SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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June 24, 2021

The Honorable John Taliaferro "Jay" West, IV
South Carolina House of Representatives
Post Office Box 11867
Columbia, South Carolina 29211

RE: DHHS Response to June 3, 2021, Subcommittee Letter

Dear Representative West:

Please see below in response to your June 3, 2021, follow-up letter.

Agency Contracts

1. Evaluate and provide a summary of current inter-agency and stakeholder partnerships, collaborations, or contractual agreements. Summary should include notable findings and changes the agency believes should be implemented.

The South Carolina Department of Health and Human Services (SCDHHS) has inter-agency agreements with other state agencies, through which it is able to draw down federal funds to help other agencies pay for the services they provide. SCDHHS funds a large portion of some other state agencies budgets, including nearly 90% of the South Carolina Department of Disabilities and Special Needs' (SCDDSN) and approximately 33% of the South Carolina Department of Mental Health's (DMH) budgets. SCDHHS pays other state agencies who are enrolled as providers, such as Department of Alcohol and Other Drug Abuse Services, for the services they render to Medicaid members. SCDHHS also has contracts with other state agencies, including the Department of Social Services (DSS), through which it draws down federal funds to help pay the other agency's administrative costs.

In addition, the agency has contracts with the state's Medicaid managed care organizations (MCOs). Through these contracts, SCDHHS makes a capitated payment to each MCO based on the Medicaid members they cover. The estimated July 2021 enrollment and state fiscal year (SFY) 2021 capitation payment for each South Carolina Medicaid MCO is provided below.

The state also has contractual agreements with vendors to provide services outside of the claims process as described in the agency's previous correspondence and during the April 19, 2021, meeting.

Beyond these formal agreements, the agency partners with medical associations, state agencies, non-profit organizations and community-based organizations to share resources and information, as appropriate, in pursuit of its mission to achieve better health outcomes for South Carolinians in need.

MCO Enrollment and Capitation Payment

MCO	June 2021 Enrollment	SFY 2021 Total Payment*
First Choice by Select Health	391,729	$1,341,857,984
Absolute Total Care	229,882	$606,486,743
Healthy Blue by BlueChoice	171,471	$620,947,113
Molina Healthcare	165,872	$629,100,823
WellCare**	0	$254,033,259
Total	**958,954**	**$3,452,425,922**

**Figure does not include any quality withhold funds or quality withhold payouts.*
***Absolute Total Care and WellCare merged during SFY 2021.*

Metrics and Evaluation

2. The agency has a metric that requires 95% of beneficiaries receive primary care services within 10 miles and 15 days.

- How can DHHS influence the distance and length of time it takes for a beneficiary to access primary care?
    - *SCDHHS has the ability to influence the distance and length of time by incentivizing primary care providers to serve the rural populations within South Carolina. The agency currently has contracts in place specifically to target reaching those areas. The agency also reviews its managed care organizations' (MCO) provider networks to ensure they include adequate access to care in any county where the MCO operates as laid out in their contract with the agency.*

3. How does the agency measure or track consumer defined value?

When measuring value from the perspective of the consumer, SCDHHS focuses on Institute of Medicine research that shows consumers prioritize staying healthy, getting better, living with illness or disability, and coping with the end of life.

For the Healthy Connections Medicaid members who are enrolled in an MCO, the agency tracks consumer defined value through the National Committee for Quality Assurance (NCQA) Insurance Plan Ratings and the consumer satisfaction survey that NCQA performs

annually. These ratings assess each managed care plan in three areas: consumer satisfaction, prevention, and treatment, to arrive at a final annual rating for each MCO. SCDHHS currently incentivizes higher performance on these ratings by utilizing the scores each MCO receives in member auto-assignment. The higher performing MCOs will receive more auto-assigned members (members electing to not make a choice of a specific health plan) than those receiving lower scores from NCQA. Annually, SCDHHS updates the member auto-assignment algorithm to account for the new NCQA health plan rating.

4. What year, of the three-year cycle, is the agency's current quality improvement strategy?

   We are in the third year of the three-year cycle.

   - Does the agency have a defined process for developing its strategy? If so, please describe the process.
     - *SCDHHS currently has a program area dedicated to quality, the Division of Quality and Health Outcomes, within its organization. This area is responsible for the creation and maintenance of the agency's ongoing quality strategy. This area analyzes data from multiple sources including NCQA, Healthcare Effectiveness Data and Information Set (HEDIS) data sets and stakeholder input to inform its ongoing quality strategy. This information is shared with executive SCDHHS staff to create an overall agency quality strategy. Once it has been internally approved, it is shared with the Centers for Medicare and Medicaid (CMS) for their review and approval. SCDHHS anticipates submitting its quality strategy for the next three-year cycle near the end of 2021.*

   - Who approves the strategy?
     - *After internal review and approval from the deputy director of health programs and the SCDHHS director, the quality strategy is submitted, reviewed, and approved by CMS.*

5. How does the agency evaluate the effectiveness of MCO quality strategies?

   SCDHHS currently evaluates MCO quality strategy effectiveness through the following methods:
   1. *Annual External Quality Reviews—The SCDHHS contracted external quality review organization evaluates each MCO's performance improvement projects to determine their success in quality improvement on those chosen projects.*
   2. *Monetarily through the withhold and bonus program—MCOs who meet and exceed SCDHHS-defined HEDIS metrics will recoup all their withhold dollars and be eligible for any dollars sacrificed by lower-performing MCOs.*
   3. *Member Enrollment—MCOs with higher quality composite ratings from the NCQA receive a higher rate of members into their MCO during auto-assignment.*

6. Explain how higher performing plans are assigned more members.

Please see the table and formula below for the member assignment algorithm based on quality weighting.

MCO Health Insurance Plan Rating	Quality Weighted Assignment Factor
1.0 or 1.5	0
2	0.5
2.5	0.75
3	1.0
3.5	1.25
4	1.5
4.5	1.75
5	2

The quality weighted assignment algorithm will determine the number of Medicaid members assigned to each plan, at the county level, as follows:

Step 1: Divide the total number of auto-assignable members for the enrollment period in the county by the sum of the quality weighted assignment factor for each MCO participating in the county.

Step 2: Multiply the result of step 1 by the quality weighted assignment factor for each MCO. This will result in the MCO's auto-assignment population for the enrollment period in each county.

- Are Medicaid MCOs aware of the number of "annual auto assignments" and the total number they received?
    - *Yes, the MCOs are aware of the total number of auto-assignments they receive. The agency provides a monthly report from its contracted enrollment broker that indicates how membership was enrolled with each MCO. The monthly report provides total members electing to voluntarily enroll and a total that were auto-assigned to the MCO.*

      In addition to these monthly reports, the member's electronic file sent to each MCO has a "choice reason code" that defines why each member chose the plan and indicates whether that specific member chose or was auto-assigned to the MCO.

7. Testimony was received stating that approximately $75 million would flow back to the agency from MCOs due to risk corridor provisions.

- Could this funding be directed towards primary care as an enhanced payment?
    - *The state is required to reimburse CMS for its share of the funding recouped through the risk corridor for state fiscal year 2020 at the current Federal Medical Assistance Percentage rate meaning that the state would only receive about 23% of the funds.*

      SCDHHS modified its physician reimbursement methodology in July 2019 to allow primary care providers to receive a physician reimbursement that is comparable to the Medicare rate. Additionally, the agency instituted a program in 2013 that rewards and incentivizes all primary care providers that elect to become a Primary Care Medical Home (PCMH) with NCQA.

      Based on current understanding of the funds related to the risk corridor, SCDHHS could utilize funds that are returned for additional provider incentives. However, this is a non-recurring source of funds, therefore, using risk corridor funds as a funding source to create a recurring obligation, such as a provider rate increase, is not sustainable. SCDHHS will continue to research and internally investigate the most appropriate and impactful way to continue to promote the highest levels of care for the least possible cost to the state.

8. The agency testified it is working on its Quality Strategy 2022. Please identify the key components of the strategy (e.g., goals, desired outcomes, metrics, etc.).

Historically the agency has concentrated on the following indices: Diabetes, Well Child Care, Behavioral Health, and Women's Care. The quality withhold and bonus measures the agency currently tracks related to the state's MCOs and the quality measures it tracks related to the state's hospitals are listed below. SCDHHS is planning to modify its future quality strategies to broaden its focus on the services received and outcomes of the broader Medicaid population. Through this, the agency will focus on areas of concern that include a larger emphasis on social determinants of health. SCDHHS is still internally evaluating its options for the final quality strategy and will need additional approval from CMS.

MCO Withhold and Bonus Measures

- ***Index 1: Diabetes***
    - *Hemoglobin A1c (HbA1c) testing*
    - *HbA1c poor control (>9.0%)*
    - *Eye exam (retinal) performed*
- ***Index 2: Women's Health***
    - *Prenatal care, timeliness of prenatal care*
    - *Breast cancer screening*
    - *Cervical cancer screening*

- ***Index 3: Pediatric Preventative Care***
    - *Well-child visits in the first 0-15 months of life, 6+ visits*
    - *Well-child visits in the 15-30 months of life, 2+ visits (w30), 2+ visits*
    - *Child and adolescent well-care visits, total*

Bonus Measures

- *Post-partum care (women's health)*
- *Antidepressant medication management, continuation phase (behavioral health)*
- *Follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication, continuation (behavioral health)*
- *Metabolic monitoring for children and adolescents on antipsychotics, total (behavioral health)*
- *Initiation and engagement of alcohol and other drug dependence treatment engagement (behavioral health)*

Hospital Quality Measures

- *Patient Experience*
    - *5%: HCAHPS – Communication with nurses, composite measure (always)*
    - *5%: HCAHPS – Discharge information, composite measure (yes)*
    - *5%: HCAHPS – Care transition, composite measure (strongly agree)*
    - *10%: HCAHPS – Overall rating of hospital, global measure (9 or 10)*
- *Readmissions*
    - *20%: Hospital-wide all-cause unplanned readmission measure*
- *Patient Safety and Harm Avoidance*
    - *5%: National Healthcare Safety Network (NHSN) facility-wide inpatient hospital-onset Clostridium difficile Infection (CDI) Outcome Measure*
    - *15%: Patient safety and adverse events composite*
    - *2%: Participation in the South Carolina surgical quality collaborative*
- *Maternal and Prenatal Care*
    - *12.5% Elective delivery 37-38 weeks*
    - *7.5%: Centering Pregnancy certification*
- *Social Determinants*
    - *5% Participation in the Social Determinants Collaborative*
- *Opioids and Behavioral Health*
    - *8% Participation in the Statewide Collaborative, Emergency Department Information Exchange*

- Based on information and data currently available to the agency, which social determinants of health have the greatest impact on the South Carolina Medicaid population?
    - *SCDHHS has just begun its analysis and additional focus around social determinants of health. Preliminary findings from the agency indicate that family/parenting stress, transportation and food insecurity seem to be some of*

the higher impact determinants. The agency has not historically required this data during its claims adjudication process. SCDHHS is continuing to analyze this data and, where reasonable and appropriate, requiring additional information from the provider community.

- Are there ways in which the General Assembly could assist the agency with its focus on social determinants of health?
    - *SCDHHS appreciates the willingness of the General Assembly to assist the agency in its ongoing efforts. SCDHHS is still analyzing its preliminary data and determining the most appropriate next steps. SCDHHS will update the General Assembly once it has performed additional analysis and looks forward to collaborating with the General Assembly to implement new and additional policies that will help improve health outcomes in the state through a larger focus on addressing social determinants of health.*

South Carolina Birth Outcomes Initiatives

9. What interventions have been put in place by the agency that directly correlate to the South Carolina Birth Outcomes Initiative (SCBOI) successes?

A list of the goals and topics SCBOI has pursued along with a summary of the interventions that support them is below.

Early Elective Deliveries

- *In August 2011, SCBOI successfully secured an SCBOI-sponsored commitment from all birthing hospitals in the state to end all non-medically necessary deliveries between 37-39 weeks gestation.*
- *In 2013, SCDHHS and BlueCross BlueShield of South Carolina (BCBSSC) stopped reimbursement to hospital and physicians for elective induction or non-medically necessary deliveries before 39 weeks. This made South Carolina the first state in the nation where the Medicaid agency and the largest commercial insurer have collaborated to establish a policy of nonpayment.*

Supporting Vaginal Births

- *In June 2014, SCBOI successfully secured a BOI-sponsored commitment from all birthing hospitals in the state to support the reduction of cesarean sections for first-time, low-risk mothers, regardless of the payor type.*

Long-Acting Reversible Contraceptives (LARCs)

- *In 2012, SCDHHS changed its policy to allow for the immediate inpatient insertion of LARCs with the reimbursement for the device being fully covered for hospitals outside the diagnosis related group (DRG). South Carolina is the first state to pay for LARC insertions inpatient outside the DRG.*

Baby-Friendly

- *Hospitals recognized nationally as Baby-Friendly promote breast milk as the standard for infant feeding and demonstrate best practices in the care of mothers and newborns.*

- *Seventeen hospitals in South Carolina are Baby-Friendly certified. Approximately 51% of all babies in the state and 56% of SC Medicaid babies are born in a Baby-Friendly hospital. The national average is 29%.*

Screening, Brief Intervention and Referral to Treatment (SBIRT)

- *Since 2012, SBIRT has incentivized providers to screen pregnant women for risk factors such as substance abuse, domestic violence, and depression.*
- *SCDHHS, BCBSSC and the South Carolina State Health Plan all now reimburse providers once per fiscal year for screenings and twice per fiscal year for brief interventions for each patient receiving these services.*

CenteringPregnancy (2013)

- *CenteringPregnancy is a national model of group prenatal care maintained by the Centering Healthcare Institute (CHI) that is shown to decrease pre-term birth.*
- *Fifteen physician practices across the state offer CenteringPregnancy to South Carolina Healthy Connections Medicaid members.*

Mother's Milk Bank of South Carolina (MMBSC)

- *SCBOI teamed up with other stakeholders to open South Carolina's first Mother's Milk Bank in April 2015 to improve the health of the state's most vulnerable infants.*
- *MMBSC provides breast milk to very low birth-weight babies – infants weighing less than 3.3 pounds - in neonatal intensive care units (NICUs) in South Carolina.*
- *Physically located in North Charleston, the milk bank, accredited by the Human Milk Banking Association of North America (HMBANA) as a developing milk bank, is operated by MUSC. South Carolina mothers can donate breast milk at 21 satellite milk bank depots around the state.*

Managing Abstinence in Newborns (MAiN) (2014)

- *MAiN is an innovative treatment model for opioid-dependent newborns that was developed and piloted at Prisma Health-Upstate.*
- *The groundbreaking program features three key components: treatment for withdrawal in the newborns is started right away to reduce pain and health complications, the mom rooms-in with the baby for a week to help provide care and gain parenting skills, and the baby continues to be weaned off the opioids at home, avoiding a lengthy hospital stay.*

Safe Sleep Initiative (2017)

- *The goal of this initiative is to eliminate sleep-related infant deaths, which are 100% preventable and are the third leading cause of infant death in South Carolina, by providing prevention education and consistent messaging and support to healthcare providers, parents, caregivers, and the community.*
- *By July 2017, SCBOI received signed commitments from all birthing hospitals in the state to participate in the Safe Sleep Initiative.*
- *The initiative was endorsed by the South Carolina Chapter of the American Academy of Pediatrics (AAP), the South Carolina Academy of Family Physicians, BCBSSC and the South Carolina Hospital Association.*
- *The initiative includes a brochure featuring unsafe sleep statistics, the ABCs of safe sleep and safe sleep recommendations, and also includes a video produced by the South Carolina Department of Health and Environmental Control (DHEC) that is shown to*

parents and caregivers at the hospital, foster care parents licensed through DSS, other healthcare provider practices, childcare providers and the community. Both the brochure and video are available in English and Spanish.

The Alliance for Innovation on Maternal Health (AIM)

- *AIM is a national data-driven maternal safety and quality improvement initiative designed to promote consistent and safe maternity care to reduce maternal mortality and severe maternal morbidity by aligning national, state and hospital-level quality improvement efforts. South Carolina was accepted as an AIM state in June 2019.*
- *The SCBOI dashboard, which is produced by the University of South Carolina Institute for Families in Society, is part of this initiative.*

Improving the Postpartum Care Affinity Group

- *In April 2021 SCBOI applied and was accepted to participate in CMS' Improving Postpartum Care Affinity Group. This group will engage in collaborative learning with CMS staff, quality improvement (QI) advisors, and subject matter experts (SMEs) in improving postpartum care. The goal of this effort is to improve postpartum care visits and the quality of visits among Medicaid and the Children's Health Insurance Program (CHIP) beneficiaries.*
- *This team is meeting monthly from April 2021-April 2022 with additional technical assistance available until October 2022.*

- Is the SCBOI dashboard assessable via the DHHS website? If no, please provide the address.
    - *It is on SCDHHS' website on our SCBOI page. It can also be found directly here: https://boi.ifsreports.com/statewide/maternalhealth.html*

Quality Through Technology and Innovation in Pediatrics (QTIP)

10. How many pediatric practices are currently participating in the QTIP project?

The SCDHHS QTIP initiative is currently working with 27 pediatric practices. These practices include: four FQHCs and rural health clinics, three academic teaching hospitals, 13 independent pediatric practices, and seven hospital-owned practices. Since 2010, QTIP has worked with 46 total pediatric practices. Currently, QTIP practices serve approximately 33% of the children enrolled in South Carolina Healthy Connections Medicaid.

- Are providers incentivized to participate in this program?
    - *There are no financial incentives; however, by participating in QTIP, practices receive the following support services:*
        - *Attendance/participation at QTIP's twice yearly Learning Collaborative session;*
        - *At least two site visits per year from QTIP staff, which includes quality improvement (QI), mental health and medical director staff;*
        - *Full access to QTIP staff and resources;*
        - *Calls on varying QI topics and community resources;*

- *Free registration to workshops and other learning opportunities sponsored by QTIP;*
- *American Board of Pediatrics Part 4 Maintenance of Certification (ABP MOC) credit for select QI initiatives;*
- *Coaching support to implement QI techniques and processes in their office; and,*
- *Support with incorporating various development, mental and/or behavioral health screening instruments and implementing protocols within their office.*

11. Does the agency have a formal QTIP strategy? If so, what are the key components of the strategy (e.g., goals, objectives, etc.)?

QTIP works with pediatric practices to improve key children's health outcomes by:

- *Providing useful strategies for working on children's core health measures;*
- *Improving children's quality of care by promoting the pediatric medical home; and,*
- *Incorporating mental health integration and/or screening within a medical home.*

Since the SCDHHS QTIP initiative is a collaborative effort with the South Carolina Chapter of the AAP, an advisory council was formed with AAP and SCDHHS QTIP staff. Through this council the vision for pediatric quality is:

1. *Children and families will be screened for developmental delays, autism, post-partum depression, behavioral health issues, socio-economic issues impacting health, and family concerns.*
2. *Children will be linked to a dental home and receiving basic oral health services including fluoride varnish.*
3. *Children will be up to date in receiving pediatric well childcare.*
4. *Children will be screened and evaluated for obesity.*
5. *Children will be screened for and, when needed, receive appropriate management for mental health conditions including ADHD.*
6. *Those with asthma will be managed effectively and control maximized.*

Additionally, the SCDHHS QTIP initiative focuses on several SCDHHS quality measures – specifically increasing the HEDIS scores for all three well child-care criteria.

- Please identify the metrics used to evaluate the effectiveness of the QTIP project. Provide the most recent results.
  - *As part of the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) grant that launched QTIP, the initiative's effectiveness was evaluated by national and state evaluation entities in 2015. The national evaluator highlighted the QTIP initiative in several publications including:*
    - *"Key Lessons from the National Evaluation on the CHIPRA Quality Demonstration Grant Program" and*

- *"Nine States Use of Collaboratives to Improve Children's Health Care Quality on Medicaid and CHIP."*

- *The Medicaid Policy Research at the University of South Carolina Institute for Families in Society (IFS) was the in-state evaluation entity. IFS published several studies on QTIP and submitted a final report to CMS. Some of the studies included:*
  - *"Improving Care for Children Enrolled in Medicaid: Using a Learning Collaborative Framework to Transform Pediatric Practices."*
  - *"Implementing CHIPRA Core Measures in SC Integrating Behavioral Health in Pediatric Primary Care."*
  - *"CHIPRA Core Quality Measures: A Look at Usefulness to Pediatric Practices"*
  - *"CHIRPA Evaluation: CHIPRA HEDIS report" and the "SC CHIPRA Quality Metric Report"*
  - *Research and Policy Briefs on: "Academic Detailing within a Quality Improvement Learning Collaborative," "Reducing Pediatric Emergency Department Utilization" and "Integrating Behavioral Health into Pediatric Care"*

- *The most recent QTIP data was included in the May 24 presentation and shows that QTIP practices ranked higher than the state average in all three well-child measures in the HEDIS-like administrative reports. This includes:*
  - *6+ Well Child Visits in the first 15 months of life*
    - *QTIP's 2011 baseline ranked in the 41.5 percentile and 2019 QTIP data ranked in the 63.8 percentile compared to the state average of the 58.5 percentile.*
  - *Well child visits for 3-6 years: QTIP's 2011 baseline ranked in the 65.6 percentile and 2019 QTIP data ranked in the 77.1 percentile compared to the state average of the 58.9 percentile.*
  - *Adolescents Well Child Care: QTIP's 2011 baseline ranked in the 50.7 percentile and 2019 QTIP data ranked in the 69.8 percentile (which is above the national 90th benchmark percentile) compared to the state average ranked of the 40.5 percentile.*

- *As presented on May 24, QTIP has also worked to promote several preventative health topics. The number of Medicaid children receiving preventative services in these targeted areas has increased and includes:*
  - *Preventative Oral Health/Fluoride Varnishing in a non-dental setting reflects a 1,606% increase since 2011.*
  - *Since 2011, the number of Medicaid children receiving developmental screenings has increased by 351%.*
  - *Emotional/behavioral health screening was introduced in 2015 and has seen a 429% increase. SCDHHS anticipates this will increase even more as a result of introducing additional screenings in 2020 on suicide, anxiety and substance abuse.*
  - *Environmental and risk assessments (including post-partum and social determinates of health screening) have increased 1,666% since 2011.*

- *Other noteworthy quality improvement projects QTIP has tracked through its data aggregator system are listed below. This real-time data is entered monthly by the QTIP pediatric practices based on random chart reviews. Over the past year-and-a-half, QTIP practices have seen improvements in:*
  - *Well visit compliance for asthmatic children ages 5-18 (11% increase)*
  - *ER visits for asthmatic children ages 5-18 (5% decrease)*
  - *Well visit compliance for adolescent children ages 13-18 (9% increase)*
  - *Screening for suicide ideation in adolescents ages 13-18 (19% increase)*
  - *Screening for anxiety in adolescents ages 13-18 (32% increase)*

12. How many pediatric practices are there in the state and how many of them are you actively engaged with?

SCDHHS does not track this data by practice; instead, it tracks by enrolled providers. Currently, 27 practices are active in QTIP. Using other data sources, SCDHHS estimates there are 123 pediatric practice groups in the state.

- Please provide a list of all the pediatric practices currently involved with QTIP (include zip code).

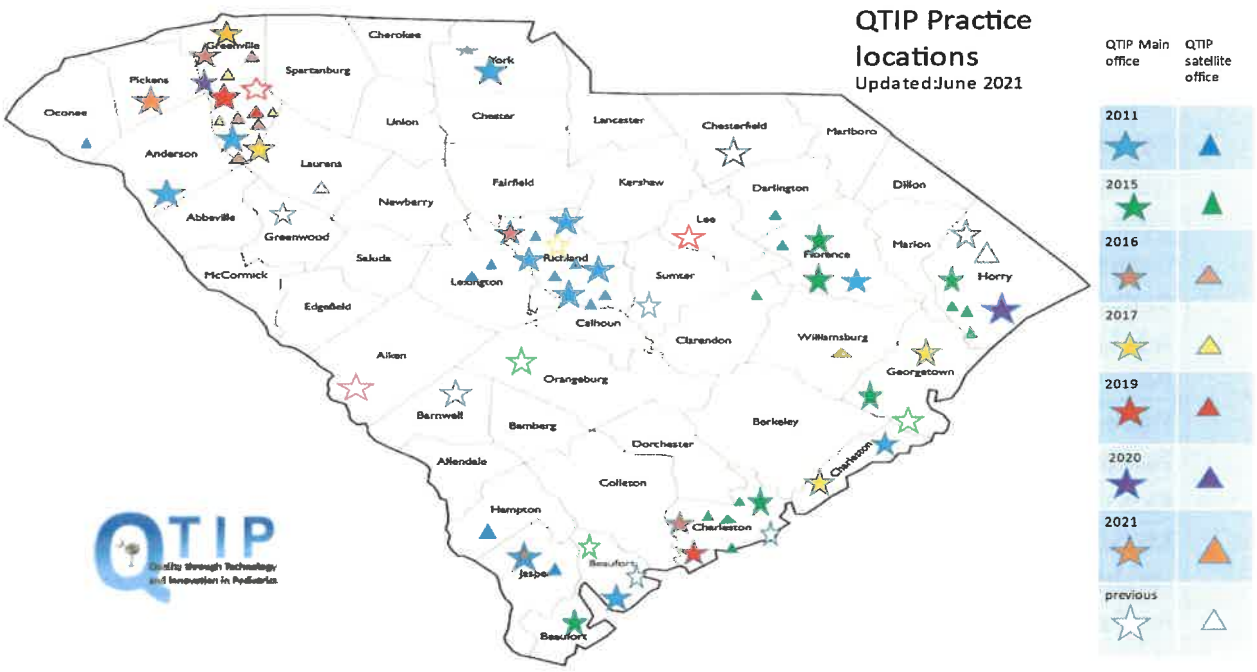
QTIP Practice	Primary County*	# of Offices	Zip 1**	Zip 2	Zip 3	Zip 4	Zip 5	Zip 6
AnMed Health Children's Healthcare Center	Anderson	4	29621	29621	29631	29621		
Ballentine Pediatrics	Richland	1	29063					
Beaufort Pediatrics	Beaufort	1	29902					
Beaufort-Jasper-Hampton Comprehensive Health Services	Beaufort	2	29909	29935				
Carolina Pediatrics	Richland	2	29203	29063				
Center for Pediatric Medicine	Greenville	3	29611	29690	29605			
Charles Towne Pediatrics	Charleston	1	29405					
The Children's Clinic-Greenville Office	Greenville	3	29607	29650	29617			
Children's Hospital Outpatient Center-Prisma Health	Richland	1	29203					
Children's Medical Center	Greenville	5	29607	29650	29673	29681	29690	

Coastal Pediatric Associates	Charleston	4	29412	29464	29486	29414		
Eastern Carolina Pediatric Associates	Florence	2	29505	29532				
Georgetown Pediatric Center	Georgetown	1	29440					
Grand Strand Pediatrics and Adolescent Medicine, PA	Horry	4	29575	29579	29579	29566		
Hope Health Pediatrics	Florence	2	29501	29102				
Kids Choice	Greenville	1	29605					
MUSC Children's Health University Pediatrics - Northwoods	Charleston	1	29406					
MUSC Pediatric Children's Health - Rutledge Tower	Charleston	1	29425					
Palmetto Pediatric and Adolescent Clinic	Richland	5	29203	29063	29072	29229	29016	
Parkside Pediatrics	Greenville	6	29607	29680	29607	29681	29301	29607
(McLeod) Pediatric Associates of Florence- West	Florence	1	29501					
Prisma Health Pediatrics- Upstate (Greer)	Greenville	1	29650					
Pelican Pediatrics	Charleston	1	29412					
Riverside Pediatrics	Georgetown	2	29440	29556				
Rock Hill Pediatrics	York	2	29732	29715				
Sandhills Pediatrics	Richland	5	29203	29203	29229	29072	29169	
Tiger Pediatrics (opening July 2021)	Pickens	1	29642					

** listed county is where the lead QTIP physician practices*

*** denotes zip code of lead QTIP office for the practice, subsequent zip codes are for satellite offices*

The map shown below denotes the location of all the practices QTIP has worked with since 2011. The column on the far right denotes the year a practice joined the SCDHHS QTIP initiative.



13. How many on-site visits, monthly calls and workshops do you conduct annually?

In 2020, QTIP pivoted from its traditional methods to virtual services to support pediatric practices during the COVID-19 public health emergency. QTIP is in the process of transitioning to its more traditional methods via a hybrid model. The chart below summarizes QTIP services from 2018 to present.

Key to be used in conjunction with table below.

Practice Site Visits: *Traditionally, practice site visits are in-person meetings held at pediatric practices. During COVID-19 these were conducted virtually. QTIP's goal is to conduct bi-annual site visits per QTIP practice.*

Purpose: *Practice site visits include the pediatric practice's QTIP team and SCDHHS QTIP staff and allow for onsite coaching and sharing about current QI projects, implementation ideas, and problem-solving QI challenges. Site visits allow participants to teach and learn from practices' challenges and successes and enable them to share this information regularly with other practices.*

Learning Collaborative (LC): *Twice a year in-person meetings held in conjunction with the SC AAP. LCs are multi-day events attended by the QTIP staff and each pediatric practice's QI team. During the pandemic, these were virtual.*

Purpose: *LCs are the main opportunity to share best practices guidelines for specific child core and/or HEDIS measures. AAP clinical guidelines, AAP*

anticipatory guidelines, community resources and quality improvement strategies are introduced to QTIP's QI teams.

QTIP Scheduled Calls: *Traditionally, QTIP has offered monthly topic specific calls to QTIP practices. During the pandemic, calls were offered weekly to share time-specific information and to provide support and networking in real time. In response to requests for more networking opportunities, QTIP added an additional call each month to discuss mental health issues using resources developed by the AAP in 2020. Call attendance is optional.*

Purpose: *Topics are selected to enhance the practice's QI work. Calls can be facilitated by experts in the field or information sharing across practices. It is an opportunity to do a deeper dive on specific topics introduced at the LC and/or children's health.*

Workshops: *QTIP offers one to two content-specific optional workshops per year.*

Purpose: *Workshops offer content specific presentations open to all QTIP and AAP members. In addition, practices can do follow-up QI work with additional support and coaching from QTIP staff. Practice participation is encouraged but not required.*

Collaborative community meetings with partners and stakeholders*: This includes meetings (virtual or in-person) with community groups, state agencies and stakeholders.*

Purpose: *Collaborations allow QTIP practices to partner with resources and supports available for children and families in their home communities and to collaborate with various state agencies or private groups.*

	Practice Visits	LC	Calls	Workshops	Community Visits/ Meetings
2018	68	2	12	HPV QI project presented nationally	67
2019	67	2	12	Smoking Cessation (1 presentation, 2 QI calls)	89
2020	53	2	30	Suicide Prevention (2 presentations, 14 QI calls)	97
Jan.-June 2021	25	1 Next LC - Aug 2021	6	Project First Line (3-1 hr. education sessions) Smoking Cessation (3 presentations, 12 QI calls)	49

- Are there regions of the state, or counties, that have low pediatric practice participation rates?

    - *There are 1,270 enrolled pediatricians who have billed SCDHHS for Medicaid services within the past 18 months; this includes 147 who are within the South Carolina Medicaid service areas in Georgia and North Carolina. In South Carolina, seven counties (Abbeville, Allendale, Bamberg, Calhoun, Lee, McCormick, and Saluda) have low or no Medicaid-enrolled pediatrician participation rates.*

14. What is the agency doing to ensure that it has an equitable distribution of provider participation across the state?

The SCDHHS QTIP initiative is a voluntary program; that actively recruits practices through the SC AAP and word-of-mouth in each region in the state. Over the lifetime of the initiative, QTIP has worked with over 46 pediatric practices across the state.

15. If the agency were to put a dollar value on the training and technical assistance available to providers, what would that amount to?

Providers who participate in QTIP have reported several tangible benefits as a result of their involvement in the program but the agency is not able to assess a monetary dollar value. Benefits of involvement in QTIP reported by providers include:

- *Focus on the HEDIS well child measures (high scores on these measures are incentivized by the state's MCOs);*
- *Alignment of the QI projects with and support of provider's NCQA Patient Centered Medical Home (PCMH) recognition (NCQA PCMH recognition equates to increased "Per Patient Per Month" reimbursement from SCDHHS and some insurance companies);*
- *American Board of Pediatrics (ABP) Part 4 Maintenance of Certification credits, which are available because of QTIP's approval as ABP project sponsor (these credits are free to QTIP practitioners when they complete QI projects and submit the required data);*
- *QTIP practices highlighted the correlation between quality improvement activities/work on children's measure(s) and the practices' ability to increase utilization for services for which they are reimbursed. Specific examples include fluoride varnishing and screenings (developmental, post-partum, substance abuse, mental health, etc.); and,*
- *Networking among pediatric practices that is facilitated by QTIP. This networking allows providers to share ideas and lessons learned with each other thus saving time and staff resources.*

BabyNet

16. Please identify the metrics used by the agency to determine the effectiveness of the BabyNet program (e.g. clinical metrics, non-clinical, etc.).

The federal government has established metrics, that the agency tracks to measure the effectiveness of the BabyNet program. These are included in the federal Individuals with Disabilities Education Act (IDEA) Part C State Performance Plan/Annual Performance Report (Part C SPP/APR) Part C Indicator Measurement Table. The U.S. Department of Education uses both results and compliance data to make determinations for each state under IDEA Part C. The federal Office of Special Education Programs (OSEP) also uses information from monitoring and specific conditions, on the state's grant award, if applicable. OSEP specifically focuses on data quality and child performance when making determinations. OSEP's data quality team examines completeness of data and any anomalies. Child performance is measured by comparing outcomes data with other states' data and is tracked over time. The indicator measurement table is available here: https://sites.ed.gov/idea/files/1820-0578_Part_C_SPP_APR_Measurement_Table_2021_final.pdf

- Exit reasons-how many kids exit prior to age three due to all goals met or at three with no need for Part B services.
    - *The state's data system tracks when Individualized Family Service Plan (IFSP) goals are met, continued or discontinued. The current data system does not have an efficient way of reporting the specific metrics requested. The agency is working to implement a new data system and is currently evaluating metrics that can be tracked with the new data system. Currently, service coordinators must record the exit date and reason for each child that transitions from BabyNet. Available exit reasons are:*
        - *Attempts to contact unsuccessful*
        - *Child is 3-Eligibility for Part B not determined*
        - *Child is 3-Not eligible for Part B-Exit to other programs*
        - *Child is 3-Not eligible for Part B with no referrals*
        - *Child is 3-Part B eligible*
        - *Deceased*
        - *Moved to other state*
        - *No IFSP-Ineligible at intake*
        - *No IFSP-Referred over 34.5 months (send to Local Education Agency [LEA] per regulations)*
        - *No IFSP-Screening passed at intake*
        - *Parent withdrawal*
        - *Program completion-Child under 3 (met all goals)*

17. Does the agency survey families regarding their satisfaction with BabyNet services?

In 2006, OSEP began requiring states to measure family outcomes. South Carolina developed a Family Outcomes Measurement process, which included surveying families upon exit from BabyNet and surveying all families once a year. This process was revised in 2020 and piloted in the BabyNet Richland district (Aiken, Allendale, Bamberg, Barnwell, Calhoun, Fairfield, Lexington, Orangeburg, and Richland counties).

The new process will be implemented statewide on July 1, 2021. Families will be surveyed after receiving six months of services and again the month following their exit from BabyNet. This process better aligns with how other states are measuring outcomes and satisfaction. This new process was developed with input and recommendations from national technical assistance (TA) providers from OSEP-funded TA centers.

The new process made drastic improvements in survey dissemination. Previously, only the state and families were included in the process. The new process includes service coordinators hand-delivering postcards with information related to the surveys along with a QR code that allows families to complete their survey on mobile devices.

18. What is the average age of a child upon entry into the BabyNet program?

Eligibility Year	Average Age in Months
2018	18.86
2019	18.29
2020	17.38
2021	18.03
Overall	18.13

- Does the agency believe that qualifying children are entering the program early enough? If no, why?
    - *The agency believes children are entering the program on time. As depicted in the data above, BabyNet has focused its efforts on lowering the average age a child enters the program.*

19. Are obstetricians, who participate in the Medicaid program, required to provide information regarding BabyNet to expectant mothers?

The obstetrician would only be required to share information if there is a reason to believe the child has a disability. If a child is identified as having a diagnosed condition prenatally, the obstetrician should (34 CFR §303.303) share information with the parents regarding BabyNet services. This information would likely be shared again by the birthing hospital.

- Are there any statutes or regulations that would prevent the agency from implementing such a requirement?

- *While nothing prevents obstetricians from sharing information with all families, the agency would need to evaluate the benefits and potential risks of implementing a requirement that all pregnant mothers receive information on the BabyNet program. IDEA regulation (34 CFR §303.303) covers referral procedures to Part C programs in general.*
    - *(a) General. (1) The lead agency's child find system described in § 303.302 must include the State's procedures for use by primary referral sources for referring a child under the age of three to the part C program.*
    - *(2) The procedures required in paragraph (a)(1) of this section must -*
        - *(i) Provide for referring a child as soon as possible, but in no case more than seven days, after the child has been identified; and*
        - *(ii) Meet the requirements in paragraphs (b) and (c) of this section.*

20. Are pediatricians, who participate in the Medicaid program, required to inform or refer patients to the BabyNet program if they diagnosis a qualifying condition?

IDEA regulations (34 CFR §303.303) cover referral procedures to Part C programs and indicate that anyone, including pediatricians, are expected to refer a child as soon as possible, but are required to do so no later than seven days after the child has been identified as having a diagnosed condition or developmental delay. The BabyNet program implemented an online referral portal that allows professionals to refer a child in five minutes or less and upload any documentation that supports their decision to refer, which speeds up the eligibility process.

- Can the agency require Medicaid providers to provide BabyNet information and refer patients?

    - *The federal regulations governing the program outline this requirement, therefore the BabyNet program does not feel it is necessary to add its own formal requirement. The BabyNet program continues to educate referral sources whenever possible and the increase in the program's overall numbers support that these efforts are having an impact.*

21. How does the agency educate physicians, healthcare professionals, early childhood workers (e.g., daycare workers, etc.) and the public about the BabyNet program?

- Outreach and education to referral sources and the public occurs frequently and in a variety of ways including:
    - *Presentations to the South Carolina Chapter of the AAP, the Pediatric Advisory Committee at DHEC, pediatricians involved in the QTIP program, and the state's managed care organizations;*

- *Workshops/sessions, which are conducted at various early childhood conferences including the South Carolina Council for Exceptional Children's Conference, the South Carolina Speech and Hearing Association Conference and others;*
- *Contracting with Family Connection of SC to assist in providing outreach to parents and professionals. Metrics for this effort are covered in the next question;*
- *Production of public awareness materials, including information provided to Medicaid members upon their enrollment; and,*
- *Brochures about the program that are mailed upon request and are available for download on the BabyNet website.*

Additionally, referral status updates are provided to referral sources to keep them informed once referrals are made to the program.

- Does the agency have metrics to determine the effectiveness of its BabyNet messaging and communication? If so, please identify the metrics and the most recent results.
  - *The BabyNet program contracts with Family Connection of SC to assist in providing outreach to parents and professionals. The agency tracks data from Family Connection of SC related to BabyNet outreach and support and other metrics including referrals by year and by referral source.*

Family Connection of SC Data

Total # of Families that Received One-on-One Support	**Total Since 2019**
# Referrals	3,745
# Served	3,137
Primary Concerns	
Developmental Delays	25%
Emotional Support	35%
Healthcare Coverage/TEFRA/Medicaid Waiver Info/Navigation questions	25%
Community Resources	15%
Outreach	**Total Since 2020**
"Your Child's Journey Begins" website dedicated to early intervention, BabyNet, American Society for Quality (ASQ), developmental milestones	36,167 pageviews/reach
Central Directory	1, 076 searches this fiscal year (2021)

  - *Referrals by Fiscal Year (FY):*

		FY 2018 (7/1/2018-6/30/2019)	**FY 2019** (7/1/2019-6/30/2020)	**FY 2020** (7/1/2020-6/7/2021)
Top 6 Referral Sources	**Physicians**	4,810	4,046	4,975
	CAPTA	2,802	3,000	4,682

	Parents	2,272	2,323	2,675
	Hospital	348	498	555
	DHEC	357	364	392
	NICU	205	282	489
	Total Referrals	**12,965**	**13,472**	**16,937**

22. Does the agency collect data from the Department of Education, school districts, or Department of Social Services, to determine if children with known qualifying conditions received BabyNet services?

BabyNet has processes to deliver transition notification data to the South Carolina Department of Education (SCDE) and all local education agencies (LEAs) each month. The following reports are sent each month to SCDE and each LEA for active children with a current plan (or IFSP) in each of the following age groups during the previous month:

- *24 Months*
- *Over 24 Months*
- *30 Months*
- *Over 30 Months*
- *Over 33 Months (late referrals to Part C)*
- *Over 34.5 Months (late referrals to Part C)*

These reports notify SCDE and the local district of BabyNet-eligible children that could enroll in their program at some point in the future.

Service Coordinators also document in the child's Part C record whether they qualified for Part B (school-based services) prior to the Part C record closing.

23. Does the agency project the total number of children likely to require BabyNet services annually? If so, please provide the methodology.

The U.S. Department of Education (USDOE) issues national projections based on demographic information. BabyNet reports expected and actual enrollment to the South Carolina Interagency Coordinating Council each quarter. The expected rate is calculated by multiplying the rate provided by USDOE with the total number of live births in South Carolina. BabyNet referral and eligibility data is available in the chart below. Please note, the referral increase in 2021 is due mainly to a new collaboration with DSS to increase Child Abuse Prevention and Treatment Act (CAPTA) referrals.

State Fiscal Year	Referred	% Increase	Eligible	% Increase
7/1/2017-6/30/18	10,728	N/A*	5,686	N/A*
7/1/2018-6/30/19	12,964	21%	6,965	22.5%
7/1/2019-6/30/20	13,463	4%	7,243	4%
7/1/2020-6/10/21	17,147	27.5%	7,925	10%

**SFY 2018 is the first year this data was tracked.*

24. Based on agency projections and national data regarding conditions that qualify for BabyNet services, what percentage of children in this state qualify for BabyNet services annually, but likely are not receiving those services (provide data to support answer) due to lack of enrollment?

From July 1, 2019 - June 30, 2020 (FY 2019), South Carolina served 3.68% of its birth to three population. The national target is 3.7%. South Carolina is on track to surpass 3.7% of its population for FY 2020, based on the 10% increase in eligibility.

25. Is the agency confident that parents with qualifying children are aware of BabyNet? If so, why?

See referral and eligibility data (and increases) in response to question #23. SCDHHS completed a total overhaul of the BabyNet referral process in 2019. Launching this new process included public awareness materials, conference workshops, community engagement opportunities, etc. Major changes to the referral process included:

- *Hiring and training a new central referral department and ending local referral processing;*
- *Designing and implementing a secure online referral portal and toll-free number managed by the central referral team; and,*
- *Communication related to this new process was sent to all providers enrolled in the state's Medicaid program, various pediatric health care groups, shared in local early intervention system and posted on the SCDHHS website.*

26. Agency data reported that approximately 27% of BabyNet referrals were a result of the Child Abuse Prevention & Treatment Act.

- Who makes these referrals?
  - *Staff at DSS are responsible for making referrals to the BabyNet program for all children who have a substantiated case of abuse and neglect.*

27. How many staff are assigned to the BabyNet program?

The BabyNet State Office employs 13 staff.
BabyNet Eligibility employs 83 staff (Note: this figure includes recent hires and vendor temporary employees in addition to full-time state staff).

28. Is staff productivity measured? If so, what metric is used?

BabyNet State Office Staff:

- *In 2020, position descriptions for BabyNet State Office staff were updated to include trackable metrics. The metrics are individualized based upon each employee's role at the agency and within the program.*

BabyNet Eligibility Staff:

- *BabyNet Central Referral Team staff's productivity is measured daily. Each Central Referral Team staff member receives a daily productivity email and employees have monthly feedback meetings with their immediate supervisor to discuss performance and productivity.*
- *BabyNet Intake Coordinators are scheduled to complete eight intakes per week. They receive two file reviews and one eligibility visit review (observation) per month. Each review tool is scored on a 100% scale, and intake coordinators must meet the minimum score of 90% to meet performance standards. This information is tracked on a metrics dashboard by their immediate supervisor.*

29. How long does it generally take for a family to receive services following the initial referral?

Data broken down by region is available below.

	Average Days from Referral to Initial IFSP (45 days is the maximum allowed)						
	Anderson	**Charleston**	**Colleton**	**Horry**	**Richland**	**Spartanburg**	**York**
FY 2017	37	38	34	40	67	58	41
FY 2018	49	51	34	50	56	52	31
FY 2019	38	57	34	39	39	33	30
FY 2020	29	33	30	30	31	28	31

30. What findings were observed following the implementation of program monitoring?

On Sept. 30, 2019, the state issued findings (for the first time in program history) based on criteria from the interim general supervision plan that was approved by OSEP. This plan reviewed data for Q2 FY 2018 (Jan. 1, 2019-March 31, 2019).

The state issued findings for two of the indicators referenced in the response to question 16 (Indicator 1 [Timely Services] and Indicator 7 [Timely Initial IFSP]) by district based on a 10% data sample.

Indicator 1 findings were issued to the state for any service that was not provided within 30 days of identification on an IFSP if there were no available providers in a certain geographic area or if the available providers were at capacity. Indicator 7 findings were issued to the state for any initial IFSP that was not in place within 45 days from referral to the program. The state repeated this process in the fall of 2020 for FY 2019 data but included a 10% sample of the entire year (instead of a quarter). Once subsequent data is pulled, if the activity eventually occurred, though late, and the district had no new instances, the finding can be cleared. Findings and cleared status for FY 2019 and FY 2020 are available below. All findings were cleared in 2021. This means when the state begins reviewing data for FY 2020, no findings from FY 2018 or FY 2019 will carry over to FY 2020.

Indicator 1 (Timely Services)

- *For FY 2018, three of the agency's seven BabyNet regional districts received findings for Indicator 1: Timely Services.*
- *These findings continued for FY 2019 and findings were also issued for the four districts that didn't receive them in FY 2018.*
- *Findings in all seven districts were cleared in 2021, as districts did not have subsequent non-compliance.*

Indicator 7 (Timely Initial IFSP)

- *For FY 2018, five of the seven districts received findings for Indicator 7: 45-day timeline.*
- *These findings continued for FY 2019.*
- *Findings in the five districts were cleared in 2021, as districts did not have subsequent non-compliance.*

Behavioral Health Benefit

31. Please summarize the issues and concerns the agency receives from behavioral health providers regarding the Medicaid behavioral health benefit.

Behavioral health providers occasionally ask about rate increases. SCDHHS also received a great deal of input regarding providing behavioral health services during the beginning of the COVID-19 public health emergency but most provider concerns subsided after the state made temporary changes to add flexibility to perform specified services via telehealth. When the agency carved in community behavioral health into the managed care benefit in 2016, the agency frequently heard concerns regarding the managed care plans; however, those have greatly diminished.

32. The agency concurred that the state of South Carolina does not have an adequate number of psychiatric beds for acute stabilization.

- Does the agency know how many Medicaid patients were unable to access a bed for acute stabilization in a timely manner in FY19-20?

- *It has been reported by the provider community that the state has a shortage of psychiatric beds. SCDHHS continues to research this issue and preliminarily has found within its managed care plans that some MCOs have experienced some difficulties placing their pediatric members, particularly children who have been diagnosed with autism spectrum disorder or who have difficult to control behavioral issues (sexually aggressive behavioral health, eating disorders, history of violence, general aggressiveness, etc.), in psychiatric residential treatment facilities (PRTF) in the state. This issue became more pronounced when the Department of Juvenile Justice closed its PRTFs, as those beds were instrumental for managing adolescents with aggressive behavioral health or other behavior that requires specialized intervention. The responses of the state's managed care plans vary by plan but consistently indicate that shortages are more isolated and vary by the type of case with those that are more difficult to manage being the most difficult to place. SCDHHS will continue to monitor this issue and work with the provider community to look for solutions that will lead to appropriate care in the most appropriate settings for its members.*

    - What were the minimum, maximum, and median wait times?
        - *Based on the responses, average wait times are 4-6 days for a psychiatric bed for the population needing these services.*

- Does the agency have a strategy for reducing chronic use of emergency room services by serious and persistent mental illness patients? If so, please identify the metrics and the most recent results.
    - *SCDHHS' managed care program has utilized strategies to reduce inappropriate emergency room usage. SCDHHS' rate development process includes a managed care efficiency measure that tracks inappropriate emergency room usage by each MCO's membership. In FY 2022, this efficiency adjustment resulted in the elimination of a total of $1.2 million for the managed care program for inappropriate emergency room usage.*

      In 2016 the code of federal regulations was amended to allow for the provision of services in an Institute for Mental Disease (IMD) for adults age 21-64. In July 2019, SCDHHS adopted this allowance, which is also known as in-lieu of services, as an ongoing strategy to address gaps in behavioral health and encourage treatment in appropriate settings outside of the emergency room.

      SCDHHS is also looking into how social determinants of health contribute to inappropriate emergency room usage specific to behavioral health. Some of the current ways in which SCDHHS and the state's MCOs are addressing this include:
        - *Adding behavioral health case management to their emergency room diversion programs to assist with reducing admissions to emergency room for behavioral health issues.*
        - *Following up with members after an inpatient stay and adding care coordination to improve members follow up with outpatient behavioral health providers to eliminate future inappropriate emergency room utilization.*

SCDHHS is currently also investigating some additional considerations that stakeholders have suggested including:

- *Establishing a workgroup to determine the status of the 988 Nationwide phone number in lieu of 911 as a resource to decrease utilization of emergency room services for serious and persistent mental illness.*
- *Potentially investigating and encouraging hospital emergency room use of the statewide DMH Mobile Crisis line as a way to divert members that seek care in an emergency room, as appropriate.*

In addition, SCDHHS has contracted with DMH since 2016 to provide 24/7/365 crisis response for all citizens of South Carolina regardless of type of insurance or ability to pay. The program was initially called Community Crisis Response and Intervention (CCRI); DMH requested a name change to South Carolina Mobile Crisis in 2020 as they proposed this was more recognizable.

According to the most recent metrics report (3QSFY21), 1,086 services were provided to 800 individuals and the response time averaged 30.3 minutes. Of these, DMH estimates that 55% were diverted from emergency departments and hospitals. South Carolina Mobile Crisis is paid for with 100% state monies since it covers all citizens in the state, not just Medicaid beneficiaries. SCDHHS requires DMH to provide quarterly reporting on the following metrics:

- *Crisis services provided by region and month*
- *Count of individuals served by region and month*
- *Total served in time frame by region*
- *Type of service provided*
- *Services by time of day*
- *Patient gender, age group, race, ethnicity*
- *Patient payor source*
- *Patient referral source*
- *Crisis types (psychiatric, social, medical legal)*
- *On-site response time*
- *Service disposition*
- *Outgoing referrals*
- *Diversions*

33. What is the average length of stay for a Medicaid patient receiving acute inpatient services?

The average length of stay is 10 days.

- How many days will Medicaid cover acute inpatient services?
    - *Medicaid will cover services for as long as they are medically necessary.*

34. What is the average hospital charge for an acute inpatient visit based on the average length of stay of the typical Medicaid patient?

The average hospital charge is $15,610.

- How much of that charge would be reimbursed by Medicaid?
    - *If the member has primary insurance, that insurance is billed first and Medicaid will make a secondary payment up to the Medicaid allowed amount. By law, Medicaid is the last payor source to be billed ("payor of last resort"). If the member does not have another form of coverage, Medicaid will pay up to the allowable limit through Medicaid funds. Medicaid payment is considered payment in full, and the Medicaid member is not charged.*

35. Please define "crisis intervention".

SCDHHS uses the term "crisis management" in its policy manuals. Crisis management is a face-to-face or telephonic short-term service that assists a member who is experiencing urgent or emergent marked deterioration of functioning related to a specific precipitant in restoring his or her level of functioning. The goal of this service is to maintain the beneficiary in the least restrictive, clinically appropriate level of care.

- Does the agency have adequate resources to support crisis intervention services?
    - *The agency believes adequate resources are in place to support these services. The agency has crisis management services available in its three major behavioral health policy manuals: Community Mental Health, Rehabilitative Behavioral Health Services, Licensed Independent Practitioners, and the South Carolina Mobile Crisis Program (partnership with DMH).*

36. How many Medicaid beneficiaries receive crisis intervention services annually?

In FY2020, 8,230 Medicaid beneficiaries received crisis management as a service via Community Mental Health, Licensed Independent Practitioners and Rehabilitative Behavioral Health Services. In FY2020, 1,914 Medicaid beneficiaries received mobile crisis services.

37. Please define "mobile crisis services".

Mobile crisis services are the front-line defense in keeping children with significant behavioral health challenges and adults with persistent mental illnesses from frequenting emergency departments, inpatient psychiatric facilities, and the judicial system. It provides access to assessment and intervention 24 per hours day, seven days per week, 365 days per year. Mobile crisis services provide individuals with clinical support either in person at the location, in person at a community mental health center clinic telephonically or via tele-video to de-escalate the crisis and connect the individual to ongoing treatment and other resources.

- How many site visits does the mobile crisis unit make annually?

- *In FY2020, 7,658 mobile crisis services were provided.*

- Provide a list of locations visited in FY19-20.
  - *SCDHHS tracks encounters based on whether they were held in-person or telephonically. Because of the nature of in-person mobile crisis services, individual locations are not always specified. In FY2020, 1,388 were in-person and 6,270 were delivered telephonically.*

Autism Spectrum Disorder (ASD) Treatment Services

38. How many total ASD providers are there in the state? How many serve Medicaid beneficiaries?

SCDHHS is able to track the total number of ASD providers who are enrolled with the Medicaid program. The agency does not track ASD providers who are not enrolled with the Medicaid program.

- *Medicaid-enrolled Board Certified Behavior Analysts (BCBA): 271 are enrolled*
- *Medicaid-enrolled Board Certified Assistant Behavior Analysts (BCaBA): 76 are enrolled*
- *Medicaid-enrolled Multispecialty Groups with at least one BCBA/BCaBA linked: 49 are enrolled*
  - *41 groups actively serve Medicaid members.*

- How does the agency determine rates?
  - *The Medicaid State Plan outlines how the agency determines rates.*
    - *4.19B of the State Plan states "To determine an hourly rate for the services provided by a Board Certified Behavior Analyst (BCBA) and a Board Certified Assistant Behavior Analyst (BCaBA), the Medicaid Agency uses the midpoint of the comparable South Carolina state government positions and determines the average hourly rate for BCBA/BCaBA staff. After applying the applicable fringe rate and adding estimated operational expenses, the sum is divided by a productivity factor representative of an estimated number of billable hours to determine an hourly billing rate. Hourly rates are then converted to the time units corresponding to approved billing codes (HCPCS/CPT) to determine the reimbursement rate by billing codes."*

      "To determine an hourly rate for the services provided by a Registered Behavior Technician (RBT), the agency uses the midpoint of the comparable South Carolina state government position and other data sources such as RBT wage surveys and interviews of ABA provider practices to determine the average hourly rate for an RBT. After applying the applicable fringe rate and adding estimated operational expenses for an RBT, the sum of each position is divided by a productivity factor representative of an estimated number of billable hours to determine an

hourly billing rate. Hourly rates are then converted to the time units corresponding to approved billing (HCPCS/CPT) codes to determine the reimbursement rate by billing codes."

39. Please provide a reimbursement rate analysis comparing South Carolina to other states in the southeast.

Please see attached spreadsheet.

40. The agency contracted with University of South Carolina and Clemson to administer grants with the intent to grow the ASD provider community.

- How long has the agency had contractual agreements with each University?
  - *University of South Carolina (UofSC) grant start date: May 1, 2019*
  - *Clemson University grant start date: April 1, 2020*

- How much funding has the agency provided these entities over the duration of the contracts?
  - *UofSC funds by state fiscal year:*
    - *FY2020: $154,023*
    - *FY2021: $128,059*
  - *Clemson University funds by state fiscal year:*
    - *FY2021: $141,200*

- Has the agency realized the returns it expected to see through these contractual arrangements?
  - *Both contractual arrangements are approximately halfway through their contracted period. Student performance metrics are included below.*
- Do contracts include any performance metrics to determine the effectiveness of the grant program? If so, please identify the metrics and the most recent results.
  - *Contracts with each university contain the following performance metrics:*
    - *Number of individuals enrolled in coursework in each cohort.*
      - *UofSC – 25 enrolled in each coursework for 3 cohorts (C1, C2, C3)*
        - *C1: 2 students*
        - *C2: 20 students*
      - *Clemson University – 20 enrolled in each coursework for 3 cohorts*
        - *C1: 20 students*
    - *Number of individuals enrolled in coursework and supervised fieldwork in each cohort.*
      - *UofSC – 6 supervised fieldwork for 3 cohorts*
        - *C1: 5 students*
        - *C2: 5 students*
      - *Clemson University – 5 supervised fieldwork for 3 cohorts*

        - *C1: 5 students*
    - *Student's grades upon the completion of each course through the duration of the course sequence.*
        - All students received an A or a B, with the majority receiving an A.
- *Contracts with each student contain the following performance metrics:*
    - *Achievement of certification within specified time frame.*
        - *All 5 will be certified before the cohort I deadline of July 29, 2021. (3 have already met this deadline)*
    - *Enrollment as a Medicaid Applied Behavior Analysis (ABA) provider within specified time frame.*
        - *2 out of 3 (as noted certified above) were enrolled as Medicaid-enrolled ABA providers before the end of Spring 2021 deadline. The third member opted not to enroll and instead reimbursed the agency for tuition/practicum costs.*
    - *Caseload of at least 50% Medicaid beneficiaries reported quarterly for the duration of the contract period.*
        - *100% of enrolled Medicaid-enrolled ABA providers are maintaining a caseload of at least 50% Medicaid beneficiaries.*

- Do the two entities have a similar performance record? Please explain.
    - *UofSC's C1 was the first cohort of the program and did not meet expected performance. This was likely due to the timing of roll out, the lack of a coordinated public information campaign and hesitancy among individuals to be the first to enroll in the new grant program.*

      Clemson University's program has seen larger enrollment, which can be partially attributed to the fact that it allows for rolling enrollment. This means if not all slots are filled by the start of the first semester of the cohort, more applications can be accepted to fill the remaining slots with the students starting later.

41. What has been the impact of the two rate increases? How have these increases impacted the provider market?

Before July 1, 2018, 151 individual providers were enrolled. A rate increase occurred on July 1, 2018, and 213 individual providers were enrolled (a 41% increase) by June 30, 2019. Another rate increase occurred on July 1, 2019 and 347 individual providers were enrolled (a 63% increase) by May 15, 2021.

42. Testimony was received at the last meeting stating that there are approximately 690,000 children with full benefit membership.

- According to the CDC 1 in 54 8-year-old children have been identified with autism. Does the agency's ASD enrollment correlate with the national rate of diagnosis?

- *There are 9,450 beneficiaries under 21 years of age enrolled in South Carolina Medicaid in CY2020 with a primary diagnosis of ASD and in CY2020 there are 755,390 total South Carolina Medicaid members under the age of 21. This equates to 1.25% of the state's Medicaid population under the age of 21 and is lower than the figure provided in the question of 1.85%.*

Therapeutic Foster Care

43. How much does the agency reimburse therapeutic foster care providers?

Description	Per Diem Rate
TFC Level 1	$29.95
TFC Level 2	$45.57
TFC Level 3	$65.10

- Is the reimbursement rate competitive enough to incentivize participation?
  - *Yes, the agency believes it is competitive enough to incentivize participation.*

44. Does the agency have regularly scheduled meetings with the Department of Social Services to discuss issues specific to therapeutic foster care and member access?

Yes, the agency's assistant medical director meets weekly with an administrative and medical disciplinary team, which includes DSS and the MCO that covers children who are in foster care.

- How many therapeutic foster care providers are in the state?
  - *There are 29 child placing agencies in South Carolina (certified by DSS) and a total of 1,009 providers.*

- Please provide a daily rate schedule.
  - *Please see response to question 43p.*

- When did the agency last increase rates?
  - *This is a new service that was added to the state plan on July 1, 2020. Rates have not been increased since July 1, 2020.*

Opioid Crisis

45. A significant amount of resources have been allocated to mitigate the opioid crisis, but death rates continue to increase.

- Identify resources needed by the agency to continue combatting opioid crisis.
  - *The agency would like to hire for a policy position that is dedicated to focusing on managing medication assisted treatment (MAT) policy, engaging with the state's Opioid Emergency Response Team and tracking data specific to the opioid crisis.*

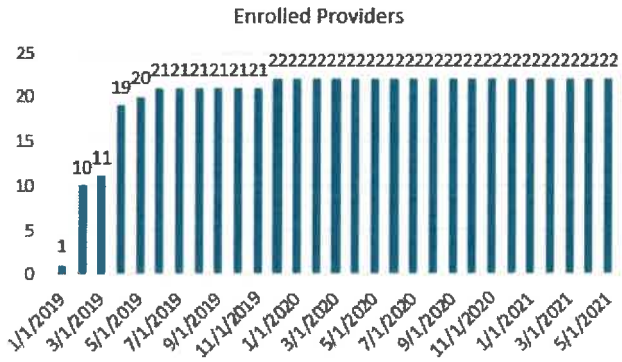
- What metrics are being tracked by the agency to gauge the effectiveness of its opioid abuse mitigation strategy?

    - *The agency tracks metrics related to its opioid prescribing rate and the percentage of members who are diagnosed with substance use disorder and are receiving treatment. The agency's goals and performance for FY 19-20 related to both metrics are available below.*

        - *Maintain an opioid prescribing rate for Medicaid members of no more than the statewide average.*
            - *Target: 709 per 1,000 (statewide average)*
            - *Actual 194.56 per 1,000 Medicaid full-benefit members*
                - *The prescribing rate for adults was 451 per 1,000.*
                - *The prescribing rate for children was 39.42 per 1,000.*
        - *Increase the percentage of members diagnosed with substance use disorder who are receiving treatment by 10%*
            - *Target: 57.8%*
            - *Actual: 58.6%*

    Additionally, the chart below includes data from calendar year 2020 on how many individuals received outpatient opioid treatment, how many received MAT and how much the agency reimbursed opioid treatment program (OTP) providers for both services.

OTP Oversight



** Provider count does not include 1 DAODAS enrolled provider*

	1/1/2020	2/1/2020	3/1/2020	4/1/2020	5/1/2020	6/1/2020	7/1/2020	8/1/2020	9/1/2020	10/1/2020	11/1/2020	12/1/2020
Outpatient OTP	1,934	1,970	1,972	1,966	1,989	2,290	1,909	1,975	2,026	2,065	2,090	1,960
DATA Waived MAT	4,232	3,755	4,016	3,927	3,791	4,079	4,175	4,035	4,174	4,173	3,887	3,579
Combined Unduplicated	6,166	5,725	5,988	5,893	5,780	6,369	6,084	6,010	6,200	6,238	5,977	5,539

	1/1/2020	2/1/2020	3/1/2020	4/1/2020	5/1/2020	6/1/2020	7/1/2020	8/1/2020	9/1/2020	10/1/2020	11/1/2020	12/1/2020
Outpatient OTP	$ 764,136	$ 769,005	$ 950,912	$ 777,589	$ 850,340	$ 891,996	$ 756,050	$ 920,861	$ 778,664	$ 799,507	$ 955,181	$ 610,732
DATA Waived MAT	$ 545,065	$ 484,675	$ 505,486	$ 473,706	$ 469,744	$ 493,202	$ 506,395	$ 499,616	$ 520,368	$ 522,754	$ 487,864	$ 439,193
Combined Dollars	$1,309,201	$1,253,680	$1,456,398	$1,251,295	$1,320,084	$1,385,198	$1,262,445	$1,420,477	$1,299,032	$1,322,261	$1,443,045	$1,049,925

Through its pharmacy benefits manager, Magellan, SCDHHS also tracks opioids through management of the preferred drug list, prior authorization criteria, call center reporting, and the agency's pharmacy lock-in program. The agency is continuing to work with its vendor to better identify potential misuse of opioids through advanced analytics.

Lastly, the state's MCOs conduct their own opioid oversight activities, which include:

- *Maintaining and tracking their own opioid treatment programs. This incudes tracking members who are misusing opioids or considered high-volume users;*
- *Conducting targeted trainings for both providers and members;*
- *Coordinating with other service providers, specifically behavioral health providers;*
- *Partnering with universities (ex. MUSC Project ECHO);*
- *Providing additional case management support; and,*
- *Providing member community resources.*

- Is there anything that the General Assembly needs to do to assist the agency with its opioid mitigation efforts?

- *Funding the policy position for which the agency would like to hire is important to the agency's mitigation strategy and efforts.*

46. Does the agency have regularly scheduled meetings with the Department of Alcohol and Other Drug Abuse Services to discuss opioid data and service utilization?

The agency has quarterly meetings with Department of Alcohol and Other Drug Abuse Services (DAODAS) to discuss this and other topics that are shared between the two agencies. Additionally, SCDHHS collaborates with DAODAS regarding the annual "Just Plain Killers" data on opioid diagnoses by gender, age group, and county.

COVID-19 Response

47. Does the agency plan to hold any additional COVID-19 webinars for legislators and providers?

The agency held webinars during the initial response to collect feedback on flexibilities that could and should be adopted to maintain access to care while limiting risk of exposure to COVID-19 for both providers and patients. The agency will conduct additional outreach to providers and other stakeholders as it evaluates data, other health care payor actions and other relevant information when making decisions regarding the potential sunset of the flexibilities it created during the pandemic.

The agency is always happy to hold webinars or conduct other forms of outreach with legislators on this topic as needed or requested.

48. If the COVID-19 policy modifications were in place during a "normal" non-COVID-19 period, does the agency believe members would receive better care and have greater access to care?

Claims data show a large increase in the number of claims billed for services delivered via telehealth during the pandemic. SCDHHS believes telehealth can help increase access to care for certain services, particularly for those who live in rural communities or who lack access to reliable transportation. The agency will continue to monitor guidance and evidence regarding the quality-of-care members receive through telehealth and will evaluate clinical guidance and data to ensure the quality of care delivered via telehealth is comparable to care delivered in-person.

49. When will the agency complete its evaluation of telehealth benefit changes?

SCDHHS is committed to continuously analyzing, monitoring, and evaluating its telehealth data and benefit. The agency does not believe it is appropriate to set an end date on its evaluation and will continue to use its ongoing evaluation to inform agency decision-making.

50. Does the agency plan to produce a formal internal COVID-19 agency response assessment once the public health emergency has been lifted?

Yes, the agency will produce an internal emergency response assessment once the public health emergency has been lifted. Program leaders from across the agency's operations, health programs, external affairs and IT program areas meet regularly to assess the agency's COVID-19 response and related actions. The agency will engage with and provide updates to providers and other stakeholders regarding the specific flexibilities it has created prior to the expiration of the federal public health emergency.

Waivers

51. Please identify each waiver, the length of time the waiver has been active, and the population it serves.

Waiver	Length of Time Active	Population Served
Community Choices	Since 2003 (17 years)	Frail elderly and individuals with physical disabilities, age 18 and older, nursing facility level of care
HIV/AIDS	Since 1988 (32 years)	Diagnosed with AIDS or HIV-positive with episodes of specific related conditions, hospital level of care
Mechanical Ventilator Dependent	Since 1994 (26 years)	Elderly and individuals with physical disabilities, age 21 or older, requiring mechanical ventilation, nursing facility level of care
Medically Complex Children (MCC)	Since 2008 (13 years) *(Previously the Medically Fragile Children's Program waiver from 1999 – 2008)*	Children age birth to 18 with chronic physical/health condition(s) expected to last at least 12 months, hospital level of care
Intellectually Disabled/Related Disabilities (ID/RD)	Since 1991 (30 years)	Diagnosis of intellectual or related disability, all ages, ICF-IID* level of care
Community Supports	Since 2009 (12 years)	Diagnosis of intellectual or related disability, all ages, ICF-IID* level of care
Head and Spinal Cord Injury (HASCI)	Since 1995 (26 years)	Diagnosis of traumatic brain injury, spinal cord injury or similar disability, age birth to

		65, nursing facility or ICF-IID* level of care
Palmetto Coordinated System of Care	Since August 2020	Youth with primary mental health diagnosis, age 21 or younger, hospital level of care

**Intermediate Care Facility for Individuals with Intellectual Disabilities*

52. Does the agency require assistance from the General Assembly to address challenges specific to members receiving services through waiver programs (e.g., Head and Spinal Cord Injury, Intellectual Disability and Related Disabilities)?

There are multiple challenges specific to members receiving services through waiver programs. Many of the identified challenges will require recurring state funding to enhance and strengthen home and community-based waiver services.

Challenges Include:

- *Access to Services*
  - *There are currently waiting lists for the ID/RD, Community Supports, and HASCI waivers. Increasing waiver capacity to the number of waiver slots is one way to improve access. If the agency were to seek funding to accommodate everyone on the waiting lists, it would require approximately an additional $250 million in recurring state funds. This includes:*
    - *Approximately $204 million in recurring state funds to add 13,539 slots to the ID/RD waiver;*
    - *Approximately $45 million in recurring state funds to add 9,300 slots to the Community Supports waiver; and,*
    - *Approximately $1.5 million in recurring state funds to add 127 slots to the HASCI waiver.*
  - *SCDHHS recognizes the General Assembly is not likely to be able to increase recurring funding to this level; however, incremental increases in state funds allocated to these waiver programs would help increase access to these services. The agency has produced this figure to provide additional perspective and scope on waiver services and expenses.*
  - *Additionally, the Community Choices waiver does not currently have a waiting list but continues to experience growth and will require additional funding to maintain access to waiver services.*
  - *Enhancing community transition efforts to assist beneficiaries to transition from nursing home or institutional settings to community-based settings. This requires a reciprocal enhancement of capacity in waiver slots.*

- *Ensuring a robust provider network to deliver high quality waiver services is also a critical issue. Funding to address provider rates for direct support professionals is necessary. Private duty nursing, personal care/home care services, respite providers and direct care workers in residential or Intermediate Care Facility settings are examples of the workforce segments that are experiencing difficulty with workforce recruitment and retention. Funding to assist with certifications and required training for service providers is needed.*
- *Strengthening assessments and person-centered planning.*

- *New/Enhanced Services*
  - *The American Rescue Plan Act provides states with an opportunity to improve and enhance home and community-based services. Recurring funding is needed to sustain service enhancements such as: environmental modifications (ramps, bathroom and home accessibility adaptations), use of assistive technology to support greater independence in community settings, individualized training in independent living skills, self-directed in-home support services, career preparation and case management services.*
- *Quality Improvements*
  - *Updating incident management systems designed to report and track incidents of abuse, neglect, and exploitation and unexplained deaths.*
  - *Updating case management systems and employing cross-system data integration efforts.*
  - *Enhanced staffing to provide administrative and programmatic oversight of waiver operations. Areas include provider oversight, quality assurance and risk management, program evaluation and performance management.*

53. What is the agency's internal process for developing waiver solutions designed to improve health outcomes?

During each waiver amendment and renewal, public notice is provided that allows the opportunity for input from the Medical Care Advisory Council, Indian Health Services, stakeholder and advocacy groups, and the general public. Ongoing communication with provider associations, participants, families, and partner agencies also helps to inform development of waiver solutions. The program area and agency leadership evaluate this feedback when considering submitting waiver amendments and renewals. These lines of communication and relationships also help the agency identify needs for new potential waiver programs.

- Where do ideas for waivers originate?
  - *Multiple approaches are used to facilitate continuous improvement. Participation in stakeholder groups/committees provides valuable input from distinct perspectives. Examples include but are not limited to the Adult*

Protection Coordinating Council, Development Disabilities Council, and Long-Term Care Leadership Council. Guidance from CMS, training and webinars from CMS and technical assistance centers, formal technical assistance that is topically driven, and outreach to other state Medicaid programs also generate ideas for waiver services and service delivery.

54. What methodology does the agency use to determine if a waiver program meets all of the Center of Medicare and Medicaid Services requirements?

Waiver programs must report to CMS annually on service utilization, costs, and quality improvement related to the waiver requirements. Waivers also must have systems in place to measure and improve performance for the following required assurances:

- *Administrative authority*
- *Level of care*
- *Qualified providers*
- *Service plan development*
- *Health and welfare of participants*
- *Financial accountability*

Quantified performance measures are in place for each of the assurances. If performance on any of the measures falls below 86%, discovery of issues is conducted and a plan for remediation is established.

The state provides a comprehensive evidence report to CMS approximately 18 months prior to waiver renewal demonstrating that it has met the required assurances for the waiver. CMS then issues a quality report to the state summarizing findings and conclusions concerning operation of the waiver.

55. Has CMS required the agency to submit a remediation plan at any point in the last 3-5 years? If so, please identify the affected waivers and the reason for the remediation designation.

The state must provide a response to the CMS quality reports identifying actions to be taken in the event it does not demonstrate the required assurances. Below is a summary of recently completed quality reports:

- *Community Choices: CMS report issued July 31, 2020. Performance measures and data collection require revision at the time of renewal.*
- *HIV/AIDS: CMS report issued July 31, 2020. Performance measures and data collection require revision at the time of renewal.*
- *MCC: CMS report issued Dec. 31, 2020. The state demonstrated all required waiver assurances; however, CMS requested that performance measures be modified or added at the time of renewal.*

- *ID/RD: CMS report issued Feb. 12, 2021. Performance measures and data collection require revision at the time of renewal.*

56. Does the agency plan to allow any of its existing waivers to expire after the approved five-year period? If so, why?

The agency does not plan to allow any existing waivers to expire after the approved five-year period.

57. Does the agency have a formal documented process for ensuring that waiver renewal applications are submitted on time?

All waiver applications are tracked and submitted in the CMS Waiver Applications Portal. Per CMS technical guidance, waiver renewal applications are due to CMS no later than 90 days prior to expiration. At the time CMS issues its final quality report to the state, there is a reminder of the submission timeframe. The agency tracks waiver expiration dates internally via a tracking chart.

58. In the past 3-5 years, has the agency failed to renew an application due to it being rejected by CMS?

No, the agency has not failed to renew an application due to it being rejected.

59. How do providers, members, or potential members learn about these waivers?

Providers, members, or potential members learn about waivers through the agency website, partner agency websites, Community Long Term Care (CLTC) area offices, presentations, and brochures. For waivers that are operated by the Department of Disabilities and Special Needs (SCDDSN), the "Services" section of their website contains information on the ID/RD, Community Supports, and Head and Spinal Cord Injury waivers.

- Does that agency's website provide definitions, resources, and other information specific to these waivers on its website? If so, is this information easily found?
    - *The agency's website includes a section dedicated to Waiver Management that contains basic information on waivers. Public notices for waiver renewals and amendments are posted to this location. The agency's site can be found at: https://msp.scdhhs.gov/hcbs/site-page/medicaid-waiver-information*

60. Do any of the waivers provide coordinated support specifically for sickle cell disease? If no, can the agency submit a waiver specifically to address sickle cell disease?

Treatment for sickle cell disease is a covered service for those enrolled in Medicaid and does not require additional eligibility criteria. For those enrolled in an MCO, care coordination is performed by the MCO.

Additionally, the MCC and Community Choices waivers serve individuals with physical disabilities that meet eligibility criteria. While they do not have services specific to any single disease or diagnosis, services are designed to coordinate care and provide supports to assist participants in community settings. For those who meet eligibility for these waiver programs, treatment for sickle cell disease is covered through their Medicaid benefits. In addition, they would receive care coordination and other services required by their service plan through their waiver enrollment.

States can also waive certain Medicaid program requirements with regard to comparability of services. This allows states to make waiver services available only to certain groups of people who are at risk of institutionalization. For example, states can use this authority to target services on the basis of disease or condition.

61. What is the agency's process for identifying and contracting with vendors who provide covered services for waiver programs?

The agency outlines policies and scopes of service for covered services for waiver programs in its provider manuals. Prospective service providers can access information on provider enrollment applications and FAQs on the SCDHHS website. Basic enrollment and screening requirements are outlined below. Providers must:

- *Be licensed by the appropriate licensing body, certified by the standard-setting agency, and/or other pre-contractual approval processes established by SCDHHS.*
- *Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.*
- *Comply with all federal and state laws and regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program.*
- *If eligible, obtain a National Provider Identifier (NPI) and share it with South Carolina Medicaid. Refer to https://nppes.cms.hhs.gov for additional information about obtaining an NPI.*
- *Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment.*

Certain services for SCDDSN-operated waivers are delivered through a statewide network of local disabilities and special needs boards and service qualified providers. Prospective SCDDSN providers can apply through a fixed-price bid solicitation via the State Fiscal Accountability Authority.

The Palmetto Coordinated System of Care waiver includes a selective contracting 1915(b) waiver under the 1915(b) authority for High Fidelity Wraparound services.

- How does the agency evaluate the services provided by these vendors?
    - *Services are evaluated through ongoing quality assurance and provider compliance reviews. For services such as Adult Day Health Care, Personal Care, and Nursing, SCDHHS conducts compliance reviews to ensure adherence to contract requirements, scopes of service, and waiver requirements. SCDDSN as the operating entity for the ID/RD, Community Supports and HASCI waivers contracts with a quality improvement organization to conduct contract compliance and licensing reviews of providers. For the MCC waiver, quality reviews are conducted by SCDHHS program staff, and an external quality review is conducted annually for the provider of waiver services.*

62. The Community Supports waiver has an individual cost limit for services.

- What is the cost limit?
    - *The cost limit for the Community Supports waiver is established per waiver year:*
        - *Year 1 = $14,928*
        - *Year 2 = $15,852*
        - *Year 3 = $16,833*
        - *Year 4 = $17,338*
        - *Year 5 = $17,858*

    These amounts are based on historical analysis and service utilization. Amounts are expected to increase each year by 3% for a cost-of-living adjustment. In each year since the waiver was developed, the individual cost cap has been determined to be reasonable and sufficient to meet the waiver needs of the participants living in their homes in the community. If, however, the waiver participant or caregiver's circumstances change suddenly requiring a greater level of need which is expected to last indefinitely, there is the possibility of a transfer to the ID/RD waiver or another form of long-term care, where appropriate.

- Is the individual cost limit a "lifetime" limit or an annual amount per year limit?
    - *It is an annual amount.*

63. What are the most significant challenges the agency encounters with the Medically Complex Children waiver population?

While medically complex children represent a relatively low percentage of all U.S. children, they represent about 1/3 of health care spending, mainly due to hospital care. Challenges include:

- *Medically complex children's ER use is high, hospitalizations long and their hospital readmissions are frequent.*
- *Medically complex is one of the fastest-growing populations of children with expensive, complex, and chronic medical conditions.*

- *Medically complex children's conditions often lead to functional limitations which are severe; requiring substantial needs for health services to maintain health, including numerous clinicians, medications, durable medical equipment, therapies, and surgeries. This results in high health resource utilization.*
- *For these reasons, using cost savings as a measure of effectiveness is problematic.*
- *Medically complex children are most likely of all children to have unmet healthcare needs due to medical complexity.*
- *Understaffing, underfunding and lack of integration, organization, and reliability result in high rates of adverse events.*
- *Medically complex children have a higher rate of being placed in foster homes and/or have DSS involvement.*
- *Administrative requirements for the MCC waiver are considerable, including ongoing annual and cyclical federal reporting for waiver performance and utilization, provider oversight and quality assurance.*

There are many other aspects that affect our state as well. Families rely on other state government programs as 54% of families that have a medically complex child have a family member that had to stop working to care for their child. Medical complexity is often combined with social complexity (ex. lack of access to reliable transportation, no permanent address, limited health literacy) and can lead to anxiety and strain within a family.

- Does the agency need or require assistance from the General Assembly to address these challenges?
    - *Providers carry out a number of non-billable activities in support of medically complex children that require re-evaluation of the current Medicaid rates paid. Staff shortages are also an issue and can be attributed to a variety of factors including geographic access challenges in rural areas, lack of home health services training programs, and payment rates that lag behind those of competing institutions or nearby regions.*

      There is currently only one pediatric medical day care serving MCC waiver participants in the state. Although a rate increase was implemented in July 2020, funding to support additional facilities would provide a critical service for families. In return, this may allow more families of MCC waiver participants to work. This is a serious challenge for some families, as the parent/guardian cannot work because they do not have care for their medically complex child, who cannot attend a regular daycare.

      There is also currently only one provider of MCC waiver care coordination and pre-admission screening services. Although the provider has a long history of supporting the MCC waiver program in South Carolina, rates for the waiver services provided have not been updated since 2014 and are in need of review.

There is also some risk to the MCC program in having only one service provider for care coordination and pre-admission screening functions.

In the current MCC waiver renewal, the addition of environmental modification services is being recommended. Recurring state funding will ensure that this necessary service remains available into the future. The waiver renewal also includes extending the maximum age for MCC waiver participants from age 18 to age 21.

Many MCC waiver participants have personal care or private duty nursing services authorized for their child. In some instances, due to the lack of staffing, the hours that are authorized cannot be filled. Funding to support competitive rates is necessary for full access to these services.

Finally, given the substantial administrative requirements for the MCC waiver, other options for enhanced efficiency may require exploration to best meet the needs of participants and families, such as managed care.

Department of Disabilities and Special Needs (waivers)

64. The Department of Disabilities and Special Needs (DDSN) customer base qualifies for several waivers (e.g., Head and Spinal Cord Injury, Intellectual Disability and Related Disabilities).

- Please discuss the relationship between DHHS and DDSN? How do the two agencies ensure member access to services?
    - *SCDHHS maintains administrative authority and oversight for the three waivers (ID/RD, Community Supports and HASCI). Operational authority is delegated to SCDDSN and includes functions such as participant waiver enrollment; level of care evaluation; review of participant service plans; prior authorization of waiver services; qualified provider enrollment; and, rules, policies, procedures, and information development governing the waiver program. SCDDSN maintains waiver manuals as well as policy directives and standards that generally set forth "how" a SCDDSN service is to be performed. As the administrative authority, SCDHHS reviews and approves waiver-related policies.*

      Quality improvement strategies have been initiated to ensure that the ID/RD, Community Supports and HASCI waivers are operated in accordance with the approved waiver application. Accountability for contract compliance, quality of services delivered, and maintaining adequate oversight to prevent operational failures are key aspects of these strategies. This includes activities in the following categories:
        - *Systemic improvement activities: policy revisions, corrective action plans and remediation, implementing an incident management system technology solution, ongoing risk management reviews with trend analysis to identify the need for systemic improvements;*

- *Implementing model practices for incident management and investigation, incident management audits, mortality reviews, and quality assurance functions;*
- *Strengthening provider training and implementing training on quality management incident investigations;*
- *Revising licensing and contract compliance standards using a risk-based approach; and,*
- *Enhancing the role of case management in monitoring health/safety and incident reports.*

SCDHHS is also incorporating clarifying language on roles and responsibilities for oversight in the respective waiver applications as these waivers are renewed.

- How does DHHS ensure that the duration of its administrative processes do not negatively impact clinical outcomes?
  - *SCDHHS strives to expedite any decisions or administrative processes that could negatively impact clinical outcomes. For example, waiver participants receive a list of potential service providers when services are initiated. Once a referral is made to a service provider, if the referral is not accepted, the next selected provider receives a referral to ensure that services are initiated in a timely manner.*

- Does the agency track the amount of time it takes to complete administrative processes?
  - *Tracking is dependent on the administrative process. For example, for SCDHHS-operated waivers, complaints are logged into the agency case management system. They are identified by participant, area, reason for complaint, owner, description, reporting entity and date reported. Open complaints can be sorted and monitored for resolution.*

- Does DHHS track metrics to evaluate waiver performance? If so, please identify these metrics and provide current results.
  - *Metrics to evaluate waiver performance are based on CMS-approved performance measures for each of six waiver assurances and associated sub-assurances. The performance measures are waiver-specific and are compiled for the first three waiver years to provide evidence of compliance to CMS.*

    The Palmetto Coordinated System of Care has not yet completed its first full waiver year and does not have performance measure results yet.

    The attached chart includes the most recently submitted performance data for the Community Choices, HIV/AIDS, Medically Complex Children and ID/RD waivers. The HASCI waiver report is not yet due to CMS. The Community Supports waiver report is pending with CMS and has not been finalized.

65. Please explain the nature of your joint Head and Spinal Cord Injury (HASCI) waiver efforts with the South Carolina Department of Disabilities and Special Needs.

- Do DHHS and DDSN have a common set of metrics to determine the effectiveness of the HASCI waiver?
    - *Please see the response noted on question #64 for the HASCI waiver performance measures.*

66. Please explain the nature of your joint Intellectual Disability/Related Disability (ID/RD) waiver efforts with the South Carolina Department of Disabilities and Special Needs.

- Do the agencies have a common set of metrics to determine the effectiveness of the ID/RD waiver?
    - *Please see the response noted on question #64 for the ID/RD waiver performance measures.*

67. For the past several years, DDSN has requested recurring general funds to support their Head and Spinal Cord Injury (HASCI) Waiver slots.

- Does DHHS provide reimbursement for services provided to this patient population? If so, why would DDSN request recurring general fund support?
    - *SCDHHS provides reimbursement for Medicaid services delivered to HASCI waiver participants. SCDDSN is responsible for the state matching portion of funds for waiver services. Therefore, SCDDSN would request general funds to support waiver slots.*

Department on Aging

68. The Department on Aging and DHHS both provide services and assistance to elderly South Carolinians.

- Does DHHS collaborate with the Department on Aging to inform the public about services?
    - *SCDHHS and the South Carolina Department on Aging (SCDOA) frequently interact and collaborate to develop the best approach to service planning and delivery for elderly and disabled citizens of South Carolina. The agencies share information concerning mutual clients (only after obtaining the written consent of the parties involved).*

      In 2019, SCDHHS and SCDOA developed a script and procedural process that is used to determine needed services and current providers. This action has helped reduce or avoid potential duplication in delivering services including: home delivered meals, homemaker or personal care services, attendant care, transportation, incontinence supplies, environmental modification, pest control and nutritional supplements. Both agencies maintain a point of contact list of

between the two agencies to verify vital information quickly. Both agencies also regularly network to stay apprised of changes in services or service delivery and to educate each other so that accurate information can be relayed to the public.

SCDHHS also directs its applicants, waiver participants and others to explore the "GetCareSC" website when non-SCDHHS services are requested. In addition, SCDOA provides and updates the South Carolina Nursing Facility Bed Locator, which displays online availability of nursing home and community residential care facility beds across the state. This valuable resource is available to SCDHHS staff, Medicaid members, and caregivers seeking long term care placement.

Replacement Medicaid Management Information System (RMMIS)

69. Is the Medicaid Management Information System (MMIS) multiple systems?

Yes, it is multiple systems.

- If yes, will disparate systems create a need for interfaces or costly upgrades in the future?
    - *Interfaces that are currently in place will be evaluated as the Medical Administrative Services Organization (MASO) is implemented. The purpose of the Medicaid Enterprise System (MES) data hub is to manage these interfaces without significant impact to the various vendors/systems. All upgrades, as needed, will be eligible for 90 percent federal financial participation (FFP) from CMS.*

- Do any external state agencies require access to the MMIS (e.g., Department of Mental Health, Department of Disabilities and Special Needs, Department of Health and Environmental Control, Department of Social Services, etc.)?
    - *No external state agencies require access.*

- Does DHHS access external agency data through the MMIS (e.g., Department of Mental Health, Department of Disabilities and Special Needs, Department of Health and Environmental Control, Department of Social Services, etc.)?
    - *Yes, data from other state agencies SCDHHS access through MMIS include:*
        - *DHEC: Death file data match and Immunization File information*
        - *SCDSS: SNAP/TANF data match and foster care data*
        - *SCDEW: Employment data match*

70. The agency is utilizing multiple vendors to develop it RMMIS.

- Will disparate IT systems, developed by different vendors, create a system interfacing issue in the future?
    - *No, this occurs today and has not been an issue nor is it expected to be an issue in the future.*

71. Is the 75% federal financial participation for operations a permanent source of funds or does it go away after a specified time?

The 75% FFP It is a permanent source of funds unless CMS changes their regulations.

72. When does the agency expect to receive final CMS certification for its system?

CMS certification occurs six to 12 months after full implementation. The implementation timeline is under development.

73. Will the agency be able to reduce the amount staff administrative hours (e.g., manual entry, etc.) dedicated to the existing system once the new system is fully implemented?

Staff roles are expected to change, and multiple manual processes are expected to be replaced by automation, which is a benefit of the new MASO contract.

74. How will the new system improve employee productivity?

Productivity benefits of the new system include:

- *Improved workflows to minimize necessary hand-offs. For example, enrolling a provider requires stopping the process for program handoffs but the new system will manage the workflows more effectively with better queueing, notification, and oversight mechanisms.*
- *Better adjunct data sources availability and more system flexibility, which will allow for more automated processing. For example, enrolling a provider requires many manual checks today, and ongoing revalidation requires the same. The new system will automate evidence collection and make automated decisions where appropriate.*
- *The availability of real-time adjudication and improved claims processing. For example, the new system will allow claims to adjudicate multiple modifiers.*
- *Less required manual entry as the new system will allow workers to click through the various parts of a record without having to copy key information from one screen to another for entry and look up.*
- *The availability of automated claims corrections, which will replace a process that is currently manual.*

75. Please provide a timeline for completion and integration of each of the modules associated with the RMMIS.

The MASO implementation timeline is being developed. All other modules have been implemented and will fall under normal procurement cycles.

76. Please identify the administrative issue(s) resolved by each of the modules recently completed or scheduled for implementation.

Three Administrative Modules:

- *Medical Administrative Services Organization (MASO)*
  - *Started Dec. 11, 2019, after a procurement process that lasted more than two years*
  - *Will deliver the following main business functions:*
    - *Medical claims adjudication and prior authorization (non-pharmacy and non-dental);*
    - *Reference file maintenance, which is crucial information needed to process a claim (examples include diagnosis codes, procedure codes, and pricing files);*
    - *Support of CMS' National Correct Coding Initiative (NCCI), implemented in 2010, which promotes national correct coding methodologies and reduces improper coding that may result in inappropriate claim payments;*
    - *Provide quality improvement pre and post service review; and,*
    - *Provider enrollment and data management to include a provider portal, call center, outreach and training.*
- *Pharmacy Benefit Administrator (PBA)*
  - *The first PBA contract was awarded in the early 2000s.*
  - *As part of the RMMIS program, SCDHHS procured and awarded a new contract, which was implemented November 2017 and certified by CMS in April 2019.*
  - *Main pharmacy-related business functions include:*
    - *Adjudicates FFS pharmacy claims through a point-of-sale pharmacy system;*
    - *Performs prior authorizations;*
    - *Performs utilization review;*
    - *Provides support related to covered benefits;*
    - *Performs most drug rebate functions;*
    - *Administers the Maximum Allowable Cost (MAC) program which encourages generic utilization by Medicaid members, prescribers and pharmacists; and,*
    - *Provides trend analysis and reporting.*
- *Dental ASO*
  - *Initial procurement was Feb. 10, 2017; Was changed into a continuation of operations with incumbent vendor due to system not being able to be certified by CMS.*
  - *Main dental-related business functions include:*
    - *Dental claims adjudication;*
    - *Prior authorization;*
    - *Dental claims payment;*
    - *Benefit plan support;*
    - *Coordination of benefits;*
    - *Grievance and appeals; and,*
    - *Utilization management and program integrity.*

Support Modules:

- *Multi-vendor Integrator*
  - *Started April 2018*
  - *Main business functions include:*
    - *Project management; and,*
    - *Coordination of RMMIS vendors including schedules, risks, issues, deliverables, quality assurance, training, testing and organizational change management.*
- *Accounting and Finance*
  - *Implemented July 7, 2019*
  - *Through this project, South Carolina's Enterprise Information System (SCEIS), the state accounting system, now manages all SCDHHS financial functions*
  - *Main business functions include:*
    - *Payments and disbursement to providers;*
    - *Claims remittance and adjustments;*
    - *1099 reporting; and,*
    - *Management of the Medicaid bank account.*
      - *Prior to implementation, SCDHHS maintained, managed and reconciled the Medicaid bank account. The check printing process was managed by SCDHHS and a vendor.*
      - *With this implementation, payments are now processed through the State Treasurer's bank account.*
      - *Checks are managed via a contract managed by the State Treasurer's Office.*
      - *Electronic payments are also managed by the State Treasurer's Office.*
- *Third Party Liability (TPL)*
  - *TPL has been part of the MMIS from the beginning. The most recent contract is part of the RMMIS program and was implemented Aug. 6, 2018. CMS certified the system in February 2020.*
  - *Main business functions include:*
    - *Identification of other insurance for Medicaid members. This is done through insurance identification and inquiry, data matches, and other verification processes; and,*
    - *Recovery operations for claims that should be paid by third party payers.*
- *Business Intelligence System*
  - *The original system was implemented in 2008 but was reprocured as part of the RMMIS program. The system was implemented in November 2018 and certified by CMS in February 2020.*
  - *Main business functions include:*
    - *Decision Support System: A data warehouse from which agency reports can be run;*
    - *Surveillance Utilization Review System: The purpose of the SURS is to improve revenues and reduce costs through identification and recovery of*

fraud, abuse and overpayments in the South Carolina Medicaid program; and,
    - *CMS required reporting tool called Management and Administrative Reporting Subsystem.*
- *Medicaid Enterprise System (MES)*
    - *Implemented in the Amazon Web Services (AWS) Cloud January 2021*
    - *Main business functions include:*
        - *Central integration point for management and distribution of data across RMMIS solutions and trading partners;*
        - *Distributed information management functionality across independent subsystems, while maintaining control over SCDHHS' data;*
        - *Flexibility for solution providers to integrate their solutions through clearly communicated architecture standards, protocols and artifacts; and,*
        - *Allows SCDHHS to incrementally retire legacy components without impacting other components.*

77. When will the agency be able to completely retire legacy components of its old system?

Once the implementation timeline for the MASO has been completed, the agency will complete its evaluation of all functionalities of the current core MMIS and provide a timeline for retirement. The current core MMIS is not expected to be fully retired for at least four years.

78. Does the agency need any additional support from the General Assembly to complete or expedite the RMMIS project?

Other than continued funding, no other support is needed at this time.

Communications

79. Does the agency have a formal marketing and communications strategy?

SCDHHS has a formal communications strategy that is designed to specifically communicate information to its members and providers as well as to the general public. The agency also regularly designs project-specific communications plans to ensure it is engaging with stakeholders relevant to the specific project or topic.

- If so, how does the agency evaluate the effectiveness of its marketing and communications strategy?
    - *The agency monitors a variety of metrics associated with its communications. These include open, click, and unsubscribe rates on agency communications that are sent through its email distribution vendor. The office of communications also regularly meets with and receives reporting from program leaders across the*

agency to identify communications gaps, address feedback, such as frequently asked questions, and prospectively plan future communications.

- Does the agency have a goal for total social media followers by platform?
    - *The agency's goal is an annual increase in following of 3% on its Facebook and Twitter platforms.*

80. What agency metrics are specific to the marketing and communications strategy? Who is held accountable for metric outcomes?

The performance metrics that were submitted to the committee that most relate to the agency's communication strategy are included below. The agency's director of external affairs is held accountable for the agency's outcomes.

- *Increase the number of providers participating in the telehealth by 5%*
    - *Target: 189*
    - *Actual: 6,120*
- *Increase the number of online applications by 10%*
    - *Target: 48,640*
    - *Actual: 51,253 (16% increase over FY2019)*

- *In addition, the office of communications plays a collaborative and supporting role in helping program areas achieve their goals through clear and effective communications delivered to the correct audience(s) at the correct time.*

81. When did the agency last do a complete user experience audit of its website? Does the agency have a documented user experience audit schedule?

The agency has not completed a user experience audit of its website.

82. Can the public access the agency's social media accounts via the agency's website? If so, are the links to these accounts visible on the main page of the website?

The agency's Facebook and Twitter accounts are available via the home page of the agency's website. Both accounts are also linked in agency team members' email signatures.

83. Does the agency have a social media strategy? If so, what metrics does the agency track to evaluate the strategy's performance?

Yes, the agency has a social media strategy, which is based heavily on the agency's editorial calendar. The agency tracks trend data weekly for the below metrics for Facebook and Twitter. The agency is baselining metrics for LinkedIn so it can track trend data on this platform as well.

- *Facebook*
  - *Page Likes*
  - *Page Reach*
  - *Page Followers*
  - *Page Views*
- *Twitter*
  - *Tweets*
  - *Impressions*
  - *Profile Visits*
  - *Mentions*
  - *Followers*
    - *In addition, the office of communications analyzes performance of individual posts each week to identify posts with a large reach and engagement. Tracking performance for trends and outliers at the individual level helps the agency improve performance for future messaging and outreach.*

84. Does the agency know which forms of communication are most effective?

Among its social media accounts, the agency has seen a significantly higher increase in its following on Facebook than Twitter (+14% year-over-year on Facebook vs. +6.2% on Twitter). The agency also typically sees a higher engagement rate with content posted to its Facebook page than Twitter.

For member and provider emails that are sent via the agency's email distribution vendor, the agency tracks several metrics to help identify optimal timing and presentation of information.

85. How does the agency determine if providers are receiving and reacting to agency communications?

The agency tracks open, click, and unsubscribe rate trends. The office of communications also regularly meets with the program areas responsible for administering the various functions of the state's Medicaid program to review feedback the agency has received and identify if additional or different forms of communication are required.

86. Please explain the community-based organization communication strategy, and note how many organizations are partnered with DHHS?

The agency regularly meets and engages with community-based, medical, and other stakeholder organizations to develop, adjust and execute communications strategy. The agency has a contractual partnership with SC Thrive who serves as a formal partner with the agency's eligibility team. This partnership includes a contract manager; monthly meetings to

discuss contract activities, progress and issues; and, monthly reporting on contract deliverables.

Beyond this formal partnership, agency staff regularly engages and partners with other state agencies, medical associations, other community-based organizations, and the state's managed care organizations to identify communications needs and opportunities. These partnerships have led to several co-branded social media graphics, handouts, and other material over the last year. Co-branded graphics around the importance of continuing well-child visits during the pandemic (partnership with the South Carolina Chapter of the AP) and suicide prevention awareness and resources (partnership with DMH, South Carolina Chapter of the American Foundation for Suicide Prevention and National Alliance on Mental Illness South Carolina) remain the agency's farthest reaching social media posts of the last year exceeding topics that received significant earned media coverage.

87. Do members automatically receive the e-newsletter upon enrollment or do they have to sign up for it?

Healthy Connections Medicaid members who have provided an email address to the agency, either on their Medicaid application or through another form of communication, automatically receive the e-newsletter. The agency has also posted instructions on how to receive this newsletter and other communications from the agency on its website. Members, and anyone who receives email updates from the agency, are also permitted to unsubscribe from email updates.

- Does that agency text updates and other reminders to members?
    - *No, the agency does not currently send text updates or reminders to members; however, some Medicaid managed care plans do send text message communications. The agency is currently discussing methods to provide text updates to members in the future but also must consider that because phone numbers are not a required field on a Medicaid application, it lacks phone numbers for a significant portion of the Medicaid population.*

88. Does the agency evaluate Medicaid MCO communication strategies or require certain types of communication be utilized to engage members and other stakeholders?

The agency is federally required to review MCO marketing and member materials to ensure they are compliant with the MCO's contract. The contract and corresponding policy and procedures guide with the state's MCOs contain chapters that outlines marketing requirements and parameters. This includes requirements for each marketing plan, such as the development and implementation of a written marketing/advertising guide, identification of target audiences and details around the plan's marketing strategy. Both documents also outline permitted and prohibited activities and are publicly available via the link below:

https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp

Email Questions from June 9, 2021

89. Per the agency's response to Question 1, please provide examples of non-monetary awards.

An example of a non-monetary award could be the agency paying for lunch for a project team upon completion of a project.

90. Per the agency's response to Question 5, please identify what 3-10% of total agency expenditures amounts to. Does the agency believe its fraud percentage is within the identified range?

SCDHHS's total expenditures for SFY2020 were $7,813,366,726. 3-10% of total agency expenditures would equate to approximately $234,400,000 to $781,300,000. The National Heath Care Anti-Fraud Association (NHCAA) estimates conservatively that health care fraud costs the nation about $68 billion annually — about 3 percent of the nation's $2.26 trillion in health care spending. Other estimates range as high as 10 percent of annual health care expenditure, or $230 billion. In accordance with national figures that cross all lines of healthcare delivery systems, one can see that the pervasive nature of fraud makes determining the actual dollars lost very difficult. The national average of 3-10% is not specific to South Carolina Medicaid. Although the nature of fraud makes it difficult to determine the actual dollars lost, the agency anticipates South Carolina's Medicaid fraud, waste, and abuse to be lower than the range calculated. SCDHHS believes its program integrity efforts are effective in combatting health care fraud, waste, and abuse. Additional staff and resources would assist with further expanding the agency's efforts.

91. Per the agency's response to Question 28, are performance-based bonuses established on objective metrics clearly understood by staff?

Eligibility Specialists have metrics-based PDs and meet with their supervisors each month to review their performance. The agency has temporarily paused formal actions related to this process. There are several reasons for the pause: to revisit the actual metrics by work type (MAGI, Non-MAGI, LTC), to revise the performance evaluation process, and to allow staff to attend training on a new system (staff is placed in "exempt" status while training).

92. Per the agency's response to Question 48, why did the agency have to secure a third party vendor via a sole source procurement? Have any other viable vendors or competitors entered the market to compete for these services?

The agency erroneously stated that it secured a third party vendor to perform the provider enrollment functions via a "sole source procurement." The third party vendor was secured/selected via a competitive procurement. Because the enrollment functions will be

absorbed by the Administrative Services Organization (ASO) contract (which was competitively procured) the agency has entered into an emergency procurement with the third party vendor until the ASO contract is fully implemented.

93. Please forward a clickable link for the website provided in Question 16.

The requested link is available here:

https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2020-statistical-chart.pdf

94. Does the agency's Human Resources division use compa-ratio to evaluate salaries across the agency?

Yes, the agency's office of human resources uses compa-ratio when completing its class and comparison analysis.

Sincerely,

Robert M. Kerr

cc: The Honorable Gil Gatch
The Honorable Rosalyn Henderson-Myers
The Honorable Timothy "Tim" McGinnis

Waiver Performance Measures
Community Choices Waiver
7/1/2016 – 6/7/2019

Sub-Assurance: An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

Performance Measure:	The number and percent of new waiver enrollees who had a LOC determination that indicated a need for institutional LOC prior to waiver enrollment and receipt of services.
Numerator:	The number of new waiver enrollees who received a LOC assessment indicating a skilled or intermediate LOC prior to the receipt of waiver services
Denominator:	The total number of new waiver enrollees

State Data	**2017**	**2018**	**2019**
Numerator	5,004	4,187	4,455
Denominator	5,004	4,187	4,455
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of all applicants who received a LOC determination.
Numerator:	The number of applicants who received a LOC determination
Denominator:	The total number of applicants

State Data	**2017**	**2018**	**2019**
Numerator	5,660	4,843	3,693
Denominator	15,412	16,034	15,305
% Compliant	37%	30%	24%

*All applicants who met intake and financial criteria and chose to proceed with medical eligibility determination received an assessment. Reasons for not receiving an assessment included: declined participation, applicant could not be located after application, death, entered nursing home, did not relocate to South Carolina, enrolled in another program.

Sub-Assurance: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.

Performance Measure:	The number and percent of all LOC determinations completed using the appropriate

	forms/instruments as required by the State Medicaid Agency.
Numerator:	The total number of determinations completed using the appropriate forms/instruments
Denominator:	The total number of determinations

State Data	2017	2018	2019
Numerator	16,206	16,606	16,107
Denominator	16,206	16,606	16,107
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of waiver applicants who enter the waiver with a LOC completed within 30 days.
Numerator:	Number of waiver applicants who enter the waiver with a LOC completed within 30 days
Denominator:	The total number of waiver applicants

State Data	2017	2018	2019
Numerator	5,004	4,187	4,187
Denominator	5,004	4,455	4,455
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of LOC determinations which differ from the Phoenix system recommended LOC are verified for accuracy by a third team member.
Numerator:	Number of LOC determinations which contain a third signature
Denominator:	Number of LOC determinations which differ from the Phoenix recommended LOC

State Data	2017	2018	2019
Numerator	31	22	26
Denominator	31	22	26
% Compliant	100%	100%	100%

Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.

Waiver Performance Measures
Community Choices Waiver
7/1/2016 – 6/7/2019

Performance Measure:	The number and percent of providers who meet the initial application criteria.
Numerator:	Number of providers who meet initial application criteria
Denominator:	Total number of providers

State Data	**2017**	**2018**	**2019**
Numerator	45	78	72
Denominator	45	78	72
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of providers who scored less than 100 as a result of on-site reviews by waiver staff.
Numerator:	Number of providers who scored less than 100 on an on-site review
Denominator:	Total number of providers reviewed

State Data	**2017**	**2018**	**2019**
Numerator	116	70	58
Denominator	196	152	149
% Compliant	59%	46%	39%

*The compliance review process changed in March 2018. Remediation activities included mandatory training added to the scope of services in 2019.

Performance Measure:	The number of provider complaints and the percentage of those complaints that were resolved that were logged in the State's case management system, Phoenix.
Numerator:	The number of complaints resolved
Denominator:	Total number of complaints received

State Data	**2017**	**2018**	**2019**
Numerator	871	979	680
Denominator	871	979	689
% Compliant	100%	100%	98%

Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Waiver Performance Measures
Community Choices Waiver
7/1/2016 – 6/7/2019

Performance Measure:	The number and percent of non-licensed/non-certified providers, by provider type, who meet initial waiver qualifications prior to providing waiver services.
Numerator:	Number of providers who meet qualifications
Denominator:	Total number of providers

State Data	**2017**	**2018**	**2019**
Numerator	680	556	564
Denominator	680	556	564
% Compliant	100%	100%	100%

Performance Measure:	For applicable providers, the number and percent of non-licensed/non-certified waiver providers, by provider type, that continue to meet waiver provider qualifications.
Numerator:	Number of non-licensed/non-certified providers that continued to meet provider qualifications
Denominator:	Total number of non-licensed providers

State Data	**2017**	**2018**	**2019**
Numerator	2,317	2,395	2,413
Denominator	2,534	2,490	2,442
% Compliant	91%	96%	99%

Sub-Assurance: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure:	The number and percent of enrolled providers that comply with state training requirements.
Numerator:	Number of enrolled waiver providers complying with training requirements
Denominator:	Total number of enrolled providers

State Data	**2017**	**2018**	**2019**
Numerator	245	194	89
Denominator	221	173	78
% Compliant	90%	89%	88%

Sub-assurance: Service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Waiver Performance Measures
Community Choices Waiver
7/1/2016 – 6/7/2019

Performance Measure:	The number and percent of participants whose identified needs were addressed in the service plan.
Numerator:	Number of assessed participants with completed service plan
Denominator:	Total number of participants assessed

State Data	**2017**	**2018**	**2019**
Numerator	16,206	16,606	16,107
Denominator	18,299	18,365	18,264
% Compliant	89%	90%	88%

Performance Measure:	The number and percent of participants with whom personal goals were discussed during the service planning process.
Numerator:	Number of participants with whom personal goals were discussed
Denominator:	Total number of participants

State Data	**2017**	**2018**	**2019**
Numerator	14,567	14,773	14,274
Denominator	18,299	18,365	18,264
% Compliant	80%	80%	78%

Performance Measure:	The number and percent of participants whose personal goals are addressed in the service plan.
Numerator:	Number of participants whose personal goals are addressed
Denominator:	Total number of participants who have identified a personal goal

State Data	**2017**	**2018**	**2019**
Numerator	14,834	17,232	17,312
Denominator	18,062	18,149	18,513
% Compliant	82%	95%	94%

Performance Measure:	The number and percent of service plans developed that involved participants and/or caregivers in the development process.
Numerator:	Number of service plans that involved participants and/or caregivers

Denominator:	Total number of service plans

State Data	2017	2018	2019
Numerator	14,119	14,743	8,986*
Denominator	16,206	16,606	9,795
% Compliant	87%	89%	92%

*The signature on the service plan is captured up to 120 days after the plan date; many Year 3 visits were not yet due at the time of the evidence report.

Sub-Assurance: Service plans are updated/revised at least annually or when warranted by changes in waiver individual needs.

Performance Measure:	The number and percent of service plans revised on or before the annual review date.
Numerator:	Number of service plans revised
Denominator:	Total number of service plans needing revision

State Data	2017	2018	2019
Numerator	9,856	10,577	10,023
Denominator	10,318	11,031	10,444
% Compliant	96%	96%	96%

Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Performance Measure:	The number and percent of participants who received services as designated in the service plan.
Numerator:	Number of months for which providers delivering service and amount agreed = yes
Denominator:	Total months of waiver enrollment

State Data	2017	2018	2019
Numerator	177,658	184,293	174,849
Denominator	192,182	196,947	186,523
% Compliant	92%	94%	94%

Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measure:	The number and percent of participants afforded choice between/among waiver services and providers.
Numerator:	Number of participants afforded choice

Denominator:	Total number of participants

State Data	2017	2018	2019
Numerator	14,119	14,743	8,986*
Denominator	16,206	16,606	9,795
% Compliant	87%	89%	92%

*The signature on the service plan is captured up to 120 days after the plan date; many Year 3 visits were not yet due at the time of the evidence report.

Performance Measure:	The number and percent of participants informed of their right to choose waiver services, from those that are available, that will best meet their needs as documented by a signed CLTC Rights and Responsibilities form.
Numerator:	Number of participants informed of their right to choose waiver services
Denominator:	Total number of participants

State Data	2017	2018	2019
Numerator	19,810	19,926	20,534
Denominator	20,754	20,715	21,195
% Compliant	95%	96%	97%

Sub-Assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation and unexplained death.

Performance Measure:	The number and percent of participants (and/or family or guardian) who received information on how to report abuse, neglect, exploitation and other reportable incident.
Numerator:	Number of participants documented to have received information/education on how to report abuse, neglect, exploitation and other reportable incident
Denominator:	Total number of participants

State Data	2017	2018	2019
Numerator	19,810	19,926	20,534
Denominator	20,754	20,715	21,195
% Compliant	95%	96%	97%

Performance Measure:	The number and percent of participants who report knowing how to report abuse, neglect, exploitation or other reportable incidents.
Numerator:	Number of participants who reported knowing how to report ANE
Denominator:	Total number of participants in sample

State Data	**2018**	**2019**
Numerator	126	154
Denominator	140	164
% Compliant	90%	94%

*During waiver year 2016/2017, a client satisfaction survey was designed and submitted for IRB approval. The survey sample started in waiver year two (2017 – 2018).

Sub-Assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measure:	The number of abuse, neglect and/or exploitation complaints reported in the Phoenix complaint system and the percentage of those complaints resulting in referrals to Adult Protective Services (APS).
Numerator:	Number of ANE complaints reported that resulted in referrals to APS
Denominator:	Total number of complaints

State Data	**2017**	**2018**	**2019**
Numerator	324	414	323
Denominator	324	414	323
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of reported incidents that are monitored until appropriate resolution.
Numerator:	Number of reported incidents that are monitored until appropriate resolution
Denominator:	Total number of reported incidents

State Data	**2017**	**2018**	**2019**
Numerator	286	360	308
Denominator	324	414	357
% Compliant	88%	87%	86%

Waiver Performance Measures
Community Choices Waiver
7/1/2016 – 6/7/2019

Performance Measure:	The number and percent of case managers who received training on their responsibilities as mandated reporters of abuse, neglect and exploitation.
Numerator:	Number of CM entity staff with documentation of training on abuse, neglect and exploitation and mandated reporter requirements
Denominator:	Total number of CM entity staff

State Data	**2017**	**2018**	**2019**
Numerator	92	86	92
Denominator	92	86	92
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of caregivers who experienced moderate to severe stress with caregiving and had appropriate interventions identified on the service plan.
Numerator:	Number of caregivers who experienced moderate to severe stress with caregiving and have appropriate interventions
Denominator:	Total number of caregivers

State Data	**2017**	**2018**	**2019**
Numerator	1,730	1,760	1,626
Denominator	1,730	1,760	1,626
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of direct care provider staff (Personal Care and Attendants) that are informed about mandated reporting requirements.
Numerator:	Number of direct care provider staff with documentation of training for staff on mandated reporting
Denominator:	Number of personnel records reviewed

State Data (personal care)	**2017**	**2018**	**2019**
Numerator	4,248	2,035	336

Denominator	4,865	2,277	2,035
% Compliant	87%	89%	86%

State Data (attendants)	**2017**	**2018**	**2019**
Numerator	2,435	2,387	2,330
Denominator	2,435	2,387	2,330
% Compliant	100%	100%	100%

Sub-Assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measure:	The number of unauthorized incidents of restrictive interventions that were appropriately reported.
Numerator:	Number of unauthorized incidents of restrictive interventions
Denominator:	Total number of reportable incidents

*During the reporting period, no incidents were reported.

Sub-Assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measure:	The number and percent of participants who have been evaluated for Emergency Disaster preparedness.
Numerator:	Number of participants who have an Emergency Disaster preparedness plan
Denominator:	Total number of participants

State Data	**2017**	**2018**	**2019**
Numerator	18,325	18,403	18,420
Denominator	20,754	20,715	21,195
% Compliant	88%	89%	87%

*As a result of the downward trend, SCDHHS created a training video for providers and staff that is available on demand.

Performance Measure:	The number and percent of participants indicating their health care needs are being addressed.
Numerator:	Number of participants indicating their current health care needs are being addressed (# of months “Yes”)
Denominator:	Number of participants reviewed (full months of waiver enrollment)

State Data	2017	2018	2019
Numerator	177,658	184,293	174,849
Denominator	192,182	196,947	186,523
% Compliant	92%	94%	94%

Sub-Assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measure:	The number and percent of claims for waiver services submitted with the correct service code.
Numerator:	Number of claims submitted with correct service code.
Denominator:	Total number of claims

State Data	2017	2018	2019
Numerator	7,092,926	7,407,078	7,262,942
Denominator	7,092,926	7,407,078	7,262,942
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of paid waiver claims submitted for participants enrolled in the waiver program.
Numerator:	Number of paid waiver claims submitted
Denominator:	Total number of claims

State Data	2017	2018	2019
Numerator	7,092,926	7,407,078	7,262,942
Denominator	7,092,926	7,407,078	7,262,942
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of waiver claims using the EVV (electronic visit verification) to document service delivery.
Numerator:	Number of EVV claims submitted for payment
Denominator:	Total number of waiver claims paid for EVV services

State Data	2017	2018	2019
Numerator	5,529,082	5,892,104	5,529,082
Denominator	5,684,569	6,012,306	5,684,569

% Compliant	97%	98%	97%

Performance Measure:	The number and percent of cases for non-EVV services where participants indicated the service was provided.
Numerator:	Number of times participants indicated services were performed and billed (# months "yes")
Denominator:	Total number of responses from participants (full months of waiver enrollment)

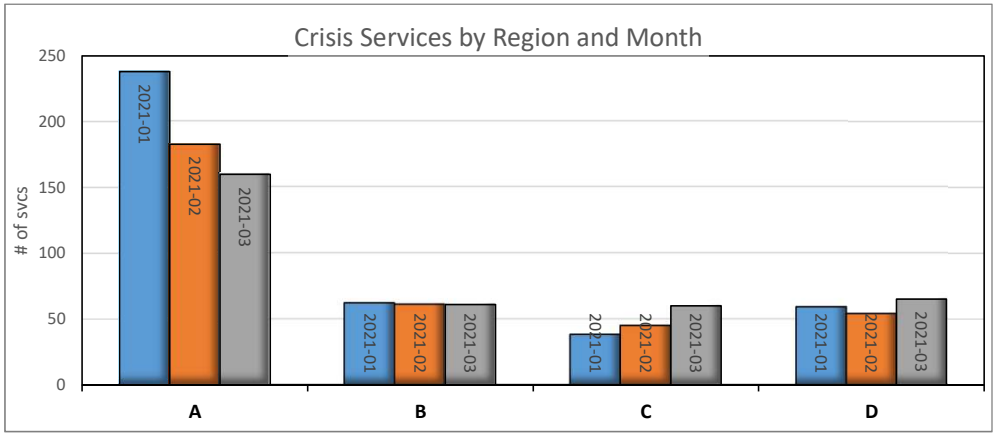
State Data	**2017**	**2018**	**2019**
Numerator	177,658	184,293	174,849
Denominator	192,182	196,947	186,523
% Compliant	92%	94%	94%

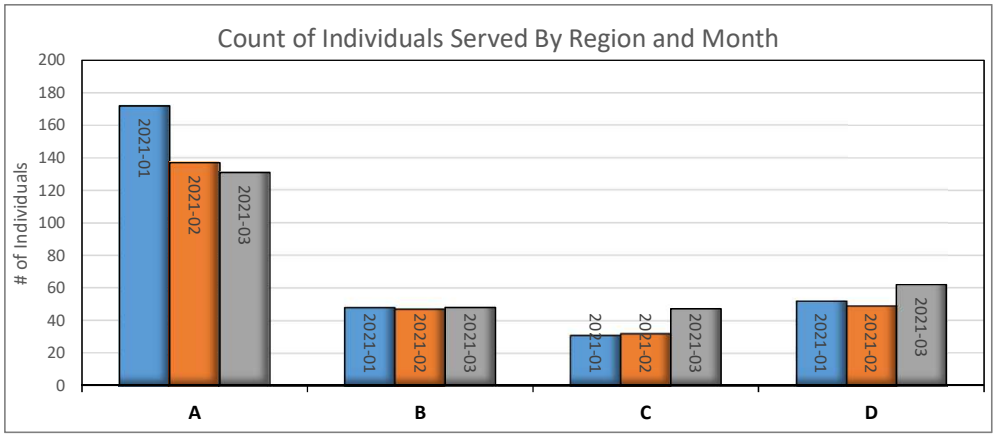
Sub-Assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Performance Measure:	The number and percent of waiver claims submitted with the correct rate as specified in the waiver application.
Numerator:	Number of claims submitted with the correct rate
Denominator:	Total number of claims

State Data	**2017**	**2018**	**2019**
Numerator	7,092,926	7,407,078	7,256,497
Denominator	7,092,926	7,407,078	7,256,497
% Compliant	100%	100%	100%

CCRI REPORTING
JANUARY 1st - MARCH 31st 2021
All REGIONS



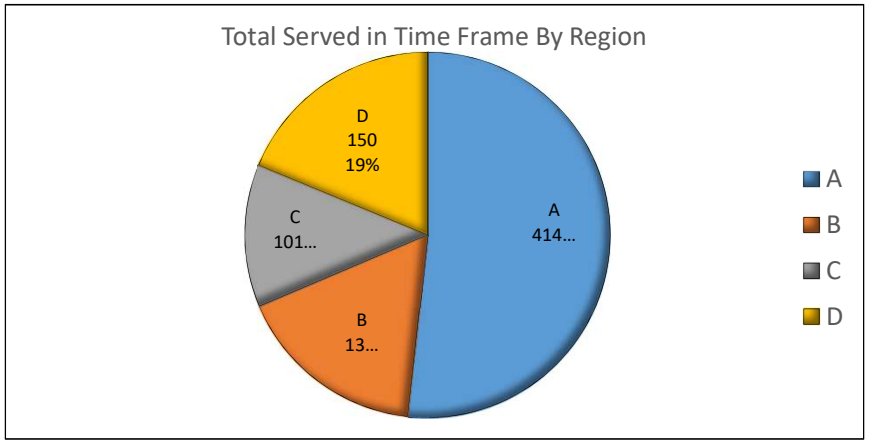


Total CCRI Services By Month and Region

Region	2021-01	2021-02	2021-03	Total
A	238	183	160	581
B	62	61	61	184
C	38	45	60	143
D	59	54	65	178
Total	397	343	346	1,086

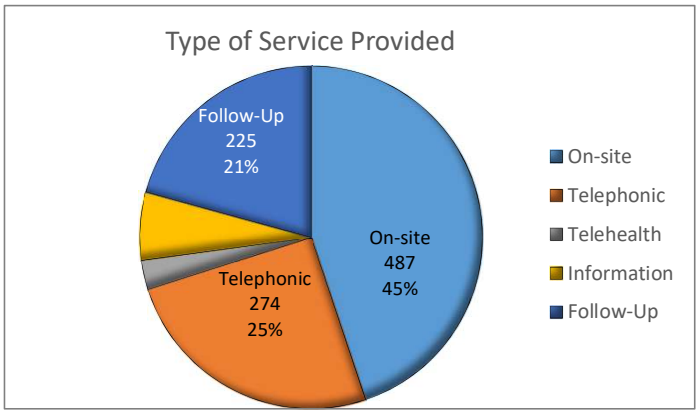
Individuals Served By Month and Region

Region	2021-01	2021-02	2021-03	Total
A	172	137	131	414
B	48	47	48	135
C	31	32	47	101
D	52	49	62	150
Total	303	265	288	800



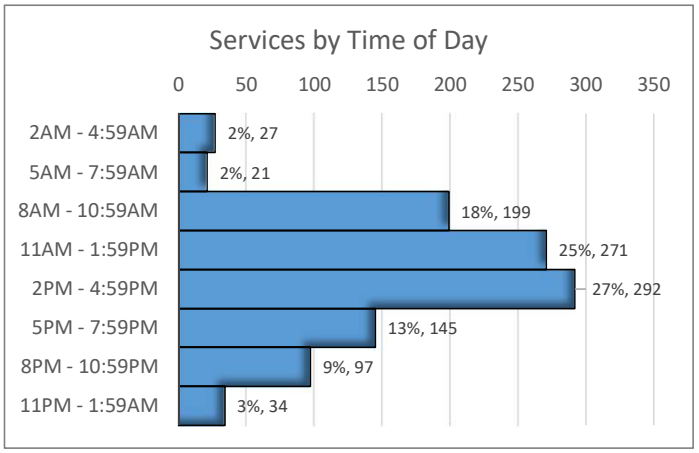
Region-A	Aiken, Bamberg, Barnwell, Calhoun, Farifield, Lexington, Orangeburg, Richland
Region-B	Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, McCormick, Newberry, Oconee, Pickens, Saluda, Spartanburg, Union
Region-C	Chester, Chesterfield, Clarendon, Darlington, Dillion, Florence, Kershaw, Lancaster, Lee, Marlboro, Marion, Sumter, York
Region-D	Allendale, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Horry, Georgetown, Jasper, Williamsburg

CCRI REPORTING
JANUARY 1st - MARCH 31st 2021
All REGIONS



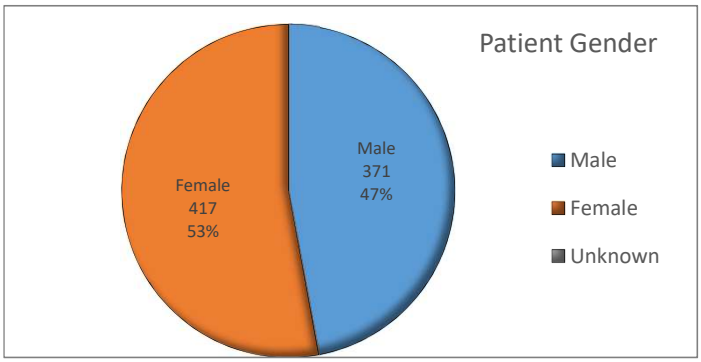
Service Type	Patients		Services	
	#	%	#	%
On-site	441	46%	487	45%
Telephonic	243	25%	274	25%
Telehealth	30	3%	30	3%
Information	68	7%	70	6%
Follow-Up	181	19%	225	21%
Total	**963**	**100%**	**1,086**	**100%**

* Patient totals unduplicated for each reporting category



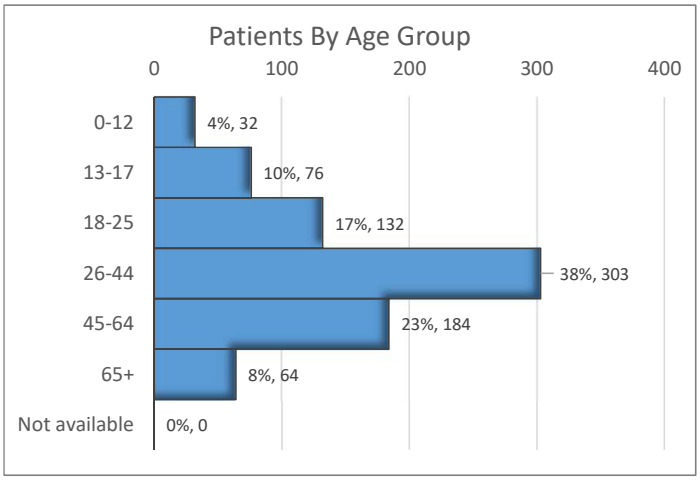
Service Type	Patients		Services	
	#	%	#	%
2AM - 4:59AM	25	3%	27	2%
5AM - 7:59AM	21	2%	21	2%
8AM - 10:59AM	175	18%	199	18%
11AM - 1:59PM	245	25%	271	25%
2PM - 4:59PM	258	26%	292	27%
5PM - 7:59PM	135	14%	145	13%
8PM - 10:59PM	92	9%	97	9%
11PM - 1:59AM	34	3%	34	3%
Total	**985**	**100%**	**1,086**	**100%**

* Patient totals unduplicated for each reporting category



Gender	Patients		Services	
	#	%	#	%
Male	371	47%	510	47%
Female	417	53%	572	53%
Unknown	0	0%	0	0%
Total	**791**	**100%**	**1,086**	**100%**

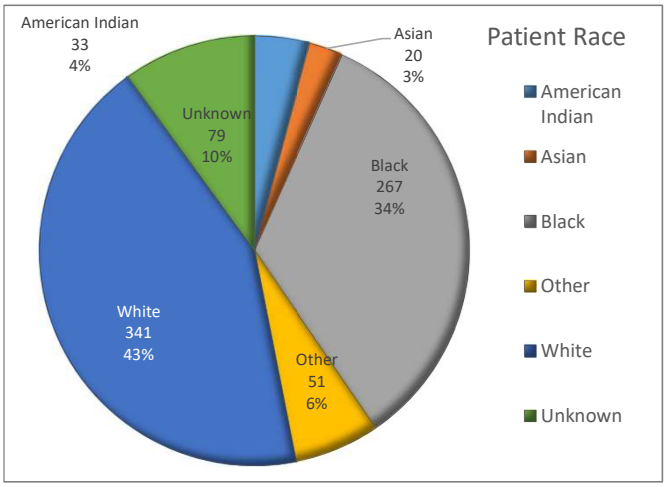
* Patient totals unduplicated for each reporting category



Age Group	Patients		Services	
	#	%	#	%
0-12	32	4%	40	4%
13-17	76	10%	87	8%
18-25	132	17%	183	17%
26-44	303	38%	419	39%
45-64	184	23%	268	25%
65+	64	8%	89	8%
Not available	0	0%	0	0%
Total	**791**	**100%**	**1,086**	**100%**

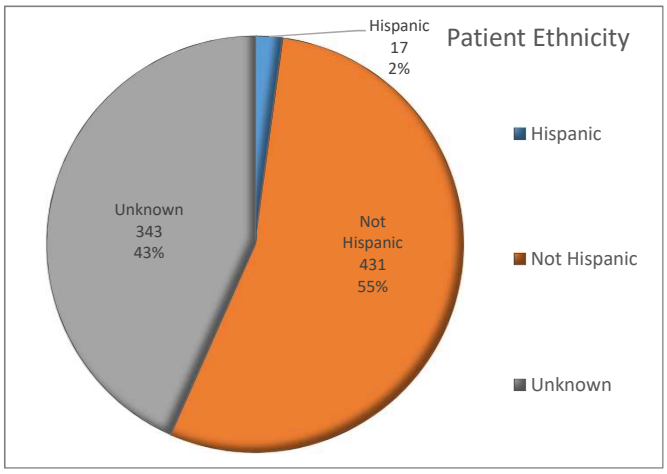
* Patient totals unduplicated for each reporting category

CCRI REPORTING
JANUARY 1st - MARCH 31st 2021
All REGIONS



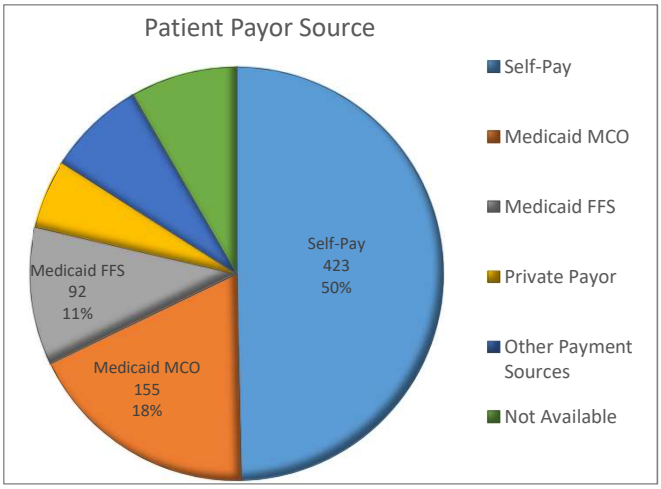
Race Group	Patients		Services	
	#	%	#	%
American Indian	33	4%	42	4%
Asian	20	3%	23	2%
Black	267	34%	371	34%
Other	51	6%	74	7%
White	341	43%	477	44%
Unknown	79	10%	99	9%
Total	**791**	**100%**	**1,086**	**100%**

* Patient totals unduplicated for each reporting category



Hispanic Ethnicity	Patients		Services	
	#	%	#	%
Hispanic	17	2%	23	2%
Not Hispanic	431	54%	606	56%
Unknown	343	43%	457	42%
Total	**791**	**100%**	**1,086**	**100%**

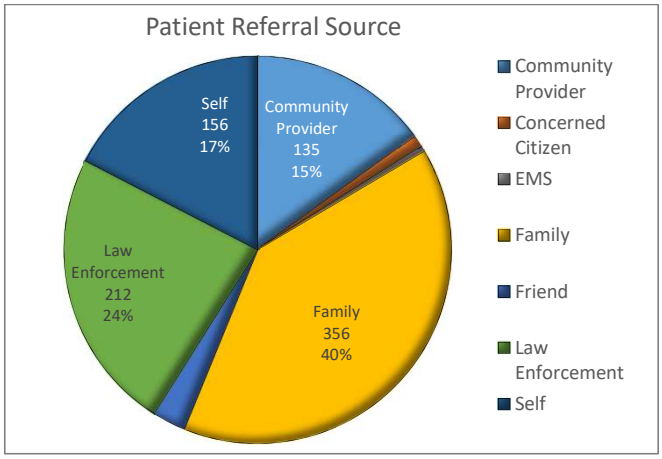
* Patient totals unduplicated for each reporting category



Payment Source	Patients		Services	
	#	%	#	%
Self-Pay	423	50%	535	49%
Medicaid MCO	155	18%	199	18%
Medicaid FFS	92	11%	109	10%
Private Payor	46	5%	61	6%
Other Payment Sources	65	8%	84	8%
Not Available	71	8%	98	9%
Total	**852**	**100%**	**1,086**	**100%**

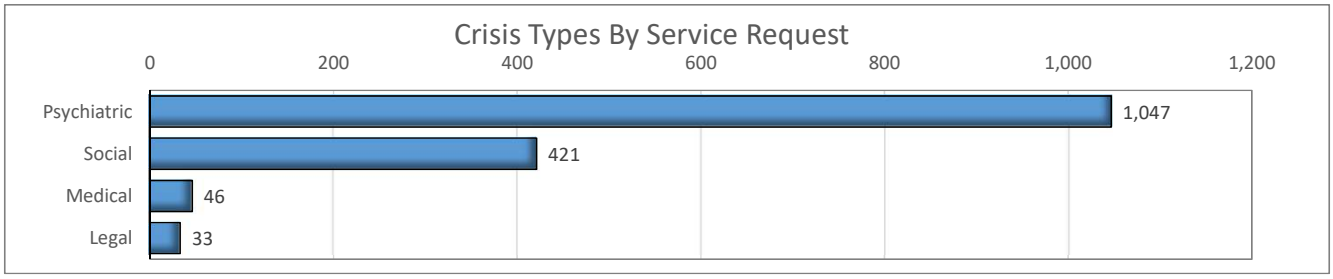
* Patient totals unduplicated for each reporting category

CCRI REPORTING
JANUARY 1st - MARCH 31st 2021
All REGIONS

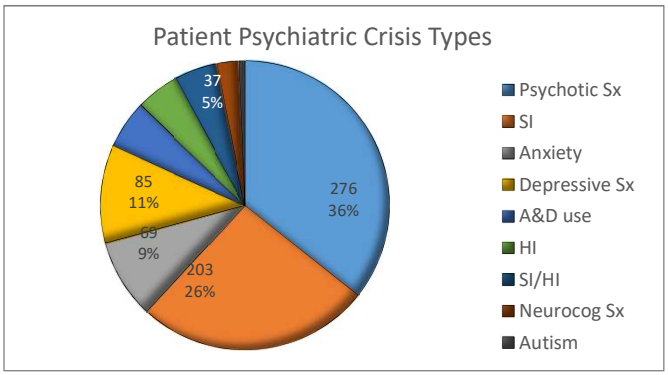


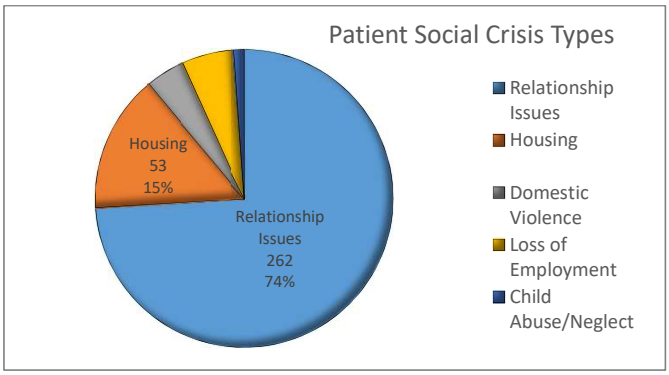
Referral Source	Patients		Services	
	#	%	#	%
Community Provider	135	15%	154	14%
Concerned Citizen	9	1%	9	1%
EMS	4	0%	4	0%
Family	356	40%	463	43%
Friend	25	3%	26	2%
Law Enforcement	212	24%	254	23%
Self	156	17%	176	16%
Total	**897**	**100%**	**1,086**	**100%**

* Patient totals unduplicated for each reporting category



* Crisis type categories not mutually exclusive

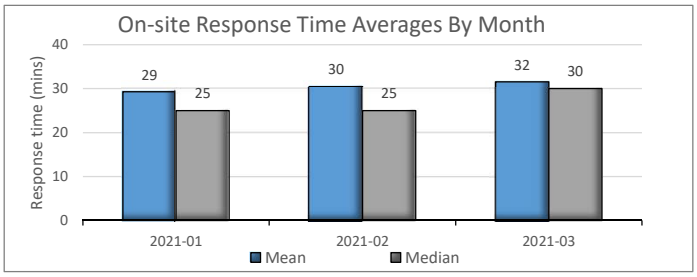




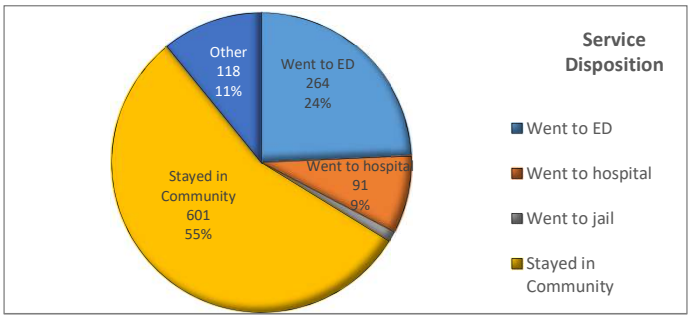
Crisis Type	Patients		Services	
	#	%	#	%
Psychatric	774	86.3%	1,047	96.4%
Psychotic Sx	276	30.8%	403	37.1%
SI	203	22.6%	230	21.2%
Anxiety	69	7.7%	109	10.0%
Depressive Sx	85	9.5%	120	11.0%
A&D use	42	4.7%	57	5.2%
HI	38	4.2%	46	4.2%
SI/HI	37	4.1%	49	4.5%
Neurocog Sx	19	2.1%	25	2.3%
Autism	5	0.6%	8	0.7%
Social	354	39.5%	421	38.8%
Relationship Issues	262	29.2%	313	28.8%
Housing	53	5.9%	60	5.5%
Domestic Violence	15	1.7%	18	1.7%
Loss of Employment	20	2.2%	24	2.2%
Child Abuse/Neglect	4	0.4%	6	0.6%
Medical	40	4.5%	46	4.2%
Legal	25	2.8%	33	3.0%

* Patient totals unduplicated for each reporting category

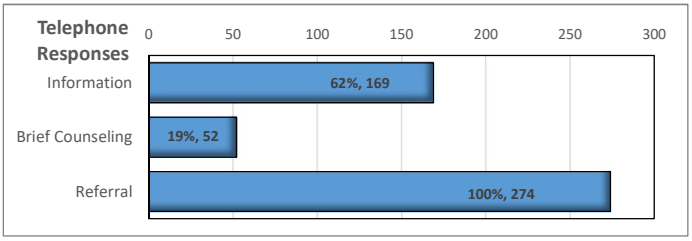
CCRI REPORTING
JANUARY 1st - MARCH 31st 2021
All REGIONS



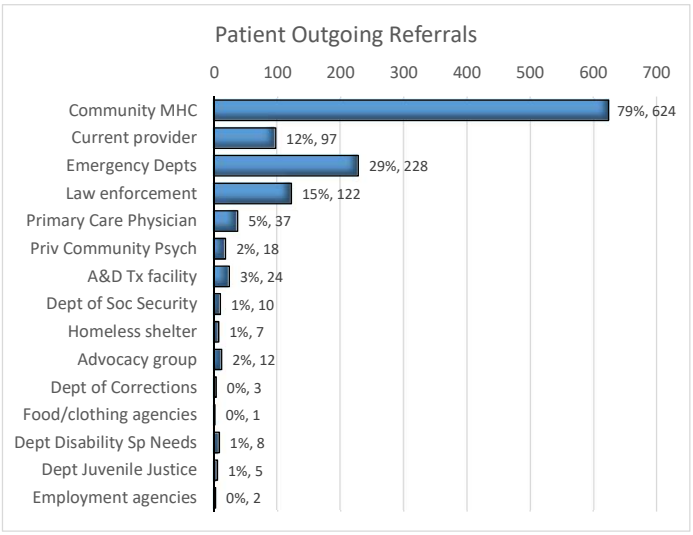
On-Site Response Times By Month and Minutes		
Month	Mean	Median
2021-01	29	25
2021-02	30	25
2021-03	32	30
Total	30	28



Status	On-Site or Call Disposition			
	Patients		Services	
	#	%	#	%
Went to ED	246	27%	264	24%
Went to hospital	88	10%	91	8%
Went to jail	12	1%	12	1%
Stayed in Community	460	50%	601	55%
Other	112	12%	118	11%
Total	918	100%	1,086	100%

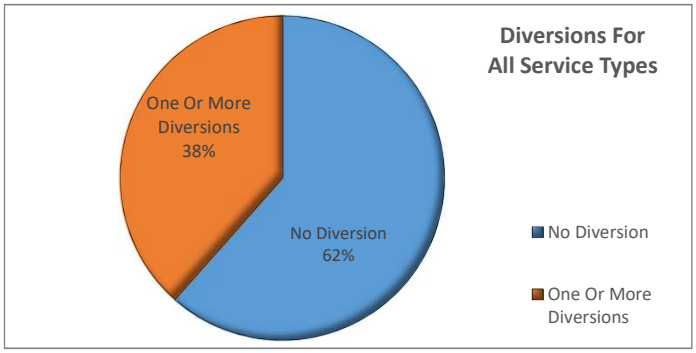


Telephonic Intervention Content	Telephonic Responses			
	Patients		Services	
	#	%	#	%
Information	156	64%	169	62%
Brief Counseling	51	21%	52	19%
Referral	243	100%	274	100%
Total	243		274	



Referrals	Outgoing Referrals			
	Patients		Services	
	#	%	#	%
Community MHC	624	79%	841	77%
Current Provider	97	12%	102	9%
Emergency Depts.	228	29%	250	23%
Law Enforcement	122	15%	130	12%
Primary Care Physician	37	5%	38	3%
Priv Community Psych	18	2%	21	2%
A&D Tx facility	24	3%	26	2%
Social Services	10	1%	11	1%
Homeless Shelter	7	1%	8	1%
Advocacy Group	12	2%	14	1%
Dept. of Corrections	3	0%	3	0%
Food/Clothing Agencies	1	0%	1	0%
Disability and Sp. Needs	8	1%	10	1%
Juvenile Justice	5	1%	5	0%
Employment Agencies	2	0%	2	0%

Patients may receive more than one referral



Crisis intervention Diversions

Service Type	# Of Svcs	Jail Diversion	ED or Hosp. Diversion	% With Any Diversion*
Telephonic	274	30	96	36%
On-Site	487	46	230	52%
All Other Service Types	325	11	67	21%
Total	1,086	87	393	38%

* Diversion figures in the graph show combined diversion totals while the table shows diversions by type. Some services are associated with more than one type of diversion.

Waiver Performance Measures
HIV/AIDS Waiver
7/1/2016 – 6/7/2019

Sub-Assurance: An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

Performance Measure:	The number and percent of new waiver enrollees who had a LOC determination that indicated a need for institutional LOC prior to waiver enrollment and receipt of services.
Numerator:	The number of new waiver enrollees who received a LOC assessment indicating a skilled or intermediate LOC prior to the receipt of waiver services
Denominator:	The total number of new waiver enrollees

State Data	**2017**	**2018**	**2019**
Numerator	58	31	42
Denominator	58	31	42
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of all applicants who received a LOC determination.
Numerator:	The number of applicants who received a LOC determination
Denominator:	The total number of applicants

State Data	**2017**	**2018**	**2019**
Numerator	60	51	25
Denominator	136	102	82
% Compliant	44%	50%	30%

*All applicants who met intake and financial criteria and chose to proceed with medical eligibility determination received an assessment. Reasons for not receiving an assessment included: declined participation, applicant could not be located after application, death, entered nursing home, did not relocate to South Carolina, enrolled in another program.

Sub-Assurance: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.

Performance Measure:	The number and percent of all LOC determinations completed using the appropriate forms/instruments as required by the State Medicaid Agency.
Numerator:	The total number of determinations completed using the appropriate forms/instruments

Denominator:	The total number of determinations

State Data	2017	2018	2019
Numerator	58	31	42
Denominator	58	31	42
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of waiver applicants who enter the waiver with a LOC completed within no greater than 30 days.
Numerator:	Number of waiver applicants who enter the waiver with a LOC completed within no greater than 30 days
Denominator:	The total number of waiver applicants

State Data	2017	2018	2019
Numerator	58	31	42
Denominator	58	31	42
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of LOC determinations which differ from the Phoenix system recommended LOC are verified for accuracy by a third team member.
Numerator:	Number of LOC determinations which contain a third signature
Denominator:	Number of LOC determinations which differ from the Phoenix recommended LOC

State Data	2017	2018	2019
Numerator	431	411	368
Denominator	431	411	368
% Compliant	100%	100%	100%

Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.

Performance Measure:	The number and percent of providers who meet the initial application criteria.
Numerator:	Number of providers who meet initial application criteria

Denominator:	Total number of providers

State Data	2017	2018	2019
Numerator	45	69	70
Denominator	45	69	70
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of providers who scored less than 100 as a result of on-site reviews by waiver staff.
Numerator:	Number of providers who scored less than 100 on an on-site review
Denominator:	Total number of providers reviewed

State Data	2017	2018	2019
Numerator	68	41	11
Denominator	137	102	46
% Compliant	50%	40%	24%

*The compliance review process changed in March 2018. Remediation activities included mandatory training added to the scope of services in 2019.

Performance Measure:	The number of provider complaints and the percentage of those complaints that were resolved that were logged in the State's case management system, Phoenix.
Numerator:	The number of complaints resolved
Denominator:	Total number of complaints received

State Data	2017	2018	2019
Numerator	16	35	16
Denominator	16	35	16
% Compliant	100%	100%	100%

Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure:	The number and percent of non-licensed/non-certified providers, by provider type, who meet initial waiver qualifications prior to providing waiver services.
Numerator:	Number of providers who meet qualifications

Denominator:	Total number of providers

State Data	2017	2018	2019
Numerator	676	551	561
Denominator	676	551	561
% Compliant	100%	100%	100%

Performance Measure:	For applicable providers, the number and percent of non-licensed/non-certified waiver providers, by provider type, that continue to meet waiver provider qualifications.
Numerator:	Number of non-licensed/non-certified providers that continued to meet provider qualifications
Denominator:	Total number of non-licensed providers

State Data	2017	2018	2019
Numerator	2,317	2,395	2,413
Denominator	2,544	2,500	2,453
% Compliant	91%	96%	98%

Sub-Assurance: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure:	The number and percent of enrolled providers that comply with state training requirements.
Numerator:	Number of enrolled waiver providers complying with training requirements
Denominator:	Total number of enrolled providers

State Data	2017	2018	2019
Numerator	124	92	42
Denominator	137	102	46
% Compliant	91%	90%	91%

Sub-assurance: Service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measure:	The number and percent of participants whose identified needs were addressed in the service plan.
Numerator:	Number of assessed participants with completed service plan

Denominator:	Total number of participants assessed

State Data	2017	2018	2019
Numerator	725	668	581
Denominator	747	686	602
% Compliant	97%	97%	97%

Performance Measure:	The number and percent of participants with whom personal goals were discussed during the service planning process.
Numerator:	Number of participants with whom personal goals were discussed
Denominator:	Total number of participants

State Data	2017	2018	2019
Numerator	661	628	537
Denominator	747	686	602
% Compliant	88%	92%	89%

Performance Measure:	The number and percent of participants whose personal goals are addressed in the service plan.
Numerator:	Number of participants whose personal goals are addressed
Denominator:	Total number of participants who have identified a personal goal

State Data	2017	2018	2019
Numerator	733	687	618
Denominator	764	724	654
% Compliant	96%	95%	94%

Performance Measure:	The number and percent of service plans developed that involved participants and/or caregivers in the development process.
Numerator:	Number of service plans that involved participants and/or caregivers
Denominator:	Total number of service plans

State Data	2017	2018	2019
Numerator	651	616	348

Denominator	725	668	363
% Compliant	90%	92%	96%

Sub-Assurance: Service plans are updated/revised at least annually or when warranted by changes in waiver individual needs.

Performance Measure:	The number and percent of service plans revised on or before the annual review date.
Numerator:	Number of service plans revised
Denominator:	Total number of service plans needing revision

State Data	**2017**	**2018**	**2019**
Numerator	323	315	287
Denominator	332	324	296
% Compliant	97%	97%	97%

Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Performance Measure:	The number and percent of participants who received services as designated in the service plan.
Numerator:	Number of months for which providers delivering service and amount agreed = yes
Denominator:	Total months of waiver enrollment

State Data	**2017**	**2018**	**2019**
Numerator	8,335	7,918	6,773
Denominator	8,754	8,183	6,989
% Compliant	95%	97%	97%

Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measure:	The number and percent of participants afforded choice between/among waiver services and providers.
Numerator:	Number of participants afforded choice
Denominator:	Total number of participants

State Data	**2017**	**2018**	**2019**
Numerator	651	616	348
Denominator	725	668	363

% Compliant	90%	92%	96%

Performance Measure:	The number and percent of participants informed of their right to choose waiver services, from those that are available, that will best meet their needs as documented by a signed CLTC Rights and Responsibilities form.
Numerator:	Number of participants informed of their right to choose waiver services
Denominator:	Total number of participants

State Data	**2017**	**2018**	**2019**
Numerator	760	721	668
Denominator	806	754	690
% Compliant	94%	96%	97%

Sub-Assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation and unexplained death.

Performance Measure:	The number and percent of participants (and/or family or guardian) who received information on how to report abuse, neglect, exploitation and other reportable incident.
Numerator:	Number of participants documented to have received information/education on how to report abuse, neglect, exploitation and other reportable incident
Denominator:	Total number of participants

State Data	**2017**	**2018**	**2019**
Numerator	760	721	668
Denominator	806	754	690
% Compliant	94%	96%	97%

Performance Measure:	The number and percent of participants who report knowing how to report abuse, neglect, exploitation or other reportable incidents.
Numerator:	Number of participants who reported knowing how to report ANE
Denominator:	Total number of participants in sample

Waiver Performance Measures
HIV/AIDS Waiver
7/1/2016 – 6/7/2019

State Data	2019
Numerator	187
Denominator	193
% Compliant	97%

*During waiver year 2016/2017, a client satisfaction survey was designed and submitted for IRB approval. The survey sample started in waiver year two (2017 – 2018) and fully reportable results were available in waiver year three (2018 – 2019).

Sub-Assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measure:	The number and percent of reported incidents that are monitored until appropriate resolution.
Numerator:	Number of reported incidents that are monitored until appropriate resolution
Denominator:	Total number of reported incidents

State Data	2017	2018	2019
Numerator	0	8	3
Denominator	0	9	3
% Compliant	N/A	89%	100%

Performance Measure:	The number and percent of case managers who received training on their responsibilities as mandated reporters of abuse, neglect and exploitation.
Numerator:	Number of CM entity staff with documentation of training on abuse, neglect and exploitation and mandated reporter requirements
Denominator:	Total number of CM entity staff

State Data	**2017**	**2018**	**2019**
Numerator	92	86	92
Denominator	92	86	92
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of caregivers who experienced moderate to severe stress with caregiving and had appropriate interventions identified on the service plan.
Numerator:	Number of caregivers who experienced moderate to severe stress with caregiving and have appropriate interventions

Denominator:	Total number of caregivers

*There were no caregivers for HIV/AIDS waiver participants who reported moderate or severe stress.

Performance Measure:	The number and percent of direct care provider staff (Personal Care and Attendants) that are informed about mandated reporting requirements.
Numerator:	Number of direct care provider staff with documentation of training for staff on mandated reporting
Denominator:	Number of personnel records reviewed

State Data (personal care)	**2017**	**2018**	**2019**
Numerator	4,248	2,035	336
Denominator	4,865	2,277	2,035
% Compliant	87%	89%	86%

State Data (attendants)	**2017**	**2018**	**2019**
Numerator	2,435	2,387	2,330
Denominator	2,435	2,387	2,330
% Compliant	100%	100%	100%

Sub-Assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measure:	The number of unauthorized incidents of restrictive interventions that were appropriately reported.
Numerator:	Number of unauthorized incidents of restrictive interventions
Denominator:	Total number of reportable incidents

*During the reporting period, no incidents were reported.

Sub-Assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measure:	The number and percent of participants who have been evaluated for Emergency Disaster preparedness.
Numerator:	Number of participants who have an Emergency Disaster preparedness plan

Denominator:	Total number of participants

State Data	2017	2018	2019
Numerator	725	684	606
Denominator	800	751	687
% Compliant	91%	91%	88%

*As a result of the downward trend, SCDHHS created a training video for providers and staff that is available on demand.

Performance Measure:	The number and percent of participants indicating their health care needs are being addressed.
Numerator:	Number of participants indicating their current health care needs are being addressed (# of months "Yes")
Denominator:	Number of participants reviewed (full months of waiver enrollment)

State Data	2017	2018	2019
Numerator	8,335	7,918	6,773
Denominator	8,754	8,183	6,989
% Compliant	95%	97%	97%

Sub-Assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measure:	The number and percent of claims for waiver services submitted with the correct service code.
Numerator:	Number of claims submitted with correct service code.
Denominator:	Total number of claims

State Data	2017	2018	2019
Numerator	107,740	107,085	95,648
Denominator	107,740	107,085	95,648
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of paid waiver claims submitted for participants enrolled in the waiver program.
Numerator:	Number of paid waiver claims submitted
Denominator:	Total number of claims

Waiver Performance Measures
HIV/AIDS Waiver
7/1/2016 – 6/7/2019

State Data	2017	2018	2019
Numerator	107,740	107,085	95,648
Denominator	107,740	107,085	95,648
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of waiver claims using the EVV (electronic visit verification) to document service delivery.
Numerator:	Number of EVV claims submitted for payment
Denominator:	Total number of waiver claims paid for EVV services

State Data	2017	2018	2019
Numerator	75,792	80,287	69,765
Denominator	82,076	82,347	76,233
% Compliant	92%	97%	92%

Performance Measure:	The number and percent of cases for non-EVV services where participants indicated the service was provided.
Numerator:	Number of times participants indicated services were performed and billed (# months “yes”)
Denominator:	Total number of responses from participants (full months of waiver enrollment)

State Data	2017	2018	2019
Numerator	8,335	7,918	6,773
Denominator	8,754	8,183	6,989
% Compliant	95%	97%	97%

Sub-Assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Performance Measure:	The number and percent of waiver claims submitted with the correct rate as specified in the waiver application.
Numerator:	Number of claims submitted with the correct rate
Denominator:	Total number of claims

Waiver Performance Measures
HIV/AIDS Waiver
7/1/2016 – 6/7/2019

State Data	2017	2018	2019
Numerator	107,740	107,085	95,648
Denominator	107,740	107,085	95,561
% Compliant	100%	100%	100%

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Sub-assurance A-i:

Performance Measure:	Policy changes related to the ID/RD waiver are approved by SCDHHS prior to implementation.		
Numerator:	The number of waiver policy changes approved by SCDHHS prior to implementation.		
Denominator:	The total number of changes implemented.		
State Data	**WY 2017 01/01/17 – 12/31/17**	**WY 2018 01/01/18 – 12/31/18**	**WY 2019 01/01/19 – 09/30/19**
Sample Universe*: (entire population from which your sample is drawn)	**17**	**6**	**8**
Numerator (# compliant):	**17**	**6**	**8**
Sample Size* (denominator):	**17**	**6**	**8**
% Compliant (pre-remediation):	**100%**	**100%**	**100%**

Performance Measure:	LOC Initial Determinations are reviewed by the QIO Contractor as required by SCDHHS.		
Numerator:	# of LOC Initial Determinations that meet criteria		
Denominator:	Total # of Initial LOC Determinations reviewed		
State Data	**WY 2017 01/01/17 – 12/31/17**	**WY 2018 01/01/18 – 12/31/18**	**WY 2019 01/01/19 – 09/30/19**
Sample Universe*: (entire population from which your sample is drawn)	**170**	**254**	**188**
Numerator (# compliant):	**170**	**254**	**188**
Sample Size* (denominator):	**170**	**254**	**188**
% Compliant (pre-remediation):	**100%**	**100%**	**100%**

Performance Measure:	Adverse LOC Determinations are reviewed by the SCDHHS QIO Contractor as required by SCDHHS.		
Numerator:	# of Adverse LOC Determinations the Contractor agreed with		
Denominator:	The total # of Adverse LOC Determinations		
State Data	**WY2017 01/01/17 – 12/31/17**	**WY2018 01/01/18 – 12/31/18**	**WY2019 01/01/19 – 09/30/19**
Sample Universe*: (entire population from which your sample is drawn)	**4**	**2**	**2**
Numerator (# compliant):	**4**	**2**	**2**
Sample Size* (denominator):	**4**	**2**	**2**
% Compliant (pre-remediation):	**100%**	**100%**	**100%**

Performance Measure:	SCDHHS will conduct look behind reviews of the findings of the DDSN QIO Quality Contractor.		
Numerator:	# of records with consistent findings		
Denominator:	Total # of records reviewed		
State Data	**SFY2017**	**SFY2018**	**SFY2019**
Sample Universe*: (entire population from which your sample is drawn)	**10**	**72**	**9**
Numerator (# compliant):	**10**	**72**	**9**
Sample Size* (denominator):	**10**	**72**	**9**
% Compliant (pre-remediation):	**100%**	**100%**	**100%**

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Sub-assurance B-i

Performance Measure:	ID/RD waiver enrollees have a LOC Determination completed within 30 days prior to waiver enrollment.		
Numerator:	The number of new ID/RD waiver enrollees whose LOC Determination was completed within 30 days prior to waiver enrollment.		
Denominator:	The total number of LOC Determinations for new enrollees in the ID/RD waiver.		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	**1018**	**1289**	**861**
Numerator (# compliant):	**1018**	**1289**	**861**
Sample Size* (denominator):	**1018**	**1289**	**861**
% Compliant (pre-remediation):	**100%**	**100%**	**100%**
State Data	**WY 2017 01/01/17 – 12/31/17**	**WY 2018 01/01/18 – 12/31/18**	**WY 2019 01/01/19 – 09/30/19**
Sample Universe* (entire population from which your sample is drawn):	**1018**	**1289**	**861**
Numerator (# compliant):	**170**	**254**	**188**
Sample Size* (denominator):	**170**	**254**	**188**
% Compliant (pre-remediation):	**100%**	**100%**	**100%**

Sub-Assurance B-ii	While the state is still required to conduct annual re-evaluations for level of care, this sub-assurance is no longer required. Therefore, it is not included in the review.

Sub-assurance B-iii

Performance Measure:	LOC determinations are conducted using the appropriate criteria and instrument.		
Numerator:	The number of ID/RD waiver LOC determinations that were conducted using appropriate criteria and instrument.		
Denominator:	The total number of ID/RD waiver LOC determinations reviewed.		
State Data	**WY2017 01/01/17 – 12/31/17**	**WY2018 01/01/18 – 12/31/18**	**WY2019 01/01/19 – 09/30/19**
Sample Universe* (entire population from which your sample is drawn):	**174**	**256**	**190**
Numerator (# compliant):	**174**	**256**	**190**
Sample Size* (denominator):	**174**	**256**	**190**
% Compliant (pre-remediation):	**100%**	**100%**	**100%**

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Sub Assurance C-i

Performance Measure:	Waiver providers continue to meet required licensing, certification and other state standards.		
Numerator:	The number of existing providers that continue to meet required licensing, certification and other state standards.		
Denominator:	The number of existing providers reviewed		
State Data	**FY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):			
Numerator (# compliant):	SEE BREAKDOWN BELOW		
Sample Size* (denominator):			
% Compliant (pre-remediation):			

New waiver provider settings that meet required licensing, certification and other state standards prior to the provision of services.			
State Data	**FY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	74	50	55
Numerator (# compliant):	74	50	55
Sample Size* (denominator):	74	50	55
% Compliant (pre-remediation):	100%	100%	100%

Waiver provider settings that continue to meet required licensing, certification and other state standards prior to the provision of services.			
State Data	**FY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	1408	1416	1412
Numerator (# compliant):	1408	1416	1412
Sample Size* (denominator):	1408	1416	1412
% Compliant (pre-remediation):	100%	100%	100%
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	38	36	33
Numerator (# compliant):	38	36	33
Sample Size* (denominator):	38	36	33
% Compliant (pre-remediation):	100%	100%	100%

Performance Measure:	New providers meet required licensing, certification and other state standards prior to the provision of waiver services.		
Numerator:	The number of new providers who meet licensing, certification and other state standards.		
Denominator:	The number of individuals/entities who apply to become providers		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	45	78	72
Numerator (# compliant):	45	78	72
Sample Size* (denominator):	45	78	72
% Compliant (pre-remediation):	100%	100%	100%
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	74	50	55
Numerator (# compliant):	74	50	55
Sample Size* (denominator):	74	50	55
% Compliant (pre-remediation):	100%	100%	100%

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Sub-assurance C-ii

Performance Measure:	New non-licensed/non-certified providers meet waiver requirements prior to the provision of waiver services.		
Numerator:	The number of new non-licensed/non-certified waiver providers that meet waiver requirements prior to the provision of waiver services.		
Denominator:	The total number of new non-licensed/non-certified individuals/entities who apply to become providers		
State Data	**Separate SCDHHS Focus/Desk Review not completed**		
Sample Universe* (entire population from which your sample is drawn):			
Numerator (# compliant):			
Sample Size* (denominator):			
% Compliant (pre-remediation):			
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):			
Numerator (# compliant**):**	SEE BREAKDOWN BELOW		
Sample Size* (denominator):			
% Compliant (pre-remediation):			

Proportion of new and existing non-licensed/non-certified SCDDSN Contracted residential service provider staff that meet Waiver requirements.			
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	57	57	58
Numerator (# compliant):	29	32	46
Sample Size* (denominator):	33	40	48
% Compliant (pre-remediation):	87.9%	80%	95.8%

Proportion of new and existing non-licensed/non-certified SCDDSN Contracted day service provider staff that meet Waiver requirements.			
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	41	41	41
Numerator (# compliant):	25	27	34
Sample Size* (denominator):	26	29	38
% Compliant (pre-remediation):	96.2%	93.1%	89.5%

Proportion of new and existing non-licensed/non-certified SCDDSN Contracted Respite/In-Home Supports provider that meet Waiver requirements.			
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	41	41	41
Numerator (# compliant):	11	8	7
Sample Size* (denominator):	12	8	8
% Compliant (pre-remediation):	91.7%	100%	87.5%
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	680	556	564
Numerator (# compliant):	680	556	564
Sample Size* (denominator):	680	556	564
% Compliant (pre-remediation):	100%	100%	100%

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Performance Measure:	Waiver Case Managers meet required education and experience for employment.		
Numerator:	The number of waiver case managers who meet the required education and experience.		
Denominator:	The total number of waiver case managers reviewed		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your	25	289	281
Numerator (# compliant):	25	277	267
Sample Size* (denominator):	25	289	281
% Compliant (pre-remediation):	100%	95.8%	95%

Performance Measure:	Existing non-licensed/non-certified providers continue to meet waiver requirements.		
Numerator:	The number of existing non-licensed/non-certified waiver providers that meet waiver requirements		
Denominator:	the total number of existing non-licensed/non-certified providers reviewed.		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	12	8	8
Numerator (# compliant):	11	8	7
Sample Size* (denominator):	12	8	8
% Compliant (pre-remediation):	91.7%	100%	87.5%
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	2534	2490	2442
Numerator (# compliant):	2317	2395	2413
Sample Size* (denominator):	2534	2490	2442
% Compliant (pre-remediation):	91%	96%	99%

Sub-assurance C-iii

Performance Measure:	Providers meet training requirements as specified in the State's scope of service or other operational directive.		
Numerator:	The number of providers who meet training requirements		
Denominator:	The total number of providers reviewed		
State Data (CMs receiving training as required)	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	25	29	35
Numerator (# compliant):	25	22	31
Sample Size* (denominator):	25	29	35
% Compliant (pre-remediation):	100%	75.9%	88.6%
State Data (CMs receiving ANE training as	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	25	29	35
Numerator (# compliant):	20	21	29
Sample Size* (denominator):	25	29	35
% Compliant (pre-remediation):	80%	72.4%	82.9%

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Proportion of SCDDSN Contracted residential service providers that meet training requirements by provider type as specified by the State's scope of service or another operational directive.			
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	33	29	48
Numerator (# compliant):	15	19	33
Sample Size* (denominator):	33	29	48
% Compliant (pre- remediation):	45.5%	65.5%	68.8%

Proportion of SCDDSN Contracted Day Service Providers that meet training requirements by provider type as specified by the State's scope of service or another operational directive.			
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	26	29	38
Numerator (# compliant):	23	24	31
Sample Size*	26	29	38
% Compliant (pre- remediation):	88.5%	82.8%	81.6%

Proportion of SCDDSN Contracted Respite/ In-home Supports Service Providers that meet training requirements by provider type as specified by the State's scope of service or another operational directive.			
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	12	8	8
Numerator (# compliant):	8	8	7
Sample Size* (denominator):	12	8	8
% Compliant (pre- remediation)	66.7%	100%	87.5%

Sub-assurance D-i

Performance Measure:	Plans for ID/RD waiver participants include services, supports and goals that are consistent with assessed needs in accordance with waiver policy.		
Numerator:	The number of ID/RD participant plans reviewed that include services, supports and goals consistent with assessed needs.		
Denominator:	The total number of ID/RD waiver files reviewed.		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	10	72	9
Numerator (# compliant):	10	69	9
Sample Size* (denominator):	10	72	9
% Compliant (pre-remediation):	100%	96%	100%
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	210	294	253
Numerator (# compliant):	209	294	253
Sample Size* (denominator):	210	294	253
% Compliant (pre-remediation):	99.5%	99.3%	100%

Sub-Assurance D-ii	While the state is still required to monitor service plan development, this sub-assurance is no longer required. Therefore, it is not included in the review.

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Sub-assurance D-iii

Performance Measure:	Support plans for ID/RD waiver participants are developed at least annually and revised when warranted by a change in participant needs.		
Numerator:	The number of ID/RD participants whose new support plans were developed at least annually and revised when warranted by a change in participant needs		
Denominator:	The total number of ID/RD waiver files reviewed.		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	10	72	9
Numerator (# compliant):	10	69	9
Sample Size* (denominator):	10	72	9
% Compliant (pre-remediation):	100%	96%	100%
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	188	253	168
Numerator (# compliant):	156	201	154
Sample Size* (denominator):	188	253	168
% Compliant (pre-remediation):	83%	79.5%	91.7%

Sub-assurance D-iv

Performance Measure:	Participants receive services and supports in the type, amount, scope, frequency, and duration as specified in their plans, in accordance with waiver policy.		
Numerator:	The number of ID/RD participants who are receiving services and supports in the type, amount, scope, frequency, and duration as specified on the plan.		
Denominator:	the total number of ID/RD waiver files reviewed		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	210	297	252
Numerator (# compliant):	195	272	245
Sample Size* (denominator):	210	297	252
% Compliant (pre-remediation):	92.9%	91.6%	97.2%
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	10	72	9
Numerator (# compliant):	10	71	9
Sample Size* (denominator):	10	72	9
% Compliant (pre-remediation):	100%	99%	100%

Performance Measure:	Waiver Case Managers complete the first required non-face-to- face contact with the waiver participant/family within 30 days of waiver enrollment per policy.		
Numerator:	The number of required first non-face-to-face ID/RD contacts completed per policy.		
Denominator:	The total number of first required non-face-to-face contacts for waiver records reviewed		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	7277	7800	8127
Numerator (# compliant):	This indicator was not measured during the review period, as Waiver Case Management was not implemented and there was no corresponding Targeted Case Management Requirement.		
Sample Size* (denominator):			
% Compliant (pre-remediation):			

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Performance Measure:	Waiver Case Managers complete four (4) quarterly face-to-face visits with the ID/RD waiver participant/family during each plan year per policy.		
Numerator:	The number of completed quarterly face-to-face visits in the plan year		
Denominator:	The total number of all face-to-face visits required in the plan year per policy		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	7277	7800	8127
Numerator (# compliant):	This indicator was not measured during the review period, as Waiver Case Management was not implemented and there was no corresponding Targeted Case Management Requirement.		
Sample Size* (denominator):			
% Compliant (pre-remediation):			

Performance Measure:	Waiver Case Managers complete two (2) quarterly face-to-face visits with the participant/family in the home/natural environment during each plan year per policy.		
Numerator:	The number of completed quarterly face-to-face visits in the home/natural environment in the plan year.		
Denominator:	Total number of required quarterly face-to-face visits in the home/natural environment in the plan year per policy		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	7277	7800	8127
Numerator (# compliant):	This indicator was not measured during the review period, as Waiver Case Management was not implemented and there was no corresponding Targeted Case Management Requirement.		
Sample Size* (denominator):			
% Compliant (pre-remediation):			

Performance Measure:	ID/RD waiver participants are offered choice among qualified providers.		
Numerator:	The number of ID/RD participants who were offered choice of qualified providers		
Denominator:	the total number of ID/RD waiver files reviewed		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	130	164	64
Numerator (# compliant):	129	163	64
Sample Size* (denominator):	130	164	64
% Compliant (pre-remediation):	99.2%	99.4%	100%
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	10	72	9
Numerator (# compliant):	9	72	9
Sample Size* (denominator):	10	72	9
% Compliant (pre-remediation):	90%	100%	100%

Sub-assurance G-i

Performance Measure:	Incidents of abuse, neglect, or exploitation (ANE) and unexplained deaths (UD) for ID/RD waiver participants are reported within the required timeframe.		
Numerator:	The number of ID/RD waiver incidents of ANE and UD that were reported within the required timeframe.		
Denominator:	Total number of ID/RD waiver reports of ANE and UD.		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	313	343	345
Numerator (# compliant):	218	242	232
Sample Size* (denominator):	313	343	345
% Compliant (pre- remediation):	70%	71%	67%

Performance Measure:	ID/RD waiver participants with substantiated incidents of abuse, neglect, and exploitation (ANE).		
Numerator:	The number of substantiated incidents of ANE for ID/RD waiver participants		
Denominator:	The total number of reported incidents of ANE for ID/RD waiver participants.		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	313	343	345
Numerator (# compliant):	6	16	8
Sample Size* (denominator):	313	343	345
% Compliant (pre- remediation): Percentage of	1.9%	6.4%	2.3%

Performance Measure:	ID/RD participants/legal guardians receive information yearly about how to report ANE.		
Numerator:	The number of ID/RD participants/legal guardians who receive information yearly		
Denominator:	The total number of ID/RD waiver participants reviewed.		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	210	295	246
Numerator (# compliant):	204	286	237
Sample Size* (denominator):	210	295	246
% Compliant (pre- remediation):	97.1%	96.6%	96.3%

Performance Measure:	Staff serving ID/RD waiver participants with substantiated allegations of ANE against them are terminated according to policy.		
Numerator:	The number of staff serving ID/RD waiver participants terminated for having a substantiated allegation of ANE.		
Denominator:	Total number of staff serving waiver participants involved in ANE reports where allegations were substantiated against them		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	6	23	9
Numerator (# compliant):	6	23	9
Sample Size* (denominator):	6	23	9
% Compliant (pre- remediation): Staff with	100%	100%	100%

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Performance Measure:	Unusual/unexplained deaths for ID/RD waiver participants are referred to appropriate State investigative agencies for additional review.		
Numerator:	Number of death report reviews for ID/RD waiver participants that result in an ANE or Critical Incident investigations due to unusual/unexplained circumstances		
Denominator:	Total number of death reviews for all waiver participants in DDSN-operated waivers		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	56	46	57
Numerator (# compliant):	56	46	57
Sample Size*	56	46	57
% Compliant (pre- remediation):	100%	100%	100%

Sub-assurance G-ii

Performance Measure:	Critical incidents for ID/RD waiver participants are reported on the incident management system.		
Numerator:	The number of ID/RD participants with critical incidents reported on the incident management system		
Denominator:	The total number of critical incidents for all waiver participants using the incident management system		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your	1422	468	779
Numerator (# compliant):	1202	338	664
Sample Size* (denominator):	1422	468	779
% Compliant (pre-remediation):	84.5%	72.3%	85.2%

Sub-assurance G-iii

Performance Measure:	ID/RD waiver participants with reported incidents of restrictive interventions that are inconsistent with policy.		
Numerator:	The number of ID/RD waiver participants with reported incidents of restrictive interventions that are inconsistent with policy.		
Denominator:	The total number of ID/RD waiver files reviewed		
State Data	**SFY 2017**	**SFY 2018**	**SFY 2019**
Sample Universe* (entire population from which your sample is drawn):	20	12	9
Numerator (# compliant):	20	12	5
Sample Size* (denominator):	20	12	9
% Compliant (pre-remediation):	100%	100%	55.6%

Sub-assurance G-iv

Performance Measure:	ID/RD waiver participants report access to healthcare services as listed on the person-centered plan/assessment per waiver policy.		
Numerator:	The number of ID/RD waiver participants who report access to healthcare services		
Denominator:	The total number of ID/RD waiver files reviewed		
State Data	**SFY17**	**SFY18**	**SFY19**
Sample Universe* (entire population from which your sample is drawn):	7277	7800	8127
Numerator (# compliant):	8589	8780	8056
Sample Size* (denominator):	8789	8955	8212
% Compliant (pre-remediation):	97.7%	98.0%	98.1%

Waiver Performance Measures
Intellectually Disabled/Related Disabilities Waiver

Sub-assurance I-i

Performance Measure:	Number of ID/RD participant claims paid in accordance with waiver or Medicaid policies.		
Numerator:	The number of ID/RD participant waiver claims that paid correctly as determined through record reviews		
Denominator:	The total number of claims for ID/RD waiver participants reviewed		
State Data	**WY 2017**	**WY 2018**	**WY 2019**
Sample Universe* (entire population from which your sample is drawn):	1454	605	1481
Numerator (# compliant):	1440	598	1466
Sample Size* (denominator):	1454	605	1481
% Compliant (pre-remediation):	99%	98.8%	98.9%

Sub-assurance I-ii

Performance Measure:	Number of ID/RD waiver service rates that remain consistent with approved methodology.		
Numerator:	The number of ID/RD service rate changes		
Denominator:	The total number of ID/RD waiver service rates		
State Data	**WY 2017 01/01/2017 - 12/31/2017**	**WY 2018 01/01/2018 - 12/31/2018**	**WY 2019 01/01/2019 - 12/31/2019**
Sample Universe* (entire population from which your	46	46	46
Numerator (# compliant):	13	12	6
Sample Size* (denominator):	13	12	6
% Compliant (pre-remediation):	100%	100%	100%

Waiver Performance Measures
Medically Complex Children Waiver
1/1/2017 – 12/31/2019

Sub-Assurance: An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

Performance Measure:	The number of new waiver applicants who met LOC prior to waiver enrollment.
Numerator:	The number of new waiver applicants who met LOC prior to waiver enrollment
Denominator:	The total number of new applicants who enrolled

State Data	**2017**	**2018**	**2019**
Sample Universe	447	448	440
Numerator	447	448	440
Denominator	447	448	440
% Compliant	100%	100%	100%

Sub-Assurance: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.

Performance Measure:	The number of participants whose initial LOC determination was conducted using the correct instruments and process.
Numerator:	Number of participants whose initial LOC was conducted using the correct instrument and process
Denominator:	The total number of initial LOC determinations reviewed

State Data	**2017**	**2018**	**2019**
Sample Universe	814	840	869
Numerator	814	840	869
Denominator	814	840	869
% Compliant	100%	100%	100%

Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.

Performance Measure:	The number and percent of new enrolled/contracted providers who meet licensure, standards, and/or qualifications prior to the delivery of services.

Numerator:	Number of new/enrolled contracted providers who meet licensure, standards, and/or other qualifications prior to the delivery of services
Denominator:	Total number of providers who enroll/contract

*During the reporting period for this report there were no new providers enrolled with SCDDHS to provide the approved waiver services.

Performance Measure:	The number and percent of existing enrolled/contracted providers who meet licensure, standards, and/or other qualifications on an ongoing basis.
Numerator:	Number of existing contracted providers who meet licensure, standards, and/or other qualifications prior to the delivery of services
Denominator:	Total number of providers reviewed

State Data	**2017**	**2018**	**2019**
Sample Universe	2	2	2
Numerator	2	2	2
Denominator	2	2	2
% Compliant	100%	100%	100%

Sub-Assurance: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure:	The number and percent of providers whose staff meet the training requirements.
Numerator:	Number of providers whose staff meet training requirements
Denominator:	Total number of provider staff reviewed

State Data	**2017**	**2018**	**2019**
Sample Universe	37	44	47
Numerator	37	44	47
Denominator	37	44	47
% Compliant	100%	100%	100%

Sub-assurance: Service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measure:	The number and percent of participant plans that include services consistent with the needs and goals identified in the assessment.

Numerator:	Plans that include needs and goals identified on the assessment
Denominator:	Total number of plans reviewed

State Data	2017	2018	2019
Sample Universe	1267	1446	1600
Numerator	1217	1337	1470
Denominator	1217	1337	1470
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of person-centered service plans that were updated within every 364 days or as needs changed.
Numerator:	Number of person-centered plans that were updated within every 364 days or as needs changed
Denominator:	Total number of plans reviewed

State Data	2017	2018	2019
Sample Universe	1267	1446	1600
Numerator	696	804	885
Denominator	768	885	930
% Compliant	91%	91%	95%

Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Performance Measure:	The number and percent of person-centered service plans that include provider type, service, amount, frequency and duration.
Numerator:	Number of plans that include provider type, service, amount, frequency and duration
Denominator:	Total number of plans reviewed

State Data	2017	2018	2019
Sample Universe	1267	1446	1600
Numerator	1217	1337	1470
Denominator	1217	1337	1470
% Compliant	100%	100%	100%

Performance Measure:	The number and percent of participants/responsible parties who received

	face to face contact with the Care Coordinator within the required timeframe.
Numerator:	Number of quarterly face to face contacts conducted
Denominator:	Total number of face to face contacts required

State Data	**2017**	**2018**	**2019**
Sample Universe	1074	1265	1413
Numerator	1054	1249	1443
Denominator	1074	1265	1413
% Compliant	93%	95%	97%

Performance Measure:	The number and percent of participants/responsible parties who received non-face to face contact with the Care Coordinator within the required timeframe.
Numerator:	Number of monthly non- face to face contacts conducted
Denominator:	Total number of non-face to face contacts required

State Data	**2017**	**2018**	**2019**
Sample Universe	1145	1304	1468
Numerator	1108	1289	1444
Denominator	1145	1304	1452
% Compliant	98%	98%	99%

Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measure:	The number and percent of participants/responsible parties who were offered choice among services and qualified providers.
Numerator:	Number of provider choice forms offered
Denominator:	Total number of case files reviewed

State Data	**2017**	**2018**	**2019**
Sample Universe	1267	1446	1600
Numerator	278	285	297
Denominator	300	305	310
% Compliant	93%	93%	95%

Waiver Performance Measures
Medically Complex Children Waiver
1/1/2017 – 12/31/2019

Sub-Assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation and unexplained death.

Performance Measure:	The number and percent of incidents of reported abuse, neglect, exploitation (ANE) and unexplained deaths (UD).
Numerator:	Number of incidents of MCC waiver ANE and UD reported
Denominator:	Total number of MCC waiver participants

State Data	**2017**	**2018**	**2019**
Sample Universe	1267	1446	1600
Numerator	12	19	9
Denominator	1267	1446	1600
% Compliant	0.9%	1.3%	0.5%

*This measure is currently being revised to better address the performance assurance requirement.

Performance Measure:	The number and percent of MCC waiver participants with reports of ANE or UD whose internal review was completed within the required timeframe.
Numerator:	Number and percent of MCC waiver participants with reports of ANE or UD whose internal review was completed within the required timeframe
Denominator:	Total number of MCC ANE or UD allegations

State Data	**2017**	**2018**	**2019**
Sample Universe	12	19	9
Numerator	12	19	9
Denominator	12	19	9
% Compliant	100%	100%	100%

Sub-Assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measure:	The number and percent of critical incidents reported (including mortality and injuries).
Numerator:	Number of critical incidents reported including mortality and injuries for MCC waiver participants
Denominator:	Total number of MCC participants

State Data	**2017**	**2018**	**2019**
Sample Universe	1267	1446	1600
Numerator	6	7	2

Denominator	1267	1446	1600
% Compliant	0.4%	0.4%	0.1%

*This measure is currently being revised to align more closely with the waiver assurance requirement.

Performance Measure:	The number and percent of MCC participants/responsible parties who report complaints.
Numerator:	Number of participants/responsible parties who report complaints
Denominator:	Total number of case records reviewed

State Data	**2017**	**2018**	**2019**
Sample Universe	1267	1446	1600
Numerator	6	13	10
Denominator	1267	1446	1600
% Compliant	0.4%	0.8%	0.6%

*This measure is currently being revised to align more closely with the waiver assurance requirement.

Performance Measure:	**The number and percent of MCC critical incident allegations reviewed within the required timeframe.**
Numerator:	Number of MCC critical incident allegations reviewed within the required timeframe
Denominator:	Total number of MCC critical incident allegations

State Data	**2017**	**2018**	**2019**
Sample Universe	9	12	7
Numerator	9	12	7
Denominator	9	12	7
% Compliant	100%	100%	100%

Sub-Assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measure:	The number of unauthorized incidents of restrictive interventions that were appropriately reported.
Numerator:	Number of unauthorized incidents of restrictive interventions that were appropriately reported
Denominator:	Total number of restrictive interventions for MCC waiver participants

State Data	**2017**	**2018**	**2019**
Sample Universe	1267	1446	1600

Numerator	286	293	304
Denominator	300	305	310
% Compliant	95%	96%	98%

Sub-Assurance: The state establishes overall health care standards and monitors those.

Performance Measure:	The number and percent of MCC waiver participants who have been evaluated for Emergency/Natural Disaster preparedness.
Numerator:	Number of participants who have an Emergency/Natural Disaster preparedness plan
Denominator:	Total number of participant plans reviewed.

State Data	**2017**	**2018**	**2019**
Sample Universe	1267	1446	1600
Numerator	278	285	297
Denominator	300	305	310
% Compliant	93%	93%	95%

Sub-Assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measure:	The number and percent of MCC claims that process through MMIS and pay according to approved reimbursement methodology.
Numerator:	Number of MCC claims that process through MMIS and pay correctly
Denominator:	Total number of claims reviewed

State Data	**2017**	**2018**	**2019**
Sample Universe	35642	44033	57953
Numerator	500	500	500
Denominator	500	500	500
% Compliant	100%	100%	100%

Sub-Assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Performance Measure:	The number and percent of waiver claims submitted with the correct rate as specified in the approved waiver document/contracts.
Numerator:	Number of claims using the correct rate
Denominator:	Total number of claims reviewed

Waiver Performance Measures
Medically Complex Children Waiver
1/1/2017 – 12/31/2019

State Data	2017	2018	2019
Sample Universe	35642	44033	57953
Numerator	500	500	500
Denominator	500	500	500
% Compliant	100%	100%	100%

STATE	CPT CODE	BILLING FREQUENCY	PROVIDER TYPE	RATE PER UNIT
Alabama	97151	15 min		$ 25.00
	97153	15 min		$ 10.00
	97155	15 min		$ 5.00
	97156	15 min		$ 30.00
Florida	H0031 (97151)	Max. 1 per recipient per fiscal year		$ 385.19
	H2014 (97153)		Technician	$ 12.19
	H2019 (97155)		Lead Analyst	$ 19.05
	H2012 (97155)		Assistant Behavior Analyst	$ 15.24
	97156			$ -
Georgia	97151	15 min	U1: Service Location U6	$ 58.21
	97151	15 min	U2: Service Location U6	$ 38.97
	97151	15 min	U3: Service Location U6	$ 30.01
	97151	15 min	U1: Service Location GT	$ 58.21
	97151	15 min	U2: Service Location GT	$ 38.97
	97151	15 min	U3: Service Location GT	$ 30.01
	97151	15 min	U1: Service Location U7	$ 74.09
	97151	15 min	U2: Service Location U7	$ 46.76
	97151	15 min	U3: Service Location U7	$ 36.68
	97153	15 min	U1: Service Location U6	$ 58.21
	97153	15 min	U2: Service Location U6	$ 38.97
	97153	15 min	U3: Service Location U6	$ 30.01
	97153	15 min	U4: Service Location U6	$ 20.30
	97153	15 min	U5: Service Location U6	$ 15.13
	97153	15 min	U1: Service Location GT	$ 58.21
	97153	15 min	U2: Service Location GT	$ 38.97
	97153	15 min	U3: Service Location GT	$ 30.01
	97153	15 min	U4: Service Location GT	$ 20.30
	97153	15 min	U5: Service Location GT	$ 15.13
	97153	15 min	U1: Service Location U7	$ 74.09
	97153	15 min	U2: Service Location U7	$ 46.76
	97153	15 min	U3: Service Location U7	$ 36.68
	97153	15 min	U4: Service Location U7	$ 24.36
	97153	15 min	U5: Service Location U7	$ 18.15
	97155	15 min	U1: Service Location U6	$ 58.21
	97155	15 min	U2: Service Location U6	$ 38.97
	97155	15 min	U3: Service Location U6	$ 30.01
	97155	15 min	U1: Service Location GT	$ 58.21
	97155	15 min	U2: Service Location GT	$ 38.97
	97155	15 min	U3: Service Location GT	$ 30.01
	97155	15 min	U1: Service Location U7	$ 74.09
	97155	15 min	U2: Service Location U7	$ 46.76
	97155	15 min	U3: Service Location U7	$ 36.68
	97156	15 min	U1: Service Location U6	$ 21.90
	97156	15 min	U2: Service Location U6	$ 17.01
	97156	15 min	U3: Service Location U6	$ 13.21
	97156	15 min	U1: Service Location GT	$ 21.90
	97156	15 min	U2: Service Location GT	$ 17.01
	97156	15 min	U3: Service Location GT	$ 13.21
	97156	15 min	U1: Service Location U7	$ 26.72
	97156	15 min	U2: Service Location U7	$ 20.78
	97156	15 min	U3: Service Location U7	$ 16.51

U1:Physician, Psychiatrist
U2: Psychologist, BCBA-D
U3: BCBA
U4: BCaBA or Master's Level Behavior Analyst
U5: Registered Behavior Technician

Location Services:
U6: In-Clinic
U7: Out-of-Clinic
GT: Telemedicine

Kentucky	97151	15 min	Psychiatrist, MD/DO	$ 25.40
	97151	15 min	APRN, Licensed Clinical Pyschologist, PA	$ 21.59
	97151	15 min	Licensed Masters Level Supervisor	$ 20.32
	97151	15 min	Associate	$ 17.78
	97153	15 min	PSS, RBT	$ 11.25
	97155	15 min	Psychiatrist, MD/DO	$ 25.40
	97155	15 min	APRN, Licensed Clinical Pyschologist, PA	$ 21.59
	97155	15 min	Licensed Masters Level Supervisor	$ 20.32
	97155	15 min	Associate	$ 17.78
	97156	15 min	Psychiatrist, MD/DO	$ 19.72
	97156	15 min	APRN, Licensed Clinical Pyschologist, PA	$ 16.75
	97156	15 min	Licensed Masters Level Supervisor	$ 15.78
	97156	15 min	Associate	$ 13.80
Maryland	97151	15 min. Daily max 32 units	Psychologist, BCBA-D, BCBA	$ 27.50
	97153	15 min. daily max 32 units	Psychologist/BCBA-D/BCBA/BCaBA/RBT	P & BA - $17.50 BB - $15 RBT-$13.75
	97155	15 min. daily max 24 units	BCBA-D, BCBA	$27.50
	97156	15 min. daily max 16 units	Psych/BCBA-D/BCBA/BCaBA	P & BA - $15 BB - $8.75
	97156 (U2)	15 min. daily max 16 units	Psych/BCBA-D/BCBA/BCaBA	P & BA - $27.50 BB - $15
Mississippi	97151	Max. 32 units	Physician, QHP	$ 34.18
	97153	Max. 8 units	Technician	$ 8.14
	97155	Max. 24 units	Physician, QHP	$ 19.92
	97156	Max. 16 units	Physician, QHP	$ 14.14
North Carolina	97151	per 15 min	Physician, QHP	$ 19.31
	97153	per 15 min	Technician	$ 17.50
	97155	per 15 min	Physician, QHP	$ 17.50
	97156	per 15 min	Physician, QHP	$ 16.91
South Carolina	97151	15 min	BCBA/BCaBA	$ 23.51
	97153	15 min	BCBA, BCaBA, RBT	$ 8.64
	97155	15 min	BCBA/BCaBA	$ 15.74
	97156	15 min	BCBA, BCaBA	$ 15.74
Virginia	97151	Contracted Rate	Contracted Rate	Contracted Rate
	97153	Contracted Rate	Contracted Rate	Contracted Rate
	97155	Contracted Rate	Contracted Rate	Contracted Rate
	97156	Contracted Rate	Contracted Rate	Contracted Rate
West Virginia	97151	15 min	BCBA/BCaBA, Direct Service, PA Required, Face to Face, 1:1	$ 29.14
	97153	15 min	RBT/BAT, PA Required, Face to Face 1:1 Service	$ 9.90
	97155	15 min	BCBA/BCaBA, PA Required, Face to Face, 1:1	$ 29.14
	97156	15 min	BCBA/BCaBA, PA Required, Face to Face 1:1 service	$ 17.43