2:29 PM
6	Already responded to the survey once. Ignore these scores.	10/12/2017 4:43 PM
7	The increased behavioral and medical needs of an aging population plus trying for community inclusion is limited by not having enough staff to accomplish these objectives.	10/12/2017 3:28 PM
8	Funding is adequate to meet DDSN ratios for day programs, but inadequate to provide for meaningful engagement activities for all individuals	10/12/2017 12:41 PM
9	Given the continued implementation of employment first as a goal under the new rule as well as community involvement expectations through volunteerism, it requires that we alter staffing levels to promote active volunteerism or job development. WE cannot safely implement without additional staff and support for non-center based trips. Why is DDHS continuing to push compliance in this arena when they have offered no additional funding for staffing ratios.	10/11/2017 11:31 AM
10	Should someone be out sick, or need a vacation day, it can throw the ratios off. We are unable to afford to staff for this type of contingency.	10/10/2017 4:14 PM
11	We currently have adequate staff now, but still struggle with retaining good qualify staff due to pay level.	10/10/2017 1:13 PM
12	We staff our day programs based on the consumers in each group. We maintain the minimum requirements, however there are certain consumers who require more than the minimum therefore we staff it based on the needs of the consumers. Do we always have adequate staffing, - No.	10/10/2017 12:51 PM
13	It is an ongoing struggle to maintain adequate staffing levels.	10/9/2017 3:56 PM
14	With more direct support staff, however, the progress many of the individuals would make would increase significantly. I am interpreting "needs" as being very basic needs.	10/5/2017 5:10 PM
15	It is difficult to retain sufficient accountability due to staff turnover. Pay is too low to keep our good people	10/4/2017 11:17 AM
16	We receive one payment structure irrespective of the needs of the individuals we serve. As a result we have challenges supporting individuals who have high needs since there is no consideration in the band rate for those differences	10/3/2017 1:24 PM

Q2 I have adequate direct care staffing levels in my Residential Program to meet my consumers' needs.

Answered: 27 Skipped: 1



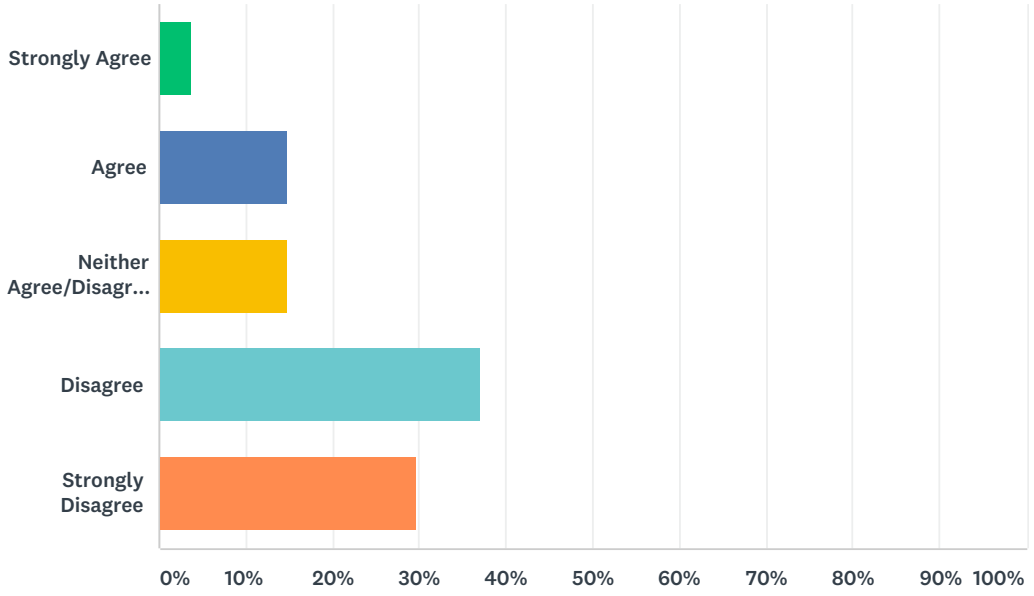
ANSWER CHOICES	RESPONSES	
Strongly Agree	3.70%	1
Agree	14.81%	4
Neither Agree/Disagree or Uncertain	14.81%	4
Disagree	40.74%	11
Strongly Disagree	25.93%	7
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	With the current workforce atmosphere it is hard to recruit and retain staff. Pay isn't the only factor but finding qualified people is also a challenge.	10/23/2017 10:29 AM
2	Random consumers behaviors warrant an additional staff in some situations.	10/19/2017 8:18 PM
3	Currently have excessive vacancies due to inability to recruit/retain employees at current pay levels. We have a high rate of turnover of existing direct support employees. Due to pay rate we are not able to attract applicants with the skill level consistent with job requirements.	10/18/2017 12:04 PM
4	Definitely not in ICF homes. Currently 60% of CTH II homes are underfunded. Fortunately moving funds around helps us to break even.	10/17/2017 11:55 AM

5	Residential rates which are in the band do not adequately cover the lower ratios required to take care of the needs of the consumers. We do not get to negotiate the rate based on consumer need. We do not ask for outliers any longer because they will denied based on the overall health of the agency's finances –so the process of doing so is a waste of our time and resources. Once again, our residential programs are staffed appropriately because ultimately when someone walks through the door of one of our homes and we agree to serve them – their needs dictate the staffing ratio not what some artificially contrived band says it will. We now set specific bands we will accept (since we have no negotiation rights) when we are taking on someone who is dually diagnosed (ID/MI), has severe medical issues, is non-ambulatory or someone from the judicial system.	10/16/2017 5:28 PM
6	Additional funding is needed for CTH I caregiver stipends	10/16/2017 4:29 PM
7	Please refer to comments for question 1.	10/16/2017 2:49 PM
8	Our residential program suffers from lack of staff in the aspect of giving individuals one on one time with activities or attention. They can only accomplish what is absolutely necessary in a day to day function.	10/16/2017 2:29 PM
9	Ignore score	10/12/2017 4:43 PM
10	Once again the increased medical and behavioral needs of our aging population requires additional staff.	10/12/2017 3:28 PM
11	Most of our residential programs operate at a deficit due to inadequate band funding	10/12/2017 12:41 PM
12	current band payments are not based on behavior needs or medical needs to support an individual. THE SIS DOES NOT evaluate behavior either. Feeding issues and choking issue grow in an aging population but we have the same staff at meal time. One staff cannot manage these issues if they are alone. Feeding must be a part of the structure for staffing if we are to be judged by the number of "criticals" for swallowing problems we submit to the IMS>	10/11/2017 11:31 AM
13	We are staffed at 1:4 most shifts - this is far from optimal.	10/10/2017 4:14 PM
14	We currently have adequate staff, but retaining them due to pay level and the fact that employees don't want to be in position where their lives will be effect providing care to the consumers.	10/10/2017 1:13 PM
15	With high turnover rates, rates of pay in comparison to our area, qualifications of direct support, length of time it takes to get someone thru the entire process, we lose a lot of candidates because they need a paycheck and cannot financially wait for all the approvals. Add in the nature of our business and sometimes the consumers physical, emotional and behavioral needs and this scares people away.	10/10/2017 12:51 PM
16	It is an ongoing struggle to maintain adequate staffing levels.	10/9/2017 3:56 PM
17	With more direct support staff, however, the progress many of the individuals would make would increase significantly. I am interpreting "needs" as being very basic needs. We do not have sufficient support staff for individuals to go places individually instead of in groups for much of the time. A problem with funding is that, while we make sure we have adequate numbers of staff in the homes to meet basic needs, we have been unable to fill vacancies which has resulted in tremendous amounts of overtime. Recent wage increases have not brought a huge influx of acceptable candidates for positions. In the ICFs/IID we operate, we maintain staffing at a level that far exceeds the revenue received because of the critical needs of the individuals in these homes. Overtime in these homes is also high as a result of vacancies. The service hours needed must be performed. In other words, inadequate funding but we make sure we have adequate staffing. The question becomes as our deficits rise, there is no way we can continue indefinitely to provide supports at the level needed. We will give up these homes before we will operate homes in an unsafe manner with inadequate numbers of direct support staff. Giving them up is seriously being considered by the Board of Directors. Financial reserves have been depleted.	10/5/2017 5:10 PM
18	It is difficult to retain sufficient accountability due to staff turnover. Pay is too low to keep our good people	10/4/2017 11:17 AM
19	We have adequate staffing levels but are not funded adequately. We subsidize the residential staffing pattern with funds from other capitated programs. This is not sustainable.	10/3/2017 3:31 PM

Q3 Band consumers' prospective monthly case management rate is adequate to cover the actual cost of case management by a provider.

Answered: 27 Skipped: 1



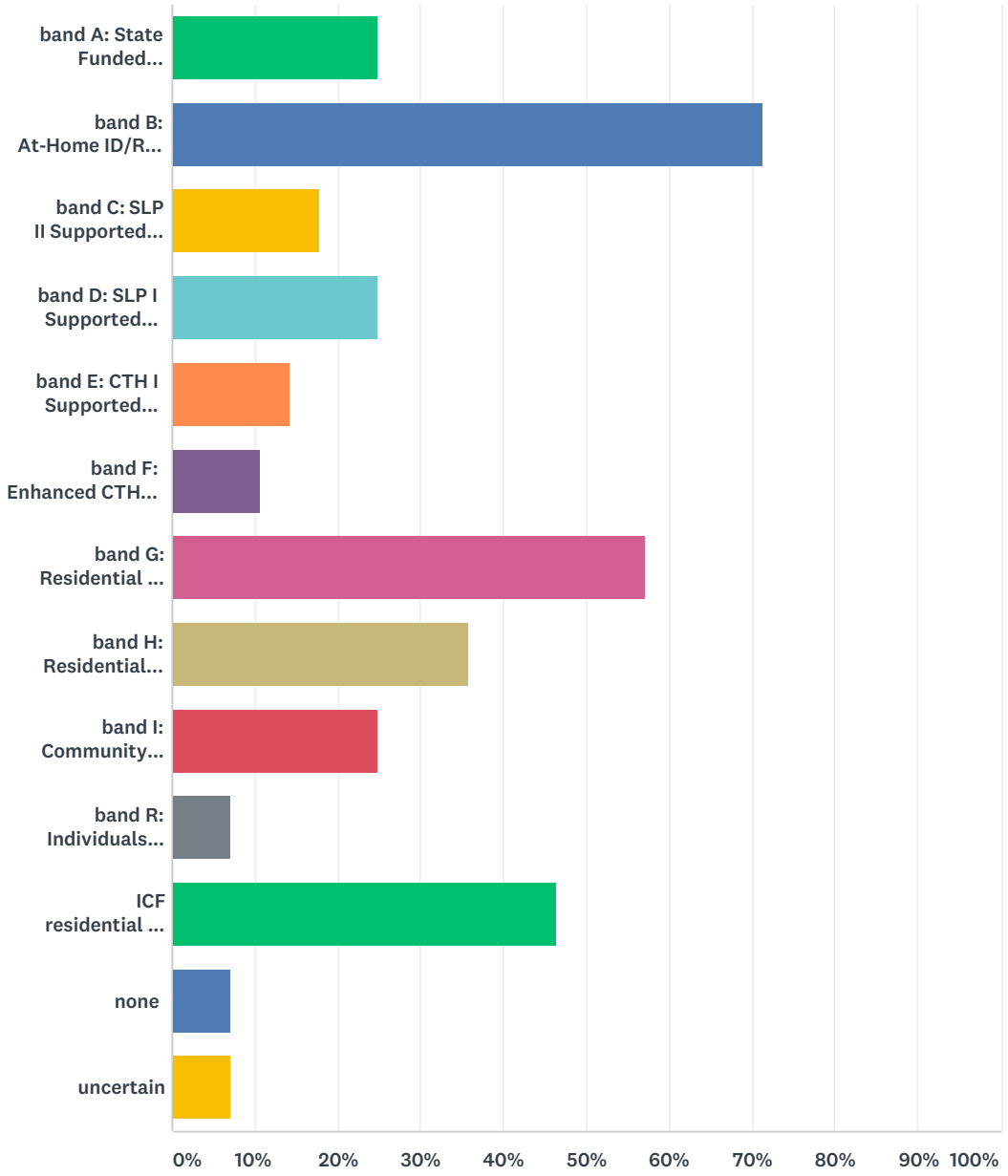
ANSWER CHOICES	RESPONSES	
Strongly Agree	3.70%	1
Agree	14.81%	4
Neither Agree/Disagree or Uncertain	14.81%	4
Disagree	37.04%	10
Strongly Disagree	29.63%	8
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	Case management is always over spent at the end of the year.	10/19/2017 8:18 PM
2	Due funding limitations we are unable to recruit, hire or retain qualified case managers.	10/18/2017 12:04 PM
3	At this time it is suficient due to increase case loads. Unfortunately had to bring on another case manager which may create a funding problem this FY. Additionally, salaries are not appropriate.	10/17/2017 11:55 AM
4	The truth is – the current CM funding system is fabricated out of whole cloth. DDSN had stated that the rate was predicated on the productivity of the CM; but we know they are not looking at productivity. They are funding us at a rate that may or may not be supported by their Medicaid billing – who knows? They sure as heck do not have the transparency for us to figure that out. What I do know is that the current 15 minute reimbursement rate as published by Medicaid is not enough to support all the activities required of a case manager. I could live getting paid after the service is rendered but I can do that for every one of our services this idea of prospective payment is a false flag. You do not pay 30 days in advance you pay 2 weeks in advance.	10/16/2017 5:28 PM
5	Case Management is poorly funded; it is not nearly adequate. It is very difficult to find quality personnel with the current funding. There is not adequately funding to cover the cost of supervision or quality assurance.	10/16/2017 4:29 PM

6	While rates are much better than actual activity payment there are never enough funds to cover anything for case management except salary and benefits.	10/16/2017 2:29 PM
7	Ignore score	10/12/2017 4:43 PM
8	Funding provides for a limited number of slots for CMs. The case load carried by each of the CMs is excessive and as a result, individuals being served are not getting quality service through case management	10/12/2017 12:41 PM
9	Band B's payments needs to be reevaluated.	10/12/2017 11:33 AM
10	We lose money even though I reduced a staff in this program. No longer do I have a supervisor who can just supervise, she carries a full caseload and the agency still loses money. Travel time must be a part of the band structure, especially if we are to serve in another county. Smaller providers cannot make it and if you look at what has happened to rural hospitals , they had to join with larger ones to spread the cost and risk. I am considering this option, joining with another provider, does DDSN really want bigger providers? Does DHHS care?	10/11/2017 11:31 AM
11	To provide the level of support that each individual need, the band sometimes does not cover.	10/10/2017 1:13 PM
12	Absolutely not. We many times do not allocate all the expenses that are incurred by Case Management to their program, because the program could not sustain the costs. (i.e. vehicles, utilities, supplies, gas, etc...)	10/10/2017 12:51 PM
13	This rate is about what it needs to be for us to be able to break even, but it is very difficult to maintain staff with the required skills to perform this function well. Much more could and should be done for the individuals and families than case managers have the time to do.	10/5/2017 5:10 PM
14	Rate does not reflect other factors of service that a case manager provides not to mention the time on computers to properly document services.	10/4/2017 11:17 AM

Q4 Please select those bands where you feel your costs associated with the services significantly exceeds the revenue from the band (select as many as applicable).

Answered: 28 Skipped: 0



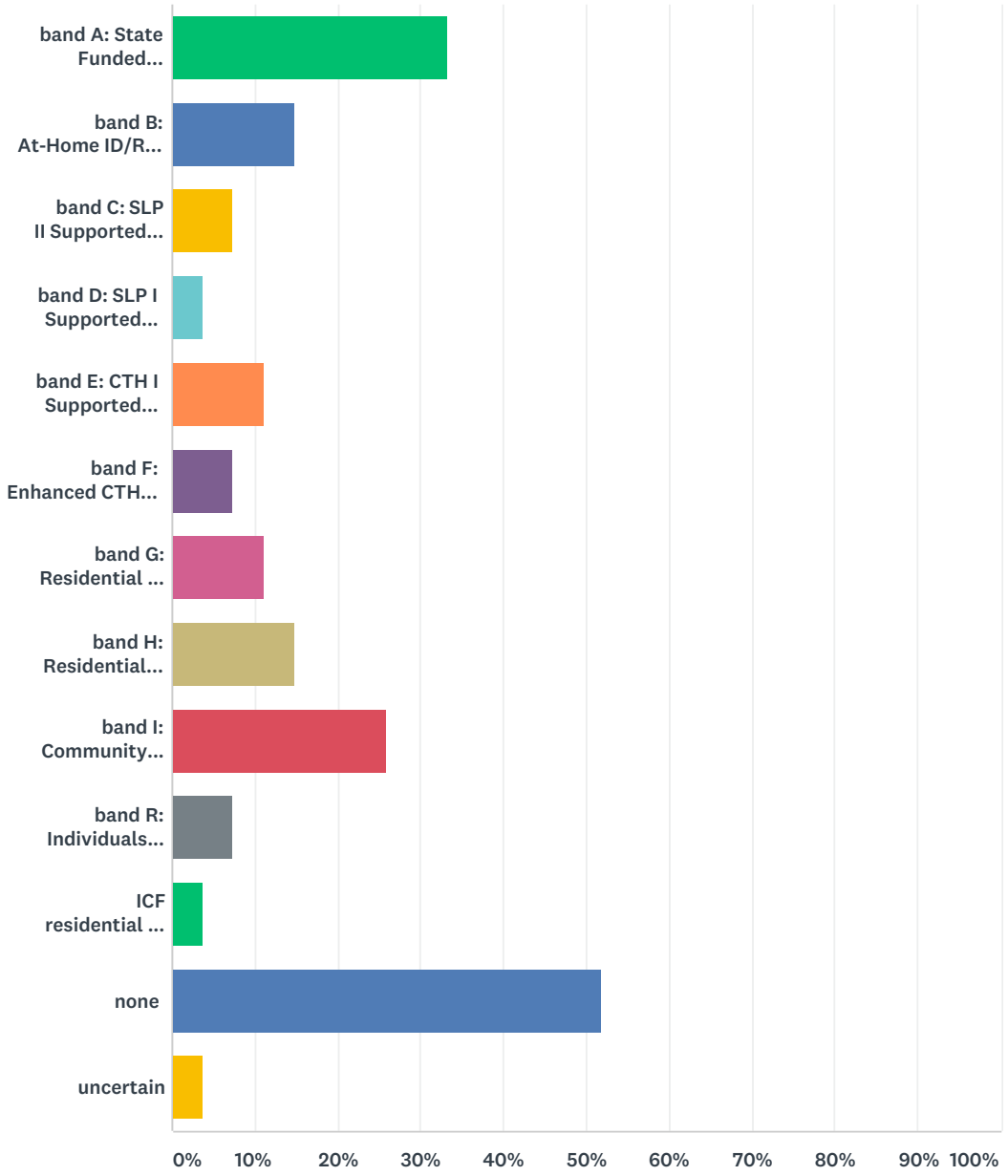
ANSWER CHOICES	RESPONSES	
band A: State Funded Community Supports (non-waiver)	25.00%	7
band B: At-Home ID/RD Waiver	71.43%	20
band C: SLP II Supported Residential	17.86%	5
band D: SLP I Supported Residential	25.00%	7

band E: CTH I Supported Residential	14.29%	4
band F: Enhanced CTH I Supported Residential	10.71%	3
band G: Residential Low Needs	57.14%	16
band H: Residential High Needs	35.71%	10
band I: Community Supports Capped Waiver	25.00%	7
band R: Individuals Moving from Regional Centers to the Community	7.14%	2
ICF residential bed (combination of bands Hs & Rs)	46.43%	13
none	7.14%	2
uncertain	7.14%	2
Total Respondents: 28		

#	OPTIONAL COMMENTS:	DATE
1	Band B's have been underwater ever since families realized that there was no cap on the service amounts. SLP I is funded at a 1:20 ratio but folks in that program need more support than that so we try to share supports with SLP-II staff – especially regarding transportation. Band G's are aging and plenty of our band G's need a lot of medical attention and physical care. The bands are not changed – you can ask; but you will not receive. Again – everything is based on the financial health of the agency. In addition, this list does not have all the various negotiated rates that DDSN has with certain providers – this is part of the problem. I do not operate ICF's but I do know that they are significantly underfunded due to the all-inclusive nature of the program.	10/16/2017 5:28 PM
2	Case management not adequately funded	10/16/2017 4:29 PM
3	The bands are not at a level that can take care of all needs for these individuals. Also some individuals budgets exceeds band amounts. While it has been SCDDSN philosophy that bands that are over in their budget can be taken care of with bands that are not over their budgets this does not take care of the overall shortage of funds.	10/16/2017 2:29 PM
4	Especially Band Gs in ICF	10/16/2017 11:29 AM
5	Ignore scores	10/12/2017 4:43 PM
6	Band B is a significant issue for us. Other Bands do not fund all the residential needs provided. ICF funding is grossly inadequate after netting the takeaway for client fees and bed fees. The cost to operate an ICF is higher that the other residential programs because all medical, dental and personal hygiene items are covered by the provider.	10/12/2017 12:41 PM
7	Band A is a loser since we only get to claim actual attendance and if they don't attend, we still have to staff for them or be available to pick them up. We 'pay back' in this area. Consider carve out home supports (respite and personal care) and pay those things separately to keep smaller providers from losing so much?	10/11/2017 11:31 AM
8	ICF beds are by far the worst funded for our situation even where we have individuals residing who all are funded at the Band H level.	10/5/2017 5:10 PM
9	The ICF programs have always been underfunded. The Band B's have no caps and controls so the provider ends up eating the excess cost.	10/3/2017 1:24 PM

Q5 Please select those bands where you your costs associated with the services are significantly less than the revenue from the band (select as many as applicable).

Answered: 27 Skipped: 1



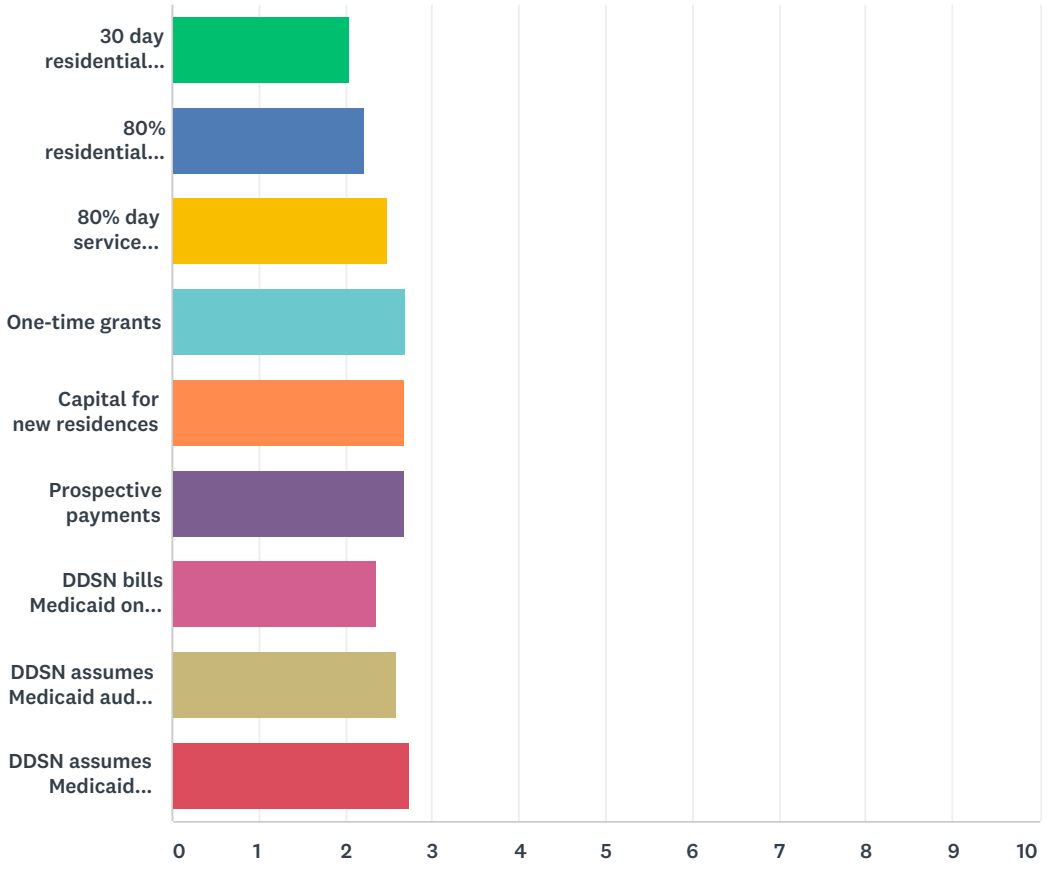
ANSWER CHOICES	RESPONSES	
band A: State Funded Community Supports (non-waiver)	33.33%	9
band B: At-Home ID/RD Waiver	14.81%	4
band C: SLP II Supported Residential	7.41%	2
band D: SLP I Supported Residential	3.70%	1

band E: CTH I Supported Residential	11.11%	3
band F: Enhanced CTH I Supported Residential	7.41%	2
band G: Residential Low Needs	11.11%	3
band H: Residential High Needs	14.81%	4
band I: Community Supports Capped Waiver	25.93%	7
band R: Individuals Moving from Regional Centers to the Community	7.41%	2
ICF residential bed (combination of bands Hs & Rs)	3.70%	1
none	51.85%	14
uncertain	3.70%	1
Total Respondents: 27		

#	OPTIONAL COMMENTS:	DATE
1	Band I is a capped waiver so you don't spend more than what you receive. However, with the influx of so many children into this waiver the surplus is mounting since the only service they receive is respite. . The sad part is that if DDSN was doing their due diligence managing the waiting list they would have predicted this issue with the Band I's. It was almost 8 years ago when they saw that the waiting list was going to move and move quickly. DDSN kept count of the slots awarded but they never analyzed the needs of the individuals on the waiting list for the waiver so adjustments could be made based on the shifting demographics – even after providers implored them to do so. Band A is also a capped waiver and is all state funds. DDSN is leaving capitol on the table since they reconcile the waivers units so late in the game – like 2 years after the fact. This would have been a great place to start with fee for service. Include a provider administrative fee in the rates for the services covered in this waiver	10/16/2017 5:28 PM
2	Especially Band Gs in ICF	10/16/2017 11:29 AM
3	Ignore scores	10/12/2017 4:43 PM
4	Band I funding has been covering the shortfall in funding for the residential and day programs. Now, with the In Home Supports, Band I will no longer generate a surplus to help cover the other capitated programs.	10/12/2017 12:41 PM
5	Band A should not be considered in this as it is a loser since we only get to claim actual costs and have to pay back the difference. I still have to have a driver and a day staff present when the consumers opt for 3 days a week support or career prep. CSWs are usually a small offset to Band Bs. the other bands G, H and R are spread through a 4 bed house so we report costs on the house , not the Band. We report costs by cost center but are paid by a band per individual. Wonky for a small provider BUT this is a so-called individualized pay structure that really is a managed care payment.	10/11/2017 11:31 AM
6	I am surprised that CRCFs were not separately surveyed under this item. Like State Funded Community Supports, I believe you would find them to be "overfunded" especially when compared to ICFs and CTHs II. Wouldn't providers' audits provide a better/more accurate source of information for many of these questions?	10/5/2017 5:10 PM
7	More people not receiving services than those listed in the detail list	10/5/2017 10:37 AM
8	Our margins are so small that to say that there is a band that is adequate is impossible to guage	10/3/2017 1:24 PM

Q6 The current band payment system has components identified by some providers as beneficial. Please assess each band component benefit in the below table (select one per component benefit):

Answered: 27 Skipped: 1



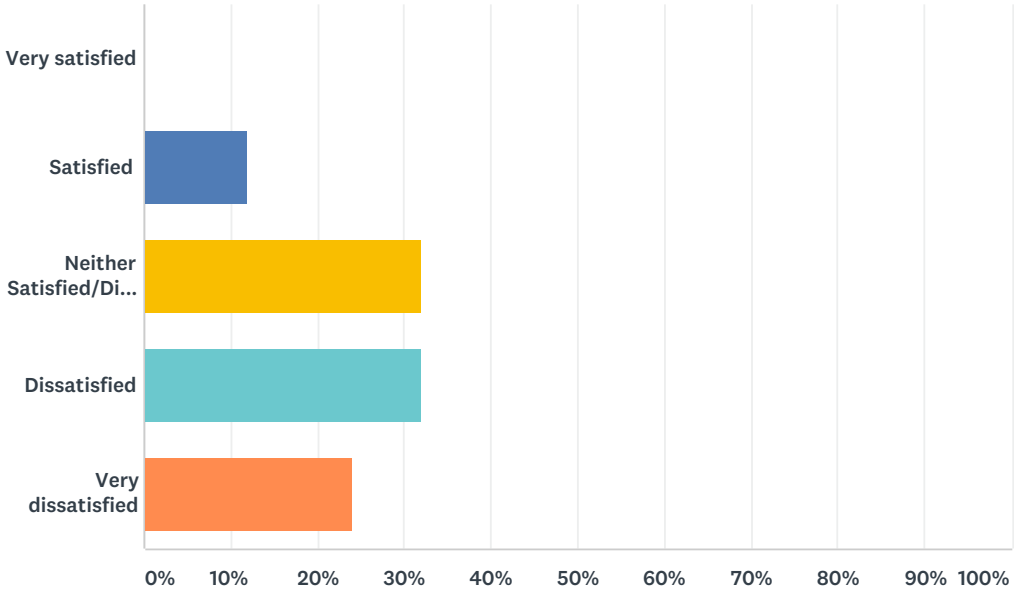
	NOT BENEFICIAL	BENEFICIAL	VERY BENEFICIAL	UNCERTAIN	TOTAL	WEIGHTED AVERAGE
30 day residential vacancy payment	25.93% 7	44.44% 12	29.63% 8	0.00% 0	27	2.04
80% residential attendance allowance	3.70% 1	70.37% 19	25.93% 7	0.00% 0	27	2.22
80% day service attendance allowance	3.85% 1	53.85% 14	30.77% 8	11.54% 3	26	2.50
One-time grants	3.70% 1	29.63% 8	59.26% 16	7.41% 2	27	2.70
Capital for new residences	7.41% 2	29.63% 8	51.85% 14	11.11% 3	27	2.67
Prospective payments	7.41% 2	25.93% 7	59.26% 16	7.41% 2	27	2.67
DDSN bills Medicaid on behalf of provider	22.22% 6	29.63% 8	37.04% 10	11.11% 3	27	2.37

DDSN assumes Medicaid audit financial risk	7.41% 2	40.74% 11	37.04% 10	14.81% 4	27	2.59
DDSN assumes Medicaid ineligible risk	0.00% 0	44.44% 12	37.04% 10	18.52% 5	27	2.74

#	OPTIONAL COMMENTS:	DATE
1	One time grants – they are not given out in any equitable fashion – we don't even know what grants are being offered. Some folks get roofs repaired and others repair their own. As far as residential grants – would rather not have the strings attached to our real estate holdings that DDSN places on them. Would rather take out a mortgage. We are getting a 2 week prospective payment – no big deal. DDSN does not assume the risk during a Medicaid audit – if you are found noncompliant, you will be paying. What DDSN does do is negotiate on your behalf – without telling you. This I find disconcerting and many of the errors found by Medicaid (on our last program integrity review) are DDSN billing errors – not the providers, yet we never are told of the outcome of these issues.	10/16/2017 5:28 PM
2	Ignore score	10/12/2017 4:43 PM
3	Not sure I agree about the risk since we do have to pay back if there is an error in Medicaid authorization. I do have recoupments but I think DDSN in the past has lessened or negotiated them down. Not sure I feel confident in todays political climate that DDSN is inclined to continue this "nicety"?	10/11/2017 11:31 AM
4	Do you mean beneficial to having an equitable funding system or beneficial to the provider? Last two items - Not sure that DDSN assumes Medicaid and Medicaid ineligible risk. Doesn't much of this get passed on to providers? With regard to the 30 day residential vacancy payments and the 80% attendance requirements - These should not be necessary if the rates sufficiently cover acceptable vacancy rates and expected attendance, If building a daily or unit rate were to include an agreed upon number of vacancies (residential)/ or absences (from attendance in day services) it would be possible to only pay providers for units served. This would be a strong incentive for providers to develop day services which individuals served would want to participate and for residential staff to try to fill vacancies as soon as possible. I do believe that there should be a residential attendance requirement but that it should be figured on an individual basis. If an individual is very frequently out of the home for more than 8 or 10 days per month, it would not appear that such an individual would really be in need of residential supports. This should probably not apply to SLP I supports and possible not SLP II supports.	10/5/2017 5:10 PM
5	30 day residential; vacancy payment is not beneficial because of the number of providers looking for beds and strict criteria for critical. There are too many beds in the state vacant vs the criticals allowed resulting in bed vacancy's	10/5/2017 10:37 AM
6	We have been hit with a huge payback that our agency had to absorb from a DHHS audit years ago. Not sure how much risk or financial responsibility they assume.	10/4/2017 11:17 AM
7	The benefits of these various components are offset by the drawbacks that are not mentioned in the questions. For example, DDSN billing Medicaid on our behalf is helpful but not if it means a lower rate paid for services. The question is not whether or not current practices have merit but whether or not they are worth the cost and with a lack of transparency the full value of the system cannot be determined.	10/3/2017 3:31 PM

Q7 In your role as a band financial manager, how satisfied are you with the process of administratively managing the billings (i.e., direct billing or waiver credits) from other providers (i.e., QPLs, supported employment) serving your waiver band consumers?

Answered: 25 Skipped: 3



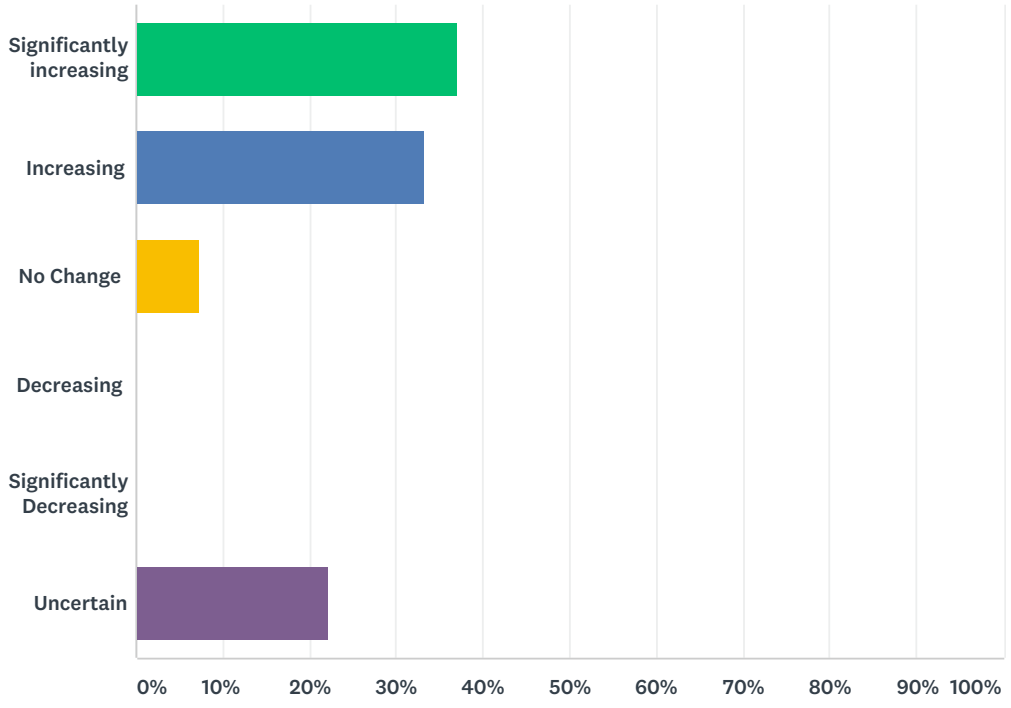
ANSWER CHOICES	RESPONSES	
Very satisfied	0.00%	0
Satisfied	12.00%	3
Neither Satisfied/Dissatisfied or Uncertain	32.00%	8
Dissatisfied	32.00%	8
Very dissatisfied	24.00%	6
TOTAL		25

#	OPTIONAL COMMENTS:	DATE
1	With us not knowing some of these providers and their processes to assess these individuals i really don't know if they are wanting us to fund a needed services or a wanted service.	10/23/2017 10:29 AM
2	System we developed working OK but is time consuming keeping track of info and it is not received timely. Many times the info is not accurate and having to make multiple phone calls to get correct information.	10/17/2017 11:55 AM

3	I don't manage that because I don't see the bills for many items – so how can you manage that? Recently SCDDSN wanted to take over $60,000 from for a service called Self-Directed, In-home Supports. Other agencies were significantly higher. Apparently DDSN was holding providers harmless for this service since it was used so infrequently. Why would they do that? What kind of oversight and fiscal management allows a service to be rendered but not get payment for it? Were they billing HHS for this service? Don't they need the match from the money they put into the bands to be that match? Worse – maybe they didn't bill for it with HHS. If not, how much federal money was loss due to their "kindhearted" act of not collecting from the providers? It ended up being a significantly large number of service units paid with an equally large bill for those services. What made them wait so long to address the problem – one agency owed over $800,000? We see what is being utilized in that service as well as all others for our individuals. Respite being paid for by Charles Lea or Jasper and IHDS being paid by Jasper – we do not see those reports. In addition, as the ED I have to approve budgets blindly. QPLs do not like to send any documentation so I have had to fight to even see the assessments for these supports. Now, I guess all that will be fixed with SCDDSN's new team plan approval experts on the job. I hope families do not suffer by the lag in approval time for needed services and supports.	10/16/2017 5:28 PM
4	Some, although not all, QPLs recruit current Board enrollees with promises of unlimited services. Upon transfer, QPL increase provided services significantly exceeding the funding band with the underage funded by the Board.	10/16/2017 11:29 AM
5	IGNORE SCORES	10/12/2017 4:43 PM
6	Currently, we have therapy (PT,OT) showing up on our WVR direct bill reports and must request every month for reimbursement.	10/12/2017 12:41 PM
7	Waiver credits are unpredictable especially for a small provider. We monitor and our casemanagers try to contact those companies who bill late, but it is beyond our control. We have attempted in the past to get a provider to correct an overbilling and that is very difficult.	10/11/2017 11:31 AM
8	it can be confusing, and we must assume that services from other agencies are being provided.	10/10/2017 4:14 PM
9	This system is a fiscal nightmare. All provider's need to be their own financial manager and they would make very different financial decisions regarding authorization of services.	10/10/2017 12:51 PM
10	I do not feel comfortable with the billing of some QPL's, such as ARC, that indicate they are providing job coach services with little evidence of their work.	10/9/2017 3:22 PM
11	In some situations the financial manager has no control over what is authorized so why should we be the financial managers? We do not have an understanding of why some individuals in a given area have one agency as a financial manager and other individuals in the same area has a different agency serving as the financial manager. This is sometimes true even when the supports received are the same. We really have found no one at DDSN who could explain how all of the financial management in our service area has been assigned to different entities within the county.	10/5/2017 5:10 PM
12	Some areas are easily managed while are not	10/5/2017 10:37 AM
13	too difficult to manage	10/4/2017 12:17 PM
14	1. Lack of controls 2. Lack of verification] 3. Inability to manage. No decision making power. Functionary only.	10/3/2017 3:31 PM
15	We are given the responsibility with no authority to hold programs accountable. We seem to carry all the risk.	10/3/2017 1:24 PM

Q8 In your role as a band financial manager, what future trend do you expect in the frequency of other providers (i.e., QPLs, supported employment) serving your waiver band consumers?

Answered: 27 Skipped: 1



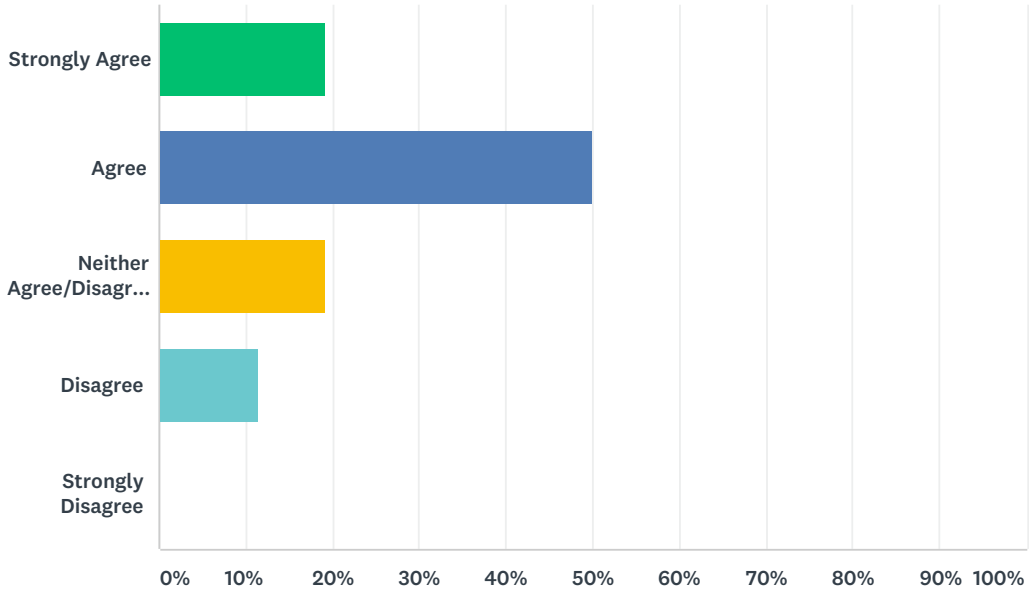
ANSWER CHOICES	RESPONSES	
Significantly increasing	37.04%	10
Increasing	33.33%	9
No Change	7.41%	2
Decreasing	0.00%	0
Significantly Decreasing	0.00%	0
Uncertain	22.22%	6
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	We would like each provider to have the ability to direct bill for their approved services rather than having the financial manager system.	10/18/2017 12:04 PM
2	Increasing but not that much – QPLs want to stay in the densely populated parts of the state. Our individuals want their service provider to be local.	10/16/2017 5:28 PM
3	Timely processing paperwork and keeping everyone up to date with individual needs, etc. Knowledge of anything with these individuals whether it is financial or personal needs and wants and budget knowledge.	10/16/2017 2:29 PM
4	IGNORE SCORES	10/12/2017 4:43 PM

5	As personal choice is emphasized, other providers will serve more and more of our WVR band individuals	10/12/2017 12:41 PM
6	somewhat increasing but the level of funding would be an issue for a new provider. I see our agency as having to combine forces with others to share the risk , much like rural hospitals are doing. Especially if the purse strings are cut , either direct billing or retrospective pay. Does DDSN want more regional , large provider agencies? Does DHHS care? Does the legislature want to see these providers join together to lessen the local input? All I see is one or 2 large case management entities expanding and growing.	10/11/2017 11:31 AM
7	You are already seeing this happening. When Case Management is separated out from the current system, more private providers will be opening their doors for other services as well. It will only increase with the CMS requirements changing.	10/10/2017 12:51 PM
8	I am hoping that direct billing will begin to be a possibility. I am also advocating that local boards and agencies no longer act as financial managers. If we are not financial managers, then this question becomes mute. If the system stays pretty much the same as it is now, I think there will be an increase in the frequency of other providers serving individuals for whom we are the financial manager. The areas of service will not include ICFs/IID unless the rate is changed tremendously. Growth of providers will be in services where profits can be seen. This is already being seen in Adult Day Health Care. Raising rates of services within bands without having a corresponding increase in the band puts the financial manager at great risk of becoming insolvent. Such practices apparently continue to occur with respite, adult day health care, etc.	10/5/2017 5:10 PM
9	Waiver services be planned and budgeted by the provider who actually provides their services	10/5/2017 10:37 AM

Q9 Band financial managers generally operate in a conflict free manner supporting their band consumers' individual choice of services and choice of providers.

Answered: 26 Skipped: 2



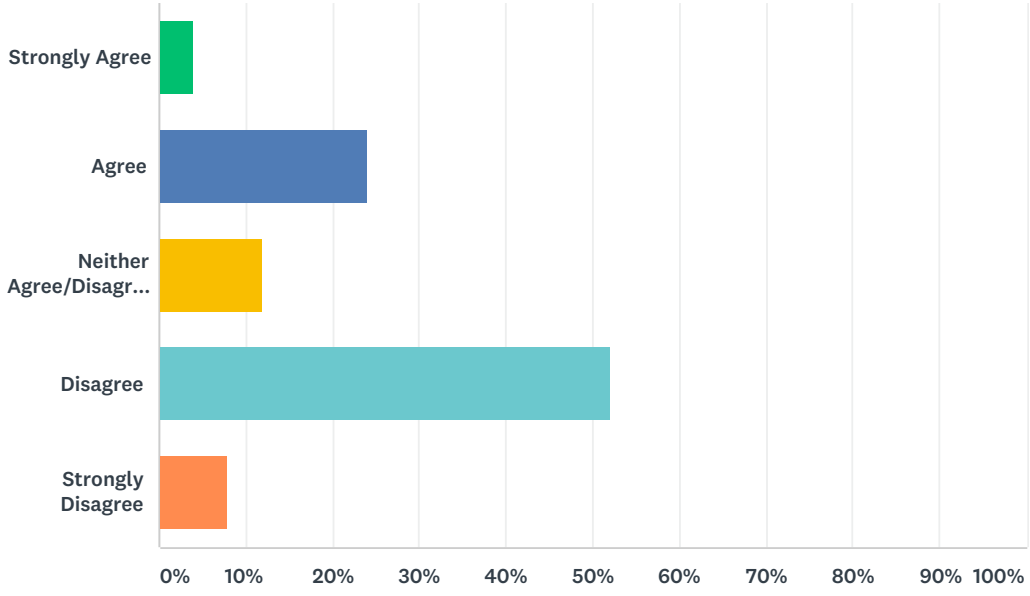
ANSWER CHOICES	RESPONSES	
Strongly Agree	19.23%	5
Agree	50.00%	13
Neither Agree/Disagree or Uncertain	19.23%	5
Disagree	11.54%	3
Strongly Disagree	0.00%	0
TOTAL		26

#	OPTIONAL COMMENTS:	DATE
1	We do not deny service needs based on funding as case managers work very hard to ensure needs are not desires of the family. When family members receive payment for services, it is frequently difficult to determine "true" need based on what the family says vs. what is observed.	10/17/2017 11:55 AM
2	I know that DDSN wants to answer this question differently but the truth is that folks get what they need. We have never withheld or reduced a service for any other reason than the need was not justified – and that has happened on an extremely rare occasion. My concern would be that the safety net provided by the boards for consumers who private providers refuse to serve will be severely damaged in the name of an imaginary conflict of interest. In addition, now that DDSN has assumed the role of plan approvals and authorization of services in the name of conflict free CM, will there be significant delays in getting what a family needs in cases of emergencies? Time will tell, but if history of system changes implemented by SCDDSN is any predictor of outcome, then the system will become even more burdensome for families and providers alike.	10/16/2017 5:28 PM
3	IGNORE SCORES	10/12/2017 4:43 PM
4	We emphasize individual choice	10/12/2017 12:41 PM

5	we often approve Adult Day health expenses and other 'at home' costs that affect our bottom line. We often encourage other community day programs to our negative bottom line. We routinely collaborate with others who HOWEVER, DHHS has made it very difficult by raising rates for things, like behavioral health, Respite recently and adult day health in the past, by just a stroke of a pen. Recently the more than a dollar raise of respite care for a direct bill provider, will hit our budget from July 1. Not one word of how we as a financial manager are to get reimbursed for that? Who knew and when?	10/11/2017 11:31 AM
6	As the financial manager, we do not prevent consumers from choice of services or providers, however we are going to have a candid conversation with the consumer and family between what is a "want" vs. "need".	10/10/2017 12:51 PM
7	I truly believe that this is the case in this county. For many years I have heard that others do not think it is true that services are offered conflict-free. I disagree with CMS that families should NOT be provided with the option of going with a provider of case management also providing services. This is a choice limitation and families should be willing to keep their current CM provider even if they are made to understand that if that agency also provides a service to them that there could be a conflict. They should have the ability to change their CM if they feel that any inherent conflict is having a negative impact on the services they are receiving.	10/5/2017 5:10 PM

Q10 The unique financial aspects of the band system (i.e., multiple contract modifications throughout the year; waiver credits; direct billings from other providers; or periodic contract adjustments, such as error adjustments or annual cost settlements) are accommodated by my financial management operations without a significant impact.

Answered: 25 Skipped: 3



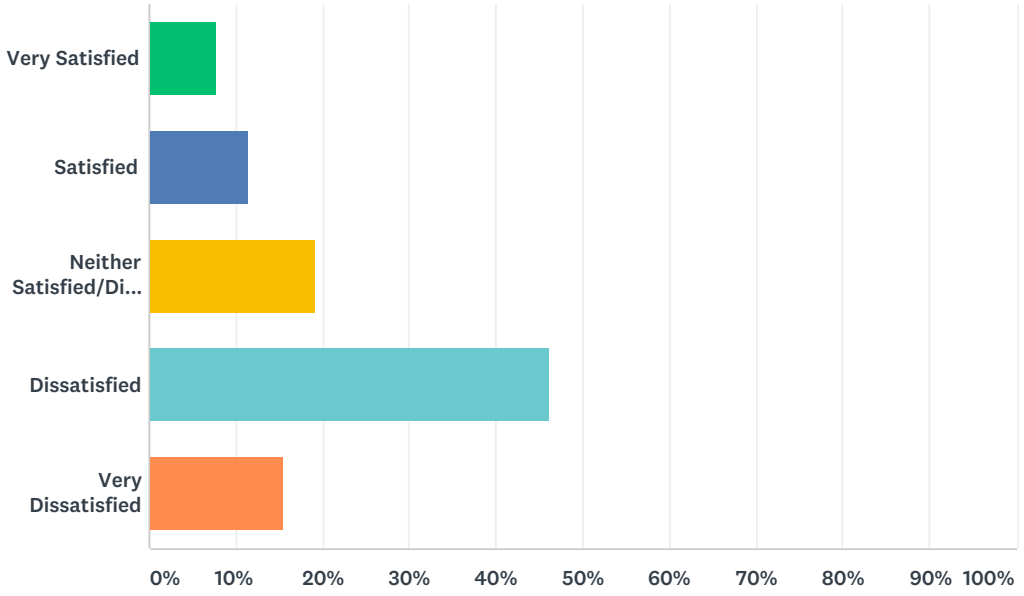
ANSWER CHOICES	RESPONSES	
Strongly Agree	4.00%	1
Agree	24.00%	6
Neither Agree/Disagree or Uncertain	12.00%	3
Disagree	52.00%	13
Strongly Disagree	8.00%	2
TOTAL		25

#	OPTIONAL COMMENTS:	DATE
1	It is hard to plan for these costs when we are not a part of the planning process.	10/23/2017 10:29 AM
2	The problem is the timelines of the amendments.	10/17/2017 11:55 AM

3	DDSN’s contract amendments are so far behind that it is difficult to match them with ease. Reconciliations are years behind. The system is so complicated and “mysterious” we cannot, with any real certainty, check the correctness of their calculations. In fact, during our audit last year we learned that DDSN was overpaying us for day programs to the tune of over $200,000? Who doesn’t miss 200k? DDSN – that’s who. Come to find out we were not the only provider they were overpaying – that that number is probably significantly higher. We didn’t see it because our finance director at the time was so overwhelmed with everything else, she was not able to match contract amendments. She should have found it sooner – but DDSN really should have known all that money was being paid erroneously. In addition, providers who directly bill Medicaid have gone to the Medicaid agency and requested rate increases and have received them – the bands have not increased accordingly. ADHC has had two such increases and have added discrete services – such as transportation and nursing. Direct billers of respite have just gotten an increase from 11:30 per unit to 12.69 – an increase DDSN staff says they never knew about. Regardless, the amount of money being paid by financial managers has increased but the bands have not.	10/16/2017 5:28 PM
4	There is very little communication between financial management and the provider. Services are provided and budgets revised without knowledge given to financial management.	10/16/2017 2:29 PM
5	IGNORE SCORE	10/12/2017 4:43 PM
6	Often, funding for a mandatory increase (such as pay) is inadequate to cover all eligible employees and receiving of those funds sometimes is months from when the increase was to go into effect. This creates a significant cash flow impact.	10/12/2017 12:41 PM
7	I consider ourselves a medium provider but cannot imagine how many spreadsheets are kept to determine whether the amendment is accurate. Waiver credits and direct billing is uncontrolled UNLESS we continuously monitor but as I said earlier, good luck getting a provider to reverse an overbilling. I have one staff in our medium size agency who just monitors. Cost settlements are wrong the last 2 years for us (to our good, DDSN bad) and we have to submit that to you. Not sure where the differences are coming from but I would gather that many of them are wrong?	10/11/2017 11:31 AM
8	It takes a lot of time to reconcile some of these services and reports. The first thing that needs to change is that State Funded Waiver services should be billed on a monthly basis to DDSN for payment of services rendered. It is a painful process to have the money sent in our monthly payment and then at the end of the year send all the money back that has not been utilized. We would prefer to bill what actual service has been provided vs. current process.	10/10/2017 12:51 PM
9	Huge direct billed services and respite billings coming in at the end of the year makes the financial statements go haywire. Some providers do not send in bills in a timely manner and then rush to get them in at the end of the year. Sometimes several months worth of bills hit at one time. This interferes greatly with providers knowing their financial status. I don't believe that within this state DDSN will ever in the foreseeable future find providers who know how to utilize all the reports available to assist them in being able to predict upcoming expenses. This is a major reason why I would like to see the state take over the job of financial manager and the authorization of services.	10/5/2017 5:10 PM
10	Unsure of how commission approval of contract will affect the process	10/5/2017 10:37 AM
11	It is extremely difficult to make strategic budget decisions when contract adjustments, waiver credits, direct billings, etc. are completed several months after the fact. This has a real impact on individuals supported because of the financial uncertainty created by this system. It impacts staffing patterns, meaningful activities, facilities, etc.	10/3/2017 3:31 PM
12	The recoupment process sometimes can take several years. While we accrue any paybacks, I am mot sure all providers do so, so it can impact cash flow as well as budgets over time.	10/3/2017 1:24 PM

Q11 Describe your satisfaction with the transparency of the current band payment system to providers.

Answered: 26 Skipped: 2



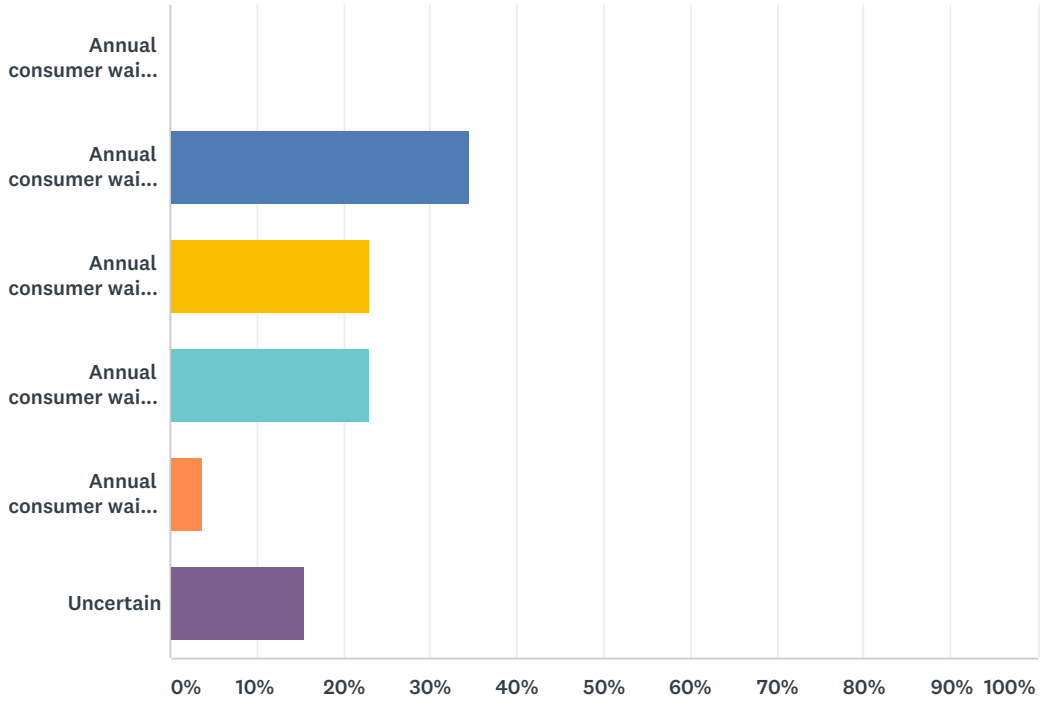
ANSWER CHOICES	RESPONSES	
Very Satisfied	7.69%	2
Satisfied	11.54%	3
Neither Satisfied/Dissatisfied or Uncertain	19.23%	5
Dissatisfied	46.15%	12
Very Dissatisfied	15.38%	4
TOTAL		26

#	OPTIONAL COMMENTS:	DATE
1	Whenever we question if something is part of the band or separate the answer is always it is in the bands but there is no source to go to that states what is covered or not. Band adjustments for increase in expenses (ie COLA, health insurance, etc.) are calculated at the state level but not explained or identified to show how it correlates to our increase in costs. The averaging method does not work across the state due to geographical cost differences.	10/18/2017 12:04 PM
2	Initially, we were aware of the type of expenses included in the bands. As the bands have only been adjusted based on state insurance or hourly rate increases, the bands no longer reflect true expenses. Additionally, the bands do not take into affect cost of living by regions of the state.	10/17/2017 11:55 AM
3	It isn't transparent at all. With the exception of one or two rates, there is no clear line between the rate being reimbursed to SCDDSN by Medicaid and the rate paid to the provider of the service. Auditors have thrown their hands up trying to unravel the band structure to see discrete service rates and are unable to do so.	10/16/2017 5:28 PM
4	We would like to know the full rate paid to SCDDSN and how much given to providers is determined.	10/16/2017 2:29 PM
5	IGNORE SCORE	10/12/2017 4:43 PM

6	When asking questions for clarifications the answer is always that it is in the band which is certainly not true.	10/12/2017 3:28 PM
7	The concept is transparent. Providing quality service is much more complicated and individualized and cannot be reconciled just by saying, "it's in the Band".	10/12/2017 12:41 PM
8	There is no regular adjustment except for the wages in the budget. No CPI , no revisiting , and if the state budget is the issue, then direct billing apparently affords routine , easy "obtained" rate changes? HOWEVER, the total elimination of the band is Not the answer, I think a rate adjustment is in order and a CPI must be included annually. Providers should not have to look to form conglomerates to survive.	10/11/2017 11:31 AM
9	I would not say that it is transparent. It is very complicated and as a newer financial manager, it is impossible to wrap your head around the intricacies. Not only is it complex, DDSN State office does not offer training to new financial managers without the Provider asking specifically for the training.	10/10/2017 12:51 PM
10	There is no transparency because we don't know how the band were developed or what's in the band. On the other hand we know what a band H is anywhere in the state. It's the same in Sumter as in Florence.	10/9/2017 3:56 PM
11	A county board several years ago suddenly received almost all Band Hs no matter who was being served in residential. The money continues year after year. A bailout for the year and assistance in getting things where they should be would have been far less costly. If we stick to a funding band system, the use of acuity and natural support environment will be the key to making the system transparent.	10/5/2017 5:10 PM
12	need more training	10/4/2017 12:17 PM
13	It's in the band is the common response. We just don't seem to be able to find it.	10/3/2017 1:24 PM

Q12 Which of the following statements bests describes the relationship between annual consumer waiver budget requests and consumers' needs.

Answered: 26 Skipped: 2



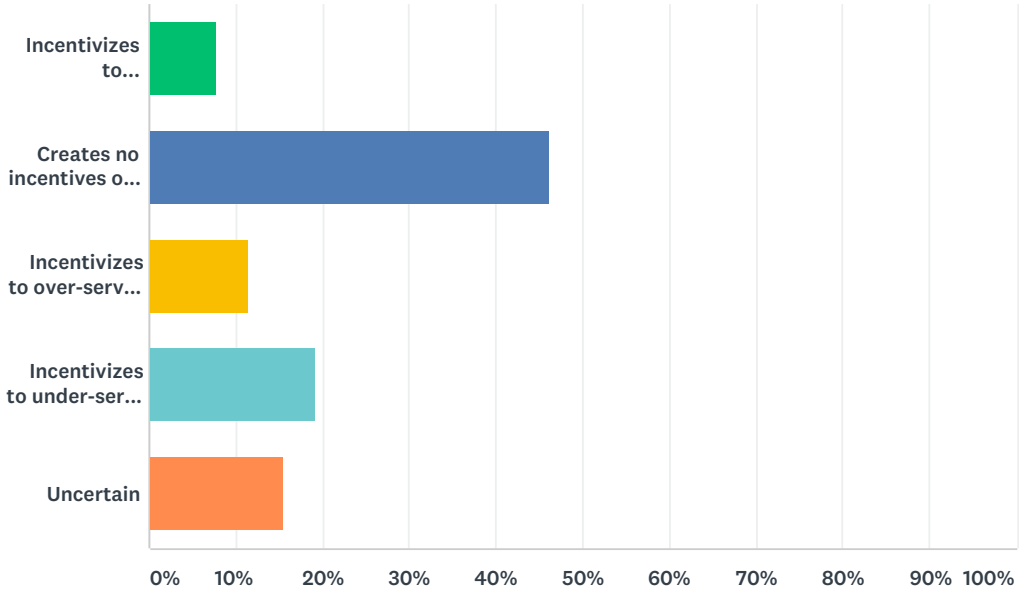
ANSWER CHOICES	RESPONSES	
Annual consumer waiver budgets generally are substantially less than consumers' needs	0.00%	0
Annual consumer waiver budgets generally are marginally less than consumers' needs	34.62%	9
Annual consumer waiver budgets generally match consumers' needs	23.08%	6
Annual consumer waiver budgets generally marginally exceed consumers' needs	23.08%	6
Annual consumer waiver budgets generally substantially exceed consumers' needs	3.85%	1
Uncertain	15.38%	4
TOTAL		26

#	OPTIONAL COMMENTS:	DATE
1	There is a large variance from participant to participant.	10/18/2017 12:04 PM
2	We do not deny service needs based on funding as case managers work very hard to ensure needs are not desires of the family. When family members receive payment for services, it is frequently difficult to determine "true" need based on what the family says vs. what is observed. We are now operating in a deficit which was not the case in past years.	10/17/2017 11:55 AM
3	Since I cannot trace the actual rates to the service – residential bands – I cannot answer this band. For non-residential consumers, the family usually has a higher budget than they utilize due to days out, finding providers etc.	10/16/2017 5:28 PM
4	it depends on the consumer - and there are numerous changes throughout the year as consumer's needs change	10/16/2017 4:29 PM

5	IGNORE SCORES	10/12/2017 4:43 PM
6	Many waiver individuals are given the approved maximum amount of services (i.e., respite) and still ask for more.This is especially the case of Band B recipients.	10/12/2017 12:41 PM
7	The Band B needs may exceed the band payment rate.	10/12/2017 11:33 AM
8	This depends on who you ask, family or our financial person. I do think many budgets are overstated but either a lack of finding a caregiver or provider can affect the expenses for the year. Then there are families who routinely get more than I get reimbursed in the outlier budget for. This 2017 year , with the respite adjustments, we have seen no band adjustment for that and weren't notified until September of this additional cost?	10/11/2017 11:31 AM
9	some budgets exceed the needs, some don't - it's a mixed bag	10/10/2017 4:14 PM
10	I selected uncertain as this is a very difficult question. In some cases, the WVR budget exceeds the needs identified. In many cases, the needs exceed the budget. Sometimes the WVR budget is spot on. You cannot answer this question as it is not black and white.	10/10/2017 12:51 PM
11	It varies greatly among individuals.	10/5/2017 5:10 PM
12	Based on the WVR310 summaries, which includes individuals budgets we find that some services are not being used over the entire year. Any surplus in the area generally offsets the increased cost in other areas	10/5/2017 10:37 AM
13	Overall the needs are greater than the budget but individually you may have some under and some over.	10/4/2017 11:17 AM
14	It is generally the outliers that cause the most difficulty. In many cases they are not funded, and when they are it is usually short term. There seems to be no mechanism to support the needs of individuals who outside of the normal range of services. At the same time these outliers are increasing.	10/3/2017 1:24 PM

Q13 Which of the below best describes the band payment system's incentives to band financial managers in serving band consumers.

Answered: 26 Skipped: 2



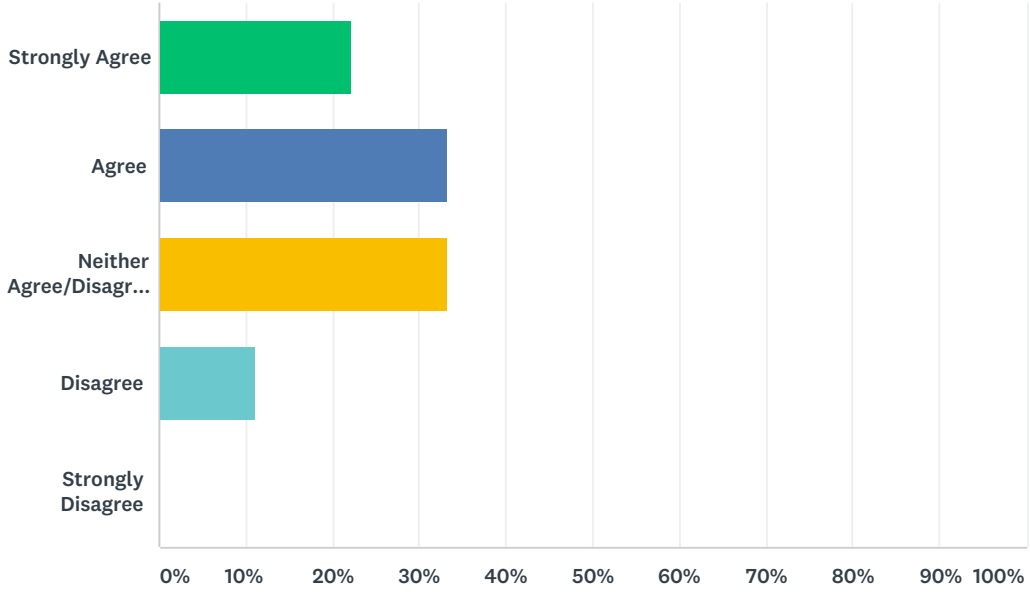
ANSWER CHOICES	RESPONSES	
Incentivizes to appropriately serve band consumers	7.69%	2
Creates no incentives on band consumers' service levels	46.15%	12
Incentivizes to over-serve band consumers	11.54%	3
Incentivizes to under-serve band consumers	19.23%	5
Uncertain	15.38%	4
TOTAL		26

#	OPTIONAL COMMENTS:	DATE
1	As the financial manager the band system provides little to no incentive for the provider to serve individuals with more medical / behavioral challenges.	10/18/2017 12:04 PM
2	Have no clue what you are really asking and think this is another trap question. I will tell you that it isn't making providers "pocket" the money and not serve the units. I know that term was recently used in testimony before the house oversight committee and it was an abhorrent thing for the director of DDSN to say about the boards.	10/16/2017 5:28 PM
3	the system creates an incentive to under-serve consumers - but this statement is not saying that is occurring. each funding band manager looks at requests differently.	10/16/2017 4:29 PM
4	For QPLs that do not serve as the financial manager.	10/16/2017 11:29 AM
5	IGNORE SCORES	10/12/2017 4:43 PM
6	Funding drives service. When funding is inadequate, services have to be cut back and the individual suffers.	10/12/2017 12:41 PM

7	We "manage" the families the best we can but the Case managers can get creative and I personally want families served, to our agency's financial detriment. I am not unhappy that there is an external review process now that keeps me away from the conflict but it still means I have less control on costs. DME stuff is okay except for WHEELCHAIRS! Excessive time to procure and pay, then there is the dual eligible problem and we get blamed for the length of time to procure.	10/11/2017 11:31 AM
8	Human nature is to not spend all of the money and still meet the needs. Again this question is very subjective. As a Provider, we are going to meet the needs of the consumers served regardless of it putting someone over budget. Same holds true if they are "under budget". The object is to serve the consumers and meet their "NEEDS". Not the "WANTS".	10/10/2017 12:51 PM
9	Forced to choose from the above. That is mostly in the past. Today, a more appropriate choice would appear to be "None of the above." Each day expenses incurred seem to be more and more out of the financial managers' control. Respite providers are permitted to threaten families with losing respite services if they do not utilize their total budgeted allotments, even if a family does not want to use the full allocation due to a change in the family's particular status during a month or two out of the year. These funds could be used for other possible supports.	10/5/2017 5:10 PM
10	We often over-serve our consumers	10/4/2017 12:17 PM
11	Needs of the consumers come first and the band system does allow to serve one consumer that has more needs from another consumer that has underspent their budget.	10/4/2017 11:17 AM

Q14 Band financial managers thoroughly document and transmit Medicaid reimbursable expenses to DDSN in order to claim maximum Medicaid reimbursements.

Answered: 27 Skipped: 1



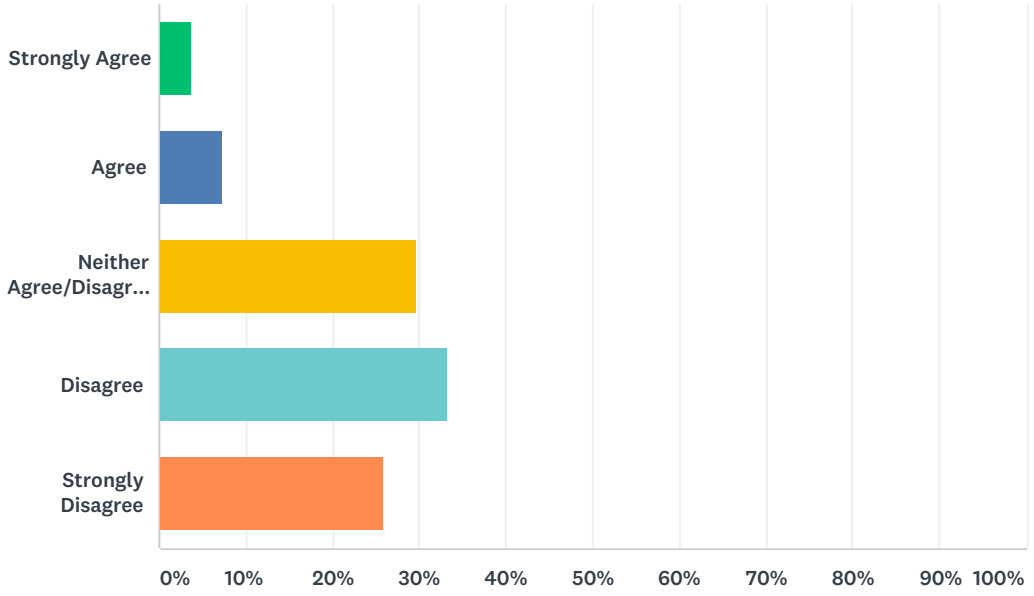
ANSWER CHOICES	RESPONSES	
Strongly Agree	22.22%	6
Agree	33.33%	9
Neither Agree/Disagree or Uncertain	33.33%	9
Disagree	11.11%	3
Strongly Disagree	0.00%	0
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	We do attendance, service provision logs and time sheets, if this is what you are talking about.	10/16/2017 5:28 PM
2	I doubt it - they are somewhat dependent on CM's to do some of this - and that is not always at the top of the list.	10/16/2017 4:29 PM
3	IGNORE SCORES	10/12/2017 4:43 PM
4	We make every effort to catch all Medicaid expenses but some get overlooked. For EM and PVM we pay large amounts upfront which affect cash flow. Then we must wait for DDSN to reimburse, although, DDSN has gotten much better with their turnaround time for reinbursements.	10/12/2017 12:41 PM
5	We do all necessary billing as much as possible, correct units submit error reports but this takes staff time!! Regarding Casemanagement, we have less time to bill for MTCM. You also have an issue with suspension of Medicaid for hospital admissions. Providers , some, are having to send staff with a difficult client, sometimes a hospital requires it. So you still pay us and yet you cannot get reimbursed? I think. Not that I like telling you this, but you all need to get DHHS to allow for this. It used to be that you DDSN had to pay for the actual hospitalization back to DHHS? Not sure if this is still true.	10/11/2017 11:31 AM

6	I think board eat a lot of cost. The burden of additional paperwork sometimes is not worth it.	10/9/2017 3:56 PM
7	Not at 100%, of course. There have been times when DDSN has said inaccurate things that have hurt the ability to bill. I am sure this has also been done by some local administrations.	10/5/2017 5:10 PM

Q15 I am satisfied with DDSN's delivery of support and training to my personnel operating the band payment system.

Answered: 27 Skipped: 1



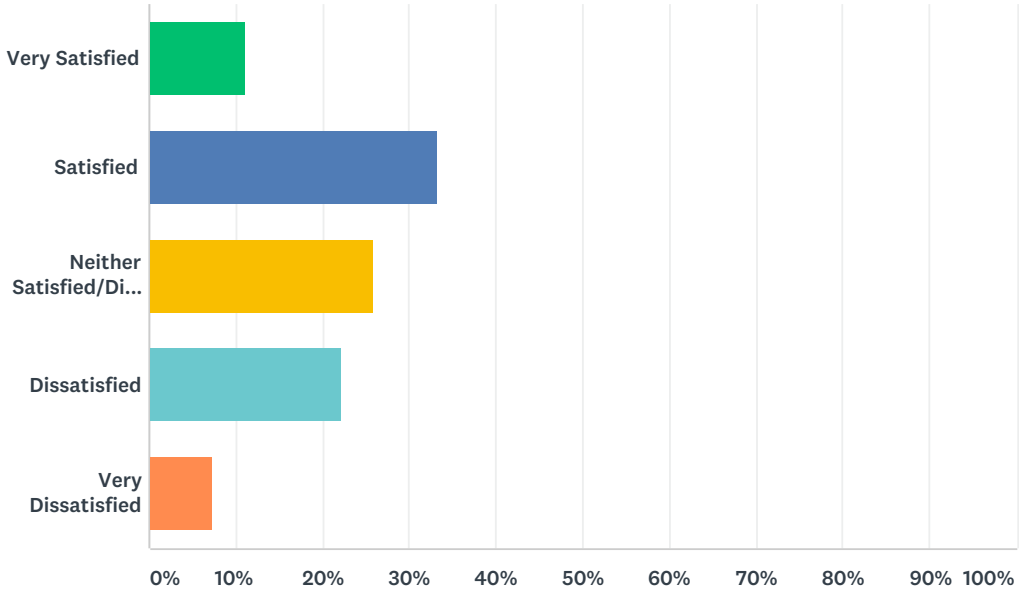
ANSWER CHOICES	RESPONSES	
Strongly Agree	3.70%	1
Agree	7.41%	2
Neither Agree/Disagree or Uncertain	29.63%	8
Disagree	33.33%	9
Strongly Disagree	25.93%	7
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	I think there should be quarterly Financial Training as our system is always changing.	10/23/2017 10:29 AM
2	It takes at least 3 years for a staff to get a good handle on the payment system. It is still confusing at times and many times questions are not able to be answered.	10/17/2017 11:55 AM
3	What training are you referring to? There is no training provided by SCDDSN.	10/16/2017 5:28 PM
4	Not sure which training this is regarding	10/16/2017 4:29 PM
5	We feel that there is never enough training from DDSN especially when it comes to finance.	10/16/2017 2:29 PM
6	would love to have training on the band payment system	10/13/2017 9:37 AM
7	IGNORE SCORE	10/12/2017 4:43 PM
8	It is extremely difficult to have our questions answered when explanations are vague. Sometimes information is not shared until the report of how the money is spent is due. Hard to keep up with information when it is not disseminated.	10/12/2017 3:28 PM
9	More training for Finance Directors would be most helpful. Often, instructions for the implementation of new directives or procedures are unclear. Available training would make implementation much smoother.	10/12/2017 12:41 PM

10	I have a general knowledge of operating the band system payment. However, the support and training to my personnel operating the band payment system is minimal.	10/12/2017 11:33 AM
11	No support. Used to be there was training for this but no longer. Some finance staff at DDSN are very responsive but others don't return calls or emails.	10/11/2017 11:31 AM
12	more training is needed	10/10/2017 4:14 PM
13	There is a need for more frequent training to personnel staff when there is a band change.	10/10/2017 1:13 PM
14	There is no training. It is sad when a new financial manager has to ask for training. Training should be offered on an ongoing basis.	10/10/2017 12:51 PM
15	Too little training has been offered. More has been offered to Case Managers than to actual finance staff.	10/5/2017 5:10 PM
16	Need more financial managers meetings with financial personnel to deal with changes and to learn from each other.	10/5/2017 10:37 AM
17	support yes, training no	10/4/2017 12:17 PM

Q16 Describe your satisfaction in understanding the funding outlier process, to include residential band increases (i.e., from G to H band).

Answered: 27 Skipped: 1



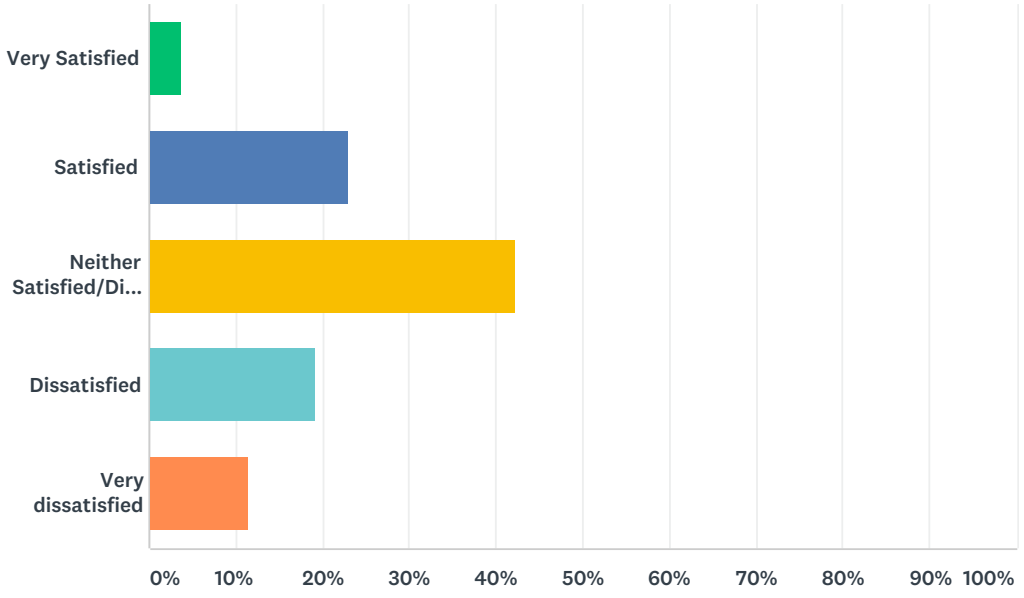
ANSWER CHOICES	RESPONSES	
Very Satisfied	11.11%	3
Satisfied	33.33%	9
Neither Satisfied/Dissatisfied or Uncertain	25.93%	7
Dissatisfied	22.22%	6
Very Dissatisfied	7.41%	2
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	The process is unclear and may not be applied consistently among all providers.	10/18/2017 12:04 PM
2	District office is supportive of our requests. After that process, not sure we understand the process. Rarely have we requested a Band G to H but generally it is funded, although some have been funded for a temporary time period to determine if situation will improve.	10/17/2017 11:55 AM
3	It isn't a matter of "satisfaction". Do you know the system or not – yes I know the system and our outliers are routinely re-justified based on the documentation submitted annually. The real question is – are you satisfied with the explanation of Outlier system – and that would be a resounding "NO".	10/16/2017 5:28 PM
4	IGNORE SCORE	10/12/2017 4:43 PM
5	Outlier requests and requests for funding to go from Band G to H is difficult to fill out.	10/12/2017 12:41 PM
6	I have a general knowledge of operating the band system payment. However, the support and training to my personnel operating the band payment system is minimal.	10/12/2017 11:33 AM

7	The forms and directive do not match the type of request for Band B's or a funding band change. The outlier process used to mean direct staff funding for one client. I do think anyone with behavior issues of a severe nature should be routinely reviewed. Again the SIS does not cover behavior needs.	10/11/2017 11:31 AM
8	it is confusing.	10/10/2017 4:14 PM
9	More training needed here as well.	10/10/2017 1:13 PM
10	But I must say that I don't trust it. This is from historical experience and is not based on actions of the current State Director.	10/5/2017 5:10 PM
11	need to be more flexible. The decision is subjective.	10/4/2017 12:17 PM
12	Very cumbersome process. Sometimes the regional office approves the outlier and central office denies the request. Becomes very confusing. Person does better band is removed. Reason for person doing better is because of the band. Makes no sense.	10/3/2017 1:24 PM

Q17 Describe your satisfaction of the fairness of the funding outlier process, to include residential band increases (i.e., from G to H band).

Answered: 26 Skipped: 2



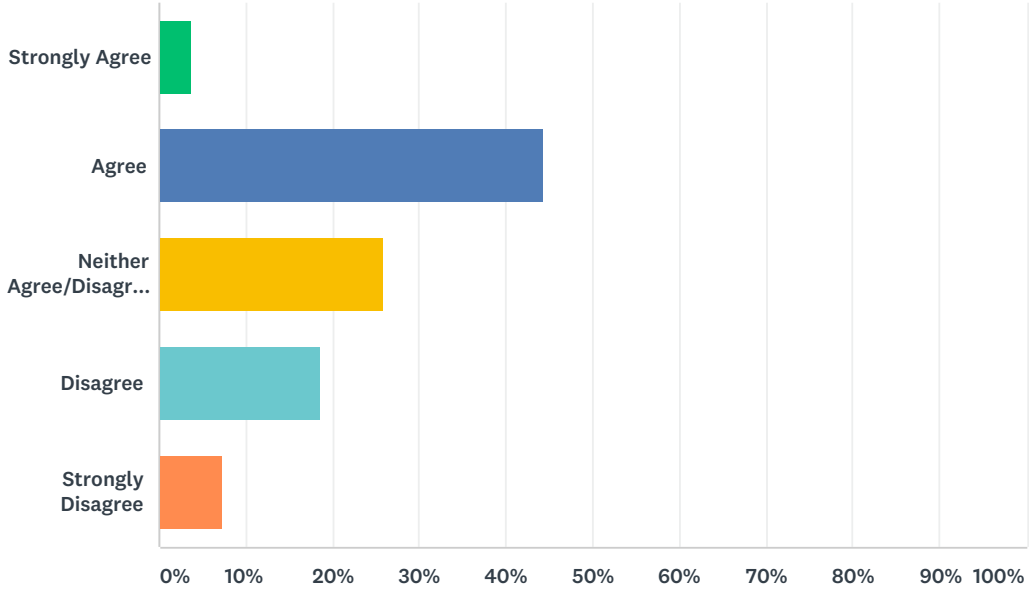
ANSWER CHOICES	RESPONSES	
Very Satisfied	3.85%	1
Satisfied	23.08%	6
Neither Satisfied/Dissatisfied or Uncertain	42.31%	11
Dissatisfied	19.23%	5
Very dissatisfied	11.54%	3
TOTAL		26

#	OPTIONAL COMMENTS:	DATE
1	The process is unclear and may not be applied consistently among all providers. It appears to be based more on current economic situation rather than consumer needs.	10/18/2017 12:04 PM
2	Not sure how they make decisions.	10/17/2017 11:55 AM
3	They don't fund the individual based on their needs they fund the agency based on their financial health.	10/16/2017 5:28 PM
4	Have had some success converting some Gs to Hs but in over 10 years, have never been granted an "outlier." Always told, outliers are maxed out.	10/16/2017 11:29 AM
5	IGNORE SCORE	10/12/2017 4:43 PM
6	Very difficult to get a new outlier approved - rarely has occurred. When reapplying the fact that DSP salaries have increased is never taken into account. So each year we receive less money and have to cut the hours.	10/12/2017 3:28 PM
7	Many legitimate requests have been sent to DDSN from this agency, but few have been granted.	10/12/2017 12:41 PM
8	I have a general knowledge of operating the band system payment. However, the support and training to my personnel operating the band payment system is minimal.	10/12/2017 11:33 AM

9	very little feedback nor guidance on what we really need to submit, who reviews, how often. Too often I hear, you have money in the bank, so we will not likely increase your funding. the Band system doesn't incentivize us to take "difficult "consumers if we are stuck because we are doing well financially? Seriously. If its about consumers and services, then why consider about our bank cash balances?	10/11/2017 11:31 AM
10	It is a convoluted system. Even with justifications, there is no guarantee that the increase in residential funding band will be approved. If you wait to the end of the fiscal year, the answer that you receive is that they (DDSN) is out of money and that is the reason for the band rate denial instead of looking at the need of the consumer(s).	10/10/2017 12:51 PM
11	It's been much better since it is processed initially at the district level instead of central office.	10/9/2017 3:56 PM
12	Better than it once was. There will always be a need for an outlier process. It should not be a bailout based upon providers' financial incompetence. When bands change this is pretty much ongoing. This ends up with the least competent, not only being able to remain solvent, eventually but also getting large profits if there is organizational improvement. An actual bailout with strong demands/expectations would be less expensive for the system.	10/5/2017 5:10 PM
13	hard to get and subjective	10/4/2017 12:17 PM

Q18 Case managers' annual consumer budget service requests generally match the consumers' unique person centered needs factoring in the consumers' natural support environment.

Answered: 27 Skipped: 1



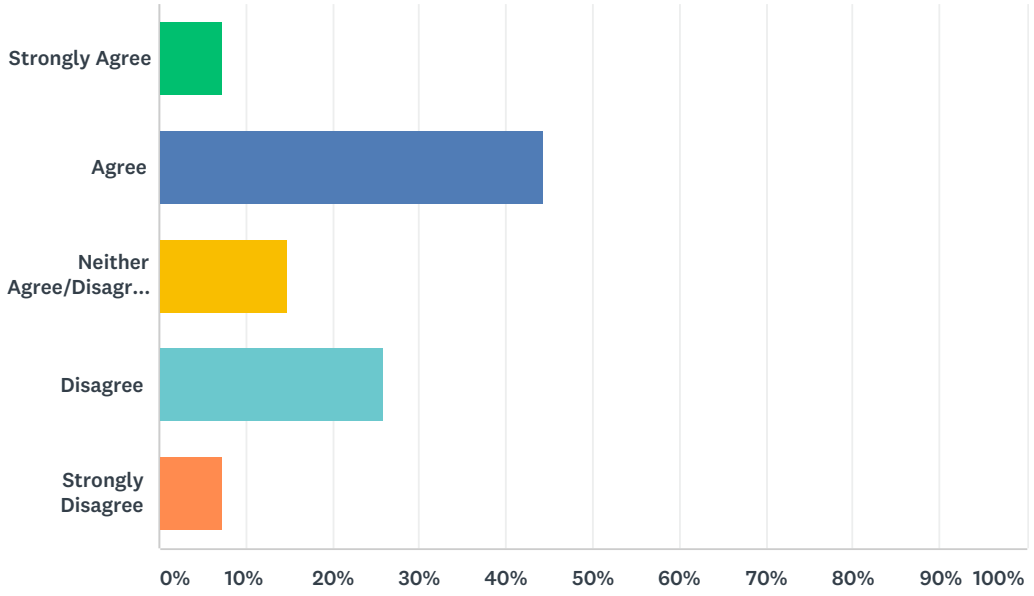
ANSWER CHOICES	RESPONSES	
Strongly Agree	3.70%	1
Agree	44.44%	12
Neither Agree/Disagree or Uncertain	25.93%	7
Disagree	18.52%	5
Strongly Disagree	7.41%	2
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	Now there appears to be a loss of control in waiver budget approval concerning consumer needs since the implementation of the waiver administration division.	10/18/2017 12:04 PM
2	They try to take into account the natural support environment but family is very resistant when the person to provide the care is a family member.	10/17/2017 11:55 AM
3	The numbers in the budgets do not correspond to the current bands for residential consumers. The consumers change – they age, get sick, break a bone, get better, decrease behaviors – they change; but their band does not so how can it ever be said that there is anything unique or person-centered about these budgets?	10/16/2017 5:28 PM
4	There are numerous changes throughout the year	10/16/2017 4:29 PM
5	IGNORE SCORE	10/12/2017 4:43 PM
6	CMs approve all services requested whether or not there is an actual need and often without any consideration regarding how the approved service is to be paid.	10/12/2017 12:41 PM

7	its only based on what a person can get via waiver, not what else is available to help the family. It is a "waiver budget" not a personal budget that considers how much a family is also out of pocketing. Don't think you really want to go there?	10/11/2017 11:31 AM
8	There are cases where the consumer's annual budget does not match their unique person centered needs. In order to adequately provide unique person centered needs, each individual budget should be funded to match their needs and desires.	10/10/2017 1:13 PM
9	I don't think that Case Managers always take the natural environment into consideration. If a CM has been working with the family for a long time, a relationship develops and Needs vs. Wants sometimes goes out the window. Hard to say no to a family when you have a friendly relationship with them and are concerned for the care and well being of the individual.	10/10/2017 12:51 PM
10	Note: ICFs/IID have no case management funded. A single funding band is received for those in ICFs/IID. All case management must come from the residential funding bands for these individuals.	10/5/2017 5:10 PM

Q19 I understand the waiver services expected and corresponding cost assumptions contained in each residential funding band.

Answered: 27 Skipped: 1



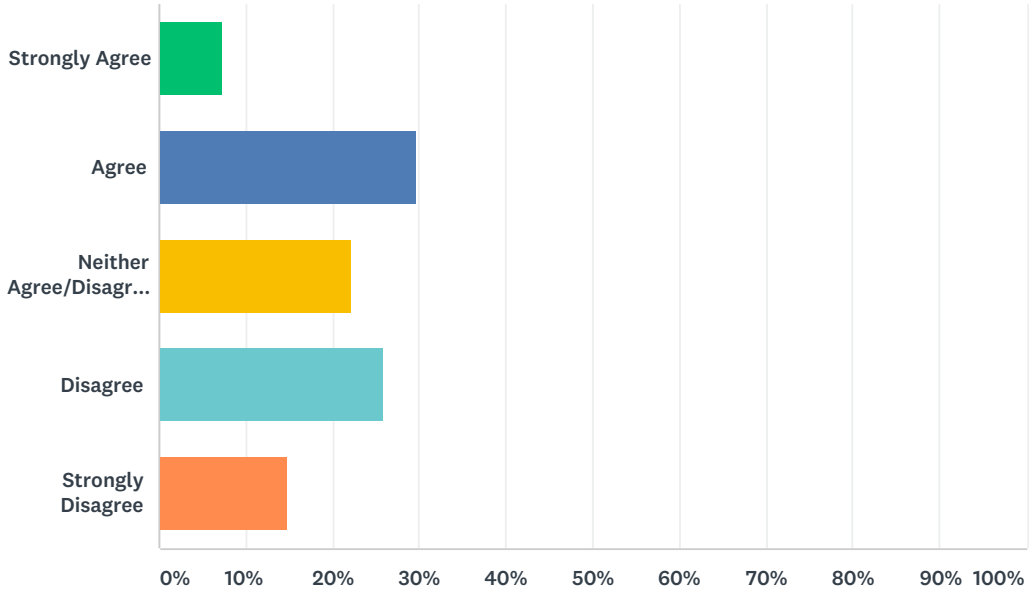
ANSWER CHOICES	RESPONSES	
Strongly Agree	7.41%	2
Agree	44.44%	12
Neither Agree/Disagree or Uncertain	14.81%	4
Disagree	25.93%	7
Strongly Disagree	7.41%	2
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	The system is confusing and inconsistently applied.	10/18/2017 12:04 PM
2	waiver service expectations - depends on whose definition of waiver services. Cost does not appear to coincide with expectations. Unfunded mandates or changes in interpretations of wavier service expectations.	10/17/2017 11:55 AM
3	I have no clue as to the thought process that goes into the development of these bands. I want to know, I asked to be told and I still do not know. I do know what waiver services are expected – and we provide them or pay for them. The assumptions that are contained in each – not so much.	10/16/2017 5:28 PM
4	We feel that we understand this process but would love to have some training in this area for any changes and bringing us up to date of all elements of this.	10/16/2017 2:29 PM
5	IGNORE SCORE	10/12/2017 4:43 PM
6	Questionable services are usually "in the band payment" per DDSN	10/12/2017 12:41 PM
7	I have a general knowledge of operating the band system payment. However, the support and training to my personnel operating the band payment system is minimal.	10/12/2017 11:33 AM

8	Moving behavior supports to within the res hab service will likely increase costs but give us flexibility. Meds now being covered is a good thing, but DME stuff is hard to understand. Wheelchair providers are NOT available and cost excessive now. the amount of time we have to wait to get someone a wheelchair is excessive and families complain and blame us.	10/11/2017 11:31 AM

Q20 The band payment system promotes a trusting business relationship between providers and DDSN.

Answered: 27 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly Agree	7.41%	2
Agree	29.63%	8
Neither Agree/Disagree or Uncertain	22.22%	6
Disagree	25.93%	7
Strongly Disagree	14.81%	4
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	Providers are painting some consumers as being more challenging to increase the funding bands. There is no reliable way to fact check what is written prior to granting band payments.	10/19/2017 8:18 PM
2	By allowing the band funding to be moved from one residence to another, without permission, does require trust in that we will use the money where needed. I appreciate that level of freedom and responsibility.	10/17/2017 11:55 AM
3	How can you have a trusting business relationship when not even a bevy of auditors can unravel the complex band system, when no one can follow the tangled money trail which makes up the band rates? How can you trust when increases are given to the rates because of retirement, insurance, raises etc. you are not privy to the formula as to how the money is distributed? The band system is as inflexible as steel for some providers and as expandable as rubber for others. No – there is no way one can have a trusting business relationship with a system that is so secretive, so manipulative and such a bully.	10/16/2017 5:28 PM
4	It has been the source of much concern over the years	10/16/2017 4:29 PM
5	We are not stating that there is a trust problem but we do think that we could have more detail explanation of the full band amount and how what each providers gets is arrived at. Knowledge of state and federal dollars.	10/16/2017 2:29 PM

6	IGNORE SCORE	10/12/2017 4:43 PM
7	The Band payment system is based on averages. There are some individuals who spend more that the Band funds and others who spend less. The idea is that the two would balance themselves out. At our agency, that is not the case. We are always substantially upside down and pay far more in services than we receive in Band B payments.	10/12/2017 12:41 PM
8	That is difficult to respond as I can only measure that against our experience. We are not privy to how DDSN deals with other providers and if they assist then when they are unable to stay within budget. I can only say, that we have not asked for additional funding outside of the band payment system, capital grant applications, housing trust fund applications, etc...	10/10/2017 12:51 PM
9	for the most part	10/4/2017 12:17 PM

Q21 If you responded “disagree” or “strongly disagree" in above questions #20, narratively describe the factor(s) associated with the band payment system undermining a trusting business relationship with DDSN.

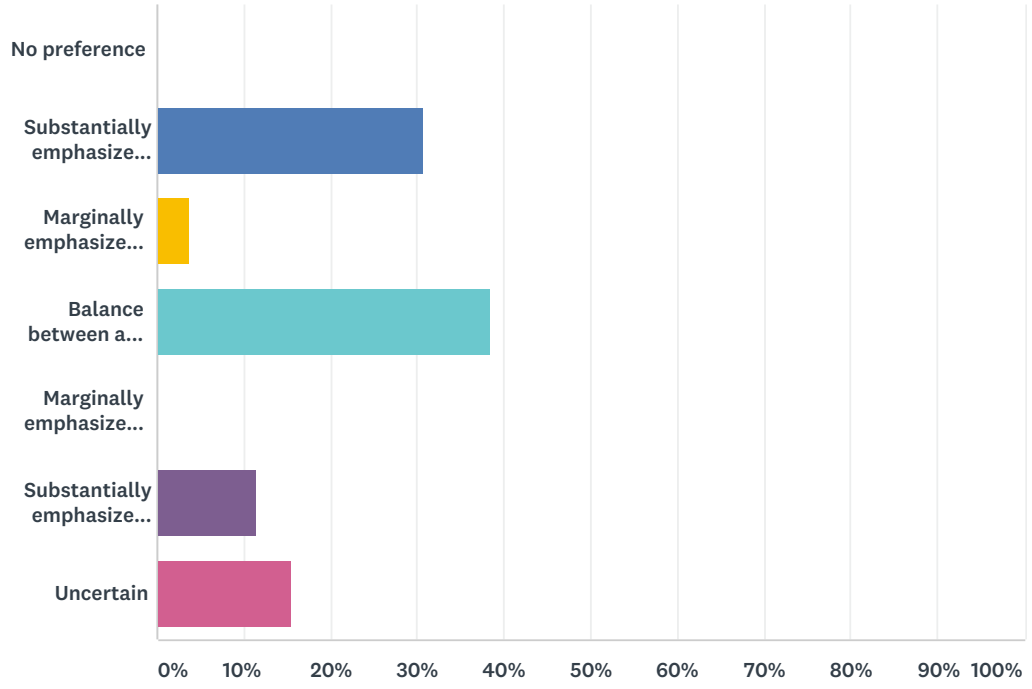
Answered: 11 Skipped: 17

#	RESPONSES	DATE
1	How can you have a trusting business relationship when not even a bevy of auditors can unravel the complex band system, when no one can follow the tangled money trail which makes up the band rates? How can you trust when increases are given to the rates because of retirement, insurance, raises etc. you are not privy to the formula as to how the money is distributed? The band system is as inflexible as steel for some providers and as expandable as rubber for others. No – there is no way one can have a trusting business relationship with a system that is so secretive, so manipulative and such a bully.	10/16/2017 5:28 PM
2	I think it has been the cause of much concern over the years. I think it is a difficult system to explain - and this has caused some questions	10/16/2017 4:29 PM
3	It appears that preferences are given to some Boards.	10/16/2017 11:29 AM
4	Providers are expected to provide services without increases due to rising costs and the increased needs of the individuals. Responses from DDSN staff do not always match or you cannot get a response.	10/12/2017 3:28 PM
5	The band payment system falls short in providing the necessary funds to provide quality care for the individuals we support. It is not so much about trust as it is about funding shortfalls.	10/12/2017 12:41 PM
6	While the band structure is a simple managed care type of payment , there is no routine adjustment that encourages us to be creative in staffing for the new CMS rule. More employment, means more 1:1 training and more staff, DUH. How does DDSN and DHHS plan to allow for that as well as punish us when we continue to see news stories about choking, deaths, abuse and the list goes on? Why do we continue to implement the CMS rule and hear about it's costs being "revenue neutral"? That is not possible. This is why I contemplate joining with another provider to spread the risk, but the irony is that several years ago "bigger" providers were not desirable. Yours and DHHS pay structure incentivize bigger providers yet small, quality operations cannot survive without an administrative structure to support competition. The only way we have survived is by growing bigger , but again, the irony is can you provide quality in a bigger agency? I personally don't think so. The fact that you consider our bank balances when making band b adjustments is interesting. Communication is lacking but it does go both ways. Certain providers have made you not trust us, yet there still needs to be informal exchange of information that used to happen or it will get worse. Effective meetings were elusive in the past with domineering personalities. Time to revisit?	10/11/2017 11:31 AM
7	the one size fits all model for bands/consumers is outdated. Some consumers need more and some less than others,but most need more than what is allocated. And anything needed seems to be "in the band" whenever funds are asked about or requested.	10/10/2017 4:14 PM
8	It is an unbiased system based on needs and placement type.	10/9/2017 3:22 PM

9	Because it can't be sufficiently explained in a manner that is understandable to most individuals working within the system including many individuals working at DDSN and especially within the provider network. All the factors making up a band are not sufficiently explained. The financial manager system is a disaster. Risk is being transferred to providers who have no control over the expenditures of other agencies. New direct billed rates get passed on to financial managers and they have no control over their authorizations, receive no new funds for them (sometimes) and if this presents a larger problem in one area of the state than another and not enough people are screaming, nothing gets done. Some providers have been bailed out by simply changing funding bands to help them financially without really looking at the needs of the individuals when compared to other individuals in other agencies with similar needs. In the past, outliers were only awarded in District I based on whether or not your overall financial statements showed gains or losses. People moving from a regional center to a community residence established especially for them were funded at a higher level than those who filled vacancies in an existing community residence. DDSN keeps saying that the beauty of the funding band system is that you can move money around where it is needed and this is how you can handle the expected ICFs/IID losses. But everyone does not have ICFs/IID. Some have quite a few; others only one. Those without any ICFs/IID can profit from the existing system. They do not have to cover such expected losses.	10/5/2017 5:10 PM
10	DDSN should annually release how the funding bands are calculated and compared to the Medicaid reimbursement rate.	10/3/2017 3:31 PM
11	Not sure what is exactly in the band rate.	10/3/2017 1:24 PM

Q22 The band payment system has been described as a payment system emphasizing stability in the statewide ID Medicaid waiver delivery system and a support safety net for providers through such policies as prospective payments; one-time grants; residential capital funding; Medicaid billing; assumption of financial risks for Medicaid ineligibles & audits; 30 day residential vacancy funding; and 80% attendance allowance in adult day & residential. On the other end of the spectrum for potential provider payment systems, the DDSN stabilizing and safety net policies could be reduced through converting these policy costs into increased rates paid retrospectively through a traditional Medicaid fee-for-service (FFS) reimbursement model. What type of payment system model preference, if any, do you have?

Answered: 26 Skipped: 2



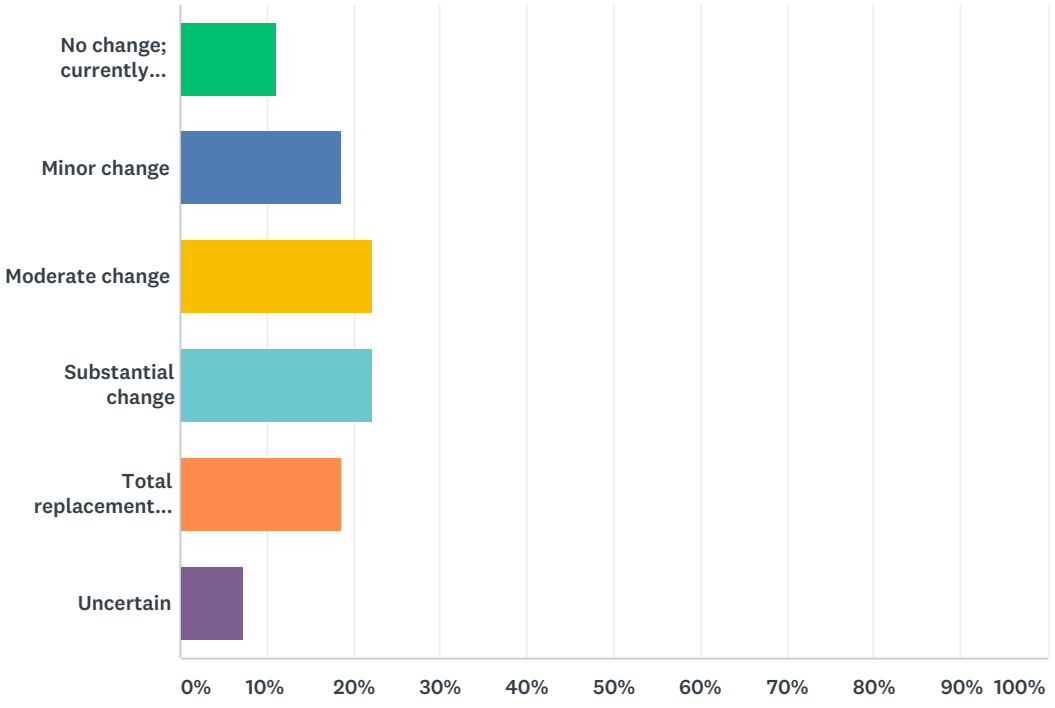
ANSWER CHOICES	RESPONSES	
No preference	0.00%	0
Substantially emphasize statewide service delivery system stabilization and support safety net	30.77%	8
Marginally emphasize statewide service delivery system stabilization and support safety net	3.85%	1
Balance between a statewide service delivery system stabilization/safety net and increased fee-for-service rates paid retrospectively	38.46%	10
Marginally emphasize increased rates fee-for-service paid retrospectively	0.00%	0
Substantially emphasize increased rates fee-for-service paid retrospectively	11.54%	3

Uncertain	15.38%	4
TOTAL		26

#	OPTIONAL COMMENTS:	DATE
1	What do the first 3 things on this list even mean? Are they code for “band system”? Does the state have a “support safety net for providers” such as hospitals, doctor’s offices, pharmacies? Do they get paid in a prospective manner? Good providers will manage properly – bad providers need to be replaced by good providers. What you state in the question regarding what has been said (and I do not know by whom this has been said but I would suspect they either work for DDSN or for an agency significantly supported by this “safety net” the question refers to) about the band system is not the only thing that has been said about the band system. It has been said that the band system is woefully inadequate to meet the needs of the more difficult people we support – as evidenced by the need for outliers, special bands, negotiated rates, capital grants. If the rate was figured correctly monies for expansion would be considered, money for transportation and maintenance would be properly included – it is not at this point. In addition, this system has created a very paternalistic relationship between the boards and the state office with the state stifling innovation and creativity by burying the provider under a mountain of regulation, data mining and plain old interference in the day to day operations.	10/16/2017 5:28 PM
2	I am interested in seeing what options are available in an effort to make an informed decision. Perhaps there are other models already available that could benefit this state.	10/16/2017 4:29 PM
3	Would love to have more detail information to determine which would be more beneficial to us.	10/16/2017 2:29 PM
4	IGNORE SCORE	10/12/2017 4:43 PM
5	Small providers will become destabilized in a retrospective system. We will have to join with others to survive.	10/11/2017 11:31 AM
6	Capital funding and grants could still be available under a system with increased fee for service rates being paid retrospectively. These are not Medicaid funds, so I do see them as different issues.	10/5/2017 5:10 PM
7	Providers need to provide services under the current system of funding with the Medicaid billing to continue being done by DDSN. providers do not have systems to deal directly with Medicaid.	10/5/2017 10:37 AM
8	We LIKE the ways things are done now. While we can improve on providing training things are fine.	10/4/2017 12:17 PM
9	Our inclination is to recommend fee-for-service system. However, this is a cost/benefit analysis that can't be completed until all the variables are known. How much would the rates increase in return for the increased risk and retrospective payment? If that amount is marginal, then the answer is to find a balance between the systems. If the rates would increase significantly, then the ability to assume additional risk and transition to FFS would be a viable option.	10/3/2017 3:31 PM
10	I think there needs to be a way to create a more flexible system that is responsive to the individual needs and costs associated with providing services. That would require more level so payments. Fee for Service while attractive in some cases puts a lot more risk on the provider. Not sure if that offsets the issues that we currently have with the bands	10/3/2017 1:24 PM

Q23 How would you characterize the level of change, if any, needed for the current band provider payment system to perform at an effective level?

Answered: 27 Skipped: 1



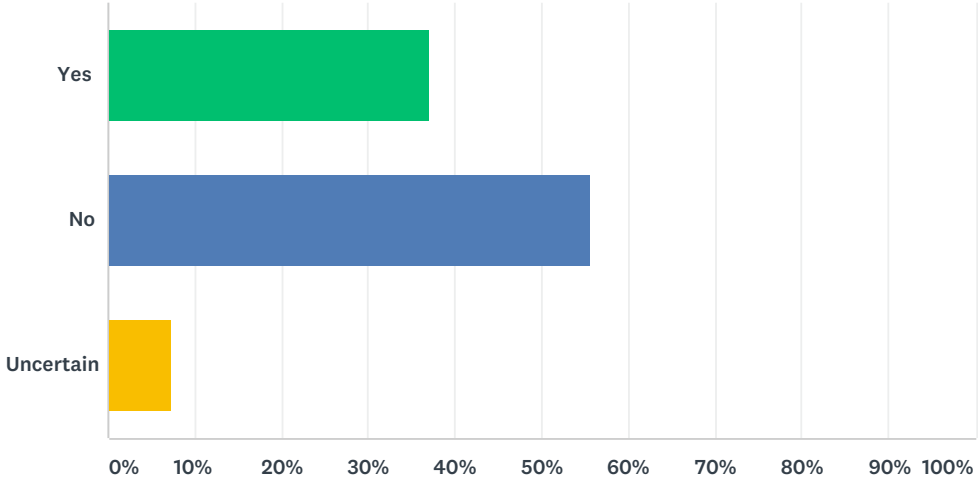
ANSWER CHOICES	RESPONSES	
No change; currently operating effectively	11.11%	3
Minor change	18.52%	5
Moderate change	22.22%	6
Substantial change	22.22%	6
Total replacement with a new provider payment system	18.52%	5
Uncertain	7.41%	2
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	A fee for service direct-billed to HHS system would be a total replacement.	10/16/2017 5:28 PM
2	I think we need to consider consumers when thinking about this question. The payment system should be easily understood and easy to articulate	10/16/2017 4:29 PM
3	As far as process of payments there should not be any changes. However if you are referring to band amounts then there should be some changes in how that is determined.	10/16/2017 2:29 PM
4	IGNORE SCORE	10/12/2017 4:43 PM
5	Substantial change is need to the Band B waiver payment structure.	10/12/2017 11:33 AM

6	Since bands does not always meet the needs of the individual with unique person centered status, the need for a new provider payment system should be considered.	10/10/2017 1:13 PM
7	There has to be a cost of living adjustment factored in.	10/9/2017 3:56 PM
8	The financial manager should move away from any service provider or CM provider doing it. I prefer its being done by the state, but there are states where there are specific entities who for the system do nothing but financial management.	10/5/2017 5:10 PM
9	we need to regularly review and evaluate the system and adjust and make changes as needed	10/4/2017 12:17 PM
10	Band levels need to be re-based to provide enough funding to properly and adequately provide services to all of our consumers.	10/4/2017 11:17 AM
11	Once again, our inclination is to recommend a new payment system. However, all of the variables have to be known in order to do a full evaluation. We do not have enough data provided to us to calculate the net impact to our organization and the individuals it serves.	10/3/2017 3:31 PM

Q24 For fiscal year 2017 (7/1/2016 – 6/30/2017), did your total annual prospective band payments provide adequate funding to meet the service needs of your consumers?

Answered: 27 Skipped: 1



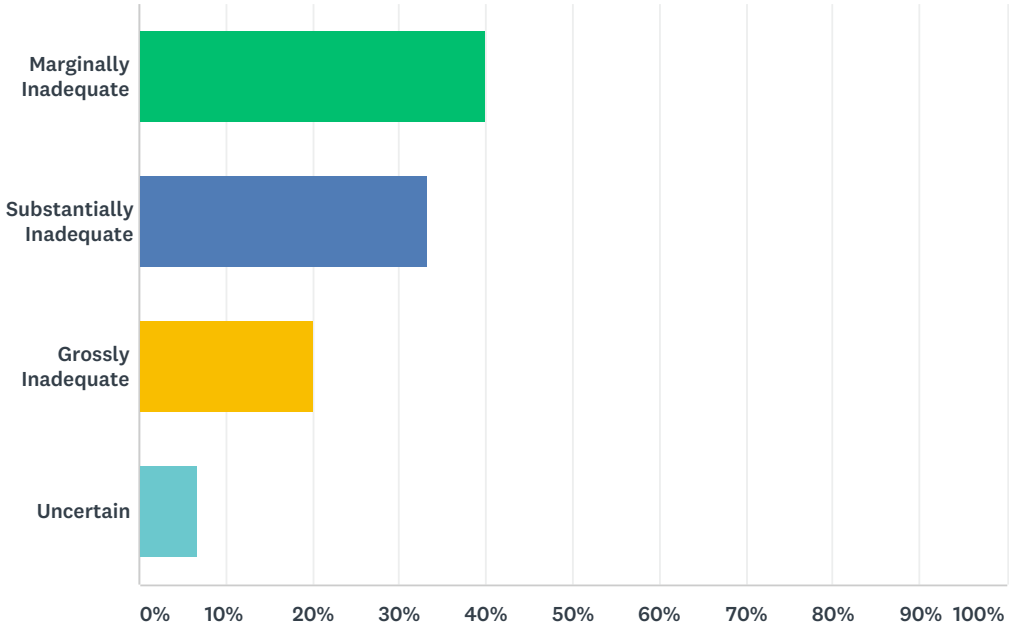
ANSWER CHOICES	RESPONSES	
Yes	37.04%	10
No	55.56%	15
Uncertain	7.41%	2
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	Not in all situations. OSS funds were used to support bands in the CRCF homes.	10/19/2017 8:18 PM
2	Barely. Only because we work hard to keep cost down and not make decisions that will have a long-term impact financially. We have not begun to address CMS final rule expectations.	10/17/2017 11:55 AM
3	I don't want to answer this because it doesn't matter what our funding is – we always meet the needs of the individuals we support. We always manage to put savings into the bank. We do this because one, it is the right thing to do and two, we manage our business well. So if I answer "yes" DDSN gets to say see "the band system is awesome and meets everyone's needs" and if I answer no, you get to say – "oh no, they are not meeting the needs of the consumers". It is, like most of these questions, a trap.	10/16/2017 5:28 PM
4	I had funding to meet needs; however, I do not pay staff or caregivers at rates that I would like to pay.	10/16/2017 4:29 PM
5	The band payments provided an adequate funding for our individuals because we were very sensitive in all our spending of these dollars.	10/16/2017 2:29 PM
6	IGNORE SCORE	10/12/2017 4:43 PM
7	Some costs were covered by reserves.	10/12/2017 3:28 PM
8	Most all of our residential programs and Band B program operated at a deficit for year end (before depreciation)	10/12/2017 12:41 PM
9	We were able to provide adequate funding to meet the service needs of your consumers, however it was due to the increases received in the day program rate and with very close budget monitoring.	10/12/2017 11:33 AM

10	Our fund balance took at $223,000 dive this year. All due to Band costs and additional staffing costs in all programs. We have not funded our GASB liabilities and I see a staff reduction forthcoming. under non-cap programs we lose in Early Intervention always. You must consider and adjustment here.	10/11/2017 11:31 AM
11	Lost $1.3 million if FASB is included. Roughly $750,000 of this was for 4 ICFs/IDD. Lost $1/2 million if depreciation and FASB are not included, which shows that locally the ICFs/IDD were by far the greatest contributor to the deficit.	10/5/2017 5:10 PM
12	Residential Vacancies proved costly due to those meeting to fill beds versus the number of critical approved for beds	10/5/2017 10:37 AM
13	We would have hired more people to provide more supervision (thus more costs) if we would have had the funding. We would have also been able to do more things to address the "final rule".	10/4/2017 11:17 AM
14	Band B's killed us.	10/3/2017 1:24 PM

Q25 If you responded "No" in above question #24, how would you assess the inadequacy of your total annual prospective waiver band payments?

Answered: 15 Skipped: 13



ANSWER CHOICES	RESPONSES	
Marginally Inadequate	40.00%	6
Substantially Inadequate	33.33%	5
Grossly Inadequate	20.00%	3
Uncertain	6.67%	1
TOTAL		15

#	OPTIONAL COMMENTS:	DATE
1	Again – a trick question. We meet the needs of our consumers, we serve all of our units and we manage our business closely, so we are able to retain a savings from the bands. It isn't because the bands are overly generous, it's because we are not top-heavy with managers, we watch overtime and keep our turnover manageable and we do not have any ICFs.	10/16/2017 5:28 PM
2	some funding bands	10/16/2017 4:29 PM
3	Funding levels are not enough to cover expected services to be provided	10/12/2017 12:41 PM
4	There were times when the annual waiver budget payment did not cover all expense associate with that individual.	10/10/2017 1:13 PM
5	The ICF/DD vs CRCF payment systems clearly show that the band payment system needs some type of overhaul or replacement and has for years. This should no longer be overlooked.	10/5/2017 5:10 PM
6	We have to pay staff more because of our location	10/4/2017 12:17 PM
7	It comes down to unfunded mandates. We keep hearing that it is in the band. Our budget shows otherwise. The Band B is particularly challenging since there are no controls on that cost center.	10/3/2017 1:24 PM

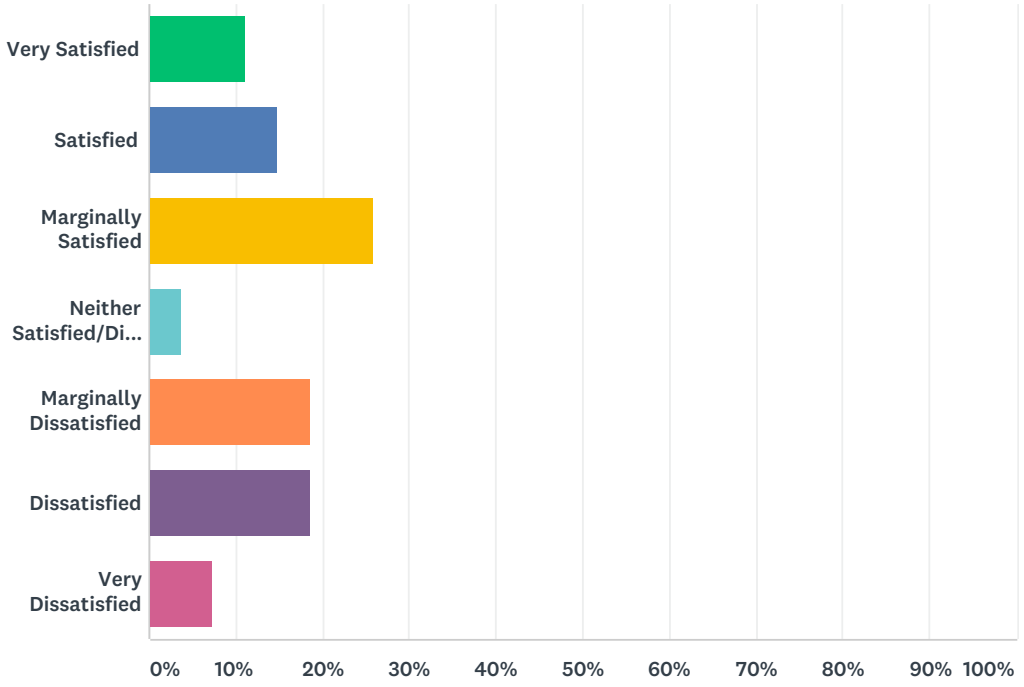
Q26 If you responded "No" in the above question #24, narratively describe how the inadequate funding impacted meeting the service needs of your consumers.

Answered: 14 Skipped: 14

#	RESPONSES	DATE
1	Lack of funding meant reductions in some areas such as recreational trips and etc. Most critical needs were adequately addressed.	10/19/2017 8:18 PM
2	ICF funding is inadequate.	10/16/2017 2:49 PM
3	Consumer's medical needs, staffing needs (overtime) to accommodate health and behavior issues exceeded the band payment for the individuals.	10/13/2017 9:37 AM
4	Issues with consumers and not having enough staff to cover their needs caused people to leave employment. With the swinging door services and consumers are directly affected.	10/12/2017 3:28 PM
5	Basic needs were met. Quality of life issues and desires of the individuals we support were sporadic at best and non-existent at worst.	10/12/2017 12:41 PM
6	I added nursing staff and direct care staff but it is causing us to take a loss to do it. I will reduce admin staff first before we let direct staff go.	10/11/2017 11:31 AM
7	difficulty with mostly residential services and supports, transportation, etc.	10/10/2017 4:14 PM
8	The consumers budget did not cover all medications/medical supplies and etc. The Board end up covering these expense.	10/10/2017 1:13 PM
9	The agency was able to maintain service with money from the agency's reserves.	10/9/2017 3:56 PM
10	We have exhausted our financial reserves to prevent a major negative impact on any individuals served. We can, of course, no longer do this and, therefore, Board is considering instructing DDSN to find another operator for our ICFs/IDD. This is not something we want to do. Individuals receiving other programs/services have been negatively impacted because we can not provide them with so much that their funding bands would otherwise permit us to provide for them. Have to channel so much of other bands to the ICFs/IDD prevents day and residential services from moving forward toward compliance with the final rule.	10/5/2017 5:10 PM
11	it did not because of supplemental funds received from the local government	10/4/2017 12:17 PM
12	We would have hired more people to provide more supervision (thus more costs) if we would have had the funding. We would have also been able to do more things to address the "final rule". This would have cut down on some critical incidents that we had because of a lack of funding.	10/4/2017 11:17 AM
13	Services remain basic, non-innovative, not focused next level quality. Inadequate staffing patterns, particularly in high maintenance settings, has contributed to high turnover in these homes.	10/3/2017 3:31 PM
14	See above.	10/3/2017 1:24 PM

Q27 Describe your satisfaction with the current band payment system for providers.

Answered: 27 Skipped: 1



ANSWER CHOICES	RESPONSES	
Very Satisfied	11.11%	3
Satisfied	14.81%	4
Marginally Satisfied	25.93%	7
Neither Satisfied/Dissatisfied or Uncertain	3.70%	1
Marginally Dissatisfied	18.52%	5
Dissatisfied	18.52%	5
Very Dissatisfied	7.41%	2
TOTAL		27

#	OPTIONAL COMMENTS:	DATE
1	I like the flexibility to move funds around and that is absolutely necessary as band levels are not appropriate. If we have to return to program specific budgeting or individual budgeting based on needs, without flexibility, the work load of finance staff will greatly increase. We are working with people whose needs and situations change frequently, flexibility is necessary.	10/17/2017 11:55 AM
2	A band system may be fine – but we don't have a pure band system. There are Band-Aids and patches all over this system. Different rates for different providers with virtually the same service (high management). Direct-billers get to go straight to HHS and change their rates and we simply have to pay. The system is way too opaque and arbitrary – it simply begs an overhaul.	10/16/2017 5:28 PM
3	I understand the system - the public does not	10/16/2017 4:29 PM

4	Again if this is referring to band amounts and when increases are given we are not satisfied with that. We feel that costs increase each year but band rates are not increased and need to be looked at in this area.	10/16/2017 2:29 PM
5	IGNORE SCORE	10/12/2017 4:43 PM
6	the process to seek adjustments is unclear. Also , DDSN reviews the overall agency health before considering an change or increase in a band.	10/11/2017 11:31 AM
7	ICF/IDD situation is being almost totally ignored by DDSN and DHHS - or at least it seems so. I have been squawking about this for many years. If they were the regional centers, I believe we would have seen some action long ago to get their rates up. The situation must change and, hopefully, this endeavor will bring about that change. Unfortunately, for some of the people served that change may come too late.	10/5/2017 5:10 PM
8	the system- yes, the money-no	10/4/2017 12:17 PM
9	I do not think the requirement that we must spend at least 98% of capitated funding and have no more than 2 months of operating is a good practice. I believe this could encourage providers to spend more in order to meet these requirements. 2 months operating is not enough. Providers should be encouraged to have more set aside especially if payments will eventually be sent after the services are delivered.	10/4/2017 11:17 AM
10	It comes down to unfunded mandates. We keep hearing that it is in the band. Our budget shows otherwise. The Band B is particularly challenging since there are no controls on that cost center. 1.	10/3/2017 1:24 PM

Q28 Please narratively describe your top 3 issues (positive or negative) in rank order (1, 2, & 3) with the current DDSN provider payment system.Mandatory Comments:

Answered: 25 Skipped: 3

#	RESPONSES	DATE
1	1. Direct Care Professionals should be paid better, at least $13.00 hrly based on their responsibilities. 2. Capital Grants for renovations should be a priority, staff/consumers being displaced for several years is negative. Projects should have reasonable completion dates. 3.ongoing /adequate training for new initiatives such as Therap prior to the implementation.	10/19/2017 8:18 PM
2	1) Positive - Money received prospectively 2) Positive - ability to request capital funding 3) Positive - 30 day funding for vacancies 1) Negative - limited to 3 month reserve (min should be 6 months) 2) Negative - Spend or pay back promotes tendency to change purchasing habits. 3) Negative - Current band system has not been reassessed to address inflation.	10/18/2017 12:04 PM
3	positive - Flexibility negative - Untimely amendments/adjustments negative - Outlier threshold is too high	10/17/2017 11:55 AM
4	1. It is not transparent 2. It is arbitrary 3. It penalizes boards who manage their businesses well while rewarding those boards who mismanage their business.	10/16/2017 5:28 PM
5	1. Rate - Case Management rates not adequate and Rate - Early Intervention rates not adequate Quality assurance is not funded 2. The public does not understand the current DDSN provider system. It is difficult for people to follow the funding	10/16/2017 4:29 PM
6	Bands need to be adjusted to meet the true cost of services. The actual cost of services has increased since 2008. I object to a statewide average cost analogy because there are always losers when that method of cost analysis is used. The larger provider always come out on top. Competitive pay for Direct Care Staff is a high need.	10/16/2017 2:49 PM
7	1. Rate of bands 2. Breakdown of funds before band rates are determined 3. Individual rate determination based on level of need are not always correct	10/16/2017 2:29 PM
8	1) Neg: No accountability with QPL budgets but responsible for costs exceeding bands 2) Neg: Favoritism for one-time grants and outliers 3) Neg: Overall funding meets basic needs for direct consumer supports but does not provide for capital improvements and maintenance	10/16/2017 11:29 AM
9	1. DSP current rates makes it extremely difficult to hire and retain staff. 2. Funding for staff (other than DSP's) does not allow for annual cost of living increases. 3. We don't fully understand how DDSN distributes the revenue for the existing bands.	10/13/2017 9:37 AM
10	IGNORE SCORE IGNORE SCORE IGNORE SCORE	10/12/2017 4:43 PM
11	Does not cover the cost of serving challenging individuals Does not increase with the cost of living Lack of training provided	10/12/2017 3:28 PM
12	1. Increased funding level amounts 2. Being paid prospectively is important to this agency because of insufficient reserves 3. Band B needs to be capped	10/12/2017 12:41 PM
13	BAND B payment structure Residential Outlier Payment	10/12/2017 11:33 AM
14	good; prospective good : attendance allowance negative: there is no routine cpi adjustment in setting rates and being dependent on the legislators to allocate new money makes them complicit in underfunding current services while they throw us all under the bus	10/11/2017 11:31 AM
15	The constant amendment changes the rules regarding family support the recoupment process from years ago - last year from 2007!! And we always have to find the "proof", when we send everything to DDSN as we go with day program consumers and schedules. lack of response from the certain members of the finance department.	10/10/2017 4:14 PM
16	# 2, - marginally satisfied with the current DDSN provider payment system. Improvements are needed.	10/10/2017 1:13 PM

17	1. Rates are inadequate as it relates to Band B population 2. Being the financial manager for other providers 3. State Funded Community Supports Waiver payment process.	10/10/2017 12:51 PM
18	Hard to budget for the year due to contract adjustment. Not transparent as to what is in the band. It fair across the board. Everyone gets the same money for the bands.	10/9/2017 3:56 PM
19	1-Waiver band B payments can be substantially less than some families demand leaving board to accept the loss. 2-Some QPL providers seem to be claiming job coach payments with no demonstration of progress. 3-The conflict free case mgt. system will be very inefficient.	10/9/2017 3:22 PM
20	ICFs/IID rates compared to CRCF rates, regional center rates and other rates Financial Manager - Shifting risk to providers of financial management and giving them insufficient power to control costs Inability to plan expenditures effectively	10/5/2017 5:10 PM
21	1) loss due to residential vacant bed 2) turnover rate due to low compensation for direct care 3) timing of amendment funding versus the actual date of change	10/5/2017 10:37 AM
22	1. the system is fine 2. lack of training for staff and lack of clear understanding as what is covered in the bands 3. not enough money in bands	10/4/2017 12:17 PM
23	1. Lack of funding. 2. Not able to understand exactly what is in the bands. 3. We do like the positive aspects of the bands mentioned above. (prospective payments, 30 day, 80%, etc.)	10/4/2017 11:17 AM
24	1. Medicaid dollars do not follow the individual but are averaged or smoothed out statewide. 2. Lack of transparency from DDSN. 3. Lack of control on the provider side.	10/3/2017 3:31 PM
25	1. Band B's not adequately funded 2. Band system does not account for outliers and new population who have more needs 3. Band system boxes providers into categories making it difficult to create flexible and creative options	10/3/2017 1:24 PM

Q29 Please use the below narrative box to communicate any other information, ideas, or thoughts that were not sufficiently captured in the prior questions (1-28):Optional Comments:

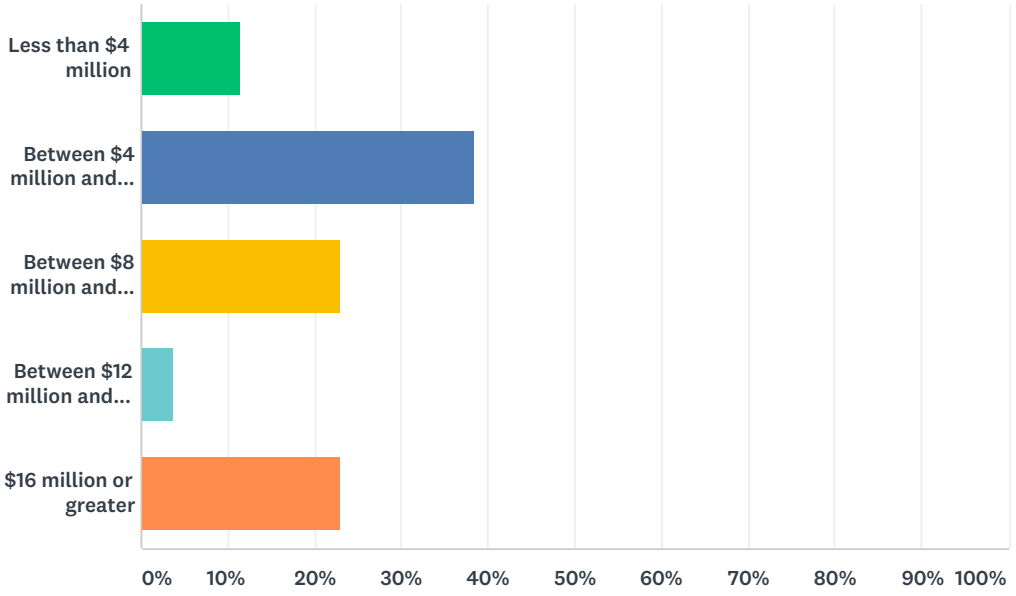
Answered: 11 Skipped: 17

#	RESPONSES	DATE
1	The department needs to have key staff provide on site visits to the provider locations more, develop real dialogue, and assist with resolving problems as they occur. Create a partnership of genuine team work to eliminate the negative publicity and highlight the great and positive work of both the dept. /providers.	10/19/2017 8:18 PM
2	While we appreciate the benefits the band system offers, the system is not functioning as originally designed and needs to be replaced.	10/18/2017 12:04 PM
3	The system has eroded the provider confidence in the state agency's capabilities, understanding of their own invention and trustworthiness.	10/16/2017 5:28 PM
4	While we are overall pleased with this system we do feel that there are areas that could be improved. We feel that there should be more up to date training in all aspects of finance not only to ED but to Financial personnel. Band rates should be increased on an annual basis based on cost of living costs.	10/16/2017 2:29 PM
5	DDSN system needs to increase communication with all providers, provide valuable support and training to providers. The system should be a partnership with the entities working together to make appropriate changes following a timeline that is attainable with the appropriate training. A lot of issues have arisen from the lack of communication, the lack of participation and then the lack of training and unrealistic timelines.	10/12/2017 3:28 PM
6	the band payment is like a managed care payment that doesn't break your bank but it sometimes breaks mine. We took at big loss this year trying to add the right things, nursing and direct care, job coaching but I can't afford to continue these efforts unless there is an adjustment. Day program even took a loss this year!! That never happens. I am seriously considering joining forces with another agency to spread the loss if possible for the future. Small providers will be in even more risk in the future with retrospective pay I believe, but for now, just adjust the bands to account for things that are service related. Our room and Board collections were down by 10% this year as well. Please also note we have lost $ on Early Intervention, non-cap program for years. I have 2 staff ftes, with 12 and 30 years longevity yet we do not get paid nearly the cost for the salaries here and we NEVER HAVE , yet it is our job. You need to review those non-cap programs as they are primary prevention activities and very important. They have become the step child for a small organization like ours. It appears that everything we do now is a loss except for our CRCFs and a few of our CTH2s. I am happy that we get OSS revenue or we would be in a bigger loss situation. I do feel as though "promises" have been broken about services we are expected to provide at the level we must provide it. Additional expectations, CMS rule, conflict free , employment first, non-centerbased programming.... equals money and more risk. Where is it coming from? DHHS ? We were told years ago to spend/pay for retiree health and put it in our cost reports. We did and where did that get us? No more cost settlements from DHHS to DDSN? so instead providers have to defund these plans? How would you feel if you were the employee and told your retirement health plan or your current health plan is changing. Broken promises goes to the trust issue.	10/11/2017 11:31 AM
7	I have been with the system a long time. The current Band system is a good unbiased system.	10/9/2017 3:22 PM
8	Enough for now.	10/5/2017 5:10 PM
9	I and please that these questions are being asked. I am of the opinion that many of the issues raised by providers is do to lack of trust from DDSN.	10/4/2017 12:17 PM
10	Re- basing the bands and keeping SCDDSN as the technical support and resource provider, (training, technical assistance, etc.) would be the easiest and least costly way to address this issue.	10/4/2017 11:17 AM

11	Ultimately, the current system needs an overhaul. Whether that means transitioning to a FFS model or incremental changes to the current system is a cost analysis that cannot be completed without all the variables on the table. What would the rate structure look like under FFS?	10/3/2017 3:31 PM

Q30 Your provider entity's fiscal year 2017 (period ending June 30, 2017) revenue (all sources):

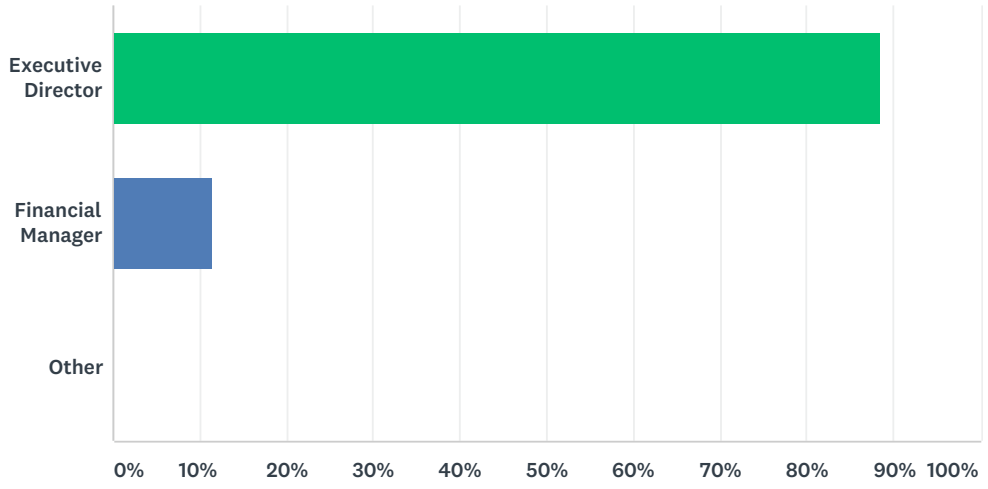
Answered: 26 Skipped: 2



ANSWER CHOICES	RESPONSES	
Less than $4 million	11.54%	3
Between $4 million and less than $8 million	38.46%	10
Between $8 million and less than $12 million	23.08%	6
Between $12 million and less than $16 million	3.85%	1
$16 million or greater	23.08%	6
TOTAL		26

Q31 Responding official's position

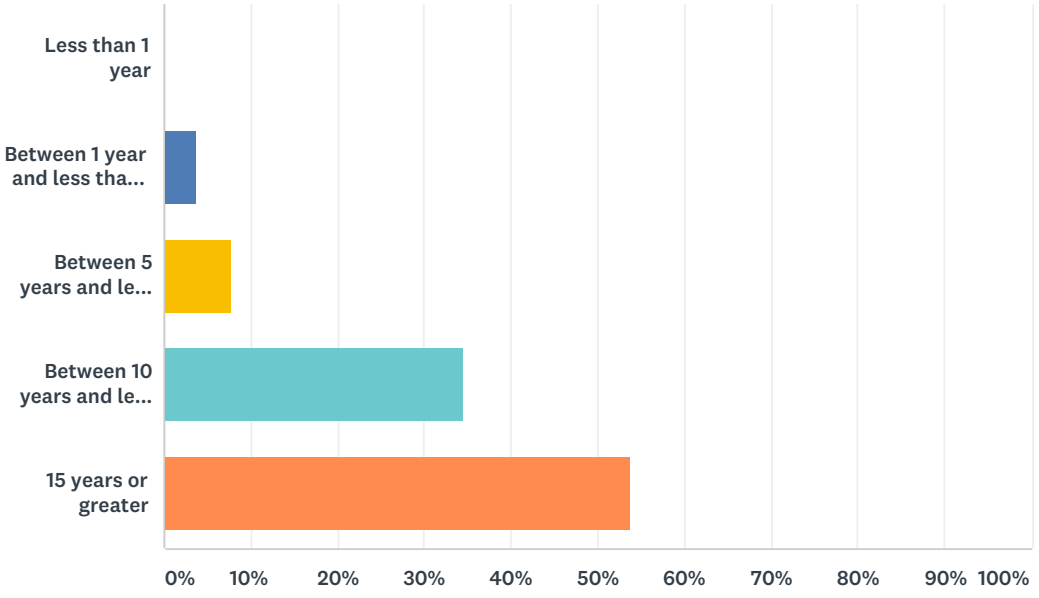
Answered: 26 Skipped: 2



ANSWER CHOICES	RESPONSES	
Executive Director	88.46%	23
Financial Manager	11.54%	3
Other	0.00%	0
TOTAL		26

Q32 Responding official's years of experience working within the DDSN band payment system:

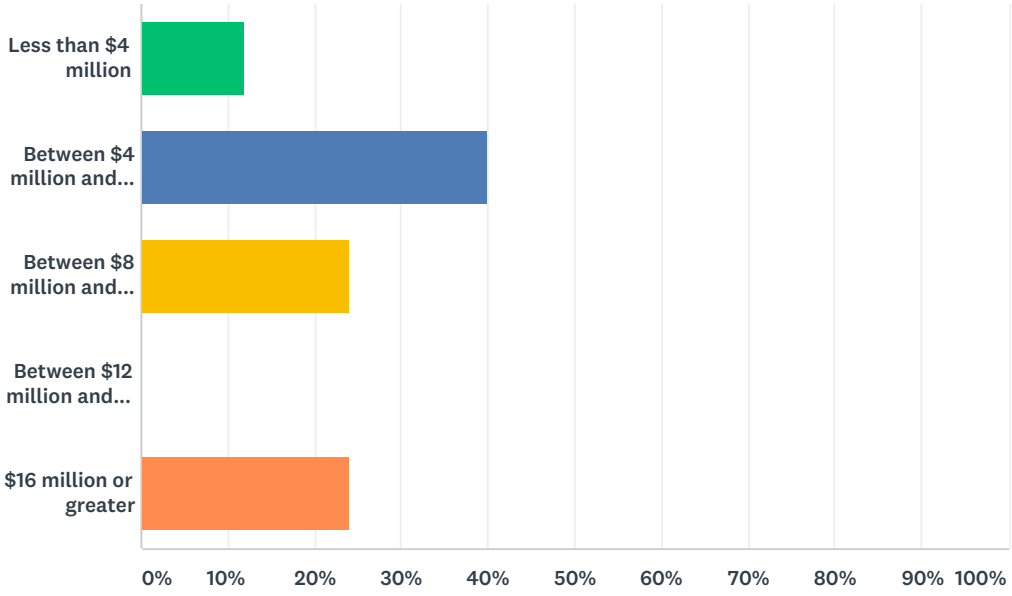
Answered: 26 Skipped: 2



ANSWER CHOICES	RESPONSES	
Less than 1 year	0.00%	0
Between 1 year and less than 5 years	3.85%	1
Between 5 years and less than 10 years	7.69%	2
Between 10 years and less than 15 years	34.62%	9
15 years or greater	53.85%	14
TOTAL		26

Q33 Your provider entity's fiscal year 2017 (period ending June 30, 2017) revenue (all sources):

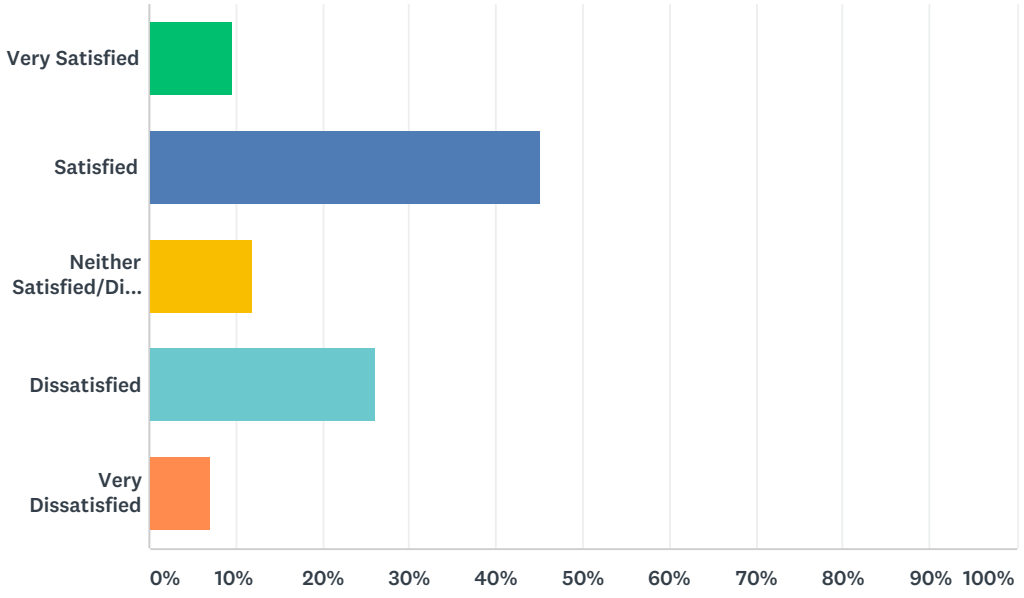
Answered: 25 Skipped: 3



ANSWER CHOICES	RESPONSES	
Less than $4 million	12.00%	3
Between $4 million and less than $8 million	40.00%	10
Between $8 million and less than $12 million	24.00%	6
Between $12 million and less than $16 million	0.00%	0
$16 million or greater	24.00%	6
TOTAL		25

Q1 Describe your satisfaction with the transparency of DDSN's current fee-for-service payment system to QPL providers.

Answered: 42 Skipped: 1



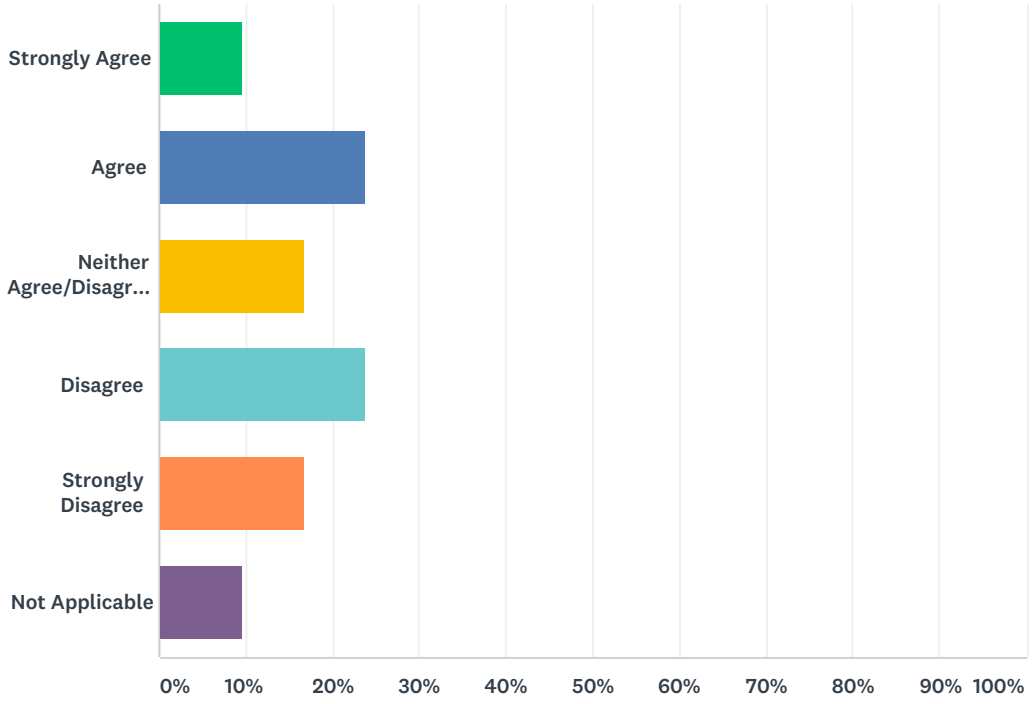
ANSWER CHOICES	RESPONSES	
Very Satisfied	9.52%	4
Satisfied	45.24%	19
Neither Satisfied/Dissatisfied or Uncertain	11.90%	5
Dissatisfied	26.19%	11
Very Dissatisfied	7.14%	3
TOTAL		42

#	OPTIONAL COMMENTS:	DATE
1	It has been very confusing trying to figure out so many payment systems at once. It has been difficult to gain info. no one knows who to call about what.	10/16/2017 1:51 PM
2	I think our payments are still coming from the state DDSN budget rather than Medicaid (Phoenix). As the rest of the Thrive Upstate team transitions to CDS, this will increasingly put pressure on your budget and it's not sustainable. Please expedite the funding process so you aren't short, and let us know how we can help.	10/16/2017 11:00 AM
3	I believe it is confusing and I also believe that it is an unfair system.	10/16/2017 8:45 AM
4	QPL's can bill for services that provider's receiving the band are not allowed to, resulting in an unfairness of the rates.	10/12/2017 3:54 PM
5	DDSN has made substantial improvements over the past year.	10/11/2017 11:39 AM
6	Still confused why a provider is paid on a fee-for-service basis, yet I am forbidden to pay employees using the same system. Arguments that fee-for-service promotes fraud are disingenuous since fraud will occur under any system.	10/11/2017 10:42 AM
7	I have not received any I formation about this. Just heard people say things about changes coming.	10/5/2017 5:48 PM

8	Our agency does not fully understand the billing procedures. Services for clients we serve are billed to the appropriate Board of Disabilities. It is not understood whether we could bill when clients are at camp or on vacation. Currently we bill only for the units the participant actually receives but I have heard DDSN representatives say that we could be billing.	10/5/2017 1:14 PM
9	It's very confusing and inconsistent	10/5/2017 10:12 AM
10	Does not compensate the agencies enough to offer higher pay to aides that offer services.	10/3/2017 9:17 PM

Q2 I am satisfied with DDSN's delivery of support and training to QPL providers' financial personnel.

Answered: 42 Skipped: 1



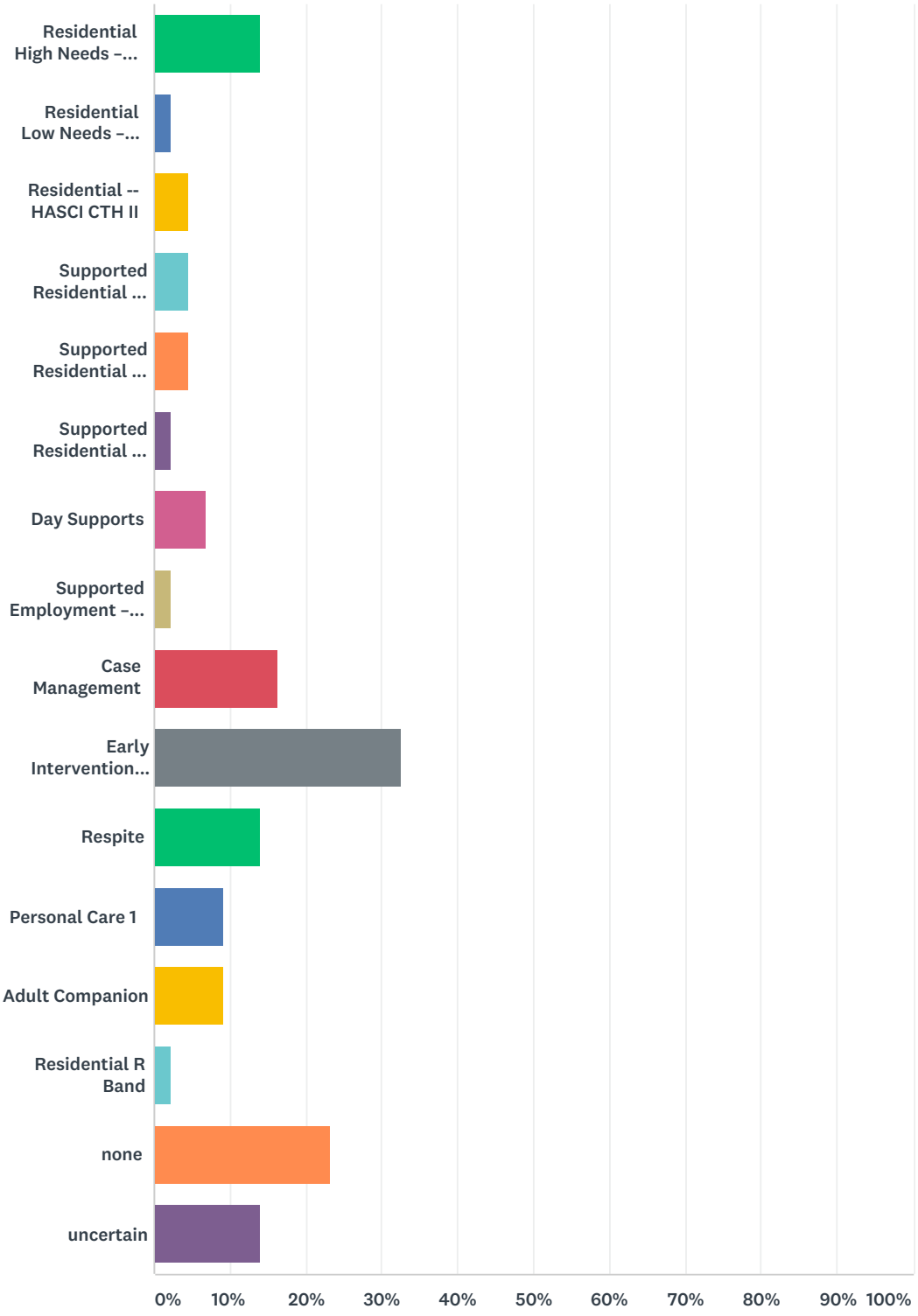
ANSWER CHOICES	RESPONSES	
Strongly Agree	9.52%	4
Agree	23.81%	10
Neither Agree/Disagree or Uncertain	16.67%	7
Disagree	23.81%	10
Strongly Disagree	16.67%	7
Not Applicable	9.52%	4
TOTAL		42

#	OPTIONAL COMMENTS:	DATE
1	There really hasn't been much in the way of training to financial personnel from DDSN. However, DDSN has been available for support questions when needed.	10/18/2017 12:34 PM
2	DDSN is supportive when we have questions however can provide a more proactive approach with training.	10/16/2017 10:38 AM
3	If there has been training, it has been very limited.	10/16/2017 8:45 AM
4	I would love training on this. When I need assistance, the people I speak to are always helpful.	10/16/2017 12:52 AM
5	We have no knowledge of the kind of training and support QPL providers get from DDSN.	10/12/2017 3:54 PM
6	The rules and the level of enforcement are becoming more intensive, without an increase in financial support to maintain the intensive level of scrutiny.	10/11/2017 11:39 AM

7	Support is excellent but training is nonexistent. I am angry that I must now furnish DDSN with a financial statement at a cost of $10,000 - $15,000 that will serve no useful purpose and reduce the owner's personal income by 25 percent on top of already very thin margins.	10/11/2017 10:42 AM
8	We have not received any training nor have we been offered any training.	10/9/2017 9:31 AM
9	In general I think QPLs need more training and support overall because so many processes are different from boards.	10/5/2017 1:14 PM
10	We received no training and have difficulty getting emails answered by the staff in Columbia when we have questions.	10/5/2017 10:12 AM
11	We have not been offered any training for financial personnel.	10/3/2017 8:34 PM

Q3 Please select those services below where you feel your costs associated with the service significantly exceeds the revenue from the service payment rate (select as many as applicable).

Answered: 43 Skipped: 0



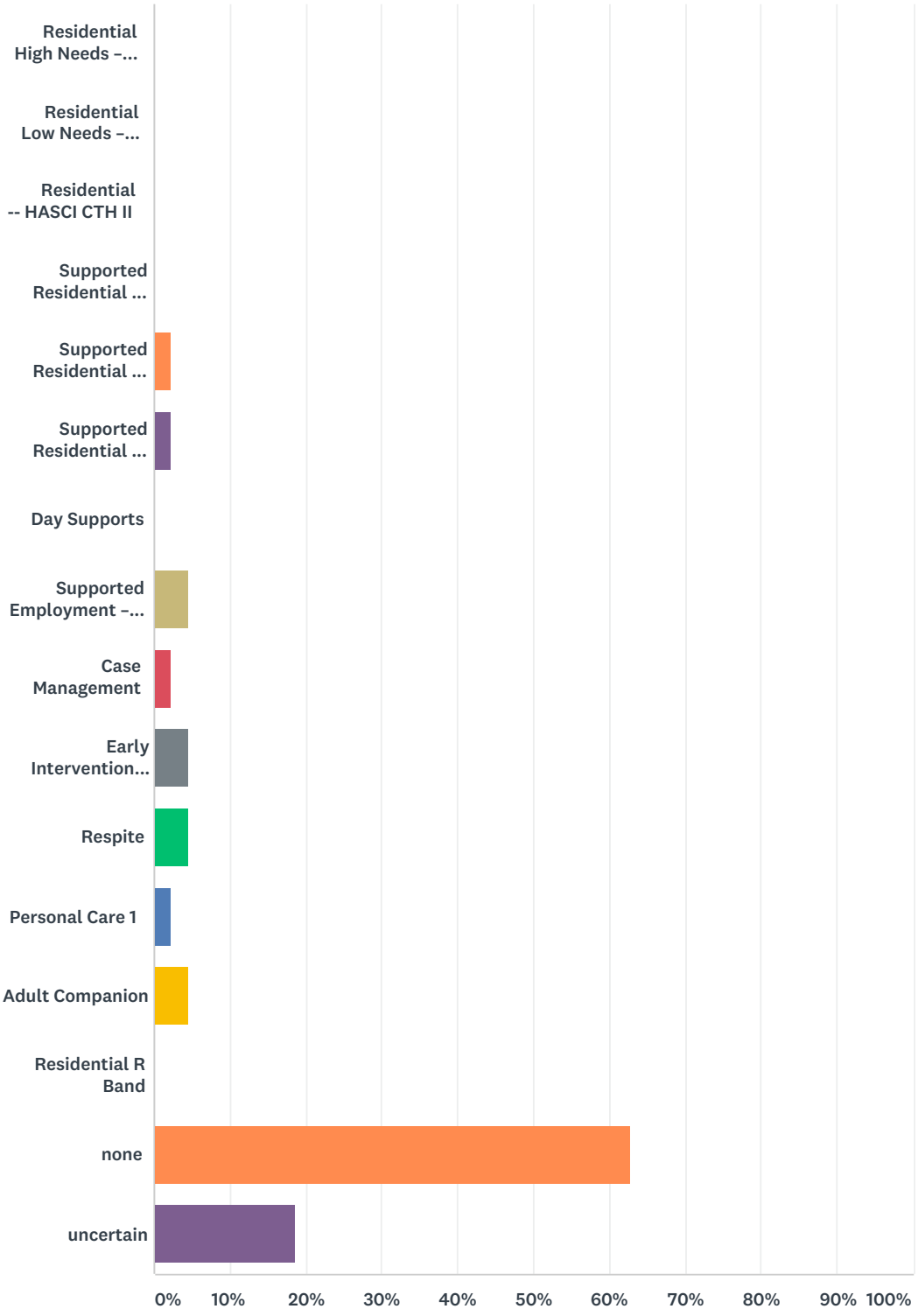
ANSWER CHOICES	RESPONSES	
Residential High Needs – CRCF/CTH II	13.95%	6
Residential Low Needs – CRCF/CTH II	2.33%	1
Residential -- HASCI CTH II	4.65%	2
Supported Residential – SLP II	4.65%	2
Supported Residential – SLP I	4.65%	2
Supported Residential – CTH I	2.33%	1
Day Supports	6.98%	3
Supported Employment – Individual	2.33%	1
Case Management	16.28%	7
Early Intervention – Family Training	32.56%	14
Respite	13.95%	6
Personal Care 1	9.30%	4
Adult Companion	9.30%	4
Residential R Band	2.33%	1
none	23.26%	10
uncertain	13.95%	6
Total Respondents: 43		

#	OPTIONAL COMMENTS:	DATE
1	With the current once per month payment rate from DDSN for case management, I feel the service is adequately paid for re: Waiver cases. Target cases on the 15 minute payment scale are not. As such, my primary focus would be for the current rate to be continued for Waiver cases with payments coming directly from DDSN as they are now.	10/18/2017 12:34 PM
2	We are still waiting on a specific breakdown of reimbursement allocations for case management. Our fiscal department cannot decipher a direct deposit receipt. Everything is dumped into one payment.	10/17/2017 9:37 AM
3	Perhaps not "significantly," but our program expenses do exceed our payment rate, generally.	10/16/2017 12:39 PM
4	I feel for the work we do we should receive more of the Medicaid payment. Also, there should be a way for us to not have to use DDSN for these services much like the School for Deaf and Blind.	10/16/2017 11:40 AM
5	Still too new at this to provide valuable feedback.	10/16/2017 11:00 AM
6	ICF's are not listed but we lost a significant amount of money.	10/12/2017 3:54 PM
7	The competition to obtain the emotionally well adjusted and educated/trained staff, DCS or salaried, is becoming ever more stressful for providers to manage. The folks, whom we serve, have profound challenges, especially making meaningful contacts in the community.	10/11/2017 11:39 AM
8	Fee schedules are about right for the above services but support for autism spectrum clients is a disaster and a disgrace. My company was prepared to become a major service provider but the type of services required and the level of reimbursement has prevented this from happening.	10/11/2017 10:42 AM
9	The cost for employment services is extremely expensive. At $70.15 per hour up to 15 hours monthly is very costly.	10/11/2017 10:06 AM
10	The upcoming required annual audit will GREATLY impact our organization. The cost of accounting fees will be close to 20% of our annual profits.	10/9/2017 9:31 AM

11	significantly exceed is a case by case response- in some instances for high needs the funding does not work. but that is not true in all instances nor the majority. selected respite, personal care1 and companion as an issue as we do not provide the services since not cost effective- cost is significantly more in our projections thus do not provide	10/6/2017 7:52 AM
12	We also have to pay for audits to be completed and reimbursement does not help cover these costs.	10/5/2017 5:48 PM
13	Intake	10/5/2017 1:17 PM
14	In most cases, participants could not receive day services without our transportation program. There is no compensation for this transport. We are held to directives related to the transportation program but it is not recognized as a benefit to be compensated for.	10/5/2017 1:14 PM
15	Outlier reviews and turn around time need to be reviewed. It should not take 3 months to get a response when behaviors happen daily.	10/4/2017 11:06 AM

Q4 Please select those services below where you feel your costs associated with the service are significantly less than the revenue from the service payment rate (select as many as applicable).

Answered: 43 Skipped: 0

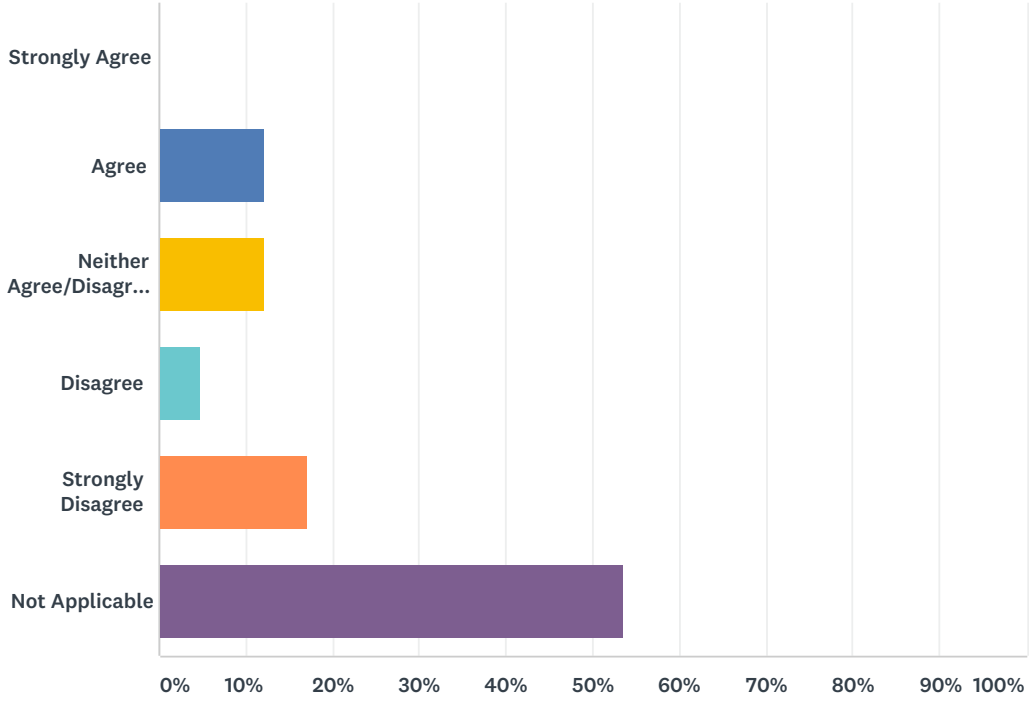


ANSWER CHOICES	RESPONSES	
Residential High Needs – CRCF/CTH II	0.00%	0
Residential Low Needs – CRCF/CTH II	0.00%	0
Residential -- HASCI CTH II	0.00%	0
Supported Residential – SLP II	0.00%	0
Supported Residential – SLP I	2.33%	1
Supported Residential – CTH I	2.33%	1
Day Supports	0.00%	0
Supported Employment – Individual	4.65%	2
Case Management	2.33%	1
Early Intervention – Family Training	4.65%	2
Respite	4.65%	2
Personal Care 1	2.33%	1
Adult Companion	4.65%	2
Residential R Band	0.00%	0
none	62.79%	27
uncertain	18.60%	8
Total Respondents: 43		

#	OPTIONAL COMMENTS:	DATE
1	Again, still too new to provide accurate feedback.	10/16/2017 11:00 AM
2	In our CRCF homes with low needs, we generally have a net surplus in revenue.	10/12/2017 3:54 PM
3	We only provide day supports and the costs associated are definitely not less than we are compensated for.	10/5/2017 1:14 PM
4	Adult Companion and Respite rates are very low in comparison to the work associated with the service.	10/3/2017 3:44 PM

Q5 The current case management rates (prospective monthly band payments and retrospective billings) are adequate to cover the actual cost of case management by a provider.

Answered: 41 Skipped: 2



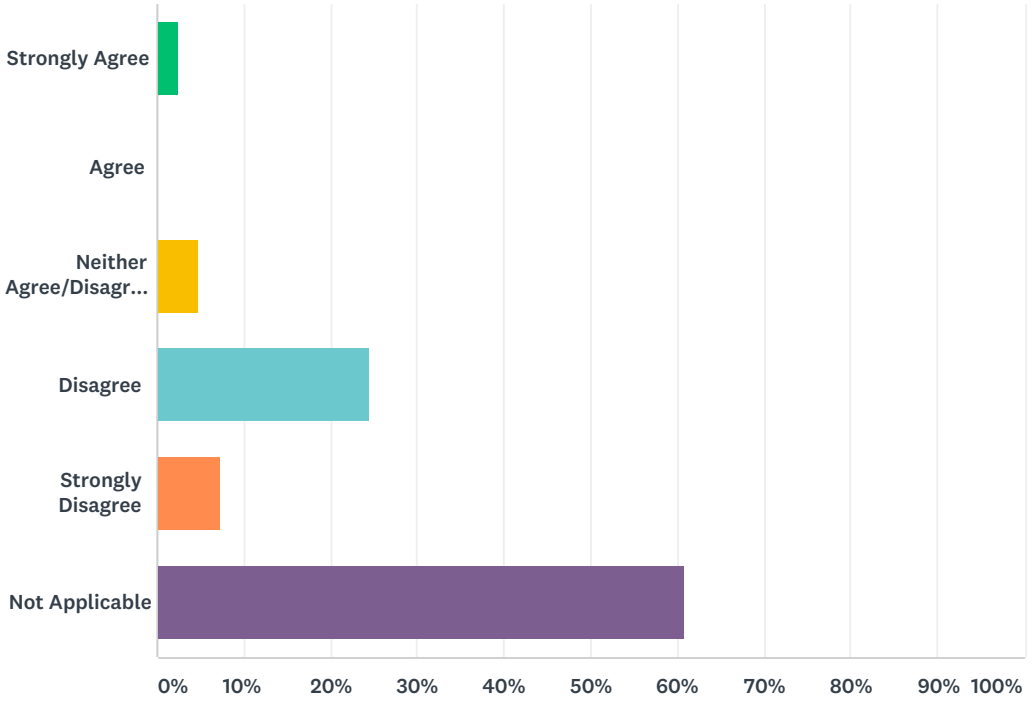
ANSWER CHOICES	RESPONSES	
Strongly Agree	0.00%	0
Agree	12.20%	5
Neither Agree/Disagree or Uncertain	12.20%	5
Disagree	4.88%	2
Strongly Disagree	17.07%	7
Not Applicable	53.66%	22
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	The monthly band rates for Waiver cases are adequate. We would NOT be able to cover costs if Waiver cases were switched to the 15 minute billing method that is in place currently for non-waiver cases.	10/18/2017 12:34 PM
2	Willing to take survey again next year when we have a better picture.	10/16/2017 11:00 AM
3	When comparing to other states, SC's rates are inadequate which leads to less oversight and higher case loads. We can not be expected to reach true goals without a higher rate.	10/16/2017 8:45 AM
4	I am not a Case Management provider, however it is difficult to provide adequate services when there is a flat rate per consumer. Payment should be based on level activity required for the consumer.	10/11/2017 9:54 PM

5	N/A	10/11/2017 10:06 AM
6	Not enough at all	10/3/2017 9:17 PM

Q6 Day Programs generally have adequate direct care staff to meet consumers' needs.

Answered: 41 Skipped: 2

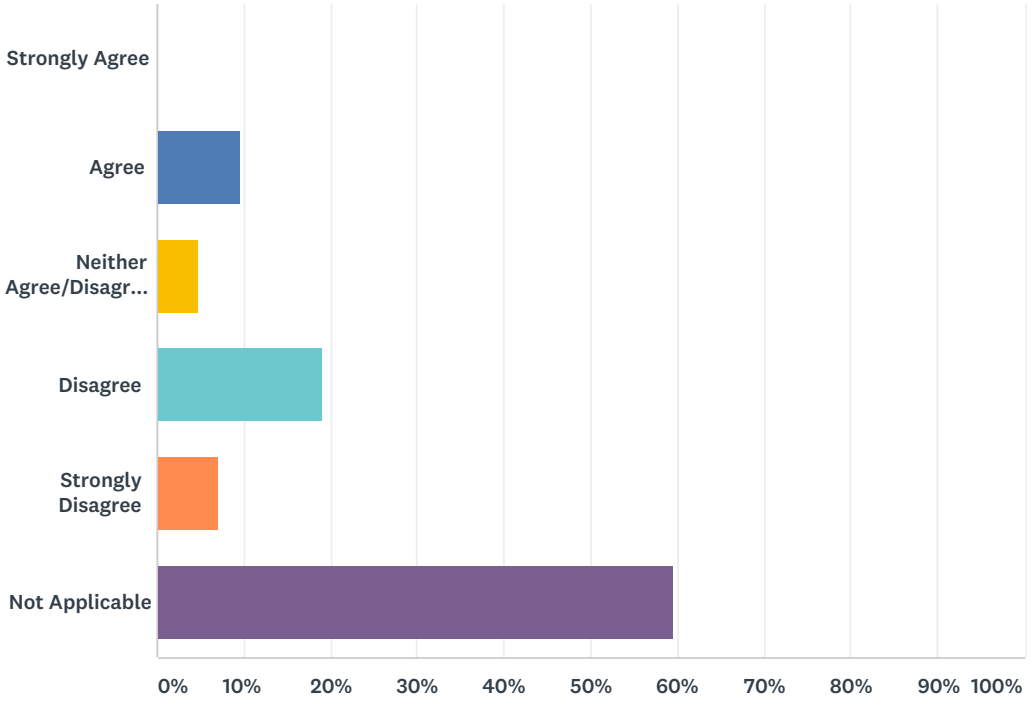


ANSWER CHOICES	RESPONSES	
Strongly Agree	2.44%	1
Agree	0.00%	0
Neither Agree/Disagree or Uncertain	4.88%	2
Disagree	24.39%	10
Strongly Disagree	7.32%	3
Not Applicable	60.98%	25
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	Staffing ratios need to increase dramatically in order to comply with the Final Rule.	10/12/2017 3:54 PM
2	Is this question related to how our program staffs the day services programs? I am unsure of how to answer this. A participants family may view that more staff is needed in the day program. Our programs are staffed to meet the consumer's needs and compliance with directives.	10/5/2017 1:14 PM

Q7 Residential Programs generally have adequate direct care staff to meet consumers' needs.

Answered: 42 Skipped: 1



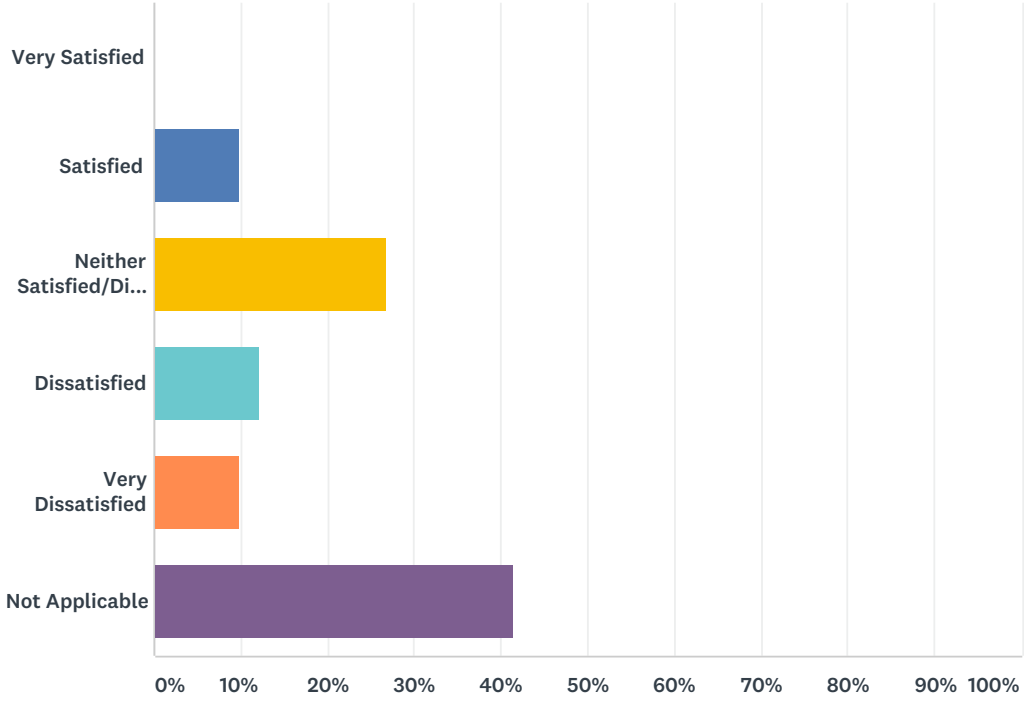
ANSWER CHOICES	RESPONSES	
Strongly Agree	0.00%	0
Agree	9.52%	4
Neither Agree/Disagree or Uncertain	4.76%	2
Disagree	19.05%	8
Strongly Disagree	7.14%	3
Not Applicable	59.52%	25
TOTAL		42

#	OPTIONAL COMMENTS:	DATE
1	We have great difficulty in filling positions in the residential program which requires us to use a lot of overtime. Another concern is that many individuals are getting old and want to stay home during the day as opposed to the workshops. There is not adequate funding or staff to meet this need.	10/12/2017 3:54 PM

2	In order to meet the ratio, providers frequently are required to use overtime. This overtime is not fully compensated to the providers. Overtime permits the employer to increase pay of employees without an overall increase for all staff, because the rate of base pay does not change. When DCS work overtime and longer hours, the potential for less thought through decisions occur. Hours and days pass with out incident, and with high needs consumers, a significant crisis will occur w/o precedent, needing the best response from DCS. The DCS is tired from too many hours. Yet, overtime is needed by DCS, because the increased pay reduces their financial stresses. Such a "round Robin" staffing pattern can be best repaired with a higher rate of regular time compensation. Raising just the existing staff to an increase base pay is not sufficient ($10 to $12 hour), because all staff, who have received pay increases above the base pay, expect to participate increased pay.	10/11/2017 11:39 AM
3	The cost to add adequate staff is not feasible.	10/11/2017 10:06 AM
4	Again, do I think the residential programs are staffed adequately or does the family think they are. We do not deliver residential programs.	10/5/2017 1:14 PM

Q8 How satisfied are you with band financial managers' process to manage the billings from other providers (i.e., QPLs, employment services, respite) serving waiver band consumers?

Answered: 41 Skipped: 2



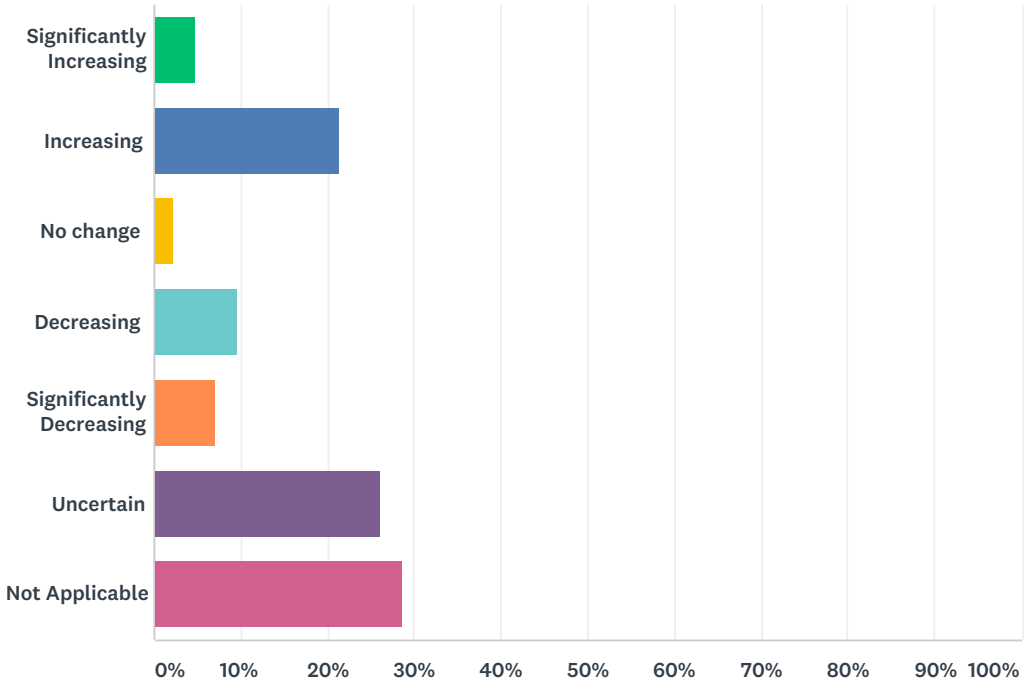
ANSWER CHOICES	RESPONSES	
Very Satisfied	0.00%	0
Satisfied	9.76%	4
Neither Satisfied/Dissatisfied or Uncertain	26.83%	11
Dissatisfied	12.20%	5
Very Dissatisfied	9.76%	4
Not Applicable	41.46%	17
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	DDSN should assume the role of financial management. If DDSN not able to provide this service a Independent Third Party who is not a Service Provider should manage billing.	10/16/2017 10:38 AM
2	The process for repayment takes too long and case managers spend lengthy amounts of time trying to expedite payments between financial managers and providers when our time could be better spent monitoring and following up.	10/16/2017 8:45 AM
3	The current process is extremely complicated which causes delays in processing billings.	10/12/2017 3:54 PM
4	Service coordinators are approving services without our (the financial manager) input. We should have some say so in this process. I also feel the service coordinators are not clear that the financial manager has input in the decision.	10/11/2017 10:06 AM

5	We bill the Board and receive our payment on average 3 to 4 weeks later. Is there a standard the band financial managers' should follow?	10/5/2017 1:14 PM
6	Our agency has received no information on how to bill for services from the Columbia staff. Our reimbursment is coming sometimes from local boards and sometimes from Columbia. We now owe money back for a SCDDSN mistake. There's no system in place that works smoothly and no where to find the information on how it actually is supposed to work.	10/5/2017 10:12 AM

Q9 What future trend do you expect in the frequency of other providers (i.e., QPLs, supported employment, respite) serving waiver band consumers?

Answered: 42 Skipped: 1

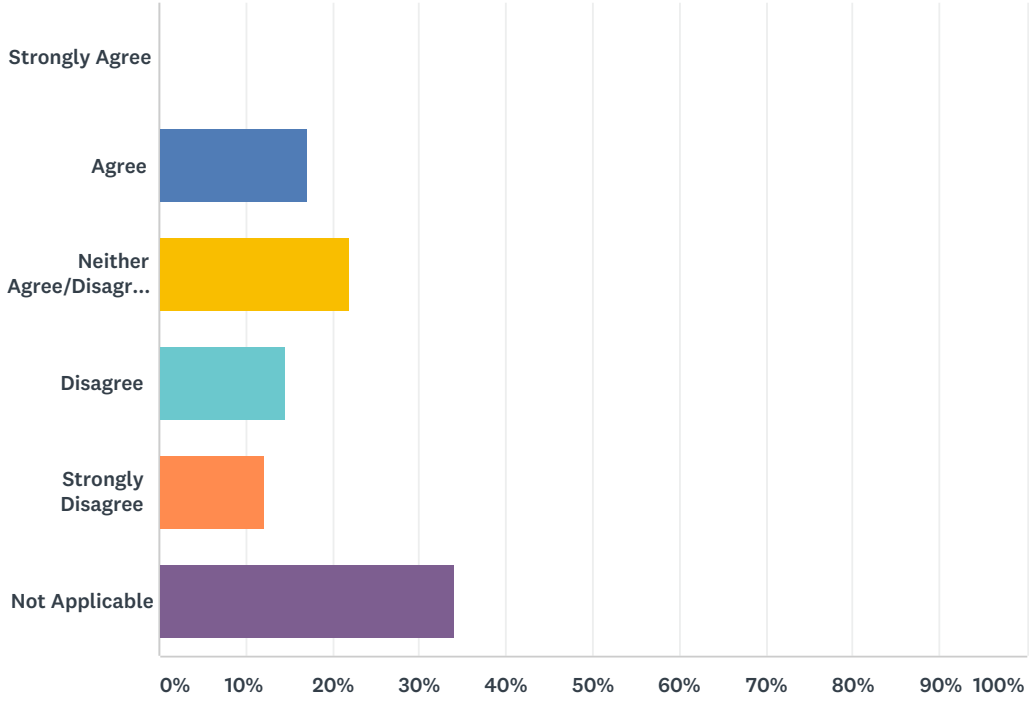


ANSWER CHOICES	RESPONSES	
Significantly Increasing	4.76%	2
Increasing	21.43%	9
No change	2.38%	1
Decreasing	9.52%	4
Significantly Decreasing	7.14%	3
Uncertain	26.19%	11
Not Applicable	28.57%	12
TOTAL		42

#	OPTIONAL COMMENTS:	DATE
1	The delay in payment and conflict of interest is a deterrent.	10/16/2017 10:38 AM
2	Our consumers are are highly challenged, and consistency is key to a productive life. Our staff must meet their needs, because transition to other providers and behavior management must remain as consistent as possible.	10/11/2017 11:39 AM
3	With the new HCBS rules, it is my understanding that Statewide changes are to be made. Likely, more QPLs will be needed to adequately serve the citizens of the State.	10/5/2017 1:14 PM
4	If other providers receive the necessary training needed for the process.	10/5/2017 10:12 AM

Q10 Band financial managers generally operate in a conflict free manner supporting their band consumers' individual choice of services and choice of providers.

Answered: 41 Skipped: 2



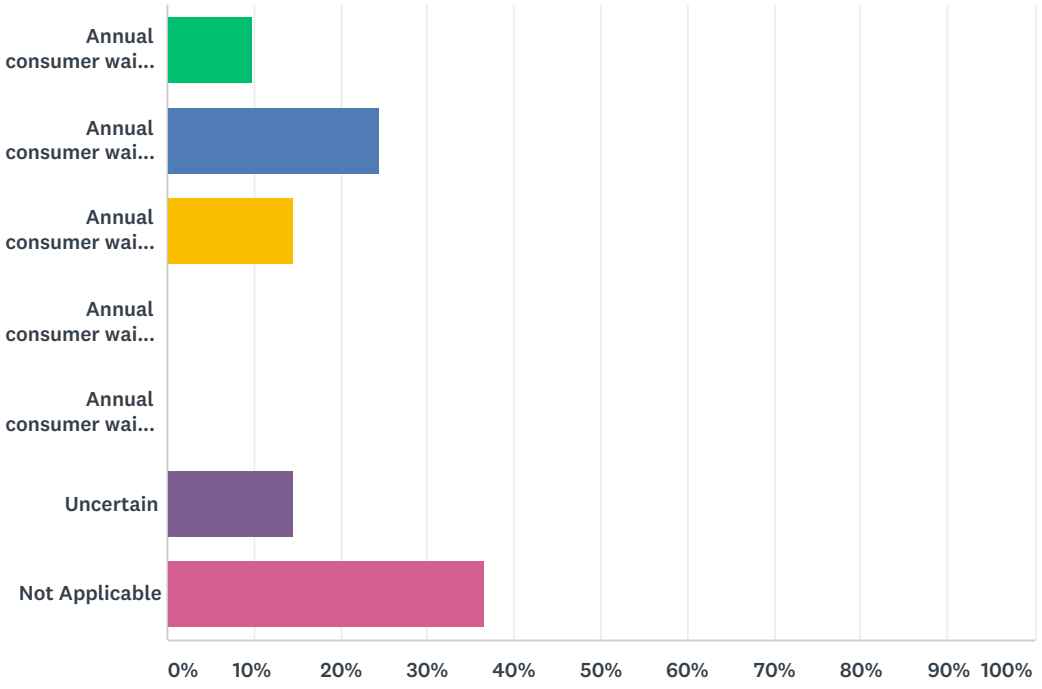
ANSWER CHOICES	RESPONSES	
Strongly Agree	0.00%	0
Agree	17.07%	7
Neither Agree/Disagree or Uncertain	21.95%	9
Disagree	14.63%	6
Strongly Disagree	12.20%	5
Not Applicable	34.15%	14
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	With respect to case management, band financial managers (boards) are certainly NOT conflict free. It is IMPERATIVE that DDSN more actively assist state wide with a truly fair and rational conflict free case management system. As of now this seems to be a very not thought of area. Some boards such as Laurens County are implementing their own conflict free case management systems that are done impartially and is fair for all QPL providers. However, a board such as Greenville County essentially chose their preferred provider for their cases which was inherently unfair to all other QPL case management providers and left a defacto link to one provider and the board/Thrive Upstate in the same manner that there was before. This was brought to DDSN's attention and we were told there was nothing to be done about it. This was discouraging at best with respect to DDSN's commitment to conflict free case management.	10/18/2017 12:34 PM

2	They set unreal expectations on qpl providers. For example, if the invoice and time sheets are not in within 60 days for respite, they will not pay for it. The true issue is that there is no "policy" where qpl providers can go to that explains processes. Each board develops there own procedures and thy are all different.	10/16/2017 8:45 AM
3	There appears to be a significant conflict when financial managers also provide Case Management.	10/12/2017 3:54 PM
4	By nature of how the Boards are set up, a conflict may exist and I don't believe consumers understand choice and how to exercise the right to choose.	10/5/2017 1:14 PM

Q11 Which of the following statements bests describes the relationship between annual consumer waiver budget requests and consumers' needs.

Answered: 41 Skipped: 2

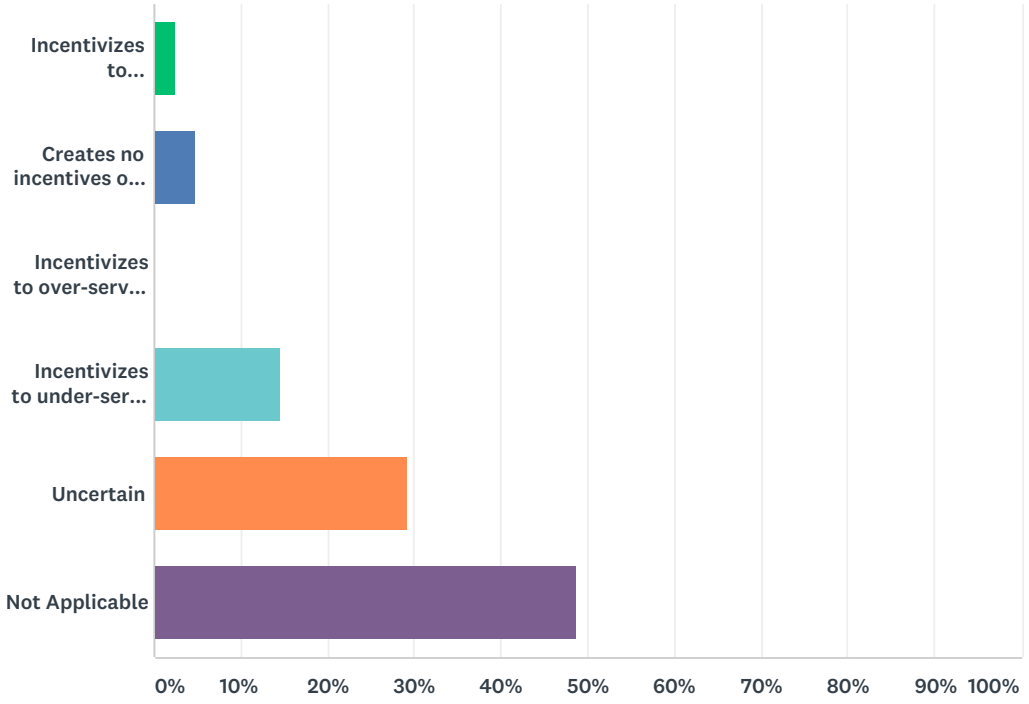


ANSWER CHOICES	RESPONSES	
Annual consumer waiver budgets generally are substantially less than consumers' needs	9.76%	4
Annual consumer waiver budgets generally are marginally less than consumers' needs	24.39%	10
Annual consumer waiver budgets generally match consumers' needs	14.63%	6
Annual consumer waiver budgets generally marginally exceed consumers' needs	0.00%	0
Annual consumer waiver budgets generally substantially exceed consumers' needs	0.00%	0
Uncertain	14.63%	6
Not Applicable	36.59%	15
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	Needs change from period to period in any persons life.	10/16/2017 8:45 AM
2	All of the above. It depends upon the individual and Case Manager.	10/12/2017 3:54 PM

Q12 Which of the below best describes the band payment system's incentives to band financial managers in serving band consumers.

Answered: 41 Skipped: 2

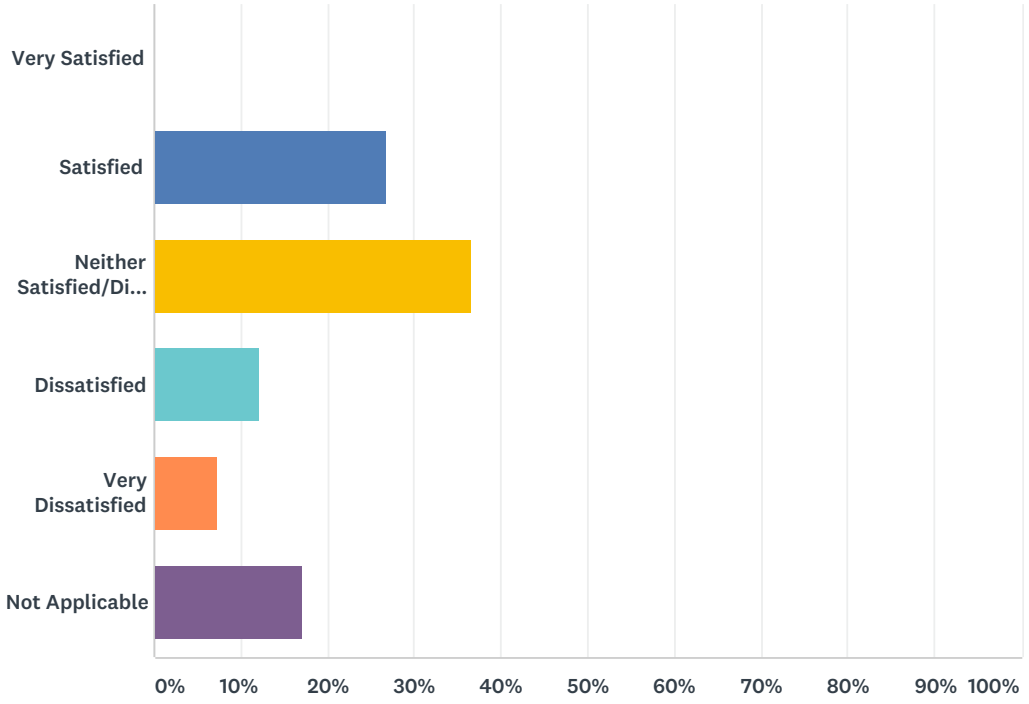


ANSWER CHOICES	RESPONSES	
Incentivizes to appropriately serve band consumers	2.44%	1
Creates no incentives on band consumers' service levels	4.88%	2
Incentivizes to over-serve band consumers	0.00%	0
Incentivizes to under-serve band consumers	14.63%	6
Uncertain	29.27%	12
Not Applicable	48.78%	20
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	With the 95/98 rule, there is a direct incentive to underserve.	10/16/2017 8:45 AM
2	This is a very confusing question.	10/12/2017 3:54 PM
3	I am not familiar with the band payment system.	10/5/2017 1:14 PM
4	incentives aren't necessary to provide reimbursable services	10/4/2017 9:12 AM

Q13 Describe your satisfaction in understanding the funding outlier process.

Answered: 41 Skipped: 2

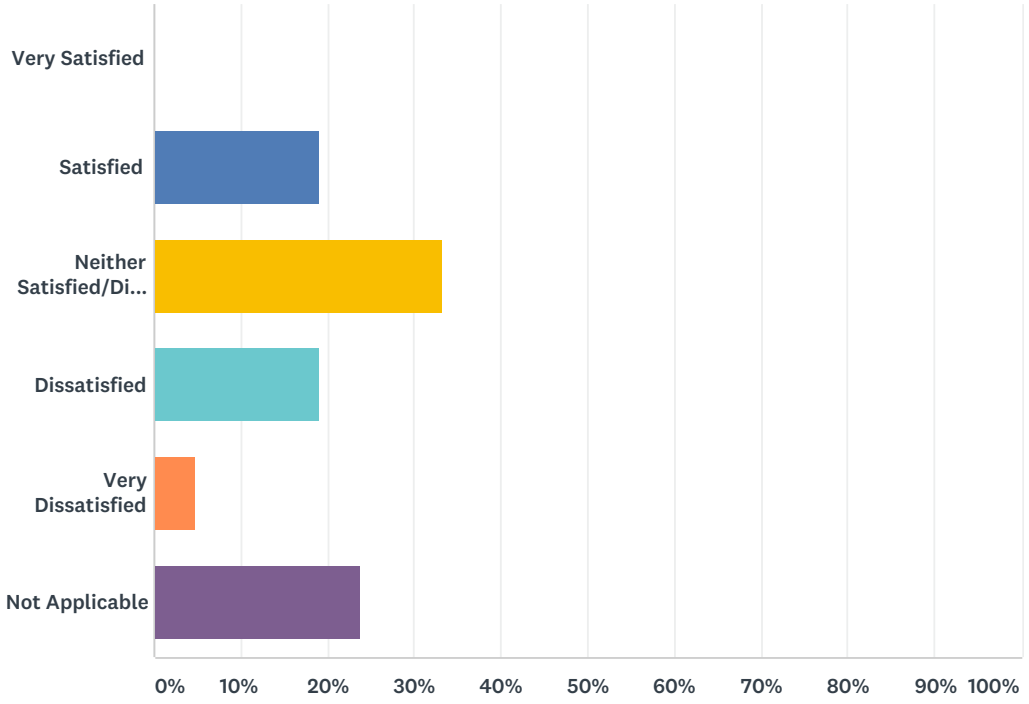


ANSWER CHOICES	RESPONSES	
Very Satisfied	0.00%	0
Satisfied	26.83%	11
Neither Satisfied/Dissatisfied or Uncertain	36.59%	15
Dissatisfied	12.20%	5
Very Dissatisfied	7.32%	3
Not Applicable	17.07%	7
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	What's the process? What is the turn around time? What is the appeals process?	10/16/2017 8:45 AM
2	In some cases Individuals that need enhanced staffing and as a provider we provide it, that outlier funding at times at a later date is not approved leaving the provider having taken on expenses that can not be recovered. A quicker decision to approve or deny would be helpful.	10/11/2017 10:06 AM

Q14 Describe your satisfaction with the fairness of the funding outlier process.

Answered: 42 Skipped: 1

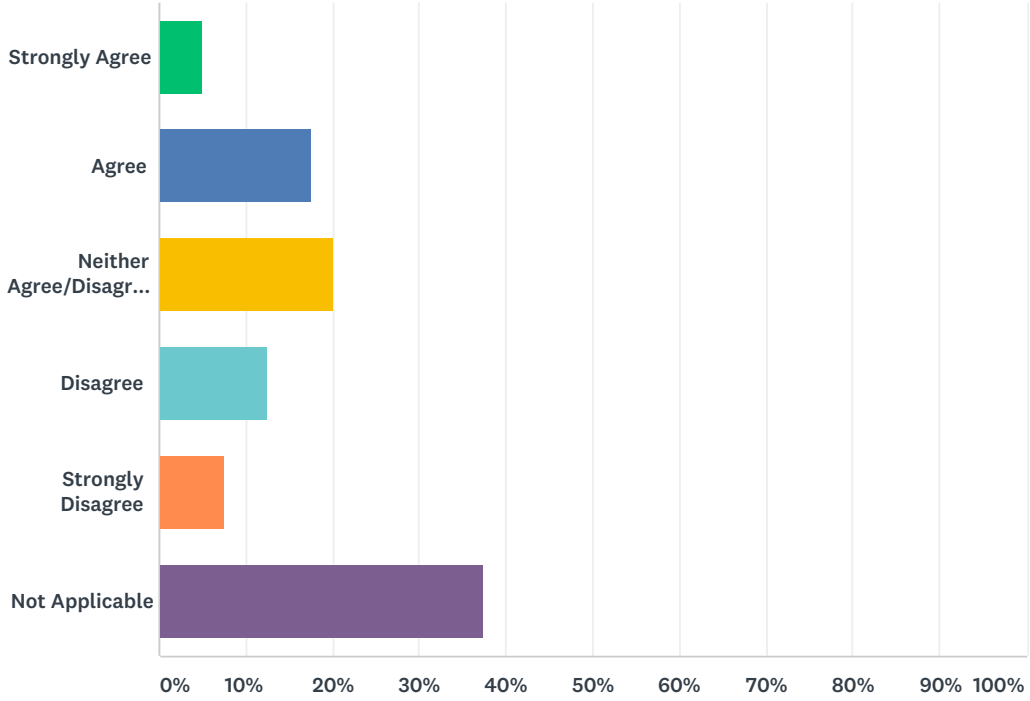


ANSWER CHOICES	RESPONSES	
Very Satisfied	0.00%	0
Satisfied	19.05%	8
Neither Satisfied/Dissatisfied or Uncertain	33.33%	14
Dissatisfied	19.05%	8
Very Dissatisfied	4.76%	2
Not Applicable	23.81%	10
TOTAL		42

#	OPTIONAL COMMENTS:	DATE
1	See comment above.	10/16/2017 8:45 AM

Q15 Case managers' annual consumer budget service requests generally match the consumers' unique person centered needs factoring in the consumers' natural support environment.

Answered: 40 Skipped: 3

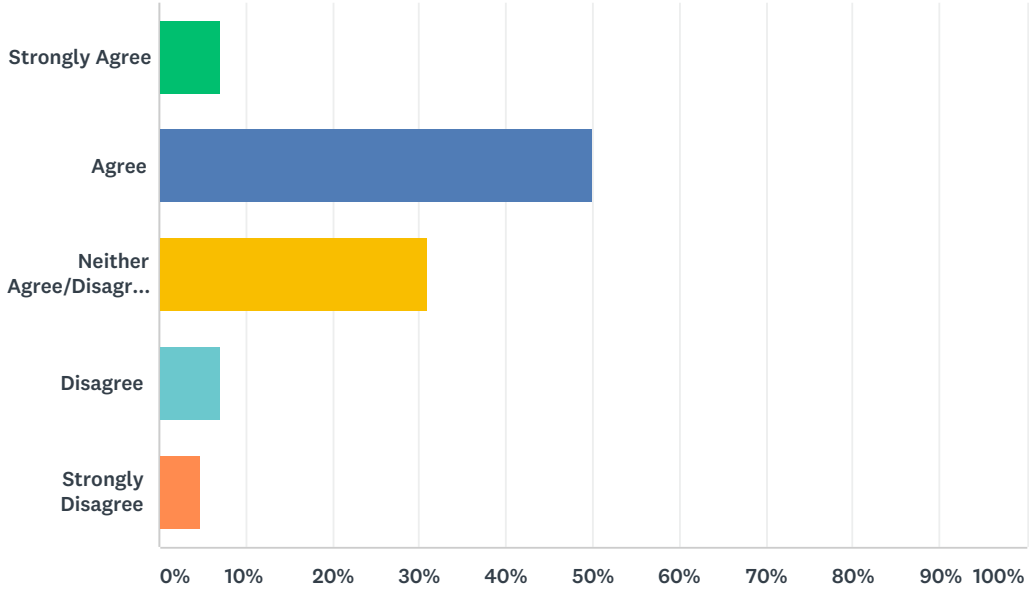


ANSWER CHOICES	RESPONSES	
Strongly Agree	5.00%	2
Agree	17.50%	7
Neither Agree/Disagree or Uncertain	20.00%	8
Disagree	12.50%	5
Strongly Disagree	7.50%	3
Not Applicable	37.50%	15
TOTAL		40

#	OPTIONAL COMMENTS:	DATE
1	I feel it is going to be hard for the new waiver group to truly assess need based on a sheet of paper.	10/16/2017 8:45 AM
2	While I know that constraints are present in funding, it can appear that not all person centered needs are met. Who advocates for the consumer? If the case manager is the main advocate - how can the financial manager and case manager be employed by the same company?	10/5/2017 1:14 PM

Q16 The DDSN fee-for-service provider payment system used by QPL providers promotes a trusting business relationship between QPL providers and DDSN.

Answered: 42 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly Agree	7.14%	3
Agree	50.00%	21
Neither Agree/Disagree or Uncertain	30.95%	13
Disagree	7.14%	3
Strongly Disagree	4.76%	2
TOTAL		42

#	OPTIONAL COMMENTS:	DATE
1	Again, turn around time limits ability for new providers to come in and provide quality service without instant capital.	10/16/2017 8:45 AM
2	You have to have trust in us to use this system. I feel like I am always tracking every minute and encouraging our team to do so as well in order to make sure the time we're reporting is as accurate as possible.	10/16/2017 12:52 AM
3	Though not perfect, the DDSN payment system is far superior to any other state agency payment system. This provider directly bills to Medicaid MCOs and one other state agency.	10/11/2017 11:39 AM
4	I am not sure how much integration DDSN has with the Boards to assess the trust in the relationship between the financial manager (in our case the Boards) and our agency.	10/5/2017 1:14 PM

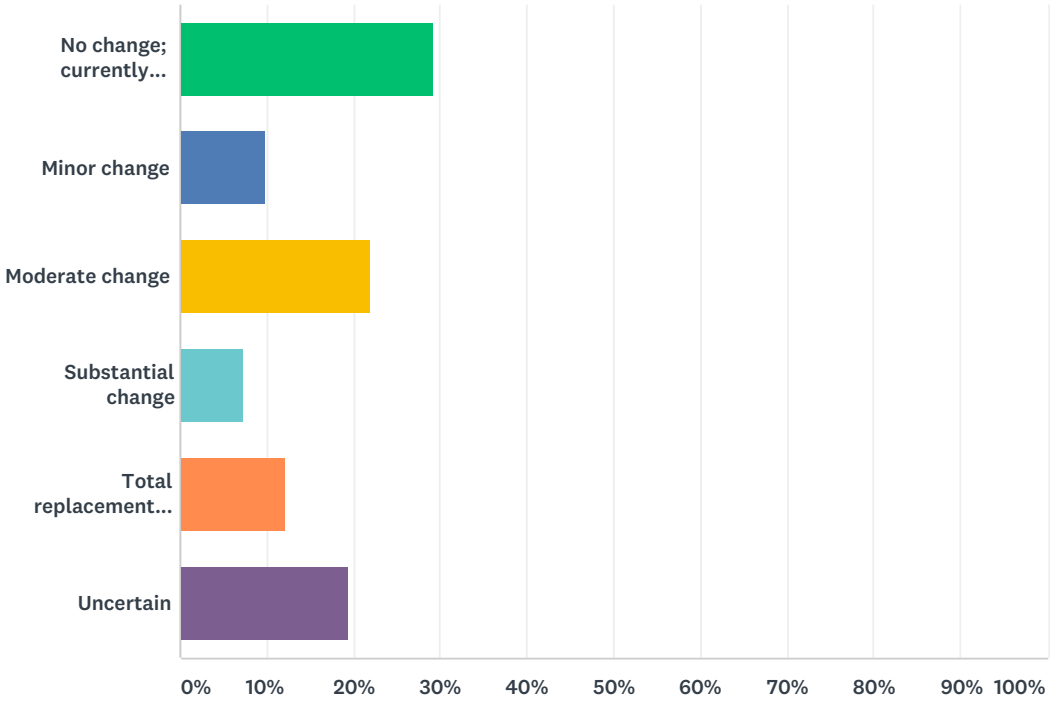
Q17 If you responded "disagree" or "strongly disagree" in above question #16, narratively describe the factor(s) associated with the band payment system undermining a trusting business relationship with DDSN.

Answered: 7 Skipped: 36

#	RESPONSES	DATE
1	Most new providers have a difficult time staying afloat while waiting on their payment from the financial managers. For example, if someone's financial manager is acme and acme serves this client residentially, but the client receives employment from another provider, we see sometimes 90-120 day turn around for payment.	10/16/2017 8:45 AM
2	There is a dichotomy between how DDSN boards are paid and how private providers are paid - block payments to boards based on employee head count while private providers are paid fee-for-service is just one example. Many rural boards serve very few children but seem to be paid a minimum of $60,000 per annum for these services. I have noted that the percentage of children seen by boards vs private providers has dropped precipitously over the last several years and boards are re-branding to appear as private providers. Expenditure of funds on advertising by some boards (e.g. Thrive upstate) is misuse of tax-payer funds by entities that should be a provider of last resort.	10/11/2017 10:42 AM
3	see above.	10/6/2017 7:52 AM
4	I do not understand this enough to comment	10/5/2017 5:48 PM
5	We have no contracts in place with DDSN financial departments that we bill for services. It's hit or miss and confusing on both parts.	10/5/2017 10:12 AM
6	trusting business partner suggests a fair partnership, but QPL is not treated fairly. You receive less for doing the same job. Your high needs paid less and not paid in advance as "boards" are paid. These situations/conditions do not build a trusting relationship.	10/4/2017 11:06 AM
7	We do not have payment issues with all QPL providers- mostly those in which Babcock is the financial manager	10/3/2017 3:44 PM

Q18 How would you characterize the level of change, if any, needed for DDSN's current fee-for-service provider payment system used by QPL providers to perform effectively?

Answered: 41 Skipped: 2



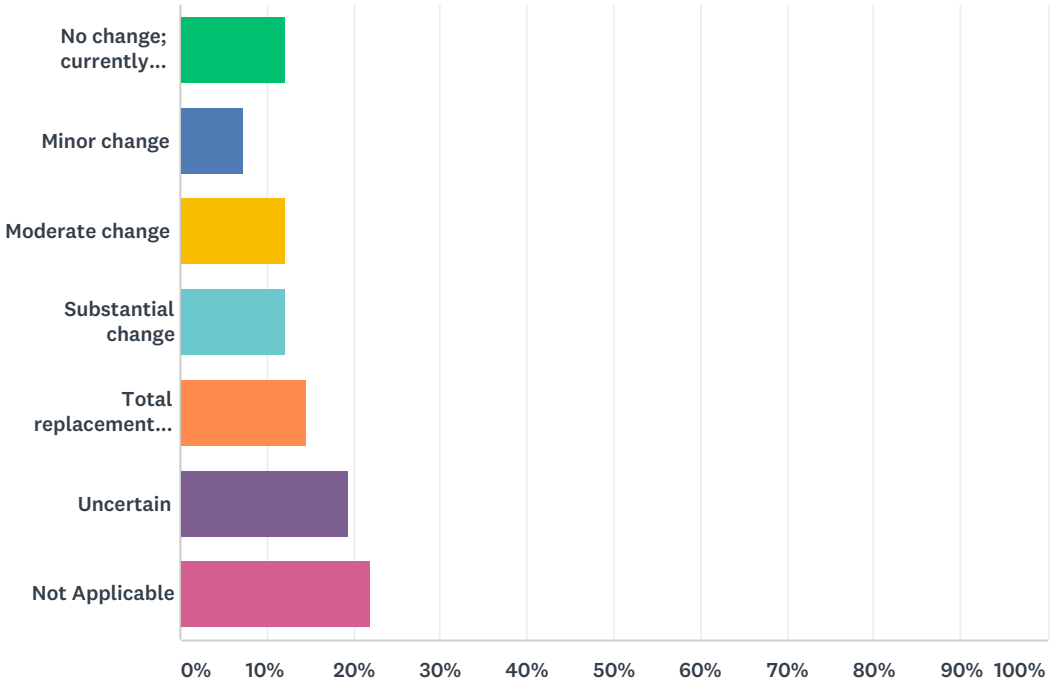
ANSWER CHOICES	RESPONSES	
No change; currently operating effectively	29.27%	12
Minor change	9.76%	4
Moderate change	21.95%	9
Substantial change	7.32%	3
Total replacement with a new provider payment system	12.20%	5
Uncertain	19.51%	8
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	Whenever state offices are closed, that should not affect our timely payment. Example: Hurricane Irma caused payment for QPL invoices to be a week late. I feel DDSN should put something in place in cases of state wide closings due to weather. I feel it's very unfair for the DDSN employee's to receive their pay on time every month but the QPL provider's pay is sometimes late due to inclement weather, etc.	10/16/2017 11:40 AM
2	Assigning the Residential Provider the role of Financial Manager creates an ineffective FFS process and essentially creates a modified band system. Rolling Day and Employment services into the Daily ResHab rate does not create a conflict free, person-centered, environment which focuses on the choice of the individual. ResHab, Day Services, and Employment Services should be broken out as true FFS.	10/16/2017 10:38 AM

3	Fee for service. For case management, I would like to see what each agency is actually billing vs what they are actually receiving.	10/16/2017 8:45 AM
4	The only issue I have ever had is being overlooked and not receiving payment as it is usually deposited. Having to call or email when payment is not received is difficult because business related expenses are set up for auto pay or automatic draft. I know that DDSN has a specific policy regarding time frames for providers to receive deposits, but it is difficult to manage a budget when payment is not received timely.	10/11/2017 9:54 PM
5	Better the system we know, than trying to reinvent a payment system.	10/11/2017 11:39 AM
6	Greater care should be taken to protect a provider's client base i.e. clients should not be allowed to follow employees to new providers. This can be financially devastating to the provider and it allows a proliferation of providers who have no idea about how to run a business. Our company now requires employees to sign noncompete / non-solicit agreements at hire.	10/11/2017 10:42 AM
7	I would recommend informing providers of rate changes sooner.	10/11/2017 10:06 AM
8	Printing, Signing, Scanning, Uploading could be streamlined to a pin-protected digital signature for submission of invoices for payment.	10/9/2017 9:31 AM
9	I am not sure what this question is actually assessing. Is this for timeliness of payment, the invoicing procedures, the verification of services, or the process of delivery of services?	10/5/2017 1:14 PM
10	should be treated as boards are and paid up-front for consumers that move into a residential setting.	10/4/2017 11:06 AM

Q19 How would you characterize the level of change, if any, needed for DDSN's current band provider payment system to perform effectively?

Answered: 41 Skipped: 2

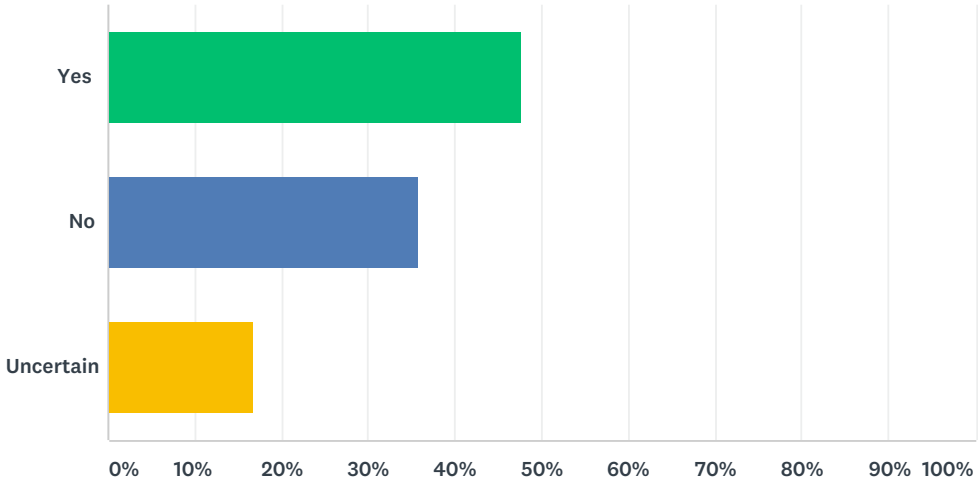


ANSWER CHOICES	RESPONSES	
No change; currently operating effectively	12.20%	5
Minor change	7.32%	3
Moderate change	12.20%	5
Substantial change	12.20%	5
Total replacement with a new provider payment system	14.63%	6
Uncertain	19.51%	8
Not Applicable	21.95%	9
TOTAL		41

#	OPTIONAL COMMENTS:	DATE
1	Again, direct billing or some type of policy mandating a quicker turn around time. CM should not have to get involved	10/16/2017 8:45 AM
2	There are advantages and disadvantages of the current system.	10/12/2017 3:54 PM
3	In the past there has been one person processing invoices. If that person is not at work then my payment is held up longer. It should not 5 days to get payment. Late payments placeca burden on payroll and other bills that have to be paid out.	10/5/2017 5:48 PM
4	I do not know enough about the band payment system.	10/5/2017 1:14 PM

Q20 For fiscal year 2017 (7/1/2016 – 6/30/2017), did your total annual service payments from DDSN provide adequate funding to meet the service needs of your consumers?

Answered: 42 Skipped: 1

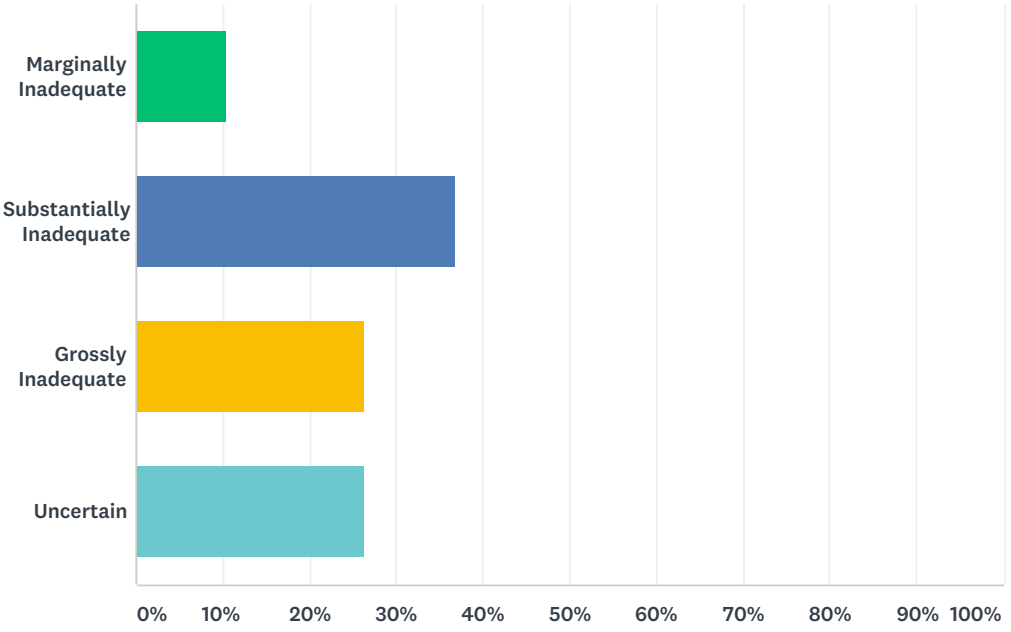


ANSWER CHOICES	RESPONSES	
Yes	47.62%	20
No	35.71%	15
Uncertain	16.67%	7
TOTAL		42

#	OPTIONAL COMMENTS:	DATE
1	Funding does not cover what is needed for consumers with severe autism in regards to ABA. A one size fits all with only 6 lead hours per week and 6 EIBI a month is not nearly enough for consumers who exhibit self-injurious behaviors and or aggression. It also is not enough for working with parents and conducting parent training.	10/16/2017 1:51 PM
2	Yes, all service needs for consumers were met, though funding received did not cover all expenses incurred by the provider.	10/16/2017 12:39 PM
3	We fund raise to try and offset costs	10/16/2017 8:45 AM
4	It provided funding to meet the basic necessities but it did not provide the funding to meet the requirements of the Final Rule. As stated previously, many individuals are being forced to go to day programs when they are at retirement age and want to stay home.	10/12/2017 3:54 PM
5	Staff continues to be a great difficulty, particularly in covering training cost, overtime, and retaining well balanced, experienced staff.	10/11/2017 11:39 AM
6	Not for consumers but for my early interventionist as well as mileage, audits, iliability insurance, etc as well as supplies that are needed to complete this job in an adequate manner.	10/5/2017 5:48 PM
7	We were able to meet the needs of the consumers, but very difficult to maintain quality staff, grow, and sustain a strong business model with current funding.	10/5/2017 2:47 PM

Q21 If you responded "No" in above question #20, how would you assess the inadequacy of your total annual service payments from DDSN?

Answered: 19 Skipped: 24



ANSWER CHOICES	RESPONSES	
Marginally Inadequate	10.53%	2
Substantially Inadequate	36.84%	7
Grossly Inadequate	26.32%	5
Uncertain	26.32%	5
TOTAL		19

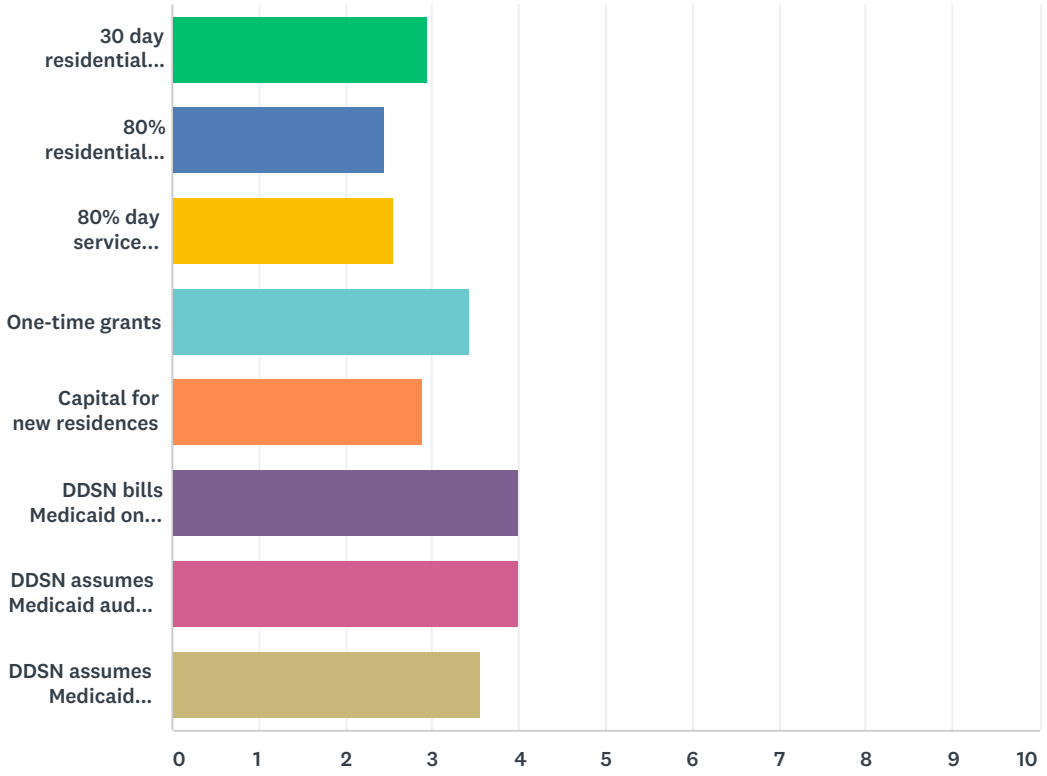
Q22 If you responded "No" in above question #20, narratively describe how the inadequate funding impacted meeting the service needs of your consumers.

Answered: 9 Skipped: 34

#	RESPONSES	DATE
1	There is not enough funding to provide a sound business model to adequately service consumers with the current degree of requirements and restrictions placed by DDSN.	10/18/2017 2:40 PM
2	Not sure how we know when no one can give our fiscal department a clear understanding or breakdown of allocated reimbursements for case management	10/17/2017 9:37 AM
3	as providers we can cover direct hours but not enough hours with highly trained individuals which is what is required to ensure programs are run efficiently	10/16/2017 1:51 PM
4	Higher caseloads.	10/16/2017 8:45 AM
5	DDSN regulators demand service perfection at a level, which is not funded. This provider must constantly assess the needs of the population served and the staff, who serve the population served, which need is the most immediate. To DDSN's staff credit, a recognition of the impossibility of perfection exists, but still perfection is demanded.	10/11/2017 11:39 AM
6	Our company's fiscal year follows the calendar year. For FY 2016 our company sustained a $38,000 loss on about $750,000 in revenue, largely because of requirements to pay annual salaries based on client head count (employees paid a full time salary often worked only a 20 hour week) and clients leaving the agency to follow former employees to new providers. Client services were unaffected during this time due to excellent contingency planning on the part of company management. FY2017 revenue was similar to FY2016 but resulted in a 10.4 percent profit margin due to implementation of an hourly-based employee fee schedule that would result in a full-time employee being paid $36,000 per annum with two weeks vacation and introduction of professional office management software that tracks employee activities.	10/11/2017 10:42 AM
7	We discontinued providing the service	10/11/2017 10:22 AM
8	Day support services require a staff with a skill set to compliment the experiential learning that is the essence of a day program. Participants have interest in being out in the community and participating in programming that enhances life skills, community involvement and relationships. Transportation is key to meeting the goals yet it is not factored into the compensation. Also, HASCI waiver participants should have an option for Adult Day Care Services (many have very high medical needs) or Support Center (when they do not wish to work on goals).	10/5/2017 1:14 PM
9	one on ones were months behind in getting approved; staff had to be paid and trained for higher needs individuals which was not funded by the state	10/4/2017 11:06 AM

Q23 For Residential & Adult Day Providers Only: The QPL payment system has components identified by some providers as beneficial. Please assess each component benefit in the below table (select one per component benefit):

Answered: 16 Skipped: 27

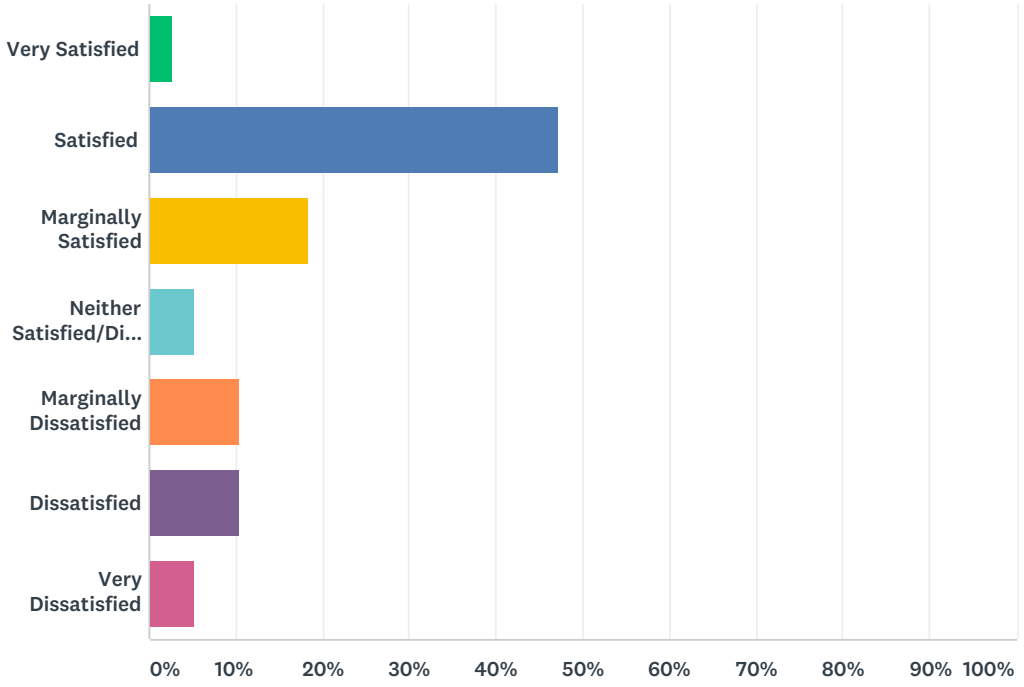


	NOT APPLICABLE	NOT BENEFICIAL	BENEFICIAL	VERY BENEFICIAL	UNCERTAIN	TOTAL	WEIGHTED AVERAGE
30 day residential vacancy payment	43.75% 7	6.25% 1	12.50% 2	37.50% 6	0.00% 0	16	2.94
80% residential attendance allowance	50.00% 8	12.50% 2	18.75% 3	18.75% 3	0.00% 0	16	2.44
80% day service attendance allowance	56.25% 9	6.25% 1	12.50% 2	12.50% 2	12.50% 2	16	2.56
One-time grants	37.50% 6	0.00% 0	18.75% 3	31.25% 5	12.50% 2	16	3.44
Capital for new residences	50.00% 8	0.00% 0	12.50% 2	37.50% 6	0.00% 0	16	2.88
DDSN bills Medicaid on behalf of provider	25.00% 4	0.00% 0	12.50% 2	50.00% 8	12.50% 2	16	4.00
DDSN assumes Medicaid audit financial risk	25.00% 4	0.00% 0	12.50% 2	50.00% 8	12.50% 2	16	4.00
DDSN assumes Medicaid ineligible risk	31.25% 5	0.00% 0	25.00% 4	37.50% 6	6.25% 1	16	3.56

#	OPTIONAL COMMENTS:	DATE
1	This provider is not always given the benefit of the 30 vacancy opportunity to bill.	10/11/2017 11:39 AM
2	Are this items really unique to QPLs?	10/6/2017 7:52 AM

Q24 Describe your satisfaction with DDSN's current fee-for-service provider payment system used by QPL providers.

Answered: 38 Skipped: 5



ANSWER CHOICES	RESPONSES	
Very Satisfied	2.63%	1
Satisfied	47.37%	18
Marginally Satisfied	18.42%	7
Neither Satisfied/Dissatisfied or Uncertain	5.26%	2
Marginally Dissatisfied	10.53%	4
Dissatisfied	10.53%	4
Very Dissatisfied	5.26%	2
TOTAL		38

#	OPTIONAL COMMENTS:	DATE
1	Only major concern we have is the Job Coach rates that the QPL's can receive and not the Boards.	10/12/2017 3:54 PM
2	Printing, Signing, Scanning, Uploading could be streamlined to a pin-protected digital signature for submission of invoices for payment.	10/9/2017 9:31 AM

Q25 Please narratively describe your top 3 issues (positive or negative) in rank order (1, 2, & 3) with the current DDSN provider payment system, which includes both fee-for-service to QPLs and band payments to county disability boards.Mandatory Comments:

Answered: 27 Skipped: 16

#	RESPONSES	DATE
1	DDSN is easy to navigate DDSN invoice logs do not always capture billable claims DDSN activity logs are very helpful	10/19/2017 4:42 PM
2	N/A	10/19/2017 9:12 AM
3	1. Inadequate funding 2. Required full audit and RoAPP, put in place AFTER the last RFP - Unfunded Mandate. 3. Antiquated billing system	10/18/2017 2:40 PM
4	1 The uncertainty with respect to moving or not Waiver cases to the same 15 minute billing system as is currently done for non-Waiver cases is of great concern. We maintain that moving to such a system for Waiver cases would definitely cause monumental strain with our budget. 2 Waiver Case Management - Again .. uncertainty about when or if it will be implemented is of great concern. 3 Direct billing to DHHS - If the option is given to QPL case management providers fine, but we do not want to be forced into this.	10/18/2017 12:34 PM
5	1. Case management reimbursements need to be clear	10/17/2017 9:37 AM
6	1. Whenever there's inclement weather that causes all state offices to close, my QPL payment is always late (Hurricane Irma, 2016 flood, 2015 ice storm, etc).	10/16/2017 11:40 AM
7	1. Financial Management should be handled through either DDSN or an entirely separate entity who is not a Service Provider. 2. FFS payment structure should be revised to reflect a cleaner system that reflects services provided both on site and off site. It should be the same for a person who lives in the community as a person in residential. 3. Adult Companion and Respite Services are underfunded services. Positives 1. Payments are processed by DDSN are timely and accurate. 2. DDSN assumes all financial audit risk. The Internal Audit Department is fair, helpful, and informative. 3. DDSN has always been committed to the development of new programs and the preservation of appropriate funding for protection of services for all people receiving services.	10/16/2017 10:38 AM
8	1. Inadequate payment for case management 2. Higher case loads due to inadequate payment 3. Positive - cm payments are paid appropriately and on time.	10/16/2017 8:45 AM
9	1. I'm concerned that what we go to might be worse than what we currently have. 2. I feel like the fee for service makes sure that we get paid for the hard work we put in. Some kids require a lot of extra work due to the child's needs or the needs of the family. I do appreciate that we are paid based on how hard we are working for the families we serve.	10/16/2017 12:52 AM
10	1. The amount of bands do not cover costs associated with Final Rule implementation or staffing needed to allow retirees to stay at home during the day. 2. The ICF rate is inadequate based on the level of individual needs. 3. Job Coach rate for QPL's is not fair.	10/12/2017 3:54 PM
11	1. The only negative is having invoice overlooked/missed and not submitted for payment, there should be something in place that automatically notifies the finance department or provider if a provider's invoice is not received or paid. 2. Payment is accurate and timely as long as there is no problem with invoice generating 3. The DDSN Reports that are specific to provider billable activity per caseworker is also helpful when looking at productivity and service delivery	10/11/2017 9:54 PM
12	1. Positive. DDSN staff work with the provider to resolve payment issues. 2. Negative. Resolution of the payment issues are not always provider supportive. 3. Positive. Payment is prompt.	10/11/2017 11:39 AM
13	Ease of uploading invoices Adequate turn around Good communication when issues come up	10/11/2017 11:14 AM

14	My issues do not reflect inadequacies in the dollars paid but rather flaws in DDSN's business model: 1) There is tremednous corruption in the referral process. We had one woman in Columbia who requested our services at the SPOE office but was told that our agency was the last she would recommend. Similar problems have been encountered in the Rock Hill area. 2) Boards should be treated exactly the same as QPLs when it comes to finances. 3) There should be more efficient methods to keep employees from moving from provider to provider and taking clients with them. Furthermore, many ex-employees when applying for new jobs mis-represent the nature of their termination. A former employee who was fired for fraud and forgery two years ago has resurfaced in a doctor's office handling confidential patient data.	10/11/2017 10:42 AM
15	N/A	10/11/2017 10:06 AM
16	1. Early Intervention payment is fair. 2. Payment is processed timely. 3. DDSN provides EI payment for non-medicaid consumers	10/11/2017 8:34 AM
17	1. Invoices are not always available at the end of business on the 5th day. This should be consistent so that business processes are not stalled while awaiting processing. 2. Printing, Signing, Scanning, Uploading could be streamlined to a pin-protected digital signature for submission of invoices for payment.	10/9/2017 9:31 AM
18	DDSN bills Medicaid on behalf of provider DDSN assumes Medicaid audit financial risk DDSN assumes Medicaid ineligible risk	10/6/2017 7:52 AM
19	overall we have no major issues with the current payment system other than funding amounts. timeliness of payments. how billing is submitted, seems a little archaic.	10/5/2017 2:47 PM
20	1. Waiting until the 5th business day for invoices is sometimes frustrating, especially if a holiday or weekend falls in those 5 days. 2. The process to upload invoices and receive quicker payment has been nice. 3. fee for services keeps it simple	10/5/2017 1:17 PM
21	Speaking as a QPL: The county disability boards generally pay the invoice in a timely manner but we do not know who to contact if there is a grievance issue. The county disability boards do not educate on billing when participants are absent. The camp absences in the summer are financially hard on our small agency. Do they get paid and just keep the money? We are okay with fee for service but if another agency is allowed to be compensated and we are not, how is that handled?	10/5/2017 1:14 PM
22	I explained my comments in the other questions. It's unclear as to who does what in regards to answering question from QPLs that need assistance with program information and billing information. Billing local boards when serving multi counties is confusing, the system isn't clear and is very loose. When a problem occurs it takes mulitple calls and emails to local boards and Columbia to figure out where it went wrong.	10/5/2017 10:12 AM
23	1. (most important) QPL not treated fairly, must wait on payments compared to DSN boards 2. QPL do not receive same notifications, training, or follow-ups with financial training as DSN boards. 3. QPL paid less for same services compared to DSN boards.	10/4/2017 11:06 AM
24	1) DDSN pays timely, unlike other state agencies with which we contract. 2) Increases are automatically passed along from DDSN when legislature approves the budget. 3) Band system is somewhat restrictive and could be more individualized based upon consumer need rather than from where the individual came.	10/4/2017 9:12 AM
25	1. The rates are too low. For EI DDSN sets a minimum salary that must be paid to EIs regardless of what they bill monthly. DDSN has increased these rates MINIMALLY over the last several years. We have to pay mileage to EIs travel to families daily as well as minimum salary, we still have to pay this even though a family may no show us repeatedly, and there is no attendance policy for families with DDSN and we obviously don't get paid for no shows. This causes providers to lose money. The rate we receive is not enough to cover this. I do not think it is fair for one EI who doesn't make up visits and work hard to provide the best service to their clients to be paid the same amount as another EI who sees their kids every week and does what is needed to do. Especially when there is a marked difference in hours billed monthly. The same goes for SC & case managers. It is aggregious that a coordinator who provides 4 hours per month to a consumer face to face should get reimbursement rate of someone who makes a phone call. What this band system promotes is complacency for some providers which causes the consumer to suffer.	10/4/2017 9:05 AM
26	Low payments to agencys	10/3/2017 9:17 PM

27	1. Fee-for-service for QPLs does not allow for adequate funding to compete for case workers/EIs with DDSN SCDDSN boards. Boards offer insurance benefits, leave time, and state retirement through state funding. The current fee-for-service rates do not allow for QPLs to offer benefits. 2. Payment rates for waiver case management does not provide adequate compensation considering the time involved for the service.	10/3/2017 8:34 PM

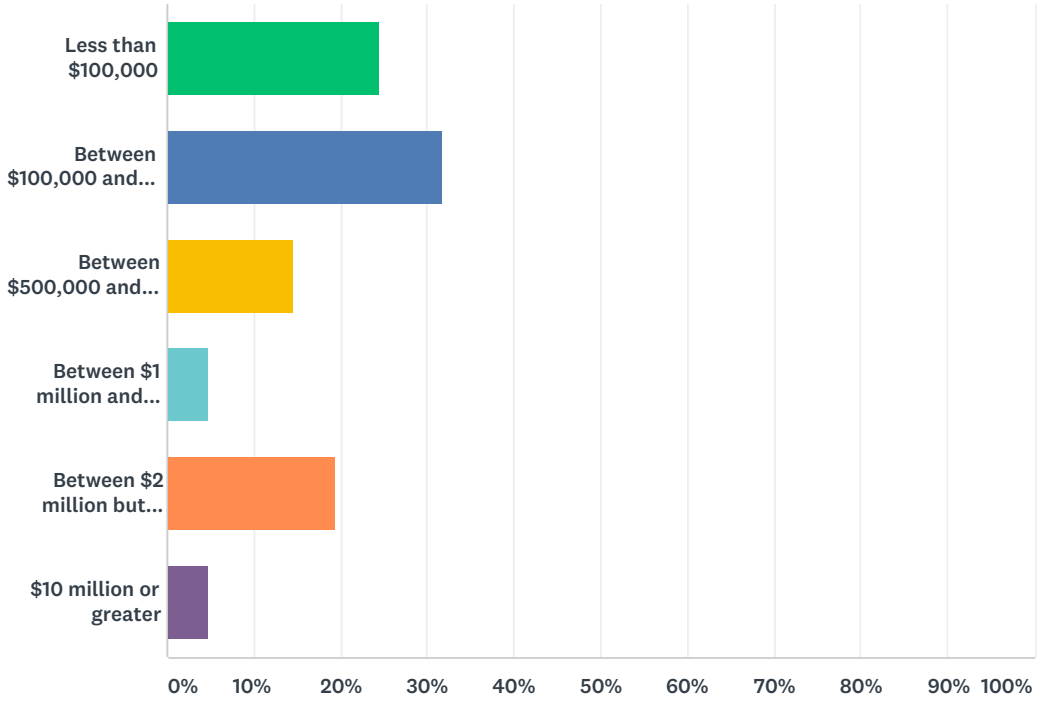
Q26 Please use the below narrative box to communicate any other information, ideas, or thoughts that were not sufficiently captured in the prior questions (1-25): Optional Comments:

Answered: 7 Skipped: 36

#	RESPONSES	DATE
1	PLEASE we request more direct involvement by DDSN to ensure that conflict free case management is implemented state wide in a fair and impartial manner.	10/18/2017 12:34 PM
2	The constant churn of change makes it difficult to adequately serve our clients. We have become a system that is more about indicators vs. quality. So many changes, lack of training on those changes and the inability to get a hold of someone at DDSN if there is a question is concerning.	10/16/2017 8:45 AM
3	Some of the questions were difficult to answer based on the way they were written. Overall the band system needs to be "tweaked" but not dissolved. Direct Billing can be a nightmare for smaller Boards that do not have the resources in their finance department to handle the extensive amount of work that will be required.	10/12/2017 3:54 PM
4	Thanks for the increase for DCS staff base pay, but staff retention requires higher rates generally.	10/11/2017 11:39 AM
5	I am delighted that these subjects are being addressed. As I reported earlier in the survey, QPLs need more training in this area as well as others. The one QPL meeting we had was so informative. While I know our agency is just a small provider, it would be nice to have a broader perspective of the system as a whole. I have no understanding of many of the questions you posed. Also, we are a private, not-for-profit agency, some of the directives are burdensome and costly for us. Some of the issues I am referring to are: minimum salaries (when we receive no compensation) for direct care providers; procurement policies (our staff is already overworked and underpaid); no understanding of how we can negotiate with Case Managers who work for county boards that are also serving as the Financial managers of participants.	10/5/2017 1:14 PM
6	none	10/4/2017 11:06 AM
7	Pay more	10/3/2017 9:17 PM

Q27 Your provider entity's fiscal year 2017 (period ending June 30, 2017) revenue (all sources):

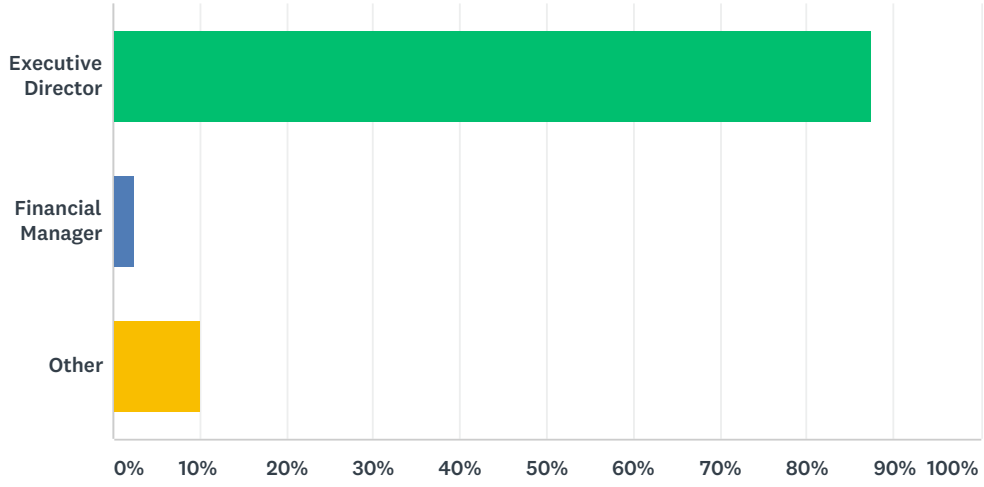
Answered: 41 Skipped: 2



ANSWER CHOICES	RESPONSES	
Less than $100,000	24.39%	10
Between $100,000 and less than $500,000	31.71%	13
Between $500,000 and less than $1 million	14.63%	6
Between $1 million and less than $2 million	4.88%	2
Between $2 million but less than $10 million	19.51%	8
$10 million or greater	4.88%	2
TOTAL		41

Q28 Responding official's position

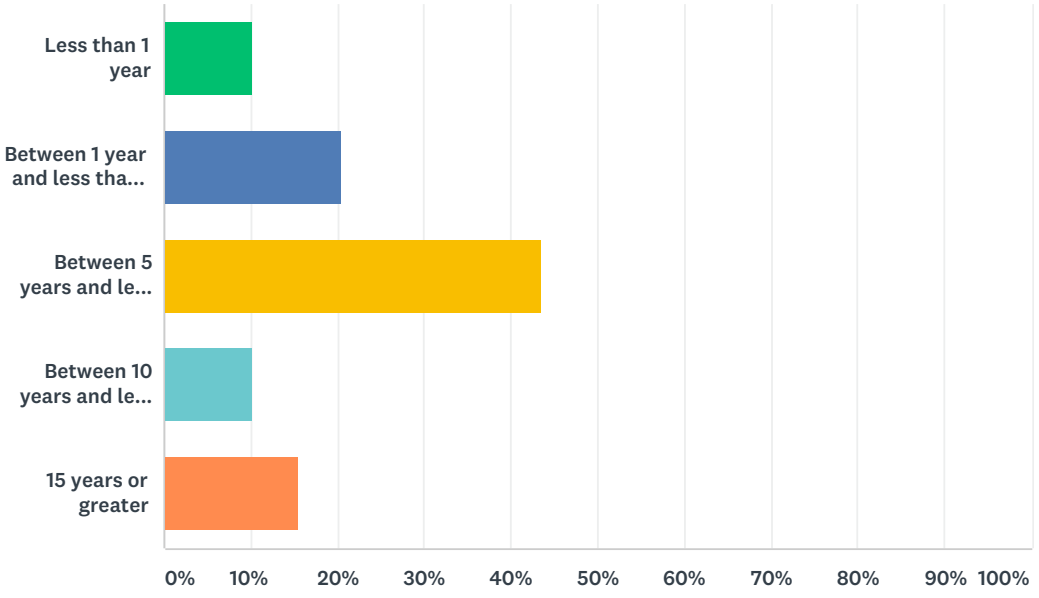
Answered: 40 Skipped: 3



ANSWER CHOICES	RESPONSES	
Executive Director	87.50%	35
Financial Manager	2.50%	1
Other	10.00%	4
TOTAL		40

Q29 Responding official's years of experience working within the DDSN provider payment system:

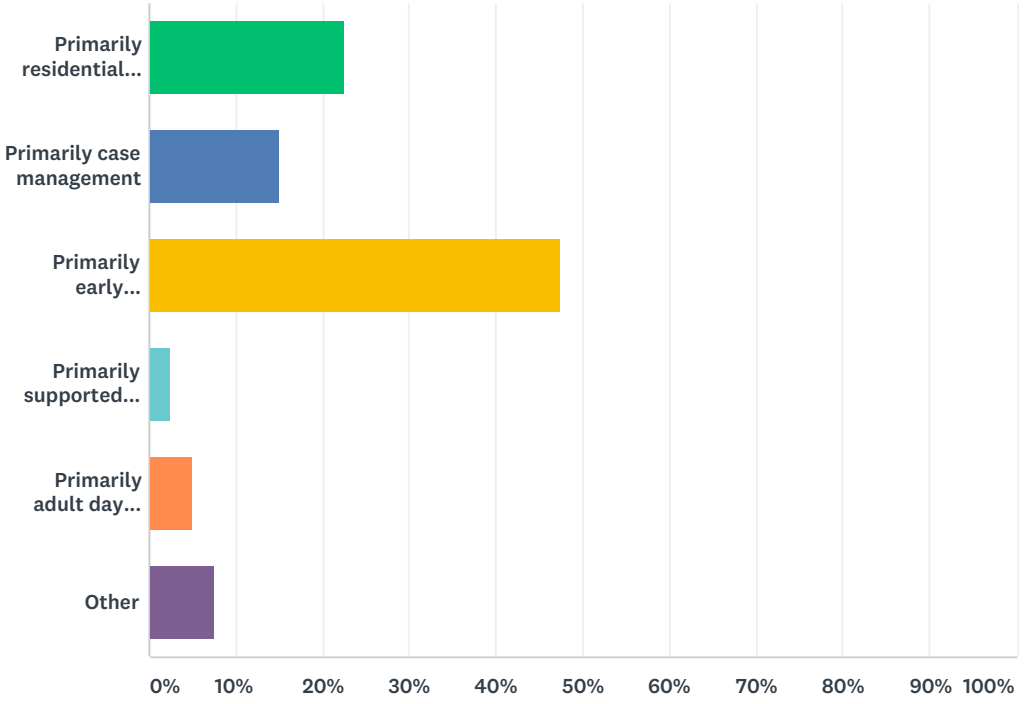
Answered: 39 Skipped: 4



ANSWER CHOICES	RESPONSES	
Less than 1 year	10.26%	4
Between 1 year and less than 5 years	20.51%	8
Between 5 years and less than 10 years	43.59%	17
Between 10 years and less than 15 years	10.26%	4
15 years or greater	15.38%	6
TOTAL		39

Q30 Type of QPL provider:

Answered: 40 Skipped: 3



ANSWER CHOICES	RESPONSES	
Primarily residential provider	22.50%	9
Primarily case management	15.00%	6
Primarily early intervention	47.50%	19
Primarily supported employment services	2.50%	1
Primarily adult day services	5.00%	2
Other	7.50%	3
TOTAL		40

COMMITTEE CONTACT INFORMATION

Legislative Oversight Committee

South Carolina House of Representatives

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