HEALTHCARE AND REGULATORY SUBCOMMITTEE
MONDAY, APRIL 19, 2021

Table of Contents

AGENDA

South Carolina
House of Representatives

Legislative Oversight Committee

HEALTHCARE AND REGULATORY SUBCOMMITTEE
The Honorable John Taliaferro "Jay" West, IV, Chair
The Honorable Gil Gatch
The Honorable Rosalyn D. Henderson-Myers
The Honorable Timothy A. "Tim" McGinnis

Monday, April 19, 2021
2PM
110 - Blatt Building

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

AGENDA

I. Approval of minutes

II. Discussion of the study of the Department of Health and Human Services

III. Adjournment

MINUTES

Healthcare and Regulatory Subcommittee

Monday, March 8, 2021
2:00 p.m.
Blatt Room 110

Archived Video Available

I. Pursuant to House Legislative Oversight Committee Rule 6.7, South Carolina ETV was allowed access for streaming the meeting. You may access an archived video of this meeting by visiting the South Carolina General Assembly's website (http://www.scstatehouse.gov) and clicking on *Committee Postings and Reports*, then under *House Standing Committees* click on *Legislative Oversight*. Then, click on *Video Archives* for a listing of archived videos for the Committee.

Attendance

I. The Healthcare and Regulatory Subcommittee meeting was called to order by Chair John Taliaferro (Jay) West, IV on Monday, March 8, 2021, in Room 110 of the Blatt Building. Subcommittee members include Representative Gil Gatch; Representative Rosalyn Henderson-Myers; and Representative Timothy (Tim) McGinnis. All members of the Subcommittee, except Representative McGinnis, were present for either all or a portion of the meeting. Representative Gatch participation virtually via Microsoft Teams. Representative McGinnis was absent attending to constituent business in Horry County.

Minutes

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

II. Representative Henderson-Myers moves to approve the minutes from the July 28, 2020, meeting. Chair West notes the July 28, 2020, was a high-level overview of agency operations. A roll call vote is held, and the motion passes.

Rep. motion to approve the minutes from the July 28, 2020, meeting:	Yea	Nay	Not Voting
Rep. Gatch	✓		
Rep. Henderson-Myers	✓		
Rep. McGinnis			Not Present
Rep. West	✓		

Discussion of the Department of Health and Human Services

I. Chair West swears in Mr. T. Clark Phillip,,Jr., Acting Director ; Ms. Nicole Threatt, Deputy Director of Eligibility, Enrollment and Member Services; and Mr. Julius Covington, Policy Analyst.

II. Other agency leadership present at the meeting include:

a. Ms. Jenny Stirling, Legislative Liaison;

b. Mr. Jeff Leieritz, Director of External Affairs; and;

c. Ms. Lori Risk, Policy and Process Director;

III. Ms. Threatt provides comments related to eligibility for South Carolina Healthy Connections Medicaid, including:

a. Purpose – mission, principles, and goals;

b. Program Evaluation Report Information;

c. agency eligibility overview;

d. organizational structure;

e. eligibility operations;

f. Medicaid benefits and funding;

g. basis of eligibility;

h. application and review process;

i. appeals process;

j. agency data;

k. COVID-19 impact; and

l. initiatives and outlook.

IV. Subcommittee members ask questions relating to the following:

a. Children's Health Insurance Program (CHIP) program;

b. Resource limits;

c. Comparison of South Carolina's Medicaid with other states;;

d. Staffing levels;;

e. Communication with other federal and state agencies;;

f. Specialty categories;

Mr. Phillip, Mss. Threatt, and Mr. Covington respond to those questions.

V. Subcommittee members note questions to include in a follow up letter to the agency.

Conclusion

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

STUDY TIMELINE

Timeline of Agency Study

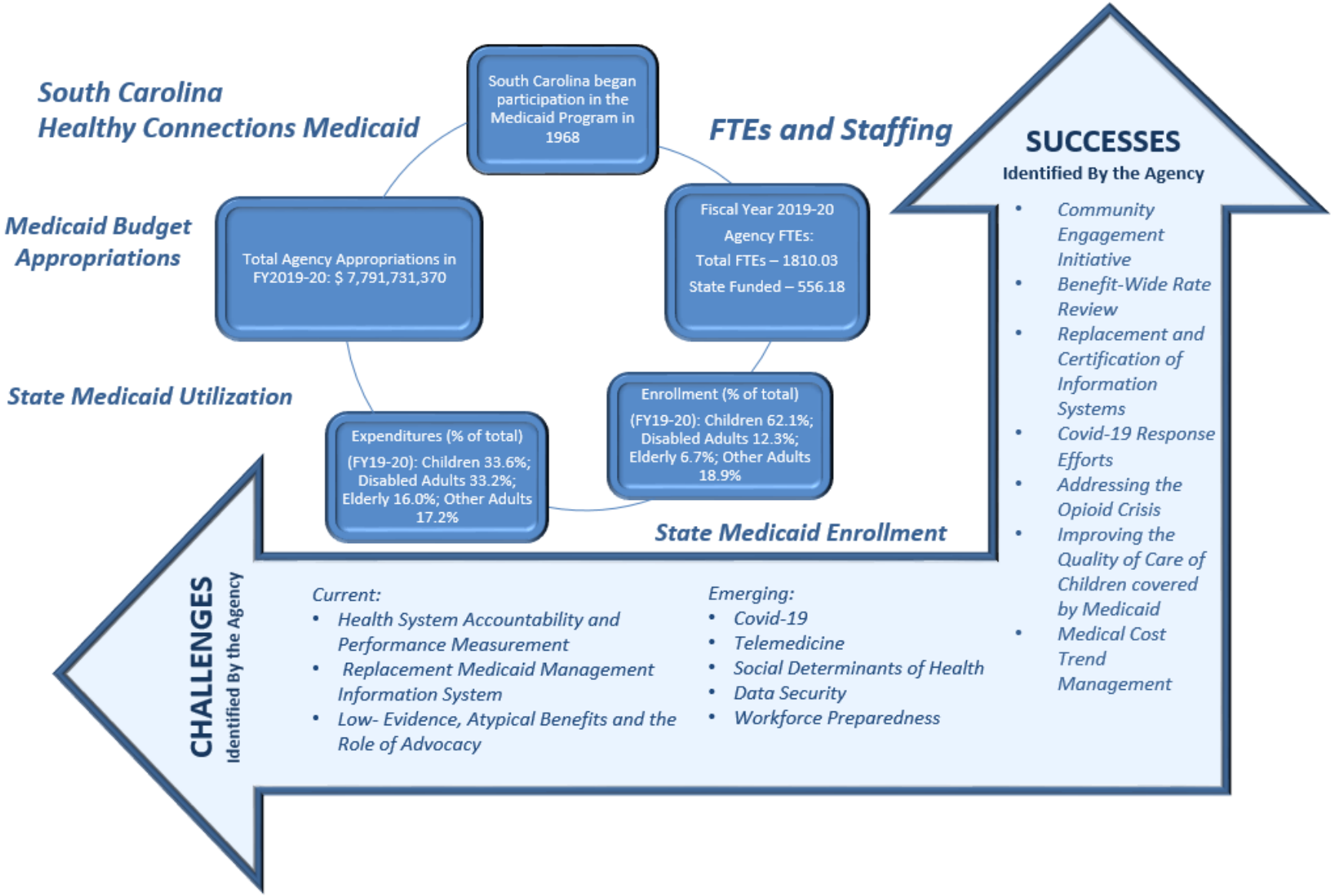
The House Legislative Oversight Committee's (Committee) process for studying the Department of Health and Human Services (agency, Department, or DHHS) includes actions by the full Committee; Healthcare and Subcommittee (Subcommittee); the agency; and the public. Key dates and actions are listed below.

December 9, 2019	At **Meeting 1,** the **Committee selects the Department of Health and Human Services** as the next agency for the Healthcare and Regulatory Subcommittee to study.
January 15, 2020	The Committee provides the agency with notice about the oversight process.
February 28 – April 1, 2020	The Committee solicits input from the public about the agency in the form of an **online public survey**.
June 2, 2020	The Department of Health and Human Services submits its Program Evaluation Report.
July 28, 2020	The Subcommittee holds **Meeting 2** with the agency to discuss an overview of its mission, history, resources, major programs, successes, challenges, and emerging issues.
March 8, 2021	The Subcommittee holds **Meeting 3** with the agency to discuss South Carolina Healthy Connections Medicaid eligibility.
April 8, 2021	At **Meeting 4** the Committee receives public input about the agency.
April 19, 2021	The Subcommittee holds **Meeting 5** with the agency to discuss Medicaid financing.

Figure 3. Summary of key dates and actions in the study process

AGENCY SNAPSHOT

Department of Health and Human Services



AGENCY FOLLOW-UP LETTER

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
T. Clark Phillip ACTING DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

April 16, 2021

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

RE: Follow-up from March 8, 2021 Subcommittee Meeting

Dear Representative West:

Please see below in response to your follow-up questions from the March 8, 2021 Healthcare and Regulatory Subcommittee meeting.

Medicaid State Plan

1. Please elaborate on what flexibility South Carolina has from the federal Centers for Medicaid and Medicare Services (CMS) with developing the state plan.

   The State Plan is a formal, written agreement between the state and federal government, submitted by the single state agency to CMS for approval, describing how the state administers its Medicaid program. The federal government mandates coverage of certain services, programs and populations while leaving some optional. CMS issues various forms of guidance to explain how laws will be implemented and what states need to do to be in compliance. States, including South Carolina, have the flexibility to submit state plan amendments (SPAs) for optional services and populations to CMS for review and approval. These SPAs include program policies, operational approaches, or other permissible program changes. They can also include updates or corrections as deemed necessary for eligibility coverage, service provisions, provider reimbursement and administrative activities. In addition, states can further tailor services to people who might not otherwise be eligible under Medicaid through various waiver program authorities. An overview of SCDHHS waiver programs will be provided in a later presentation in this series.

Medicaid Data and Demographics

2. During the meeting, agency leadership mentioned that the Department of Health and Human Services (DHHS) is a source of population data.

   a. Who is permitted to access this data?

Population data is available to the public on SCDHHS' website. The agency also regularly shares appropriate data upon request with other organizations including partner state agencies, community-based organizations, academic and research partners, CMS and the media.

b. What type of data can be shared?

De-identified aggregate data can be shared and is available on SCDHHS' website.

3. Does South Carolina's Medicaid population look similar to other states in the southeast? Please provide data to support your response.

Using data from Medicaid.gov and state population data from the U.S. Census Bureau, about 20% of the population in each state in the southeast is enrolled in Medicaid. Using the same data source, children represent anywhere from 57-70% of the Medicaid population in southeastern states. The numbers in the table below are in millions.

Percentage of State's Population Enrolled in Medicaid

	Medicaid Enrollment	State Population	% of State's Population Enrolled in Medicaid	% of Medicaid Enrollment that is Children/CHIP
SC	1.09 million	5.15 million	21.2%	61.8%
NC	1.92 million	10.49 million	18.3%	64.8%
GA	2.00 million	10.62 million	18.8%	69.8%
AL	0.98 million	4.90 million	20.0%	69.9%
MS	0.66 million	2.98 million	22.1%	67.8%
TN	1.54 million	6.83 million	22.5%	56.4%
FL	4.00 million	21.48 million	18.6%	65.4%

Sources: Centers for Medicare and Medicaid Services; U.S. Census Bureau
Medicaid data as of September 2020

4. Please provide the total number of residents per county and total number of Medicaid beneficiaries by county.

The attached table includes a breakdown of Healthy Connections Medicaid members by county and U.S. Census Bureau estimates for population by county.

5. Testimony was received indicating the South Carolina Medicaid program has approximately 1.1 million full benefit beneficiaries (20% of population).
   a. What percentage of South Carolinians will likely qualify for Medicaid benefits at some point in their life?

In any given month, approximately 20% of South Carolina's population is enrolled in the Healthy Connections Medicaid program as a full-benefit Medicaid member. This number increases to approximately 25% of the state's population when looking at South Carolinians who were enrolled for at least one month throughout the fiscal year.

While uncertainty in economic conditions, demographic changes and other extenuating factors makes it hard to predict how many may qualify for Medicaid benefits at some point during their lifetime, SCDHHS does track what percent of those who are eligible for full-benefit Medicaid coverage are enrolled in the program. Over the past several years, approximately 90% of children who meet income limits for Medicaid in South Carolina have been enrolled in any given month. This percentage is in line with state Medicaid data across the country. Similarly, between 60-70% of adults who are eligible for full-benefit Medicaid coverage are enrolled in any given month. This percentage is currently higher than its historical trend due to the suspension of annual reviews required by the Families First Coronavirus Response Act (FFCRA).

Organizational Structure and Processes

6. Agency leadership mentioned the organizational structure of Eligibility, Enrollment, and Member Services (EEMS) could be improved. What initiatives will the agency implement to improve the organizational structure of EEMS?

   Changes to EEMS' organizational structure have been designed to create a seamless continuum through the Medicaid application and enrollment process for Healthy Connections Medicaid applicants. This begins with application submission and extends through the financial determination, completion of a medical determination and enrollment in services for those who are determined eligible for Medicaid. This improved organizational structure and collaboration across EEMS functional areas allows for the coordination of policies and procedures and helps to promote a positive customer experience.

   The agency is constantly evaluating workloads at both a regional and statewide level to identify potential efficiencies that support the goal mentioned above. This includes identifying work, such as case assignments and application processing, that can be performed at a statewide level and does not require increased staffing or resources in an individual county or area office; and work, such as level-of-care assessments, that do need to be performed at a local level but may be able to be performed by staff located in a neighboring area office.

   In addition, the agency is continuing to post and backfill positions and explore other incentives, such as flexible work schedules to hire for hard-to-fill positions.

7. Please provide a staff allocation plan for the division of EEMS.

   The agency utilizes a dynamic approach to hiring and staff allocation, that allows it to maximize staffing resources, based on the volume of statewide work regardless of work type or geographical location. This approach helps to minimize hiring challenges as the agency must compete for similarly skilled candidates with large regional health care providers in some counties. This more centralized approach also allows for resources to be shifted as needed, based on demand.

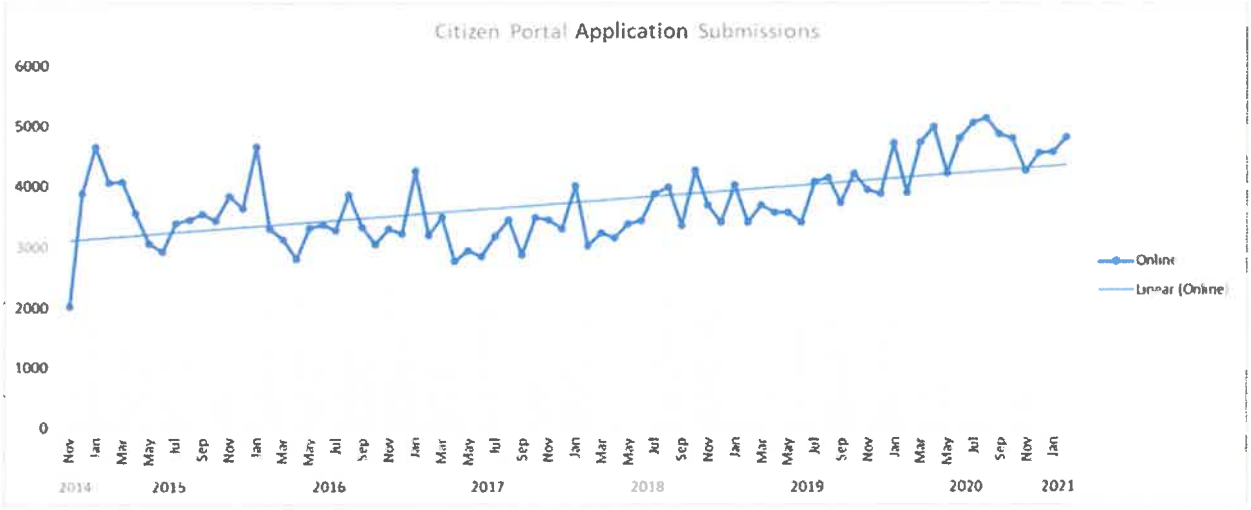
8. Has online acceptance of applications, which began in 2014, improved the efficiency and timeliness of processing applications?

Through SCDHHS' online Citizen Portal (CP), the agency has been able to reduce the amount of time it takes for a member to receive a Medicaid determination while also reducing the effort required by SCDHHS staff to make accurate eligibility determinations.

The CP was launched Oct. 1, 2013, allowing citizens to apply for Medicaid benefits online. Since that time, SCDHHS has implemented several enhancements to offer increased functionality to CP users. Features of these enhancements include:

- *Automating several types of modified adjusted gross income (MAGI) eligibility determinations;*
- *Enabling "straight-through" processing when an applicant's information can be automatically verified through other state or federal data sources. When needed information can be verified through this process, applications can be processed the same day they were received without any action required by an EEMS staff member;*
- *Automatically generating and mailing request for information notices to Healthy Connections Medicaid members who could not be processed straight-through, as well as automatically denying applications where requested information was not returned by the applicant;*
- *Allowing Healthy Connections Medicaid members to securely update their own information online;*
- *Allowing Healthy Connections Medicaid members to add household members to their case online;*
- *Allowing Healthy Connections Medicaid members and applicants to view eligibility notices and other communications online;*
- *Improving ability to automatically ingest and process applications received from the Federally Facilitated Marketplace (FFM) to reduce data entry and associated staff and eligibility determination time; and,*
- *Updating the online application process to gather additional information needed for non-MAGI determinations.*

In addition, SCDHHS is currently planning two major enhancements for the CP. These enhancements will improve the agency's document upload and identity management capabilities. These enhancements will further improve the CP user experience and help the agency increase efficiency by encouraging greater utilization of the CP.



9. Please create an appeals process flow chart explaining what occurs at each step.

   Please see attached chart.

Employee Engagement

10. Please provide the results and findings from the agency's FY2018-19 employee satisfaction survey.

    Please see attached report.

    a. Does the agency have a strategy for improving employee satisfaction?

       Yes, a key component of this strategy is the launch of the agency's Office of Training and Development. This team was established in 2019 and offers a variety of training and professional development opportunities in support of the agency's commitment to employee engagement and success. In addition, over the last year as the pandemic changed agency operations, the agency re-focused several resources on ensuring agency employees remained engaged as many moved to a full-time remote work environment. This included regular all-staff calls and more frequent and engaging employee communication with an emphasis on employee wellness. As the agency has returned to normal operations, it has surveyed employees and maintained and adapted several of these resources, which are still in operation.

    b. Has the agency ever surveyed employees to determine if they are confident in the reporting process for workplace concerns? (e.g., harassment, bullying, discrimination, interpersonal conflict, gossip, communication problems, etc.)?

       Yes, the agency's annual employee satisfaction survey includes opportunities for employees to report these and any other concerns. Employees can either report these concerns anonymously or by name. SCDHHS distributed its 2021 Employee Engagement Survey on April 5, 2021.

Member Services

11. Does the agency assist eligible enrollees with the selection of optional benefits that may best meet their specific healthcare needs?

    The agency assists applicants in determining the eligibility category that best meets their needs for which they qualify. This is based, in part, on the information the applicant provides on their application, telephone calls and their financial and medical circumstances. Individuals eligible for full-coverage Medicaid receive the full array of covered services or benefits as laid out in the State Plan. Healthy Connections-enrolled providers work directly with Healthy Connections Medicaid members to determine medically necessary services. Healthy Connections Medicaid members can contact the member contact center or their managed care organization, if they are enrolled in a managed care plan, for questions about whether a service is covered.

Eligibility Verification

12. Explain how the agency tracks the eligibility of beneficiaries.

    The SCDHHS eligibility system maintains beneficiary eligibility including tracking to allow for an annual review of continued eligibility. The agency incorporates electronic data sources to process applications and reviews and to discover and verify a change in circumstances. Some of the agencies and data sources SCDHHS has access to includes the Social Security Administration, the U.S. Department of Homeland Security, South Carolina Department of Employment and Workforce, South Carolina Department of Health and Environmental Control, South Carolina Department of Social Services and South Carolina Public Employee Benefit Authority. These data sources are incorporated into the agency's eligibility systems to automatically update information. They can also be used by agency staff to verify and record information in the eligibility system. The eligibility system can utilize rules to make Medicaid determinations for an initial application, an annual redetermination or to respond to a change in circumstances.

13. How does the agency determine or validate an applicant's personal assets? Is the information received from the applicant available to be shared with other entities? (e.g., judicial department)?

    The agency uses the Asset Verification System (AVS), self-reporting and request for documentation. SCDHHS uses the applicant's attestation of assets and verifies the information using documents supplied by the applicant, third-party sources and by checking electronic data sources. Additionally, electronic data sources may discover assets not reported by the applicant, such as utilizing online property searches or AVS for bank accounts.

    Generally, information cannot be shared with other entities such as a judicial department. Federal regulations (including 42 CFR §431.300, §431.302, §431.305 and §431.306) prevent disclosure or use of information and records of a beneficiary unless it is related to administration of the State Plan for Medicaid, or unless the beneficiary consents to the release of their information. However, if a court of adequate jurisdiction issues a court order for records after being advised of Medicaid confidentiality but finding there is still a need for records, then the agency will release the records upon the issuance of a court order.

14. Does the agency require a beneficiary to obtain a Social Security Card?

    With certain exceptions as outlined in 45 CFR §435.910(a), an individual is required to provide a Social Security number—or have applied for one—to receive Medicaid benefits.

15. Does the agency assist beneficiaries in obtaining a Social Security Card?

    Consistent with federal law, the agency assists beneficiaries who need a Social Security card by directing them to the U.S. Social Security Administration.

Public Health Emergency

16. If the Public Health Emergency (PHE), as a result of the continued consequences of the COVID-19 pandemic, continues until the end of the calendar year:
    a. Approximately how many pending reviews will the agency have?

       As of March 22, 2021, SCDHHS had the following number of pending reviews by application type:
       - *MAGI = 74,496, no pending reviews will be older than Jan. 1, 2020*
       - *Non-MAGI = 1,904, no pending review is older than March 1, 2020*
       - *Long term care= 901, no pending is older than March 1, 2020*
       - *Total = 77,301*

       SCDHHS is continuing to engage with and review updated guidance issued by CMS regarding annual reviews and the impact of the PHE. As such, the number of pending reviews is subject to change.

    b. How long will it take to work those reviews?

       CMS has provided guidance for resuming normal review processing operations at the end of the PHE. The plan the agency has submitted to CMS calls for the pending reviews to be addressed during the year-long period beginning after the end of the PHE.

17. Will the agency, once annual reviews resume, "clawback" payments to providers if it is found that certain beneficiaries no longer qualified for services?

    No, SCDHHS will continue to follow CMS guidance related to the FFCRA's continuous enrollment requirement. Section 6008 (b)(3) of the FFCRA prevents states seeking to claim the temporary Federal Medicaid Assistance Percentage (FMAP) increase from terminating eligibility for individuals enrolled as of or after March 1, 2020, through the end of the month in which the PHE ends, even if the individual no longer meets eligibility requirements, unless the person voluntarily disenrolls or is no longer a state resident.

18. Will the agency continue to provide COVID-19 testing, treatment, and vaccination for full benefit members after the PHE is lifted?

The agency will continue to cover the services needed to diagnose and treat COVID-19 after the PHE, consistent with CMS guidance.

19. Will the agency continue to provide the COVID-19 limited benefit coverage after the PHE is lifted?

    Coverage of the optional group that was established in July 2020 will end with the conclusion of the federally declared PHE.

20. Will the agency continue to provide telehealth services implemented during the pandemic after the PHE is lifted?

    Telehealth is a valuable tool to be used in appropriate situations that can be used to address issues faced by the state's Medicaid members related to access to care and social determinants of health, most notably transportation concerns, that often lead to missed or rescheduled appointments or emergency department visits. The South Carolina General Assembly's previous investment in telehealth infrastructure and technology and SCDHHS' existing telehealth benefit put the state in a tremendous position to respond to the COVID-19 pandemic.

    Throughout the period of preparation and response to the COVID-19 pandemic, SCDHHS has committed to modifying the state's existing Medicaid telehealth benefit to align with social distancing principles while maintaining clinically appropriate levels of care. During the first six weeks of the PHE, SCDHHS implemented dozens of targeted, temporary telehealth policy flexibilities. These flexibilities are outlined at www.scdhhs.gov/covid19 and were issued after coordinating with the South Carolina Department of Labor, Licensing and Regulation, CMS and commercial healthcare payors in the state in order to create similar flexibilities and processes to reduce administrative and regulatory burden on providers.

    During the pandemic, the agency has consistently communicated to providers that while some of the COVID-19 related flexibilities will be temporary, any changes to the temporary policy flexibilities will be announced in a manner that allows ample notice for providers and Healthy Connections Medicaid members to plan and ensure continuity of care. The temporary COVID-19-related policy flexibilities and corresponding data have given SCDHHS a loose idea of what continued extended telehealth coverage may resemble. Some procedure codes have seen heavy utilization, while others have seen limited use. For example, the agency has received feedback from the provider community that pediatric sick visits have been extremely beneficial as providers have been able to diagnose and treat without the threat of unnecessary exposure. However, pediatric well-visits performed using telehealth do not allow for the personal touch most providers prefer. As SCDHHS considers each of the flexibilities it has issued during the pandemic, it will continue to evaluate utilization data, clinical data, provider and stakeholder feedback and the actions of other health care payors when deciding which telehealth flexibilities will be extended permanently. Using this measured, data-driven approach will ensure continued access to care for Healthy Connections Medicaid members, clinically sound guidance for healthcare providers and proper stewardship of taxpayer funds through the administration of the state's Medicaid benefit.

Information Technology

21. How will the Cúram Global Income Support (CGIS) project improve the processing of non-Modified Adjusted Gross Income (MAGI) and long-term care applications?

    With the CGIS implementation in November 2020, the online Medicaid application has been enhanced to gather additional information needed for Non-MAGI and long-term care (LTC) eligibility. This enhancement decreases the need for applicants to provide additional required information for Non-MAGI determination after application receipt.

    CGIS implementation also reduces the work required by SCDHHS eligibility specialists by performing automated eligibility determinations using defined business rules and eligibility criteria. Online applications are automatically loaded into CGIS, removing the need for SCDHHS staff to manually enter those applications into the eligibility determination system. Additionally, some verification items, such as citizenship and identity, can often be verified in real-time without action required by an SCDHHS staff member. CGIS also allows SCDHHS staff members to generate and mail Request for Information (RFI) notices from within the system. This improves efficiency from the previous system, which required each RFI to be manually produced and mailed by an SCDHHS eligibility specialist.

Optional State Supplementation (OSS)

22. The legislature establishes the Community Residential Care Facility (CRCF) fee each year.
    a. What is the process for amending the CRCF fee and does the agency provide an opinion regarding the fee?

       The South Carolina Code of Regulations Chapter 126 Article 9, section 126-940 E states: "Cost-of-living adjustments in benefit programs made by the federal government will result in adjustments to the OSS program as directed by the South Carolina General Assembly in the legislative budgetary process." Further this subsection states: "In the event that no specific direction is provided for the treatment of a federal cost-of-living adjustment, such adjustment will result in no change to the OSS net income limitation, the OSS facility rate, or the personal needs allowance; OSS benefit payment amounts will be adjusted to reflect the changes in recipients' countable income."

       SCDHHS establishes the maximum number of OSS recipients that can be funded with the appropriations made available through the South Carolina legislative budgetary process and provides information annually to CRCFs on cost-of-living adjustments for OSS participants. The facility maximum billing amount is the maximum payment rate minus the personal needs allowance amount.

       The Senate Finance Committee introduced and adopted a proviso that would allow the agency to adjust the OSS net income limitation, the OSS facility rate or the personal needs allowance to ensure that payment amounts are not reduced because of a federal cost-of-living adjustment in benefit payments. Such an adjustment will reflect the change in recipient's countable income.

b. When was the CRCF fee last amended?
    i. *The CRCF fee was last amended in 2019.*

Material for Inclusion in Future Meetings

23. Identify any noncompliance issues the agency has experienced with CMS for the past three years.
    a. Explain what the agency has done to remedy or resolve these issues.

Issue	***Corrective Action Plan (CAP)***
Annual Eligibility Reviews: The agency did not perform annual eligibility reviews for Medicaid and CHIP recipients in accordance with Section 101.10 of the South Carolina Medicaid Policies and Procedures Manual.	Prior to the PHE, the CAP in progress included: • Stabilize and enhance eligibility system for streamlined processing and automated renewal processes • Build staff capacity by creating processing centers and hiring staff to meet workload demands • Improve accountability systems to measure and improve accuracy and timeliness of eligibility determinations Progress related to the CAP continues but some processes have been put on pause based on CMS guidance related to annual reviews during the PHE.
CHIP Funding Allocation: Funds allocated for the CHIP program may only be used for individuals eligible for the CHIP program.	See CAP included under "Annual Eligibility Reviews."
Discontinuation of Medicaid Benefits: The agency must, in a timely manner, discontinue benefits for ineligible beneficiaries.	See CAP included under "Annual Eligibility Reviews."

Eligibility Condition - Documentation: SCDHHS did not maintain adequate documentation for a portion of sampled eligibility determination cases.	The electronic document management system implemented in 2014 has partially resolved this issue. This finding continues to be mitigated by SCDHHS' strategy of encouraging paperless determinations, improvements to the annual review process through automated reviews and accountability systems that promote accuracy of determinations, including presence of required documentation.
Family Planning: Incorrectly claimed enhanced 90/10 Federal Participation for services/diagnoses identified as Family Planning related.	System coding errors were identified as the root cause and modification efforts are being conducted to correct system logic along with claim adjustments. Modifications and adjustments are in process with regular updates to CMS.
837 EDI Transaction: Inappropriate editing of electronic data interchange (EDI) transactions for redundant provider codes in loop 2310 and 2420.	An editing correction was completed and monitoring was performed to ensure appropriate results. The correction was completed on Nov. 18, 2019, and the agency is now compliant.
Health Insurance Portability and Accountability Act 277 EDI Transaction: Failure to provide EDI 277 Health Care Claim Response transaction (ASC X12 Version 00501 OX212), which potentially violates 45 CFR 162.1402(c) – Standards for Health Care claim status transaction.	Technical analysis is under review by the agency's fiscal agent, Clemson University, to identify why the system is providing more status information to providers than is requested. The correction was completed on March 30, 2021 and the agency is now compliant.
Electronic Notices: CMS mandates that individuals receive electronic notices and alerts as applicable via their preferred mode of communication (42 CFR	SCDHHS remedied this issue prior to the issuance of a formal CAP.

431.210-214, 42 CFR 435.917-918). In September 2020, CMS raised a concern that SCDHHS was not compliant in this regard and that failure to remedy the issue could result in the issuance of a CAP following the HCR Certification Review.	
Health Care Reform Eligibility & Enrollment System - Reasonable Opportunity (#1) Terminating Eligibility: Potential retention of enrollment/eligibility of beneficiaries beyond the Reasonable Opportunity Period (ROP) allowed by regulation 42 CFR 435.956.	SCDHHS is working to ensure enrollment is terminated appropriately for individuals whose citizenship and immigration status cannot be ascertained within the 90-day ROP. A correction is in progress with estimated completion mid-2021.
Healthcare Reform Eligibility & Enrollment System - Reasonable Opportunity (#2) **Notice Dates:** SCDHHS system showed functionality to generate notices for the ROP. However, the date on notices informing applicants of the ROP provides only 75 days for the applicant to respond, as opposed to the 90 days stated in 42 CFR 435.956.	SCDHHS is working to ensure notices are updated to allow the full 90 days for applicants to respond in accordance with 42 CFR 435.956. Correction in progress with implementation expected mid-2021.
Fingerprint-based Criminal Background Check: Failure to require "high-risk" providers to consent to criminal background checks, including fingerprinting in accordance with 42 CFR455.434.	A CAP was developed and submitted to CMS on March 4, 2021, with completion timelines. A correction is in progress with estimated completion date of Oct. 1, 2021.
Electronic Visit Verification: Failure to require/implement the use of an Electronic Visit Verification (EVV) system for Personnel Care Services that require in-home visits by providers in accordance with section 12006 of the 21st Century Cures Act.	The agency is working to expand the legacy EVV solution to meet all EVV requirements. A correction is in progress with anticipated implementation by July 1, 2021.

Dental Administrative Service Organization (DASO): Failure to receive Prior Written Approval (PWA) to draw down enhanced matching funds from the federal government (Federal Financial Participation [FFP]) for the DASO project after the contract went into legal dispute and reverted to Operational from implementation status. With the original award, SCDHHS did initially receive PWA of the Advance Planning Document (APD) and approved budgets through Federal Fiscal Year (FFY) 2021. As a result of the reversion to Operational status, CMS issued another budget approval letter for only FFY 2019. SCDHHS failed to recognize and communicate internally that the subsequent approval letter negated the previously approved funding for FFYs 2020 and 2021 and continued to draw enhanced FFP as previously approved during FFY 2020.	When the mistake was identified in FFY 2021, SCDHHS worked with CMS to retroactively adjust the funding received from the enhanced 75% FFP rate to the appropriate 50% FFP rate, which is the appropriate rate for a system in operations that has not achieved CMS certification. The adjustment amounted to approximately $500,000 dollars in remanded FFP. SCDHHS subsequentially sought and received approval of continued funding at the correct, regular FFP rate for FFY 2021 and going forward.

24. Explain the agency's process for monitoring and mitigating vendor fraud (e.g., providers, contractors, etc.).

    Provider fraud is monitored and mitigated through SCDHHS' Division of Program Integrity function. When a credible allegation of fraud exists, the case is referred to the South Carolina Attorney General's Medicaid Fraud Control Unit for investigation and the provider is placed on payment suspension.

    The agency's process for monitoring and mitigating vendor fraud includes oversight of vendor contracts by our Division of Federal Contracts and Vendor Management and program area contract owners. Vendor contracts are also subject to random audits conducted by our Internal Audit Division. Any fraud detected would be referred to the appropriate law enforcement agency for investigation.

25. Please note the subcommittee members have expressed an interest in agency leadership elaborating on the following topics during future meetings:
    a. Training and development
    b. Marketing and communications
    c. Employee recruitment and retention/compensation

d. Medicaid provider network
    i. Access to care across the state
    ii. Primary and specialty services
e. BabyNet
f. Sickle Cell services
g. Behavioral health services
h. Medical contracts
i. Disproportionate share
j. Graduate Medical Education

Thank you for your feedback. Each of these topics will be incorporated into future presentations.

Sincerely,

T. Clark Phillip
Acting Director and Chief Financial Officer

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

LEGISLATIVELY MANDATED CONTRACTS

FY 19-20 SCDHHS Legislative Directed Contracts	
Organization	**Amount**
Feeding the Carolinas	$ 200,000
Phoenix Center	$ 400,000
Oconee County (Foothills) YMCA	$ 500,000
First Impressions	$ 25,000
Pleasant Valley	$ 25,000
Center for Educational Equity	$ 25,000
Donaldson Revitalization Center	$ 25,000
Lisa's Schoolhouse Rocks	$ 25,000
Emma Wright Fuller Foundation	$ 50,000
Strap em Up Boot Camp for Kids (Stepping Stone Foundation)	$ 25,000
Osprey Village	$ 200,000
Changed Lives Ministry	$ 350,000
Wateree Community Action Agency	$ 250,000
James R. Clark Sickle Cell	$ 150,000
Auntie Karen Foundation	$ 250,000
Community Initiatives, Inc.	$ 100,000
Middle Tyger Center	$ 50,000
ReGenesis Health Care	$ 200,000
Vital Aging	$ 300,000
SC HIV Council - Wright Wellness Organization	$ 300,000
Pee Dee Community Action Agency	$ 100,000
Dillon County Council on Aging	$ 35,950
Pee Dee Healthy Start	$ 50,000
The Therapy Place	$ 100,000
Autism Academy of SC (new name is Unumb Center for Neurodevelopment)	$ 350,000
Women in Unity	$ 100,000
Savannah River Corridor Mammography machine	$ 250,000
Palmetto Palace	$ 250,000
Community Med Clinic of Kershaw County	$ 819,154
Community Medicine Foundation (North Central Family Medicine)	$ 100,000
Palmetto Project	$ 100,000
Trinity Technology Center	$ 200,000
Dickerson Children's Advocacy Center	$ 250,000
Summerville ARK	$ 200,000
Camp Happy Days	$ 150,000
Donate Life	$ 50,000
CR Neal	$ 300,000
Antioch Center	$ 300,000
Nurse Family Partnership	$ 750,000
Joe Neal Collaborative	$ 700,000
Arc of Oconnee	$ 50,000
Circle Park 301	$ 500,000
Sandhills Medical Foundation	$ 300,000
Seneca Senior Center	$ 50,000
Senior Citizens Association in Florence County	$ 60,000

FY 19-20 SCDHHS Legislative Directed Contracts	
Coastal Southeastern	$ 550,000
Sumter 301	$ 3,000,000
Trinity 301	$ 500,000
United Way of Kershaw County	$ 10,000

MEDICAID: COUNTY DATA

South Carolina Medicaid Members in January 2021

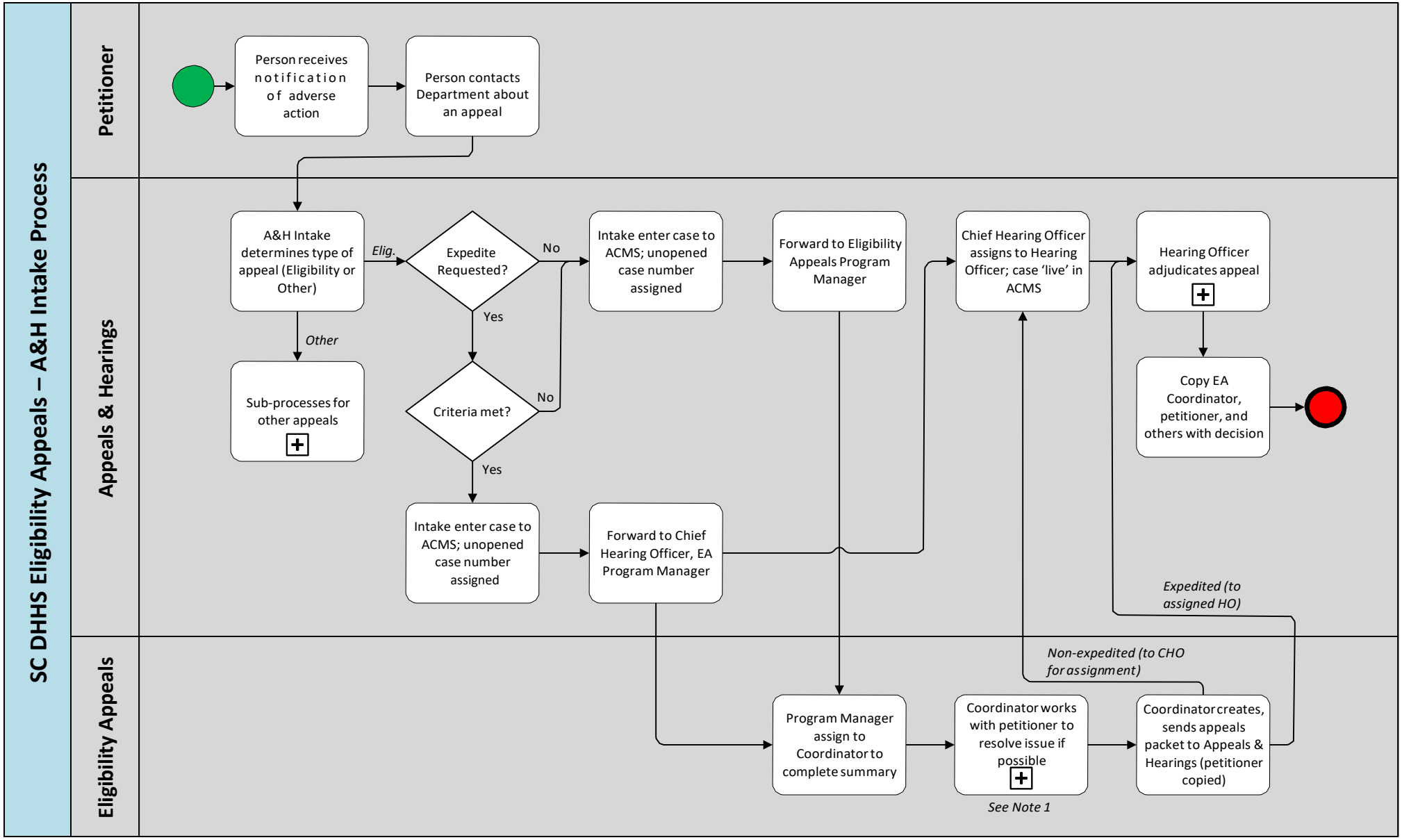
County Code	County Name	Total Estimated July 1, 2019 Population	Full Benefit Medicaid Membership	Limited Benefit Medicaid Membership	Total Medicaid Membership
01	ABBEVILLE	24,527	5,647	1,188	6,835
02	AIKEN	170,872	37,773	7,638	45,411
03	ALLENDALE	8,688	3,123	573	3,696
04	ANDERSON	202,558	44,807	8,740	53,547
05	BAMBERG	14,066	4,496	977	5,473
06	BARNWELL	20,866	7,650	1,302	8,952
07	BEAUFORT	192,122	27,963	5,775	33,738
08	BERKELEY	227,907	40,787	8,854	49,641
09	CALHOUN	14,553	3,361	759	4,120
10	CHARLESTON	411,406	71,739	15,547	87,286
11	CHEROKEE	57,300	15,546	2,989	18,535
12	CHESTER	32,244	10,352	1,943	12,295
13	CHESTERFIELD	45,650	13,182	2,535	15,717
14	CLARENDON	33,745	10,268	2,147	12,415
15	COLLETON	37,677	12,887	2,577	15,464
16	DARLINGTON	66,618	20,223	4,172	24,395
17	DILLON	30,479	11,961	2,386	14,347
18	DORCHESTER	162,809	30,558	6,444	37,002
19	EDGEFIELD	27,260	5,324	1,121	6,445
20	FAIRFIELD	22,347	6,229	1,407	7,636
21	FLORENCE	138,293	41,485	8,892	50,377
22	GEORGETOWN	62,680	14,687	3,209	17,896
23	GREENVILLE	523,542	100,356	20,734	121,090
24	GREENWOOD	70,811	18,206	3,135	21,341
25	HAMPTON	19,222	6,322	1,239	7,561
26	HORRY	354,081	73,668	18,802	92,470
27	JASPER	30,073	7,889	1,671	9,560
28	KERSHAW	66,551	15,616	3,021	18,637
29	LANCASTER	98,012	18,302	3,601	21,903
30	LAURENS	67,493	17,894	3,243	21,137
31	LEE	16,828	5,789	1,216	7,005
32	LEXINGTON	298,750	55,858	10,865	66,723
33	MCCORMICK	9,463	1,960	434	2,394
34	MARION	30,657	11,887	2,426	14,313
35	MARLBORO	26,118	9,216	1,972	11,188
36	NEWBERRY	38,440	9,979	1,832	11,811
37	OCONEE	79,546	16,508	4,193	20,701
38	ORANGEBURG	86,175	28,996	5,927	34,923
39	PICKENS	126,884	23,420	4,892	28,312
40	RICHLAND	415,759	90,329	19,034	109,363
41	SALUDA	20,473	5,213	1,173	6,386
42	SPARTANBURG	319,785	75,398	15,350	90,748
43	SUMTER	106,721	31,314	5,940	37,254
44	UNION	27,316	8,145	1,587	9,732

45	WILLIAMSBURG	30,368	10,544	2,201	12,745
46	YORK	280,979	47,938	9,340	57,278
UN	UNKNOWN		3	9,639	9,642
Grand Total			**1,130,798**	**244,642**	**1,375,440**

Note: Preliminary counts.

Source: Member month data table updated 3/10/2021, U.S. Census Bureau Data accessed 4/1/2021
Provided by: SCDHHS Data Analytics Division, ran on 3/26/2021

ELIGIBLITY APPEALS: FLOWCHART



Timeline	*Business Days*
• *A&H Intake Receives Appeal – A&H Intake Forwards to EA PM / CHO*	*2*
• *EA PM Assigns to EAC – EAC Sends Appeals Packet to CHO / Petitioner*	*5**
• *CHO Assigns to HO*	*2*
	Total 9

**Does NOT include the 15 calendar days allowed for the petitioner to respond to requests for more information*

Note 1

The petitioner has 15 calendar days to provide information needed to resolve the case when requested by the EAC.

AGENCY PRESENTATION

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Healthy Connections Medicaid Finance Overview

Thomas "Clark" Phillip, Jr.

Acting Director and Chief Financial Officer

South Carolina Department of Health and Human Services

Oversight Presentation Series Topics

- Agency Overview
- Medicaid Eligibility
- **Medicaid Financing**
- Program Integrity
- Medicaid Managed Care
- Home and Community Based Services Waiver Programs
- Health Improvement Programs
- Replacement Medicaid Management Information System
- Emerging and Priority Issues

Today's Agenda

- Purpose
- Program Evaluation Report Information
- Organizational Structure
- Agency and Program Framework
- Major Financing Concepts
  - Federal Portion
  - State Portion
  - Ways SCDHHS Pays
- Expenditure Data
- COVID-19 Impact
- Outlook

Purpose

SCDHHS Mission, Principles, and Goals

Mission

The mission of the South Carolina Department of Health and Human Services (SCDHHS) is to purchase the most health for our citizens in need at the least possible cost to the taxpayer.

Principles

Engagement, Stewardship, Quality, Access, and Integration

Goals

- Purchase and evaluate care through evidence-based systems and models
- Strengthen the health and well-being of South Carolinians across their lifespan
- Limit the burden to provide and receive care
- Utilize public resources efficiently and effectively
- Maintain or improve healthcare marketplace stability

SCDHHS Strategic Plan

Agency Deliverables

7) Exercise fiscal responsibility in the use of taxpayer resources.

Strategic Plan Alignment				
Stewardship	**Access**	**Quality**	**Integration**	**Engagement**
				

Program Evaluation Report (PER) Information

FY 2019-2020 Performance Measures

- Maintain 100% monthly production submission to the Centers for Medicare and Medicaid Services (CMS)
  - Target: 100%
  - Actual: 100%
- Maintain or decrease the agency's percent share of the state's general funds appropriation over a three-year period
  - Target: <16.46%
  - Actual: 16.34%
- Maintain general fund expenditures within 3% of forecast
  - Target: <3%
  - Actual: 1%

FY 19-20 Performance Measures *(cont.)*

- Keep per-member cost increases below national benchmarks
  - Target: Less than healthcare cost growth rate (4.6%)
  - Actual: 3.8%
- Increase the percentage of expenditures analyzed for third-party liability by 5%
  - Target: 89%
  - Actual: 83.5%
- Implement metric-driven planning documents for 60% of the agency's staff by June 30, 2020
  - Target: 60%
  - Actual: 60%+
- Improve employee engagement scores by 5%
  - Target: Vendor procurement delayed
  - Actual: Vendor procurement delayed

Turnover Data

- Finance (budget, controller, reimbursement, federal contracts and vendor management)
  - 2019-2020: 25.21%
  - 2018-2019: 19.82%
  - 2017-2018: 13.22%
  - 2016-2017: 14.68%

Statutes Included in PER

- S.C. Code § 44-6-40(3)
  - Review programs to determine the extent to which they: (a) meet fiscal, administrative, and program objectives; and (b) are being operated cost effectively
- S.C. Code § 44-6-70(b)
  - Cost effectiveness
- S.C. Code § 44-6-80
  - Annual and interim reports
- S.C. Code § 43-7-50
  - Payments for professional services under State Medicaid Program shall be uniform within State
- S.C. Code Title 43, Chapter 7, Article 5
  - Assignment and Subrogation of Claims for Reimbursement for Medicaid Services

Statutes Included in PER *(cont.)*

- 42 U.S. Code § 1396a. State plans for medical assistance
  - (a)(4) – proper and efficient administration of the Medicaid program
  - (a)(6) – reporting (CMS 37, 64, etc.)
  - (a)(13) – rate methodologies
  - (a)(18) - liens, adjustments and recoveries, and transfers of assets
  - (a)(25) – third party liability
  - (a)(30(A) – payments are consistent with efficiency, economy, and quality of care
  - (a)(32) - prohibits State payments for Medicaid services to anyone other than a provider or beneficiary, except in specified circumstances
  - (a)(37) – timely claims payments
- 42 U.S. Code § 1396b. Payment to States
  - Proper Federal Medical Assistance Percentage (FMAP) allocations
- 42 U.S. Code § 1396p.
  - Liens, adjustments and recoveries, and transfers of assets
- 42 C.F.R. Part 447
  - Payments for services

Department Cost

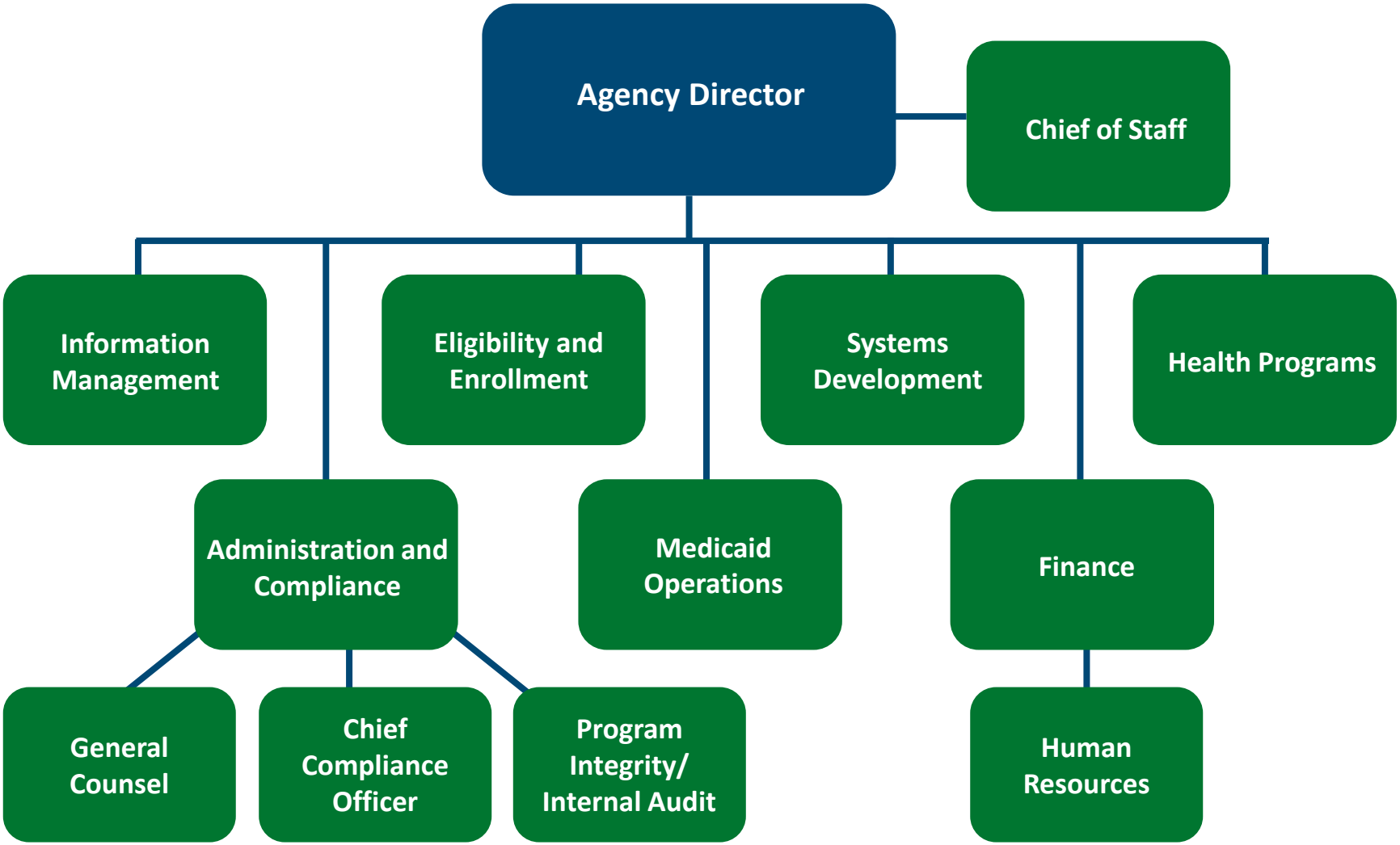
- Employee Equivalents:
  - FY 2019-2020: 65
  - FY 2018-2019: 64
  - FY 2017-2018: 72
  - FY 2016-2017: 60
- Costs:
  - FY 2019-2020: $20,647,840
  - FY 2018-2019: $13,837,397
  - FY 2017-2018: $17,823,501
  - FY 2016-2017: $23,029,699
- Percent of Total Spend:
  - FY 2019-2020: 0.26%
  - FY 2018-2019: 0.19%
  - FY 2017-2018: 0.25%
  - FY 2016-2017: 0.32%
- Cost per Deliverable:
  - FY 2019-2020: N/A
  - FY 2018-2019: N/A
  - FY 2017-2018: N/A
  - FY 2016-2017: N/A

Employee Satisfaction

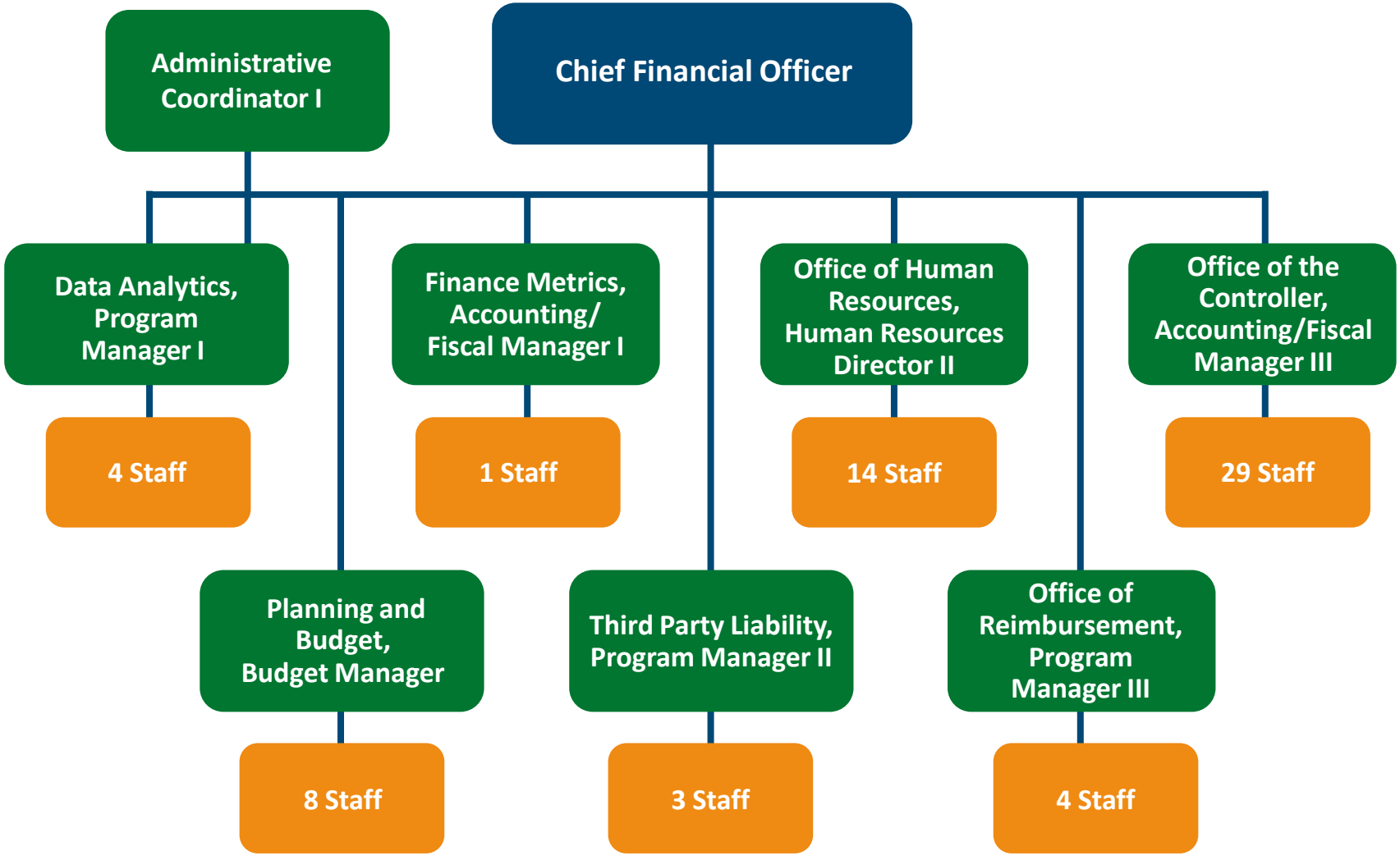
- Employee satisfaction tracked?
  - FY 2019-2020: No (new vendor awarded Sept. 2020)
  - FY 2018-2019: Yes
  - FY 2017-2018: Yes
  - FY 2016-2017: Yes

Organizational Structure

Agency Composition - Organizational Chart



Finance - Organizational Chart



Agency and Program Framework

Single State Agency

- As a condition for receipt of federal Medicaid funds, states must designate a single state agency to administer the state's Medicaid program
- In South Carolina, SCDHHS is the administering agency and the Medicaid program is called "South Carolina Healthy Connections Medicaid"

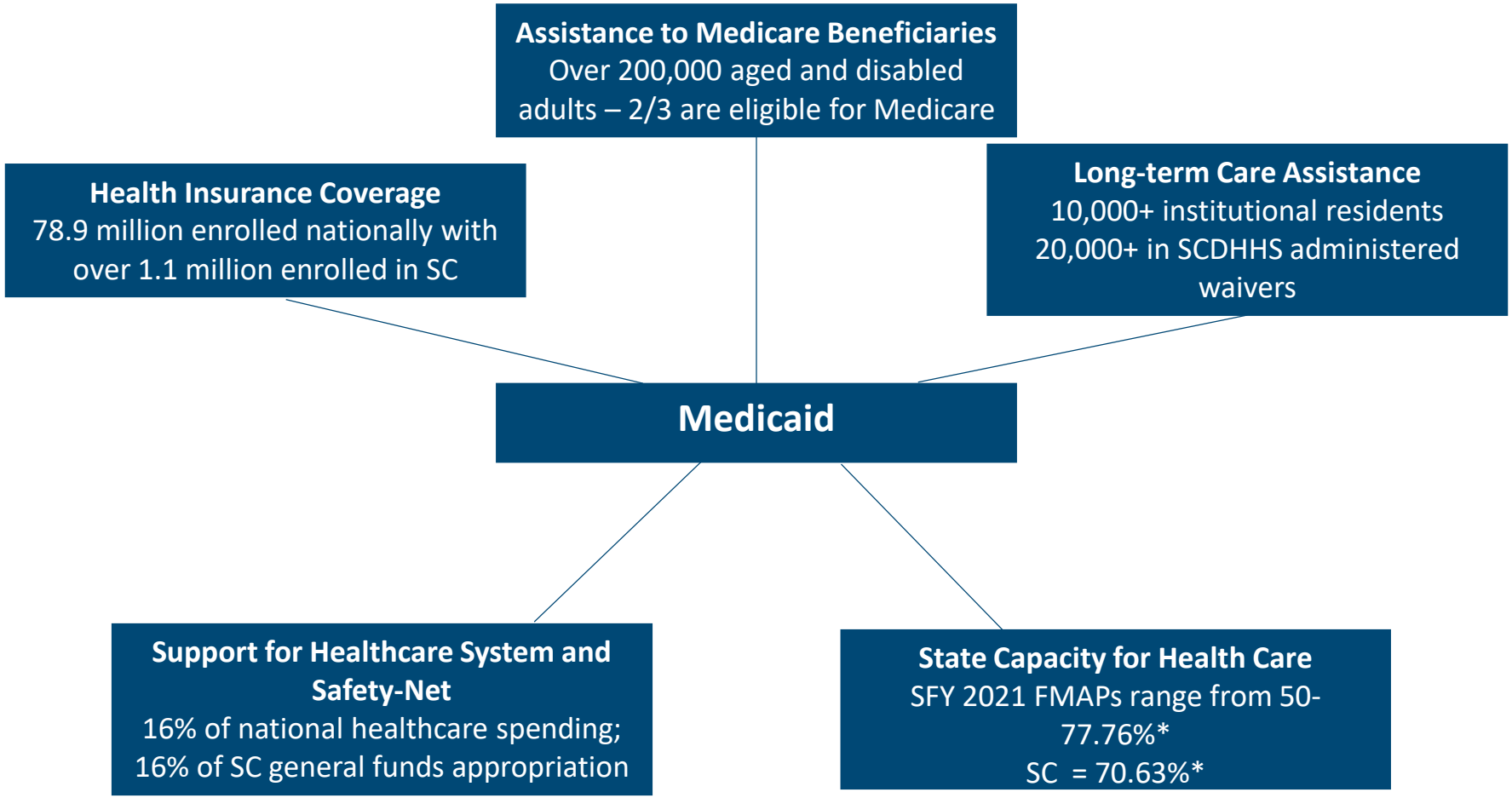
We Are

- Health policy and finance
- Countercyclical
- Additional programs administered by SCDHHS include:
  - Optional State Supplementation (OSS) Program
  - Optional Supplemental Care for Assisted Living Program (OSCAP)
  - Certified Nurse Aides (CNA) Program
  - Individuals with Disabilities Education Act Part C Program (BabyNet)
  - Medicare Premiums Payment

We Are Not

- A provider
- A regulator
- Commercial insurance
- A prosecutor

Medicaid Obligations Beyond Coverage



**Does not include temporary 6.2% increase included in the Families First Coronavirus Response Act (FFCRA) that expires at the end of the current federal public health emergency.*

Level-setting

- Who is responsible for what?
- What is the value proposition for healthcare coverage?
- Who pays for it all?

Who is Responsible for What?

- Healthcare coverage is a public cross-subsidy
- SCDHHS is the single state agency responsible for administering the Medicaid program
- Responsibility is to determine:
  - Is a service covered?
  - Is the population it applies to covered?
  - Are the beneficiaries receiving quality services?
  - Do Medicaid members have sufficient access to care?

Value Proposition for Healthcare Coverage

- Risk mitigation
- Collective purchasing power
- Care management and coordination
- Quality of services
- Social determinants of health

Major Financing Concepts

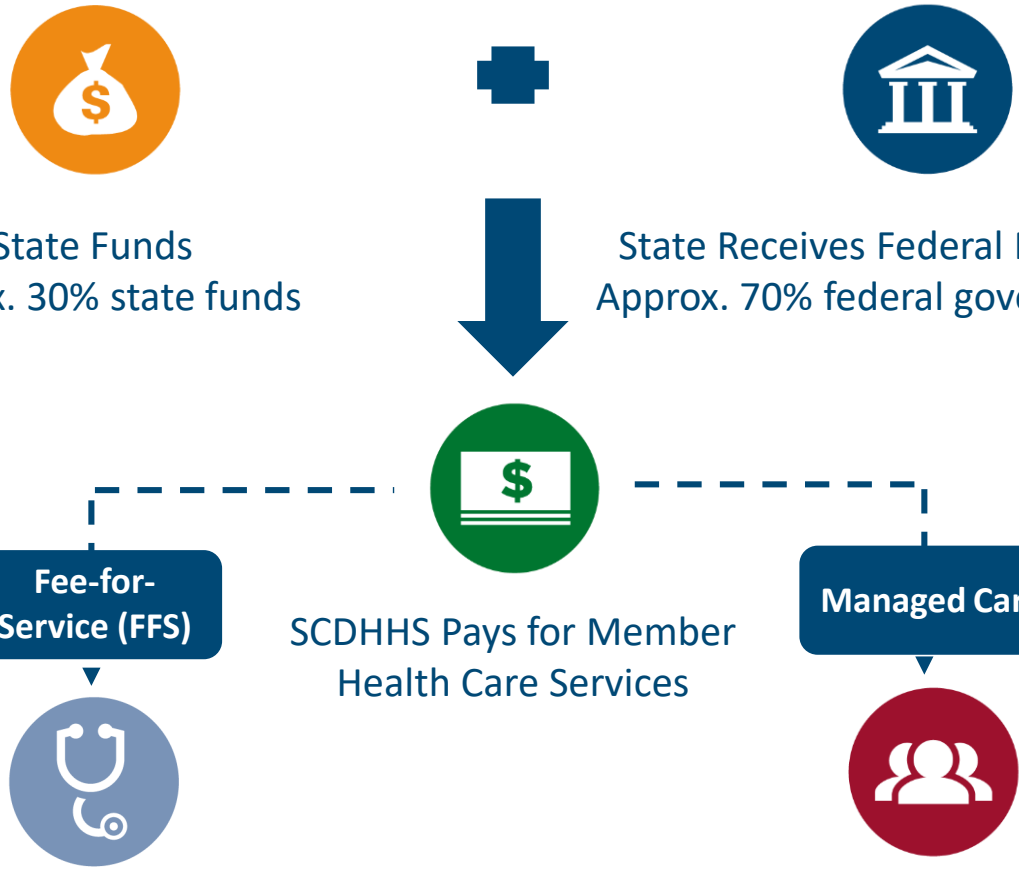
Projection Concepts

- Budget projection timeline FY 2022 example
  - FY 2020 actual expenditures used as baseline
  - Agency budget request submitted in Sept. 2020
- Total number eligible
- Utilization of services by Medicaid members
- Changes in provider reimbursement
- Federal mandates and policy issues
- Advances in clinical care and pharmaceuticals

Who Pays for Medicaid?

- Public sources of funds
  - General fund expenditures
  - Directly allocated taxes
  - Federal taxes
  - Federal debt
- Providers
- Minimal beneficiary copayments
- Payor of last resort

Funding Medicaid Coverage



Decision-making at the Margins

- Medicaid isn't one program; it is many programs made by many Congresses and many state Medicaid directors
- All Medicaid directors inherit a state plan
  - Contract with CMS, contracts with providers
- Policy changes are often difficult to reverse

Levers and Counterbalances

Controllable Variables

- Unit price
- Number of units
- Types of units covered
- Utilization management
- Preferred Drug List
- Provider qualification
- Place of service
- Third-party liability (TPL)
- Program Integrity
- Managed care organizations (MCOs)
- Care coordination
- Pharmacy rebates

Variables Outside Agency Control

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Advocacy/society
- Legislation
- Maintenance of effort (MOE)
- Any willing and qualified provider
- Network adequacy
- Payor mix
- Disproportionate Share Hospital (DSH)
- Upper Payment Limit (UPL) supplement
- Supplemental Teaching Physician (STP) Program
- Graduate Medical Education (GME)

Major Financing Concepts—Federal Portion

Medicaid Funding

- Medicaid is the third largest mandatory program in the federal budget
- Federal Medicaid funds must be matched with non-federal funds
- Under current law, Medicaid provides a guarantee to individuals eligible for services and to states for federal matching payments with no pre-set limit
- States must provide certain mandatory benefits to core populations without imposing waiting lists or enrollment caps to get federal funding
- Federal funds are drawn down on a weekly basis as authorized by the quarterly CMS 37 submission

Mandatory Benefits

Certified pediatric and family nurse practitioner services	Nurse midwife services
EPSDT services	Nursing facility services
Family planning services	Outpatient hospital services
Federally Qualified Health Center services	Physician services
Freestanding birth center services (when licensed or otherwise recognized by the state)	Rural Health Clinic services
Home health services	Tobacco cessation counseling for pregnant women
Inpatient hospital services	Transportation to medical care
Laboratory and x-ray services	

Optional Benefits

Chiropractic services	Podiatry services
Dental services	Prescription medications (not all drugs are covered)
Home and community based services (HCBS)	Private duty nursing services
Hospice	Rehabilitative behavioral health services
Inpatient psychiatric care	Speech-language therapy
Intermediate care facility services	Targeted case management
Occupational and physical therapy	Vision care

Federal Medical Assistance Percentage (FMAP)

- The percentage of Medicaid funded by the federal government varies based on the FMAP rate, which is driven by state-specific economic indicators
- South Carolina's FMAP is historically approximately 70%
  - The formula is designed so that the federal government pays a larger share of program costs in states with lower per capita income
- Administrative activities are funded at a 50/50 rate
- Some activities and services (ex. IT claims processing development) carry enhanced match rates

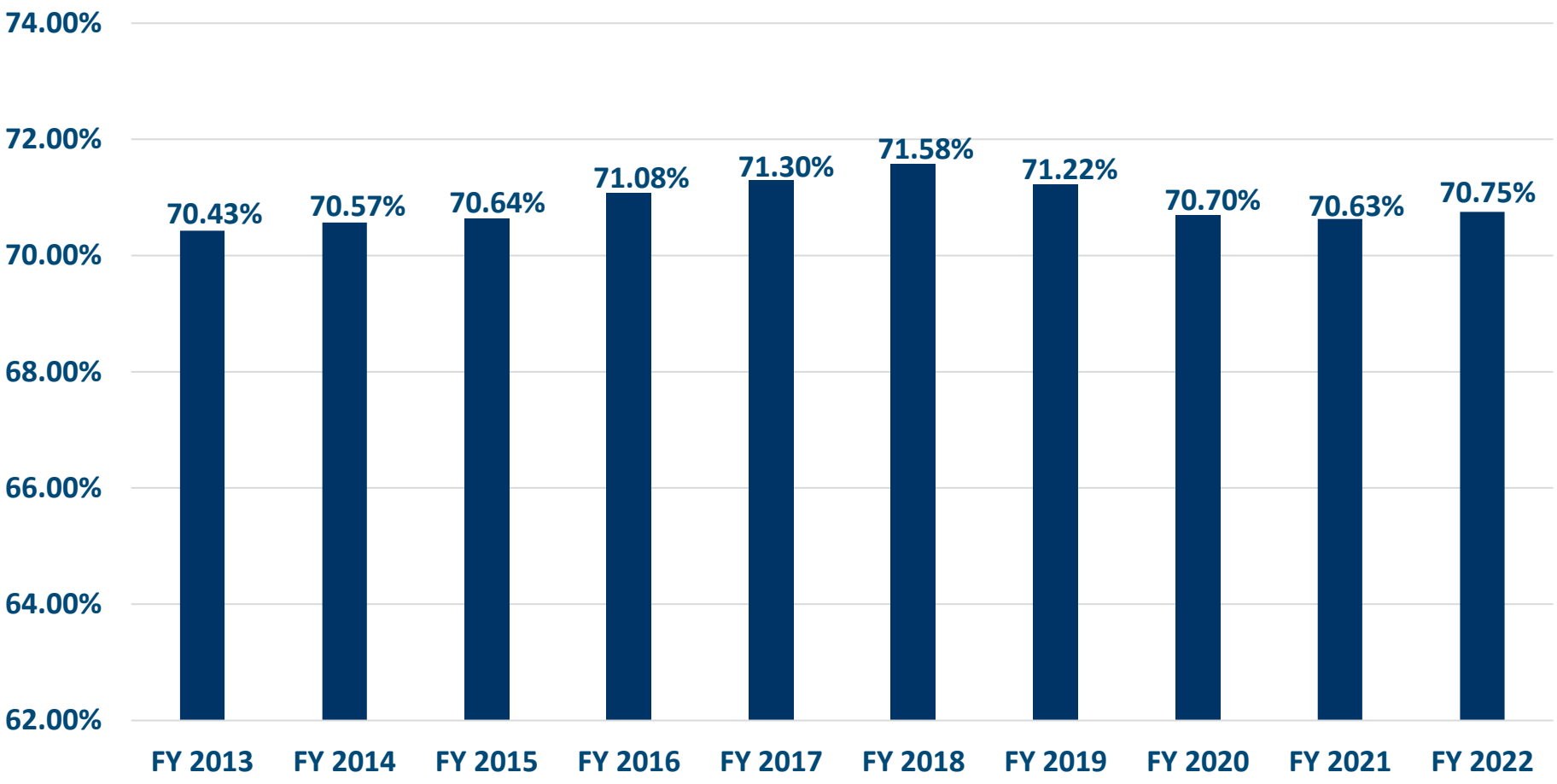
FMAP for Southeast Region (FFY 2022)

State	FMAP Percentage
Alabama	78.57%
Florida	67.23%
Georgia	73.05%
Mississippi	84.51%
North Carolina	73.85%
South Carolina	76.95%
Tennessee	72.56%

* Percentages include 6.2% FMAP increase from FFCRA

Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier | KFF

10-Year South Carolina FMAP History

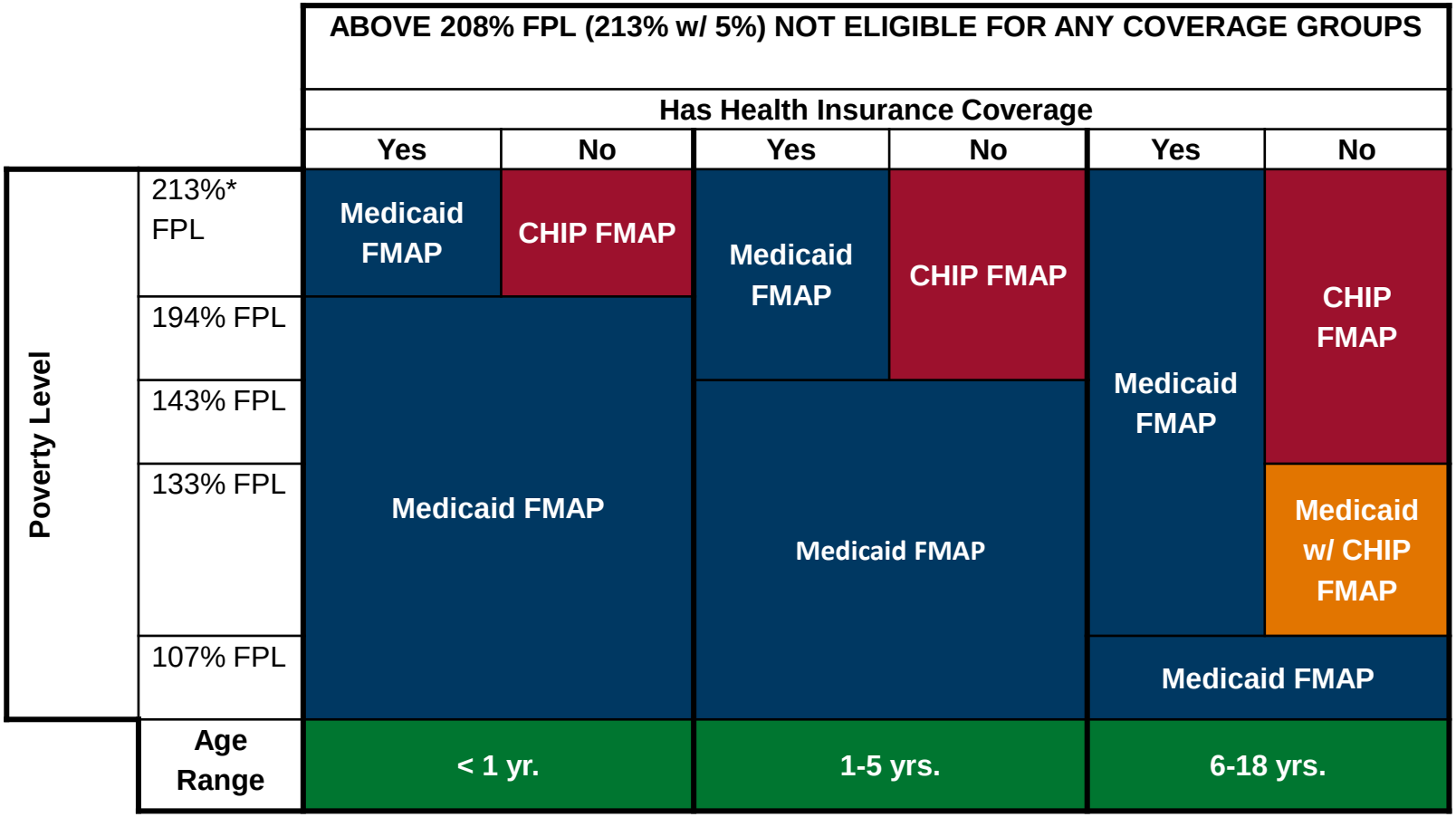


Based on federal fiscal year – FFCRA temporarily increased FY20/FY21 FMAP by 6.2% (not included in %s above)

Children's Health Insurance Program (CHIP) Funding

- CHIP was funded at 100% by the federal government from October 2015—October 2019
- CHIP is now funded at approximately 80% federal match
  - The FFCRA temporarily increases this match by 4.34%
- CHIP provides Medicaid coverage for children who live in families with income at or below 213% of the federal poverty level (FPL)

CHIP Funding *(cont.)*



**includes 5% income disregard*

CHIP FMAP for Southeast Region (FFY 2022)

State	FMAP Percentage
Alabama	85.00%
Florida	77.06%
Georgia	81.14%
Mississippi	85.00%
North Carolina	81.70%
South Carolina	83.87%
Tennessee	80.79%

* Percentages include 4.34% FMAP increase from FFCRA

Source: Kaiser Family Foundation

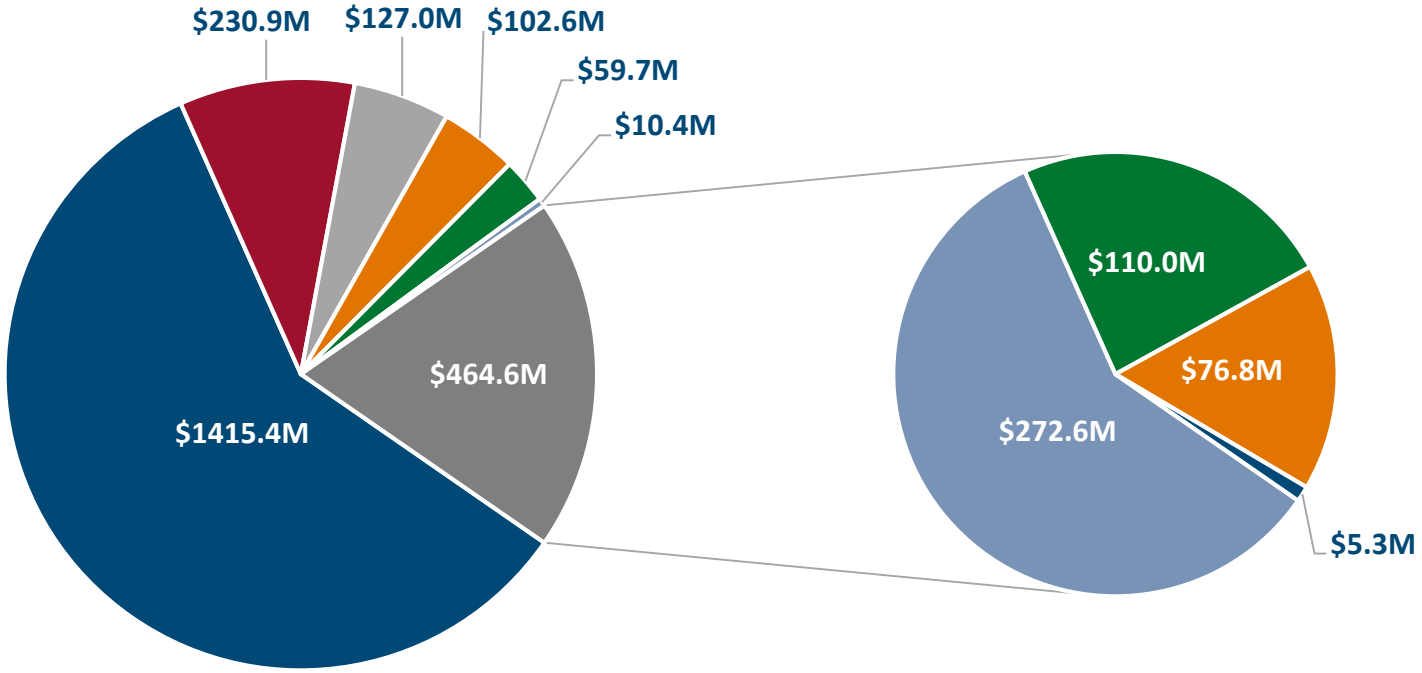
Major Financing Concepts—State Portion

Match Funding

- Match funding comes from several sources
  - General funds in General Appropriations Act - Approximately $1.3 billion
  - Earmarked authorization - Approximately $450 million
    - Intergovernmental Transfer (IGTs)
    - Certified Public Expenditures (CPEs)
    - Pharmacy rebates
    - County Medically Indigent Assistance Program (MIAP) § 44-6-146(B)
    - Other
  - Restricted authorization - Approximately $458 million
    - Tobacco Master Settlement Agreement (MSA)
    - Hospital Tax § 12-23-810
    - Cigarette Tax Surcharge
    - Nursing Home Sanctions
    - Education Improvement Act (BabyNet) § 63-11-1735

Financing Medicaid - SFY 2021 Projected State Funds

- General Funds Recurring
- CPE
- §1903(w)(6)(a) STP
- Hospital Tax
- Tobacco Master Settlement Agreement (MSA)
- IGT
- Pharmacy Rebates
- Miscellaneous Revenue
- Cigarette Tax - $.50 Surcharge
- County MIAP

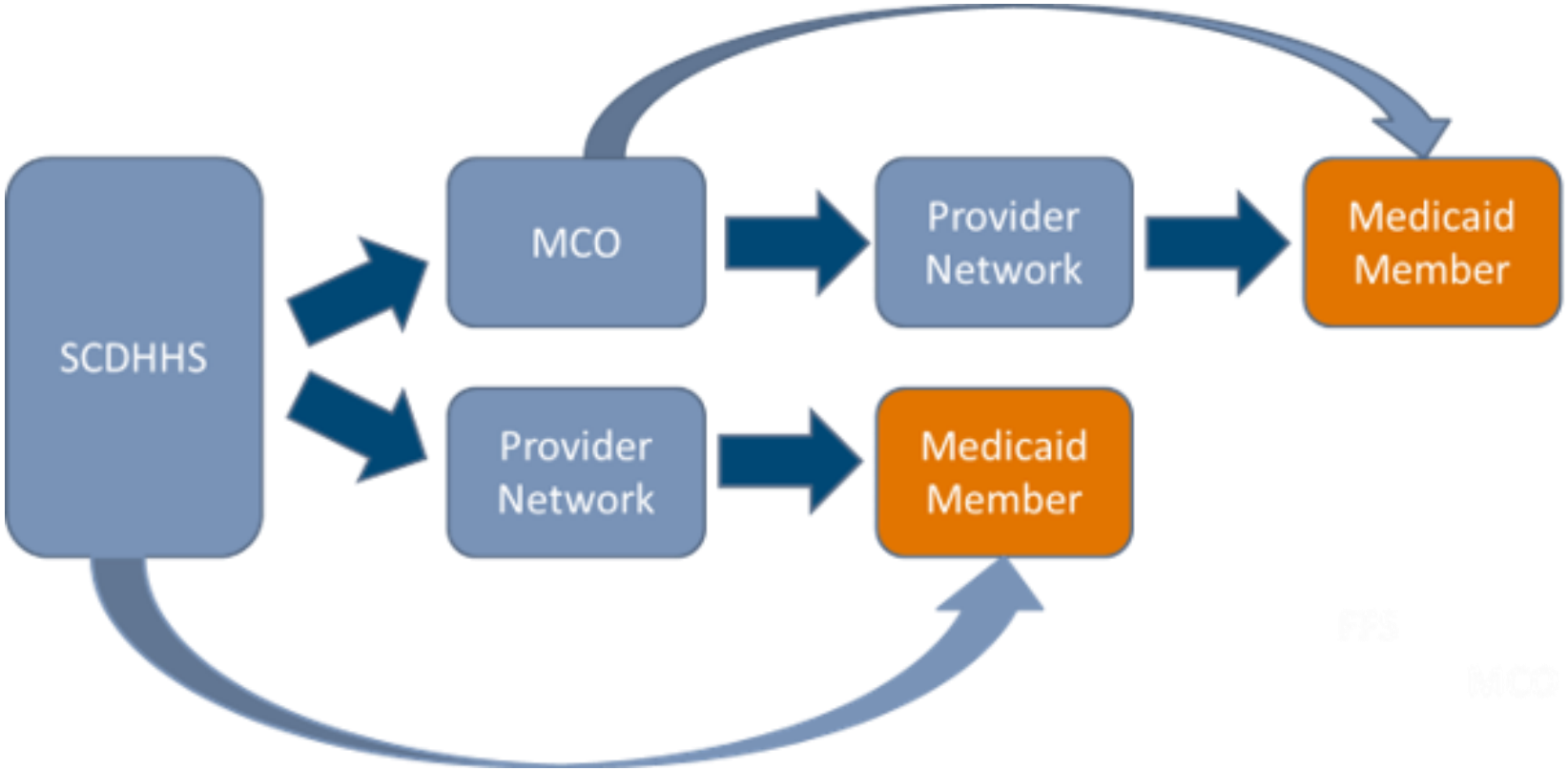


Major Financing Concepts—
Ways SCDHHS Pays

Ways SCDHHS Pays

- Capitation rates to MCOs
- Direct payments to providers
- DSH
- UPL
- STP
- GME
- Medicare Savings Program
- Contracts

Delivery Model in Medicaid



Managed Care Capitation

- Transfer of risk with limits
- Minimum loss ratio
- Risk corridors
- Quality withhold
- Incentive payment
- Pass-through payments
- Required to be developed through actuarily sound process

Capitation Rate Development

- Base period experience
- Completion
- Programmatic adjustments
- Trend
- Administrative load
- Final projected statewide rate
- Individual MCO risk-adjusted factor
- Risk-adjusted MCO rate

How a Physician Service Becomes a Claim

A Healthy Connections Medicaid Member receives a service from an enrolled provider.

The service corresponds with a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

Provider Reimbursement

- Social Security Act 1902(a)(30)(A)
  - (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to **assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available** under the plan at least to the extent that such care and services are available to the general population in the geographic area

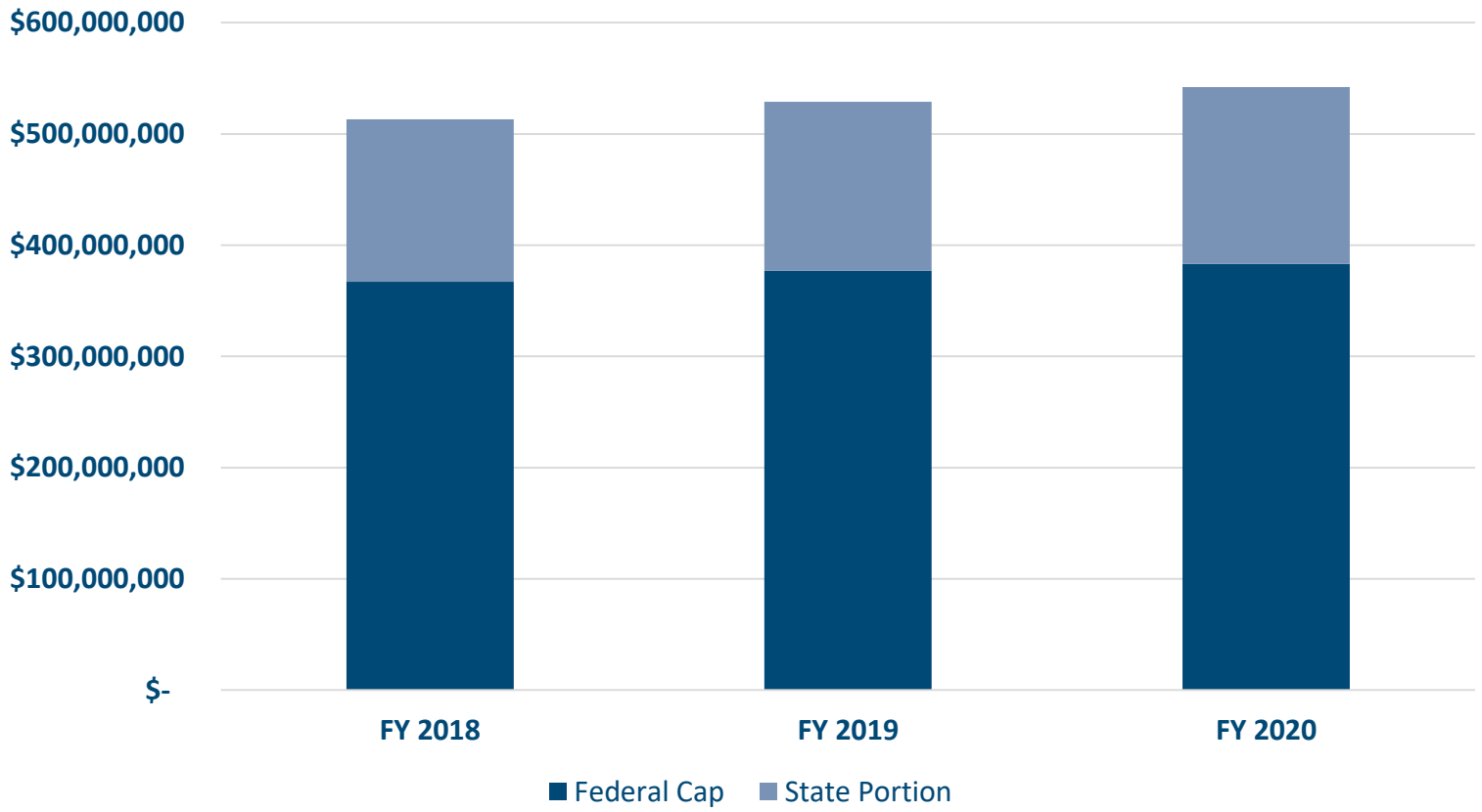
Pricing Project Phases

- Phase I - Effective July 1, 2019
  - Professional provider types
  - Projected impact = $26.2 million total funds
- Phase II – Effective July 1, 2020
  - January 2020 – Private duty nursing received a 5% rate increase
  - July 2020 - Vision, ambulatory surgical centers, anesthesia, attendant care, adult day health care transportation, pediatric day care, private duty nursing
  - Projected impact = $49.3 million total funds
- Phase III – TBD
  - Institutional providers, including hospitals and inpatient psychiatric units
  - Skilled nursing facilities for two years of rate re-baselining
  - Dental services
  - Projected impact = $122 million total funds

Disproportionate Share Hospital (DSH)

- **Intent of payment:** offset hospitals' uncompensated care costs applicable to Medicaid-eligible and uninsured individuals, which improves access for Medicaid and uninsured patients as well as the financial stability of safety-net hospitals
- **Who receives payment?** Qualifying hospitals that meet SCDHHS-defined DSH qualification criteria
- **What are the limits?** Federal DSH allotment amount is determined by CMS each federal fiscal year (FFY), which is then subjected to South Carolina's FMAP rate to calculate and pay the total DSH payment pool. 100% of the total DSH payment pool is normally spent each year unless significant budget shortfalls are incurred
  - There are three DSH pools: SC Defined Rural, SC DMH, and Non-Rural Hospitals.

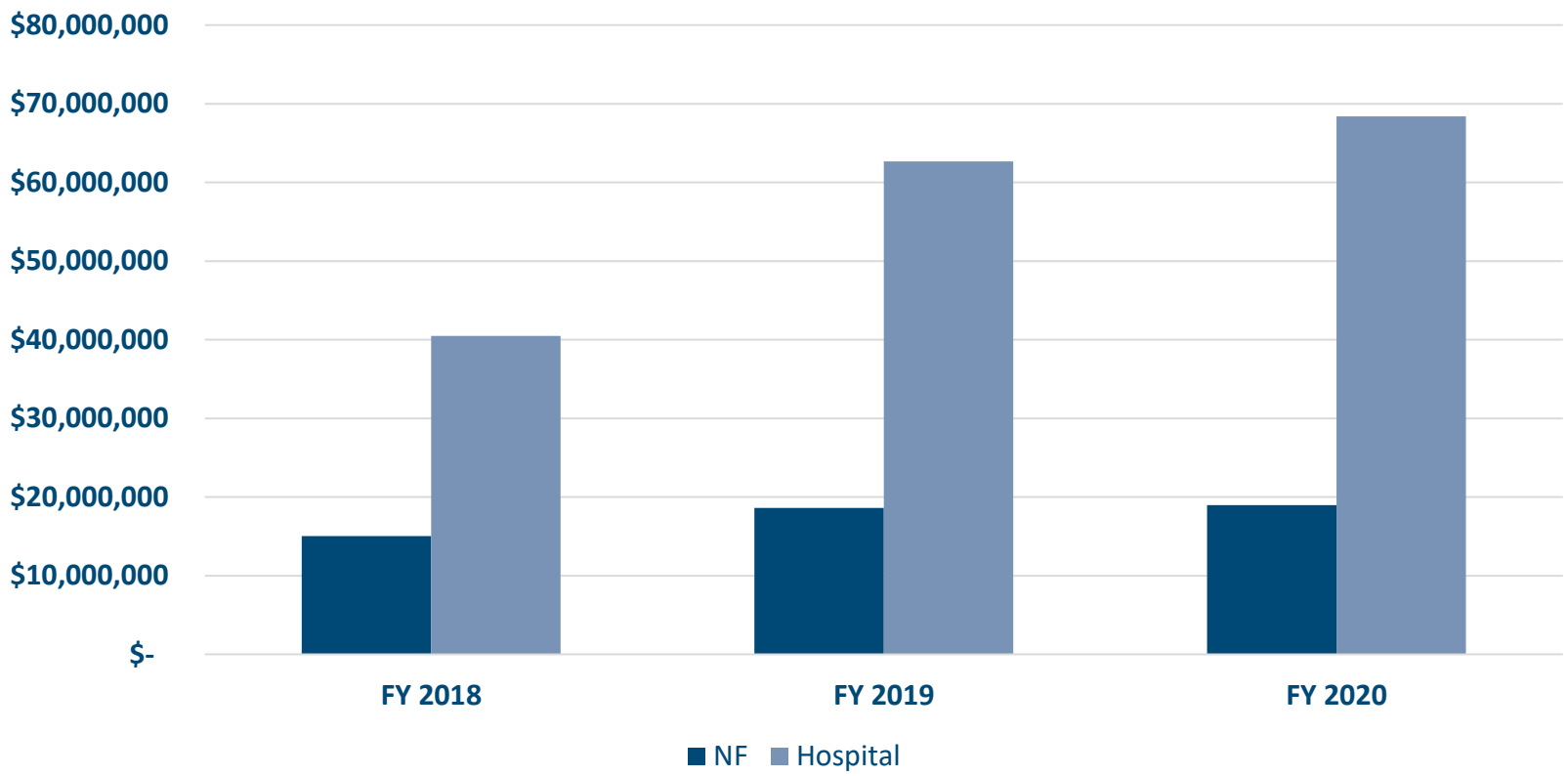
DSH *(cont.)*


$600,000,000
$500,000,000
$400,000,000
$300,000,000
$200,000,000
$100,000,000
$-
FY 2018
FY 2019
FY 2020
Federal Cap
State Portion

Upper Payment Limit (UPL)

- **Intent of payment:** pay up to, but not more than, what Medicare would pay for the same services for eligible providers
- **Who receives payment?**
  - Inpatient hospitals: eligible non-state-owned governmental hospitals and private hospitals that qualify based on SCDHHS qualification criteria
  - Nursing facilities: qualifying non-state-owned governmental nursing facilities based on SCDHHS qualification criteria
  - In each case, the non-state-owned governmental entity and SCDHHS will draw down federal funds at its FMAP rate to determine total payments for each UPL payment program
- **What are the limits?** UPL payments are subject to the same broad federal requirements as most Medicaid payments. The payment methodology must be approved by CMS and documented in the South Carolina Medicaid State Plan

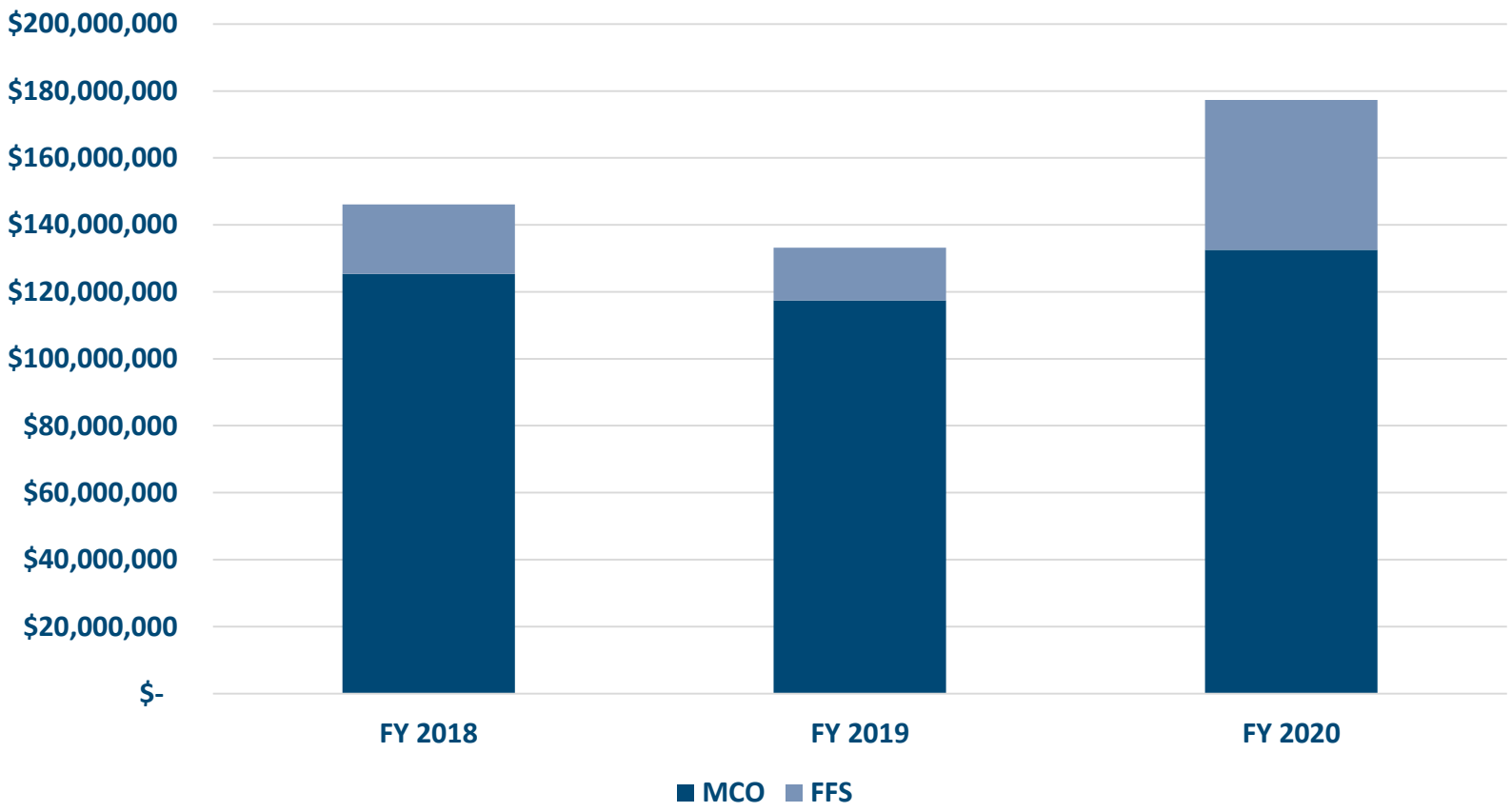
UPL *(cont.)*


$80,000,000
$70,000,000
$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$-
FY 2018
FY 2019
FY 2020
NF
Hospital

Supplemental Teaching Payments (STP)

- **Intent of payment:** to pay providers for the loss of productivity of teaching physicians incurred while teaching residents and/or medical students in the professional setting
- **Who receives payment?** Providers with teaching physicians who are employed by or under contract with South Carolina medical universities and/or their component units
- **What are the limits?**
  - FFS STP is paid directly to hospitals while MCO payment is a pass through that is distributed to Health Sciences South Carolina who then distributes to individual hospitals
  - The medical universities, area health education consortium (AHEC), and non-state-owned STP providers provide the state match and SCDHHS pulls down federal money at normal FMAP for total payments

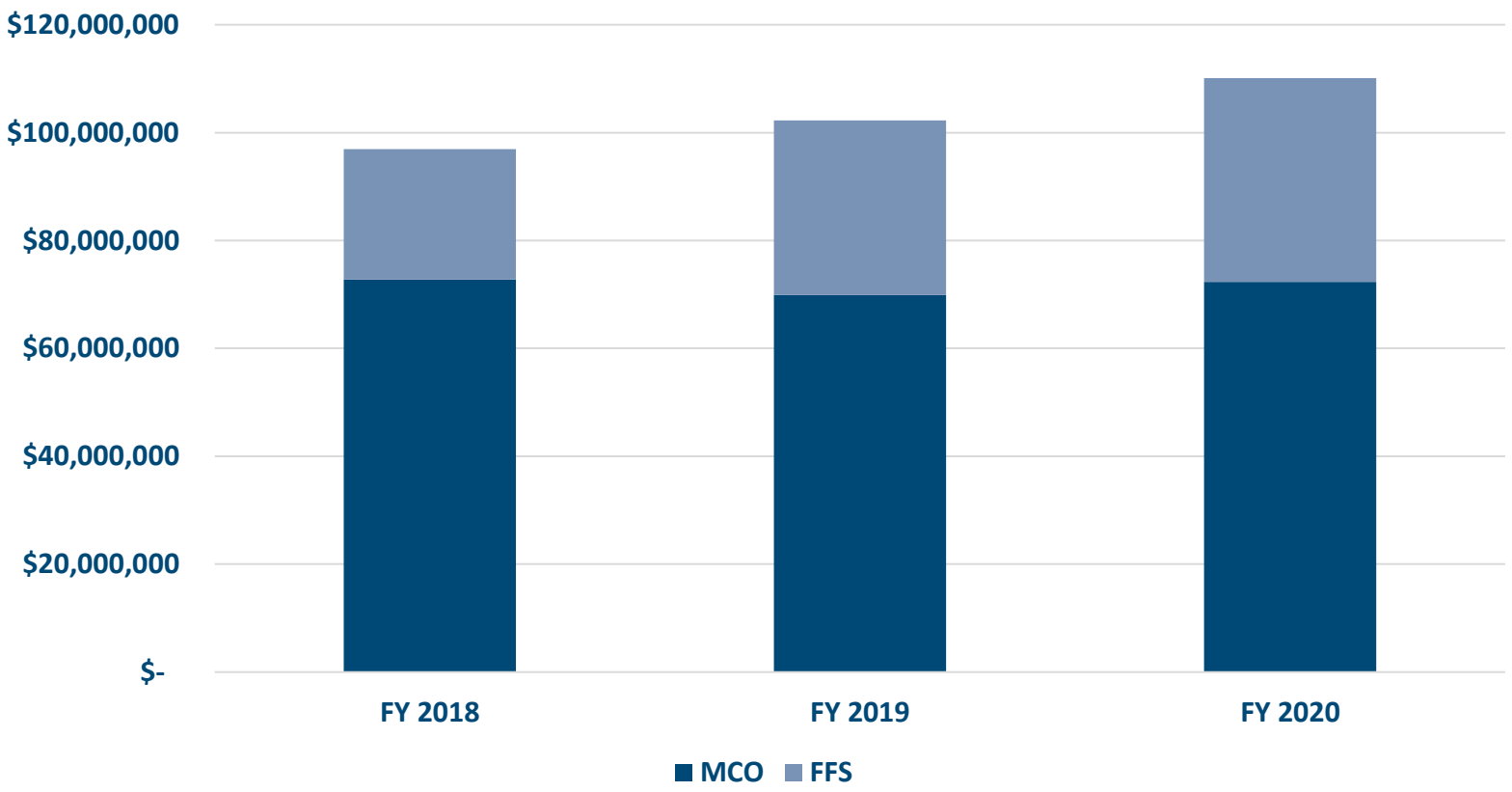
STP *(cont.)*


$200,000,000
$180,000,000
$160,000,000
$140,000,000
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$-
FY 2018
FY 2019
FY 2020
MCO
FFS

Graduate Medical Education (GME)

- **Intent of payment:** to reimburse teaching hospitals for the costs incurred by an approved teaching program of training interns and residents in a hospital-based setting
- **Who receives payment?** Teaching hospitals with an approved training program
  - FFS amount included in diagnosis-related group, per discharge rate, and paid via inpatient hospital claims
  - MCO GME payments are determined by SCDHHS and paid via a quarterly gross adjustment to each teaching hospital
- **What are the limits?** General funds are used as the state match, which is then used to draw down federal funding at South Carolina's FMAP rate

GME *(cont.)*


$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$-
FY 2018
FY 2019
FY 2020
MCO
FFS

Medicare Savings Program

- Created to help low-income seniors and individuals with disabilities afford some out-of-pocket costs for Medicare, including premiums
- To qualify, individuals must be eligible for Part A and meet income/resource limits, which may vary by state
- Medicaid programs are required to cover Medicare Savings Programs for certain populations while others are optional
- There is an additional program where states help pay for part of the costs of Part D coverage for full-benefit duals
- SCDHHS receives monthly reports from CMS indicating how many recipients are eligible and payment amount
- Approximately $390 million dollars spent in in SFY20 and increasing annually due to Medicare premiums increasing and more eligible recipients

Contracts

- SCDHHS enters into contractual agreements with vendors to provide services outside of the claims process
  - Service contracts include:
    - Non-emergency medical transportation - $88 million
    - Medication assistance - $8 million
    - Community Crisis Response and Intervention $3.8 million
    - Proviso contracts:
      - Healthy Outcomes Program (HOP) - $25 million
      - Rural Health Initiative - $13.3 million
      - Telemedicine - $13 million
  - Administrative contracts include (non-IT contracts):
    - Medicaid administrative activities (MAA) - $35 million
    - Enrollment broker -$6 million
    - Pharmacy benefit plan support - $4.2 million
    - Dental claims adjudication - $4 million
    - Prior authorization services - $3.5 million

Information Technology Contracts

- SCDHHS is replacing its 40-year-old Medicaid Management Information System (MMIS) with a more efficient, modern system that will reduce administrative burden on providers and agency staff
- SCDHHS is using a modular approach to transition from its legacy systems, including the MMIS. This includes the implementation of multiple system and service modules
- Some of these modules have already been implemented including:
    - Accounting and finance module
    - Business intelligence system (BIS)
    - Pharmacy benefits administrator (PBA) module
    - Third-party liability (TPL) module
    - Eligibility system
- The remaining modules include:
    - Administrative services organization (ASO)
    - Dental administrative services organization (DASO)
    - Electronic visit verification (EVV)
    - Pharmacy benefits administrator (PBA)

Legislative-directed Medical Contracts

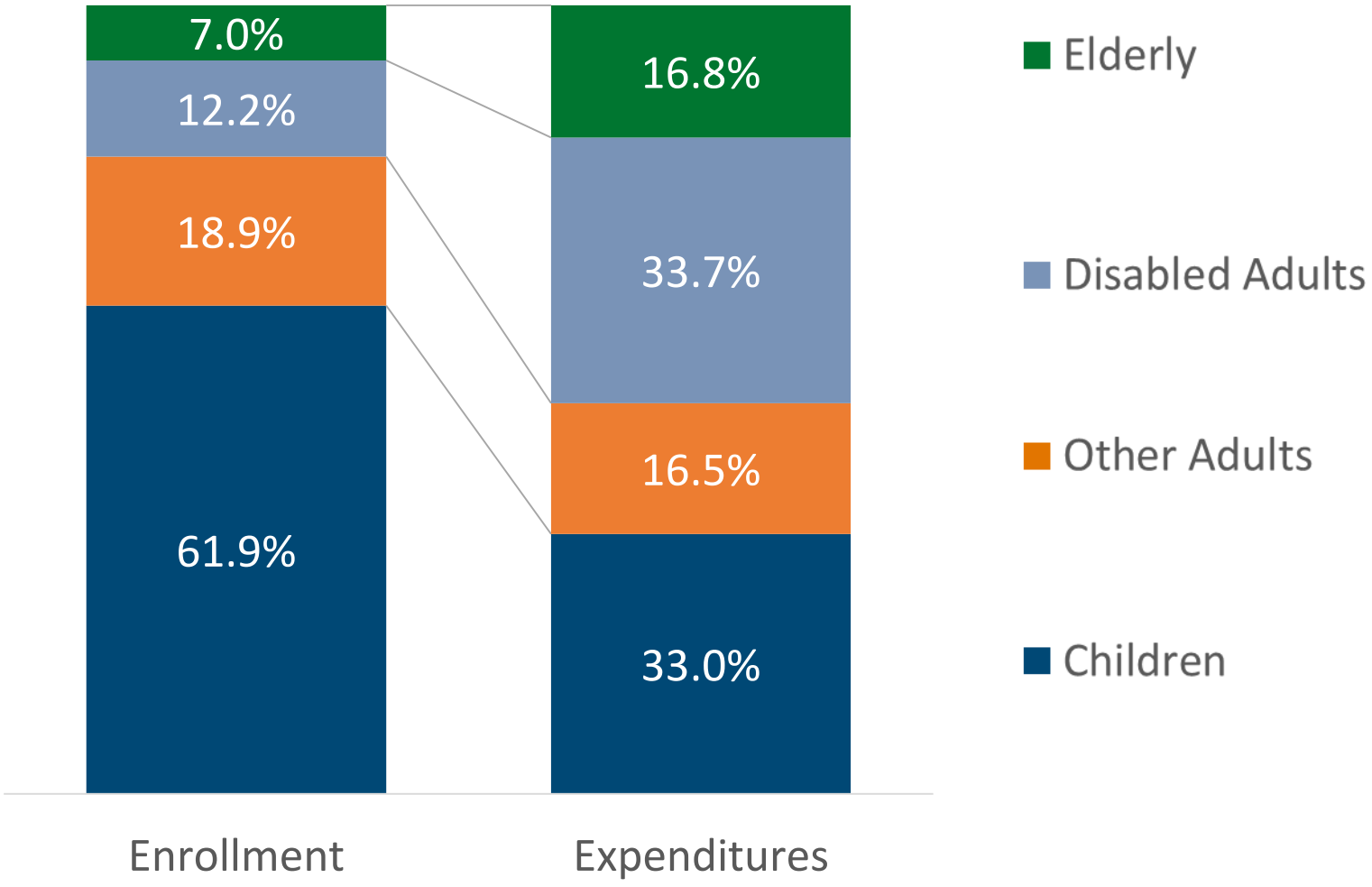
- Through the appropriations process, the General Assembly directs the agency to contract with organizations to perform various functions
  - SCDHHS enters into a contract with each organization as directed
  - Each contract contains a scope of work and reporting requirements that is unique to the work described in the contract
- During FY 19-20, SCDHHS was directed to enter into medical contracts with 49 organizations through the appropriations process
  - A list of the organizations and the contracts SCDHHS entered into has been provided to the committee

Expenditure Data

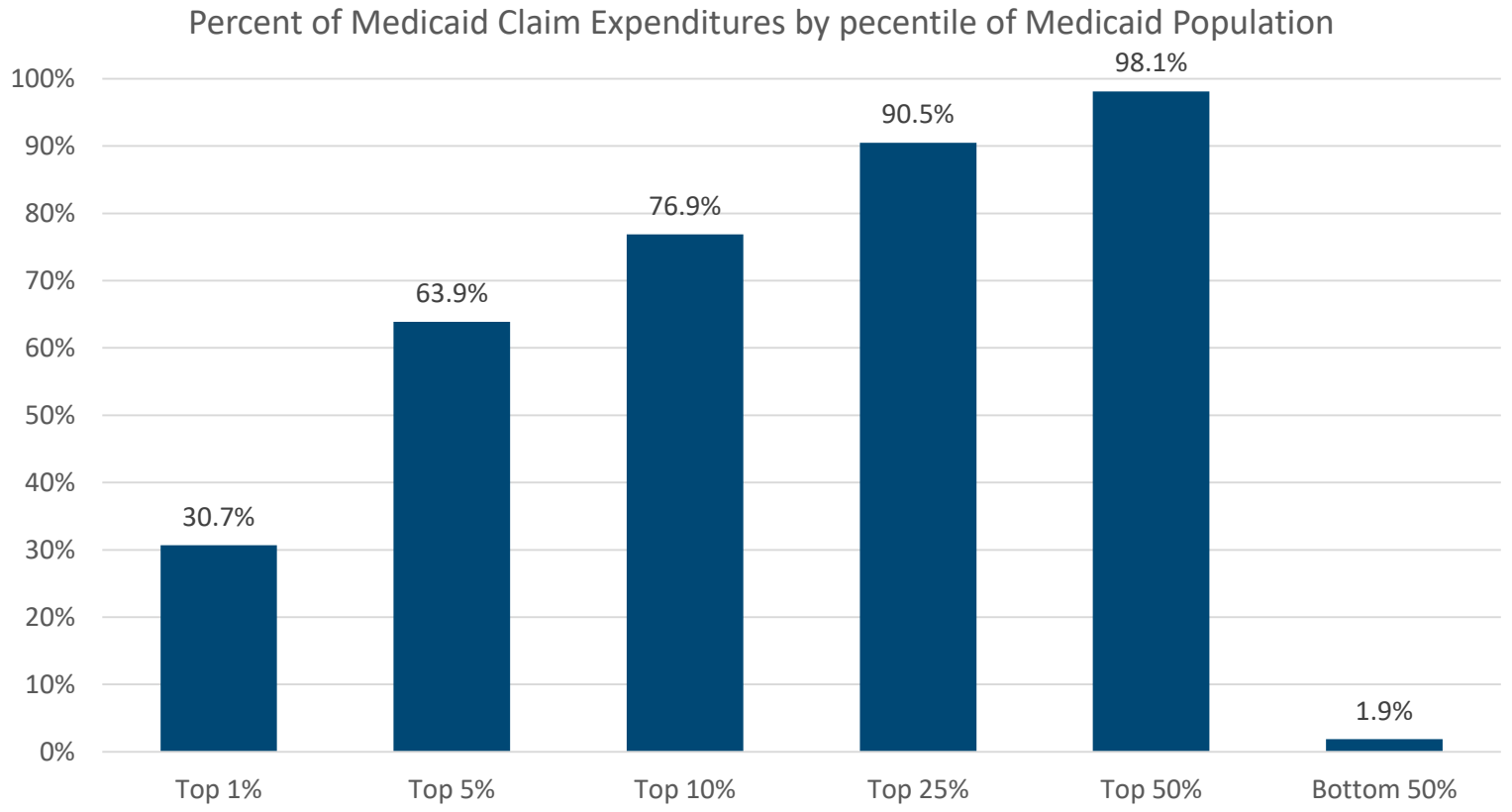
Medicaid Budget

- Total U.S. Medicaid spending was **$613.5 billion** in FFY 2019 with 63.2% paid by the federal government and 36.8% by states
  - SCDHHS spent $7.55 billion in FFY 2019 with 69.7% paid by the federal government and 30.3% by South Carolina.
- Medicaid spending accounts for approximately 16% of national health expenditures

Covered Populations - SCDHHS Members and Costs



Covered Populations - SCDHHS Members and Costs *(cont.)*

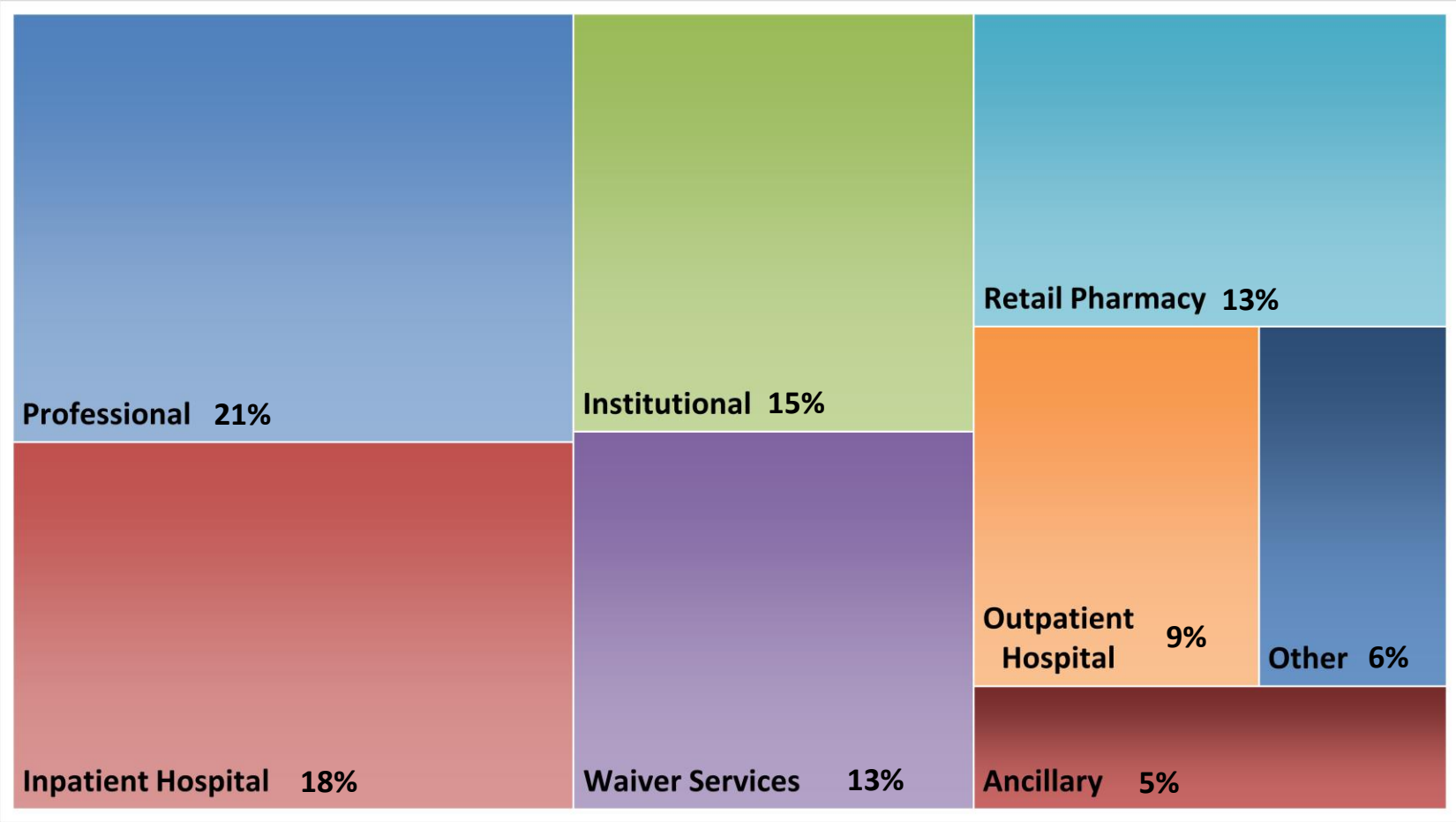


The top five percentile of the most expensive members make up over 60% of claims expenditure over a 12-month time period.

SFY 2020 Expenditures

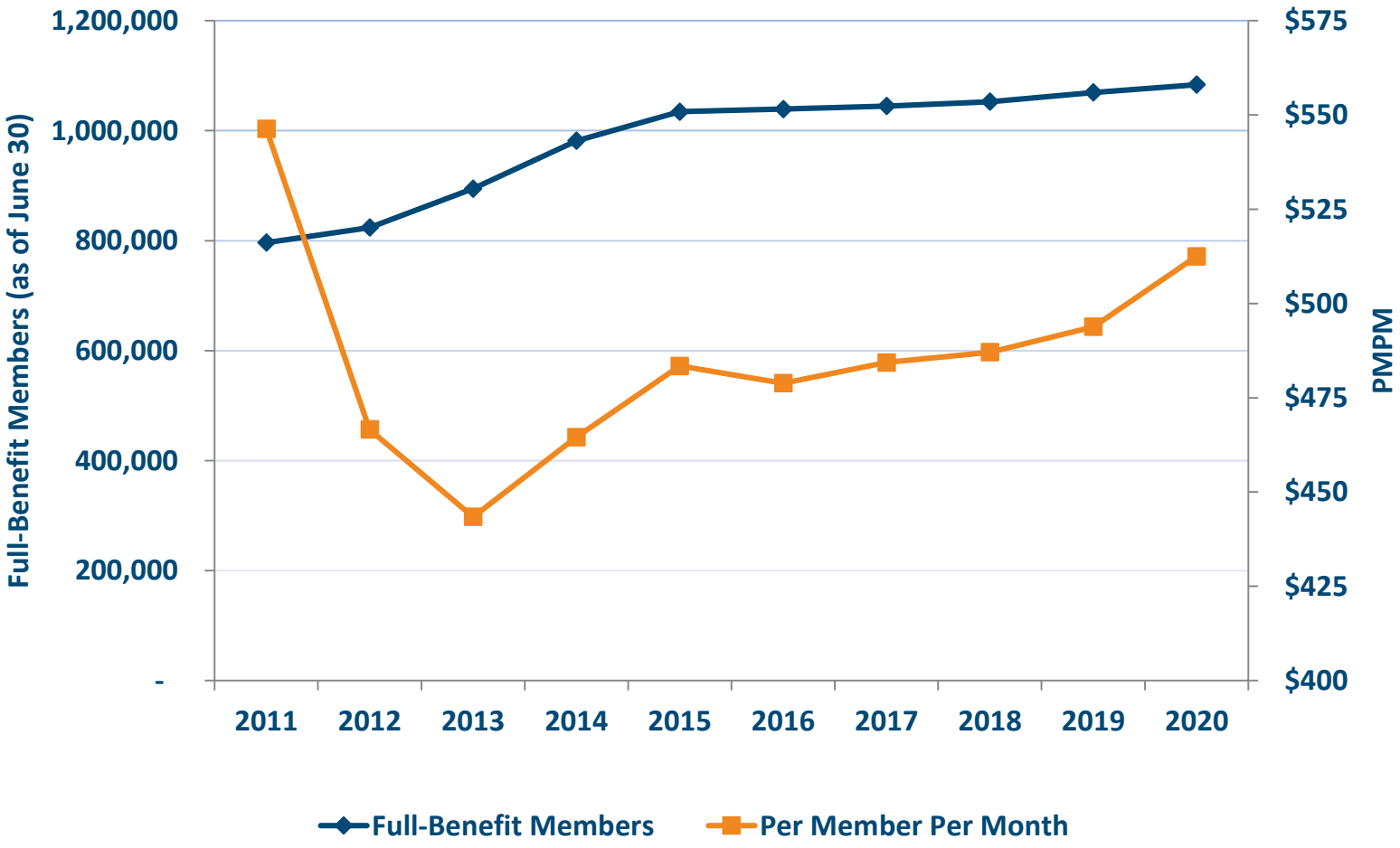
	FY2020 Expenditures	% of Total Expenditures
Managed Care Organization (MCO)	$3,304,289,343	42.3%
Fee For Service (FFS)	$2,040,551,030	26.1%
SCDHHS Administered and Operated Waiver Svcs.	$ 197,357,960	2.5%
Disproportionate Share (DSH)	$ 536,208,501	6.9%
State Agencies & Other Entities	$ 837,525,033	10.7%
Medicare Premiums	$ 391,850,513	5.0%
Personnel & Benefits	$ 81,416,222	1.0%
Medical Contracts and Operating	$ 424,168,124	5.4%
Total	**$7,813,366,726**	

SFY 2020 Claim Expenditures by Category

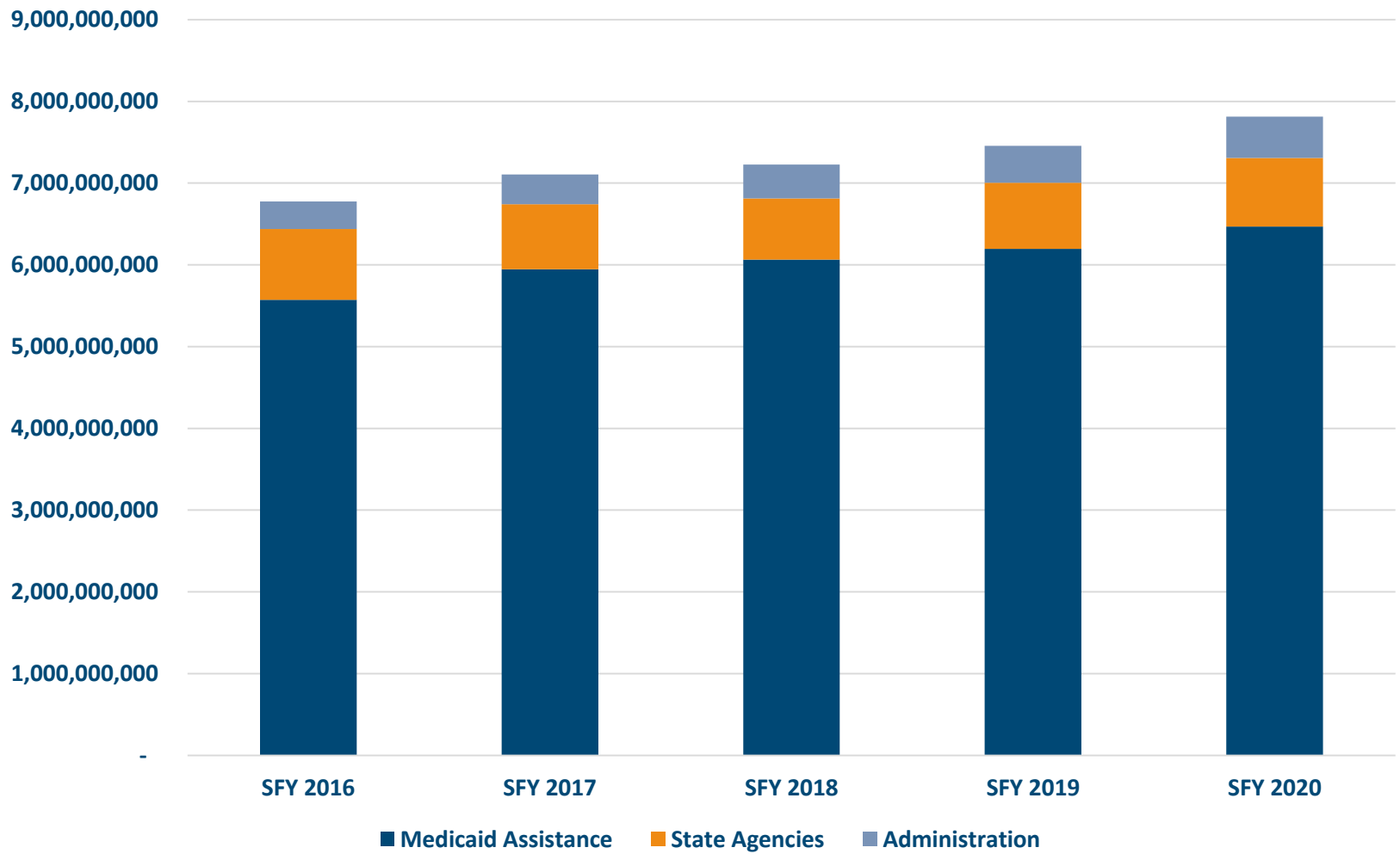


*Based on dates of services; claims only

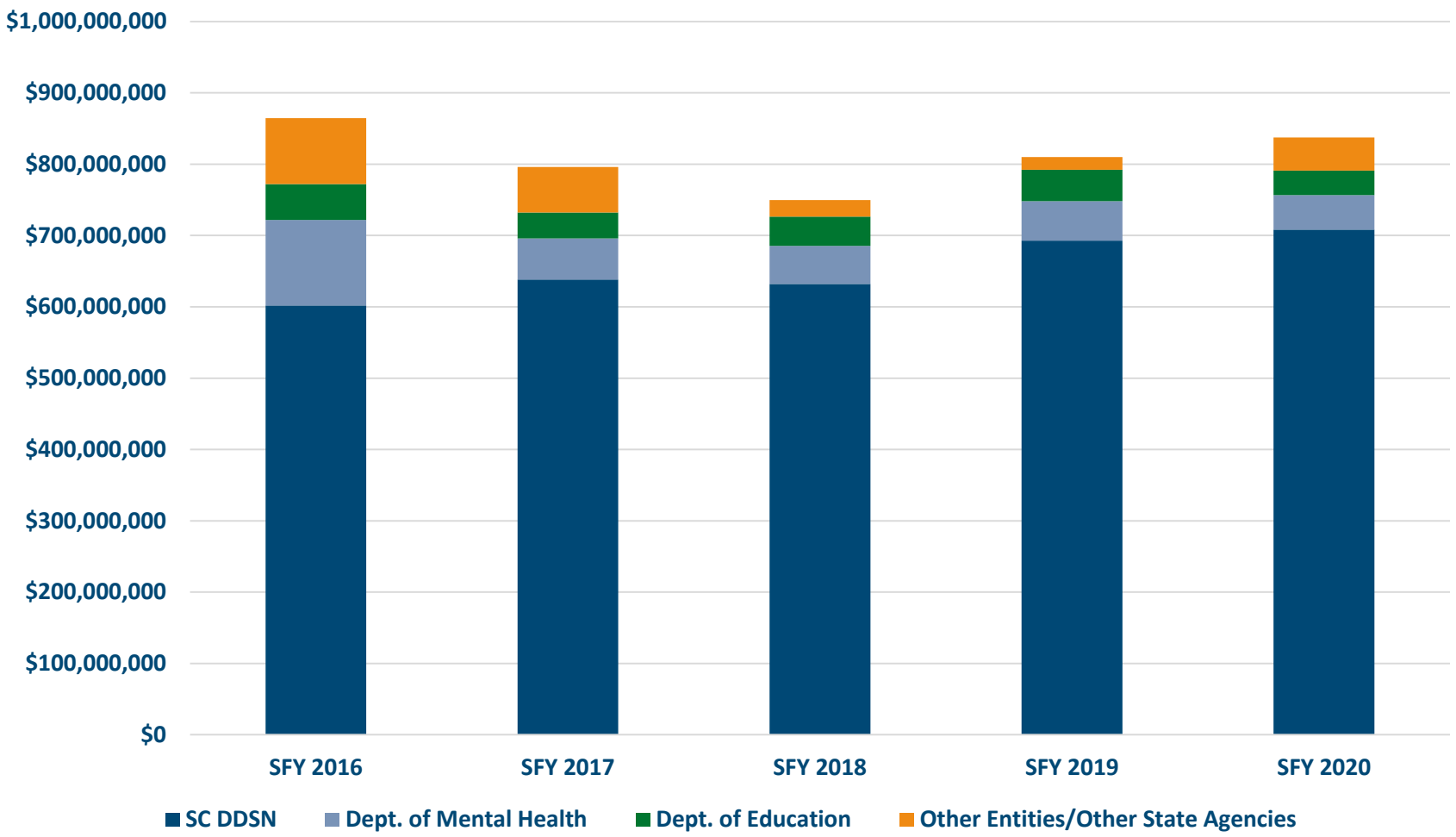
SCDHHS Per Member Per Month (PMPM) Trend



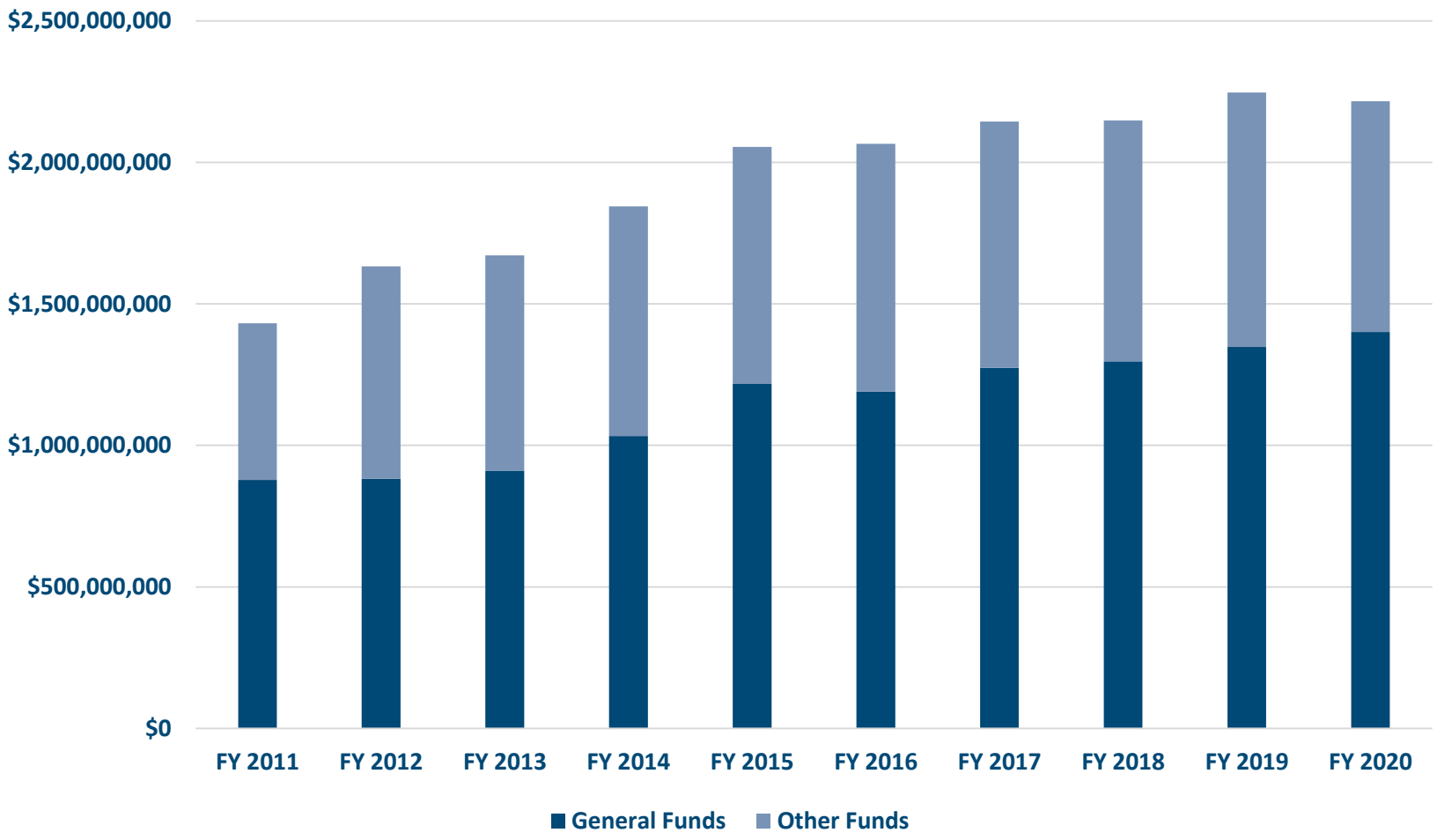
5 Year - Total Expenditures Trend



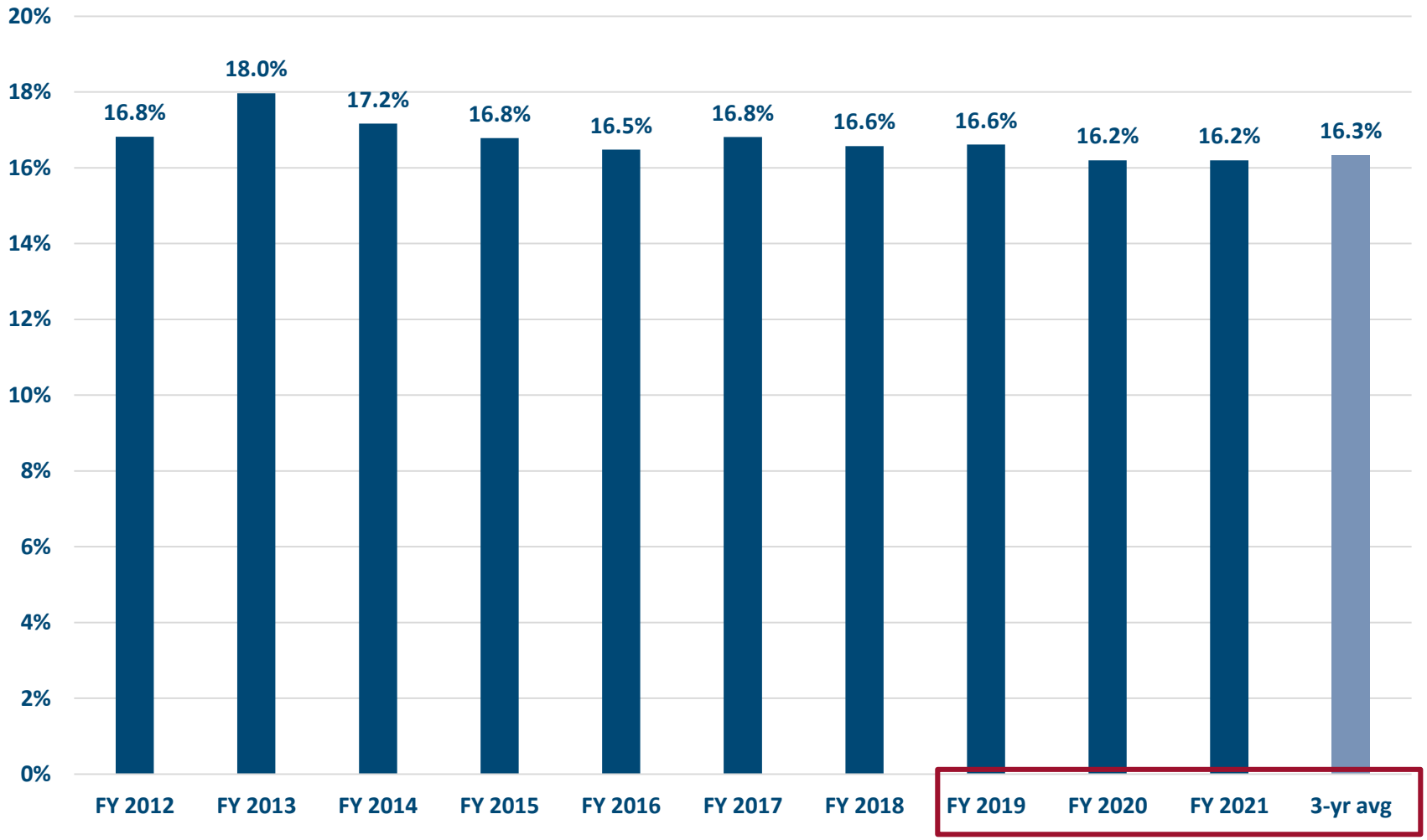
5 Year - Funds Paid to Other State Agencies



10 Year – State Expenditure Trend



SCDHHS Share of South Carolina's General Fund Appropriations



FY 2019-2020 Year End

	General Funds	Other Funds	Federal Funds	Total
Amount appropriated and authorized to spend	$1,415,395,316	$990,481,944	$5,385,854,110	$7,791,731,370
Additional other or federal funds authorization received	$0	$0	$315,000,000	$315,000,000
Total actual expenditures during the fiscal year	$1,400,648,102	$815,191,564	$5,597,527,060	$7,813,366,726
General fund carry forward total*	$97,339,051	$0	$0	$97,339,051

*Proviso 33.16

COVID-19 Impact

Coronavirus Disease 2019 (COVID-19) Update

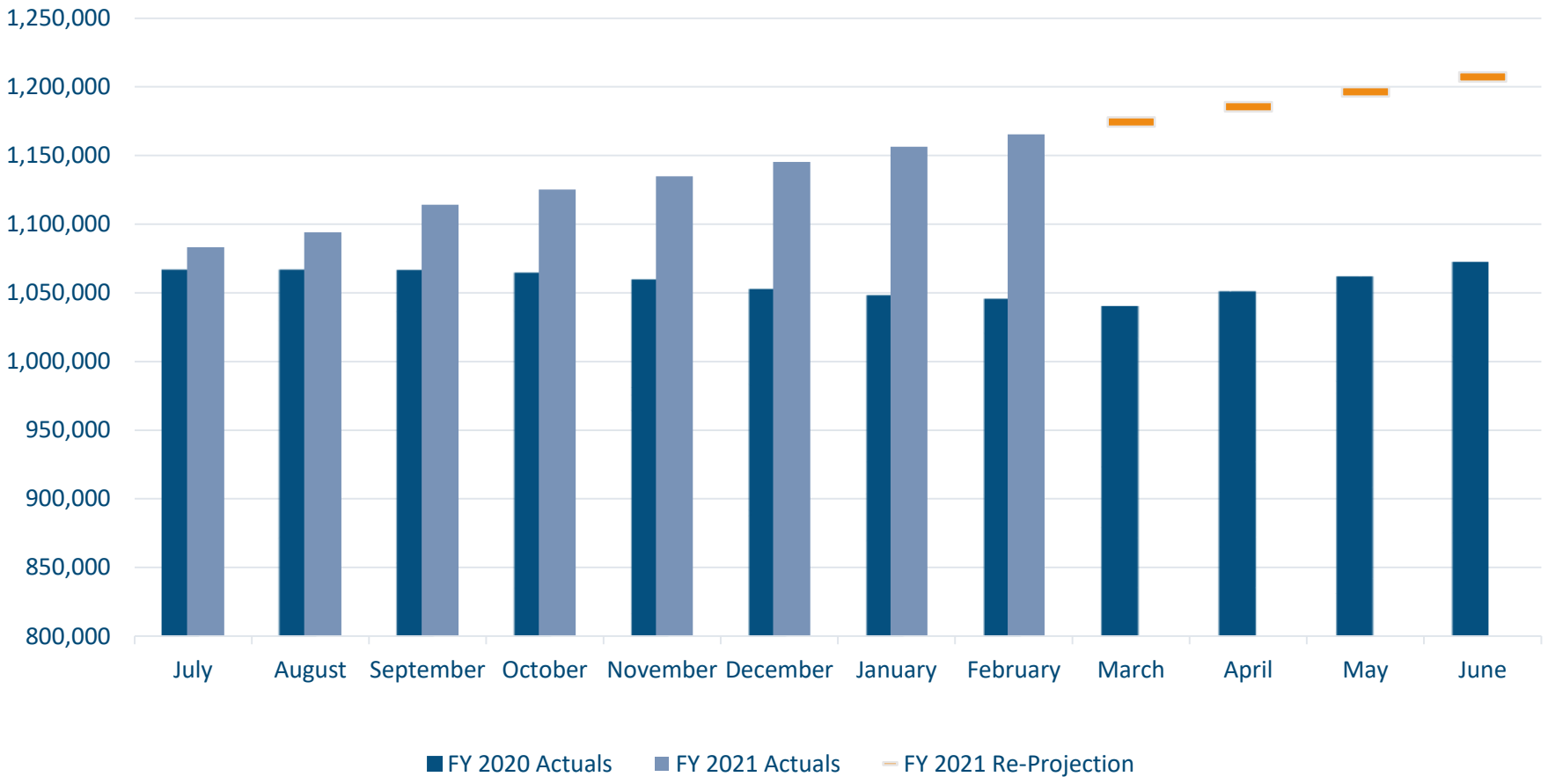
- Reserves, temporary enhanced FMAP and agency policy changes have helped mitigate the uncertainty of medical costs related to COVID-19 and the public health emergency
- Healthcare delivery flexibility (including expansion of existing telehealth benefit)
- Increase in enrollment
- Creation of new limited benefit program to cover cost of COVID-19 tests and vaccination administration
- No current plans to reduce provider reimbursement rates
- No current plans to drop optional services

Outlook

FY 2022 Budget Request

	General Funds	Total Funds
Recurring Requests		
Total Annualization/MOE	$ 94,239,009	$ 278,032,066
Total Initiatives	$ 36,973,963	$ 122,035,253
Community Long Term Care (CLTC) Census	$ 22,672,755	$ 76,545,093
Disproportionate Share Hospital (DSH) Allotment Increase	$ 8,831,395	$ 28,799,669
Un-funded contracts for non-covered populations	$ 35,800,000	$ 1,000,000
SC DDSN Appropriation Transfer	$ (1,808,437)	$ (1,808,437)
FY 2020-21 Recurring Changes	**$ 196,708,684**	**$ 504,603,644**
Non-Recurring Request		
Non-Recurring: MMIS	**$ 16,678,434**	**$ 117,048,236**

FY 2021 Full-Benefit Enrollment



*Projection does include impact related to the FFCRA

Oversight Presentation Series Topics

- Agency Overview
- Medicaid Eligibility
- **Medicaid Financing**
- Program Integrity
- Medicaid Managed Care
- Home and Community Based Services Waiver Programs
- Health Improvement Programs
- Replacement Medicaid Management Information System
- Emerging and Priority Issues


SOUTH CAROLINA
ANIMIS OPIBUSQUE PARATI
DUM SPIRO SPERO
SPES
1776