HEALTHCARE AND REGULATORY SUBCOMMITTEE
MONDAY, MAY 24, 2021

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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, May 24, 2021
2PM
321 - 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

Legislative Oversight Committee
Monday, May 3, 2021
2:00pm
Blatt Room 321

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 Subcommittee Chair John Taliaferro West, IV, on Monday, May 3, 2021, in Room 321 of the Blatt Building. All members (Representative Gil Gatch, Representative Rosalyn D. Henderson-Myers, and Representative Timothy A. McGinnis attended virtually via Microsoft Teams) were present for all of the meeting.

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.

Approval of Minutes

I. Representative Henderson-Myers makes a motion to approve the meeting minutes from the April 26, 2021, meeting. A roll call vote was held, and the motion passed.

Rep. Henderson-Myers motion to approve the April 26, 2021, meeting minutes.	Yea	Nay	Not Voting
Rep. West	✓		
Rep. Gatch			Not present
Rep. Henderson-Myers	✓		
Rep. McGinnis	✓		

Discussion of Department of Health and Human Safety (HHS)

I. Chair West swears in the following individuals:
   a. Mr. Michael Jones, COO and Deputy Director for Medicaid Operations; and
   b. Mr. Jonathan Tapley, Operations Manager, Managed Care .

II. Mr. Jones discusses the following topics during his presentation on Medicaid Managed Care:
   a. PER information;
      i. Related deliverables;
      ii. Performance measures;
      iii. Turnover data;
      iv. Statutes applicable to managed care;
      v. Claims and capitation costs;
      vi. Employee satisfaction;
      vii. Managed care and operations organizational chart;
   b. S.C. Medicaid Health Payment Models;
      i. Definitions of key terms;
      ii. Timeline for how HHS progressed through different managed care models from 1968 through present;
      iii. Fee for service overview;
      iv. Managed care overview;
      v. Capitation calculation example;
      vi. Flow chart illustrating how Medicaid coverage is funded;
      vii. Diagram for fee for service transactions v. managed care transactions;
      viii. Fee for service v. Managed care coverage structure and flexibilities and efficiencies;
   c. S.C. Medicaid Population;
      i. Population groupings;
   d. Matching S.C. Populations to Models;
      i. Care delivery flow chart;
      ii. Selection and enrollment process for managed care plans;
   e. S.C. Medicaid by the Numbers;
   f. Managed Care Incentives and Quality;
      i. Medical loss ratio;

ii. Quality withhold program;
iii. Selection criteria for index measures;
iv. Current quality indices for managed care plan;
v. Multicultural health care quality standards;
vi. External quality review;
vii. Financial oversight;

g. COVID-19 Impact; and
h. Evolution of S.C. Managed Care.

III. Subcommittee members ask questions relating to the following:

a. Number of provider applications processed annually;
b. Time within which to process electronic payments;
c. Explanation of HEDIS – national standard for metrics applicable to the healthcare industry;
d. Causes of employee turnover;
e. Motive for transitioning from fee for service to managed care;
f. Method for controlling costs while still ensuring quality care;
g. Ability for capitation rates to be negotiated;
h. Services available for those utilizing managed care plans versus fee for service plans;
i. High enrollment of certain MCOs like Select Health;
j. Explanation of Healthy Connections Prime;
k. Method for determining medical loss ratio;
l. Method for keeping abreast of national standards for benchmarking;
m. Process for selecting an external vendor for quality control services;
n. Explanation of risk corridor ;
o. Significant changes in overall utilization of services seen during COVID-19; and
p. Analysis of data for determining whether to retain any of the service modifications made during COVID-19.

Agency staff respond to the members' questions.

Adjournment

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

STUDY TIMELINE

Timeline of Agency Study

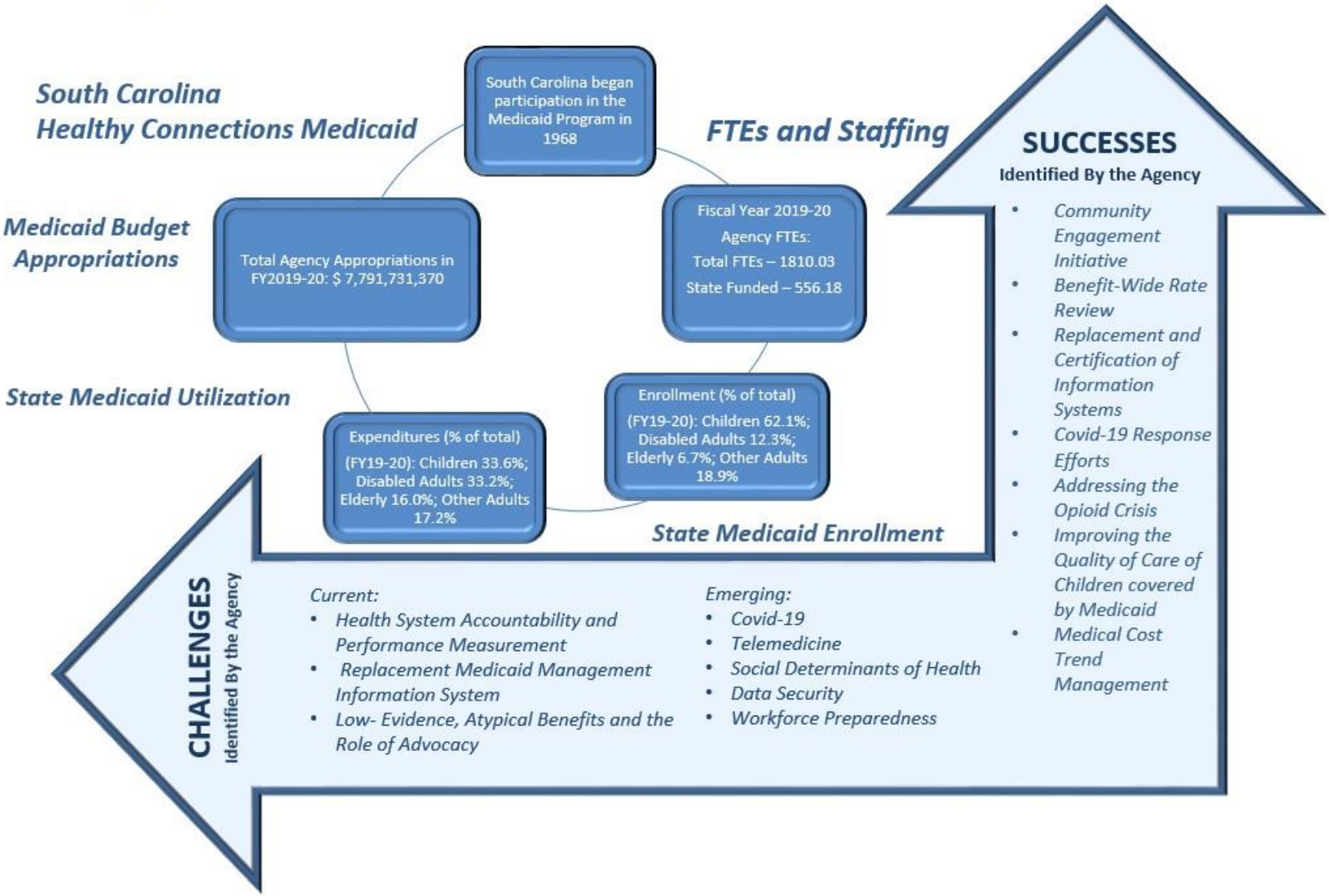
The House Legislative Oversight Committee's (Committee) process for studying the Department of Health and Human Services (agency, Department, or DHHS) includes actions by the full Committee; Healthcare and Subcommittee (Subcommittee); the agency; and the public. Key dates and actions are listed below.

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.
April 26, 2021	The Subcommittee holds Meeting 6 with the agency to discuss the Program Integrity division.
May 3, 2021	The Subcommittee holds Meeting 7 with the agency to discuss the Basics of Medicaid Managed Care.
May 24, 2021	The Subcommittee holds Meeting 8 with the agency to discuss Waiver Programs; Health Improvement Programs; and Replacement Medicaid Management Information System

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

AGENCY SNAPSHOT

Department of Health and Human Services



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AGENCY PRESENTATION

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Healthy Connections Medicaid Health Improvement Programs & Home and Community-Based Services Waiver Programs Overview

Janelle Smith

Deputy Director for Health Programs

South Carolina Department of Health and Human Services

Oversight Presentation Series Topics

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

Health Improvement Programs Agenda

- Program Evaluation Report (PER) Information
- Medicaid Population
- Quality Improvement and Payment Reform
- Individuals with Disabilities Education Act (IDEA) Part C (BabyNet)
- Behavioral Health Benefit
- Opioid Crisis Strategies
- COVID-19 Impact

PER Information

Agency Deliverables

1) Provide for an eligibility system that allows citizens to apply for Medicaid, processes that application and determines which citizens are eligible for Medicaid benefits.

2) Design and provide reimbursement for evidence-based, high value health benefits to Medicaid beneficiaries, based on medical necessity.

3) Establish an adequate network of qualified providers to provide care for Medicaid beneficiaries and provide reimbursement to those providers for care delivered pursuant to the Medicaid benefit.

4) Provide and operate a process for member and provider appeals.

5) Safeguard taxpayer resources against fraud, waste and abuse.

6) Administer the Medicaid program in a manner that is consistent with state and federal law.

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

8) Lead Agency for South Carolina's Individuals with Disabilities Education Act Part C Program, known locally as "BabyNet."

FY19-20 Performance Measures

- Ensure performance at or above the regional average for targeted Healthcare Effectiveness Data Information Set (HEDIS) measures
  - Target: 100%
  - Actual: 83% (10 of 12 met regional avg.)
- Implement social determinants of health screenings in 10% of high needs communities
  - Target: 10+%
  - Actual: 7.8%
- Reduce avoidable emergency department visits by 5% in one year
  - Target: 328,023 visits
  - Actual: 277,056 visits
- Maintain performance at or above the regional Medicaid standard for Consumer Assessment of Healthcare Providers and Systems (CAHPS) measurements of access to care (child measure)
  - Target: At or above SFY19-20 rates (base rate is 77.7%)
  - Actual: 74.4%
- Maintain performance at or above the regional Medicaid standard for CAHPS measurements of access to care (adult measure)
  - Target: At or above SFY19-20 rates (base rate is 61.4%)
  - Actual: 63.9%

FY19-20 Performance Measures *(cont.)*

- Increase the percentage of beneficiaries diagnosed with substance use disorder who are receiving treatment by 10%
  - Target: 57.8
  - Actual: 58.6
- Ensure 95% of beneficiaries receive primary care services within 10 miles and 15 days
  - Target: 95%
  - Actual: 90%
- Ensure 95% of beneficiaries receive specialty care services within 40 miles and 45 days
  - Target: 95%
  - Actual: 90%
- Increase the number of providers participating in the telehealth by 5%
  - Target: 189
  - Actual: 6,120
- Reduce the rate of low birth weight babies by 3%
  - Target: 8.7%
  - Actual: 12%
- Increase the relative share of long-term care beneficiaries in community settings by 3%
  - Target: 61.22%
  - Actual: 69.4%

Turnover Data

- Health Programs (Behavioral Health, Pharmacy, Dental, Coverage and Benefit Design, etc.)
  - FY19-20: 19.13%
  - FY18-19: 14.06%
  - FY17-18: 29.27%
  - FY16-17: 18.63%
- Long Term Care Program Support [Community Long Term Care, Nursing Home, Optional State Supplementation (OSS)/Optional Supplemental Care for Assisted Living Participants (OSCAP), Home Health, Hospice]
  - FY19-20: 17.10%
  - FY18-19: 15.56%
  - FY17-18: 23.89%
  - FY16-17: 13.86%
- South Carolina Department of Disabilities and Special Needs (SCDDSN) Program Support
  - FY19-20: 25.00%
  - FY18-19: 30.77%
  - FY17-18: 10.00%
  - FY16-17: 0.00%

Statutes Included in PER

- S.C. Code § 44-6-30(1) – Administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment (EPSDT) program and the community long-term care (CLTC) system
- S.C. Code § 44-6-40(1) – Prepare and approve state and federal plans prior to submission to the appropriate authority as required by law for final approval or for state or federal funding, or both. Such plans shall be guided by the goal of delivering services to citizens and administering plans in the most effective and efficient ways possible.
- S.C. Code § 44-6-70 – Preparation of state plan and resource allocation recommendations.
- S.C. Code of Reg. Article 3 Medicaid, Subarticle 1 Scope of the Program (for all covered services)
  - Medical necessity
  - Prior authorization
  - Copayment
  - Service limits

Statutes Included in PER *(cont.)*

- 42 U.S. Code § 1396a – State plans for medical assistance
  - (a)(30) – Utilization management
  - (a)(43) – EPSDT services and vaccines
  - (a)(62) – Pediatric vaccine distribution program
  - (a)(67) – Programs of All-Inclusive Care for the Elderly (PACE) program
  - (a)(70) – Non-emergency Medical Transportation (NEMT) program
  - (bb) Payment for services provided by Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
  - (oo) Drug review and utilization requirements
- 42 U.S. Code § 1396d – Mandatory and optional service definitions
- 42 C.F.R. Part 440 – Services: General Provisions
- 42 C.F.R. Part 441 – Services: Requirements and Limits Applicable to Specific Services

Statutes Included in PER *(cont.)*

- S.C. Code § 44-6-70(f) – Assurance of maximum utilization of private and nonprofit providers in administration and service delivery systems, provided quality of care is assured
- S.C. Code § 44-6-70(g) – Encouragement of structured volunteer programs in administration and service delivery
- S.C. Code § 44-6-110 – Medicaid providers; boundary clarification
- 42 U.S. Code § 1396a. – State plans for medical assistance
  - (a)(13) – Rates and methodologies
  - (a)(23) – Any qualified and willing provider
  - (a)(27) – Provider agreements
  - (a)(35) – Ownership and disclosure requirements
  - (a)(59) – Maintain a list of all physicians who are certified to participate under the State Plan
- Executive Order 2016-20
- 2019-2020 Appropriation Act, Part 1B Section 33.23. (SCDHHS: BabyNet Compliance)
- 20 U.S. Code § 1400 et seq. – IDEA Act, Subchapter III (Infants and Toddlers with Disabilities)

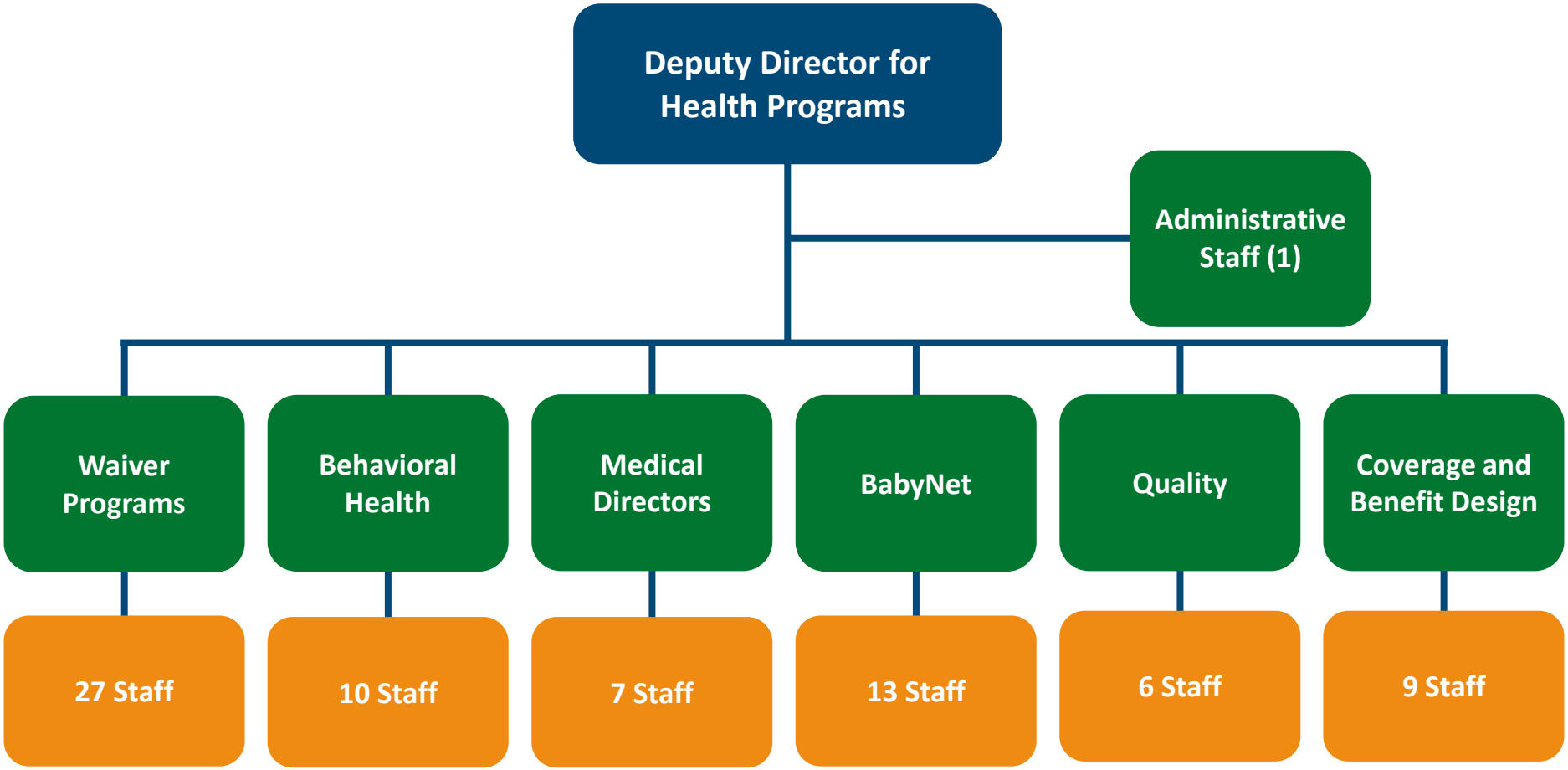
Statutes Included in PER *(cont.)*

- S.C. Code § 44-6-30(1) – Administer Title XIX of the Social Security Act (Medicaid), including the EPSDT program and the CLTC System
- S.C. Code § 44-6-40(1) – Prepare and approve state and federal plans prior to submission to the appropriate authority as required by law for final approval or for state or federal funding, or both. Such plans shall be guided by the goal of delivering services to citizens and administering plans in the most effective and efficient ways possible.
- S.C. Code § 44-6-70 – Preparation of state plan and resource allocation recommendations.
- S.C. Code of Reg. Article 3 Medicaid, Subarticle 1 Scope of the Program (for all covered services)
  - Medical necessity
  - Prior authorization
  - Copayment
  - Service limits
- 42 U.S. Code 1396n – Waivers
  - (c) Home and community-based waivers
- 42 C.F.R. Part 440 – Services: General Provisions
- 42 C.F.R. Part 441 – Services: Requirements and Limits Applicable to Specific Services

Employee Satisfaction

- Employee satisfaction tracked?
  - FY19-20: No (new vendor awarded Sept. 2020)
  - FY18-19: Yes
  - FY17-18: Yes
  - FY16-17: Yes

Health Programs - Organizational Chart



Medicaid Population

South Carolina Medicaid Population

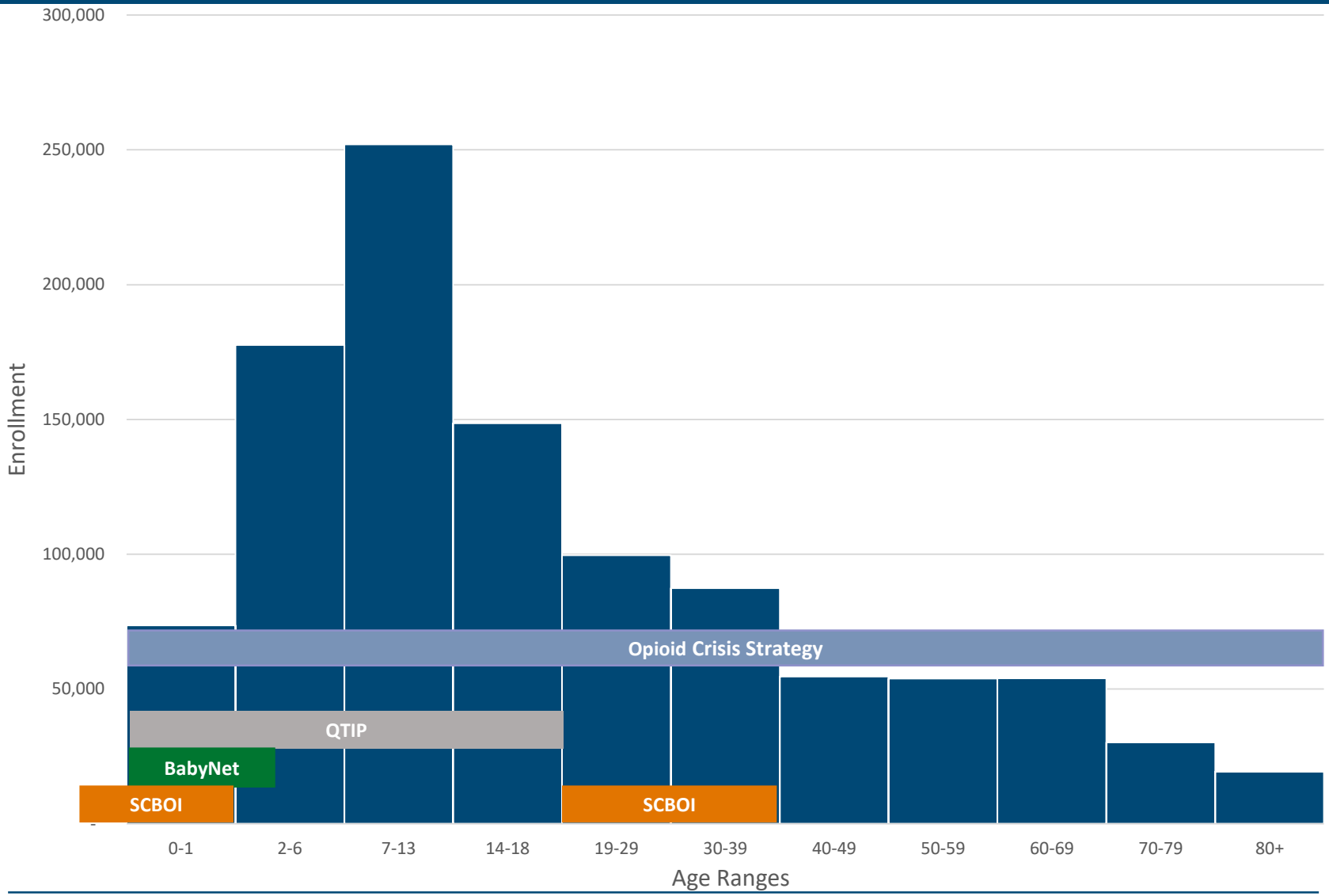
- Full benefit membership: Approximately 1.1 million

Children	**690,000**
Disabled Adults	**130,000**
Other Adults	**240,000**
Elderly	**80,000**
Limited Benefits	**250,000**

**Data as of Dec. 31, 2020*

- **60%** of South Carolina Medicaid members are age 0 to 18
- Roughly **60%** of all children in South Carolina are covered by Medicaid
- In South Carolina, Medicaid covers nearly **60%** of all births
- More than 75% of full benefit members are enrolled in managed care

Healthy Connections Medicaid Enrollment by Age



Quality Improvement and Payment Reform

Setting Context Definition

Healthcare quality is

"...the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Institute of Medicine, 2019

Where Does the Consumer Place Value?

- Staying healthy
  - Getting help to avoid illness and remain well
- Getting better
  - Getting help to recover from an illness or injury
- Living with illness or disability
  - Getting help with managing an ongoing, chronic condition or dealing with a disability that affects function
- Coping with the end of life
  - Getting help to deal with a terminal illness

Institute of Medicine, 2019

Capturing Quality Snapshot

- Quality measurements
  - Can be identified
  - Have a reasonable degree of control over the aspect of care being evaluated
  - Rigorous
  - Systematic
  - Quantifiable
- Quality measures can be used to evaluate:
  - Managed care organizations (MCOs)
  - Health plan or program
  - Hospital
  - Health care practitioner

Guided by Federal Regulations

- Code of Federal Regulations (CFR) and Social Security Act
  - State must:
  - Develop and implement quality assessment and improvement strategy for its managed care programs
    - Access standards
    - Other measures
    - Monitoring procedures
    - Periodic review
  - Provide for an annual external independent review of managed care activities
  - Must update and review quality strategy at least every three years

SCDHHS Quality

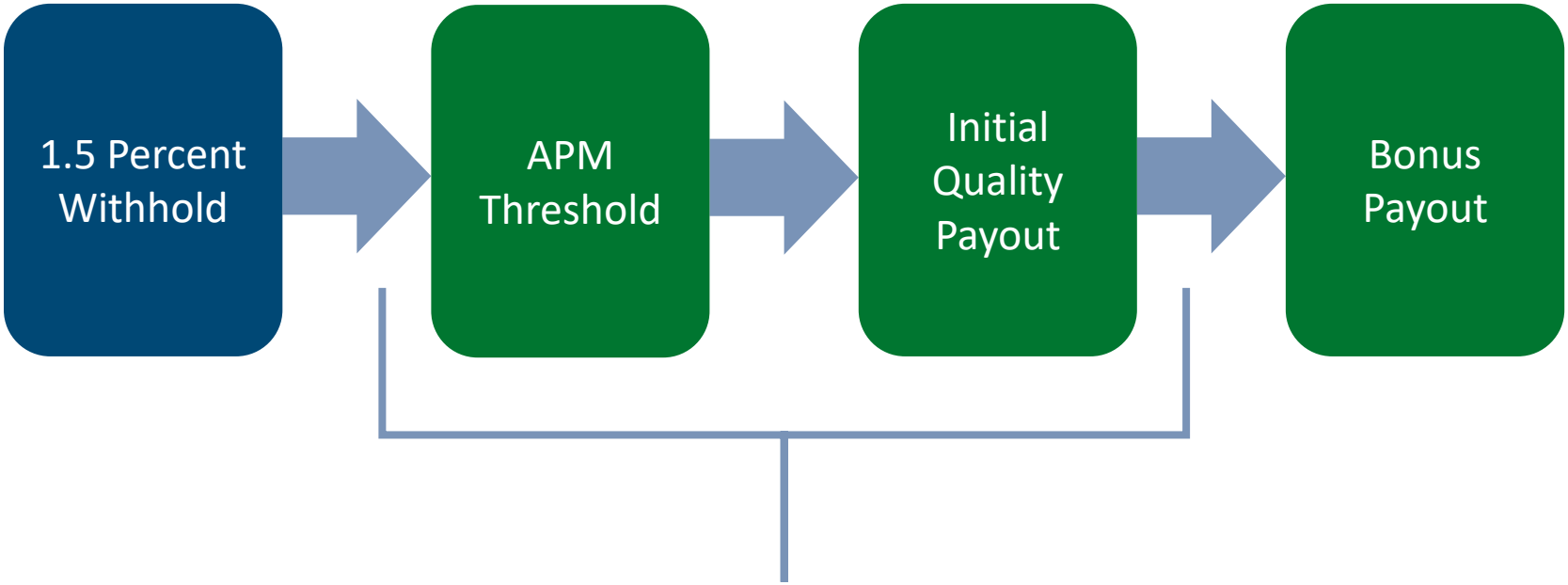
- MCO Quality Strategy
  - Alternative Payment Model (APM)
  - Withhold Bonus Program
  - Patient-Centered Medical Home Incentive
  - Primary Care Enhanced Payment

APM Overview

- An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.
  - Control spending
  - Improve care
  - Increase accountability within Medicaid and across the health care system

Withhold Program

Holds approximately $40 million in total MCO capitation payments that must be *earned back* by the MCOs based on quality of care



Blending Quality and Payment Reform

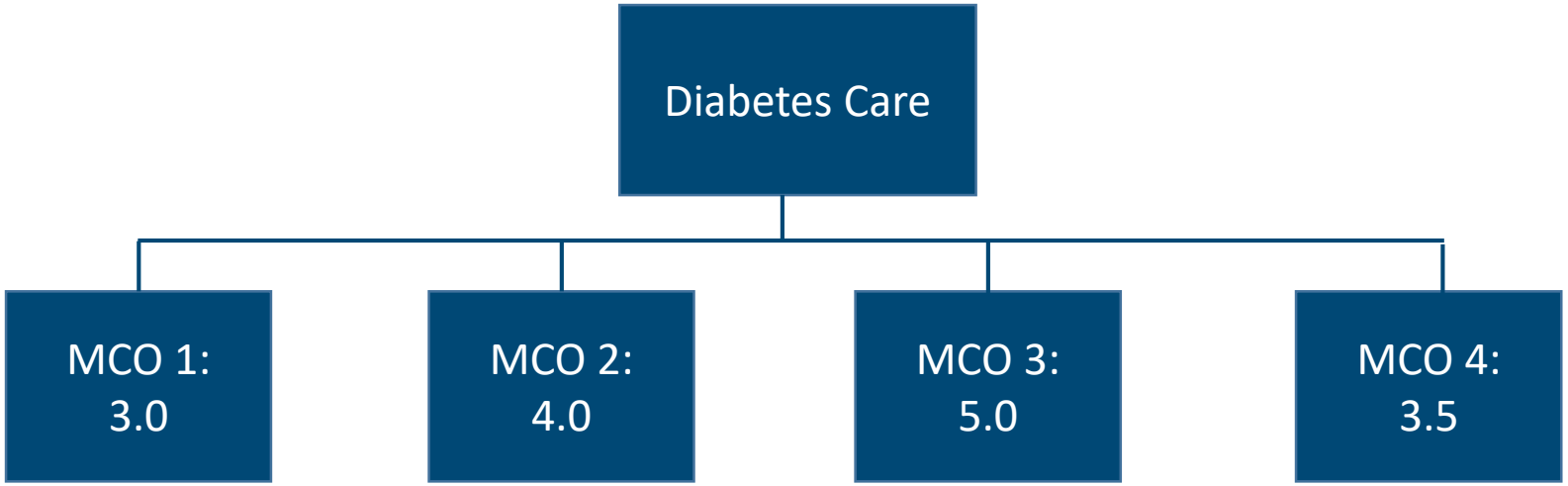
Measuring APM Success

- Since 2015, MCOs must make a percentage of provider payments pursuant to APMs.
- Benchmarks:
  - 2015: 5%
  - 2016: 12%
  - 2017: 20%
  - 2018-2021: 30%
- Failure to meet the benchmark will result in the loss of withholds.

Current Indices of Quality

- Diabetes care
  - A1c testing, A1c poor control, testing for nephropathy, eye exam
- Women's preventive health
  - Timeliness of prenatal care, breast cancer and cervical cancer screenings, chlamydia testing
- Children's preventive health
  - Well-child visits (15 months, 3-6 years, adolescent) and body mass index
- Incentive-only quality metrics
  - Heavily weighted towards behavioral health
  - Includes integration of several metrics

MCO Quality Withold Example



Withhold: $1,000
Amount forfeited: 25% ($250)
Earned Back: $750

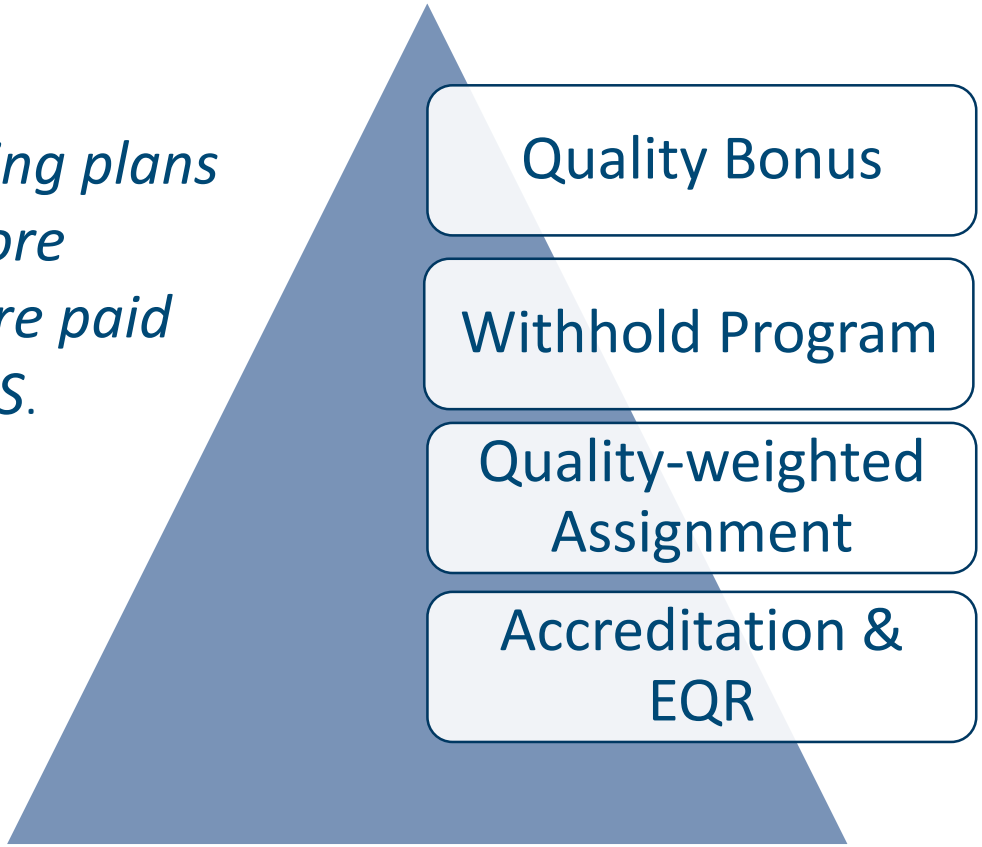
Withhold: $1,000
Amount forfeited: 0% ($0)
Earned Back: $1,000

Withhold: $1,000
Amount forfeited: 0% ($0)
Earned Back: $1,000
Bonus: $500

Withhold: $1,000
Amount forfeited: 25% ($250)
Earned Back: $750

Incentivizing Quality

Higher performing plans are assigned more members and are paid more by SCDHHS.



Patient-Centered Medical Home Incentive

- Improve quality and the patient experience and increase staff satisfaction—while reducing health care costs.
- Practices that earn recognition have made a commitment to continuous quality improvement and a patient-centered approach to care.
- In partnership with the South Carolina Medical Association and the SC Office of Rural Health

Primary Care Enhanced Payment

- Extension of the Affordable Care Act Enhanced Physician Payment Program that ended in 2014
- Provides additional payment for primary care providers for certain evaluation and management (E/M) codes
- Applies to:
  - Family Practice
  - Internal Medicine
  - Pediatrics
  - OB/GYN
  - Psychiatry

The Future…

1. Continued integration of quality and payment reform (and electronic health data)
2. Increased focus on performance and national benchmarking
3. Focus on social determinants of health
4. National Committee for Quality Assurance Distinction in Multicultural Health Care for MCOs
5. Inclusion of fee-for-service and hospital quality into 2022 Quality Strategy

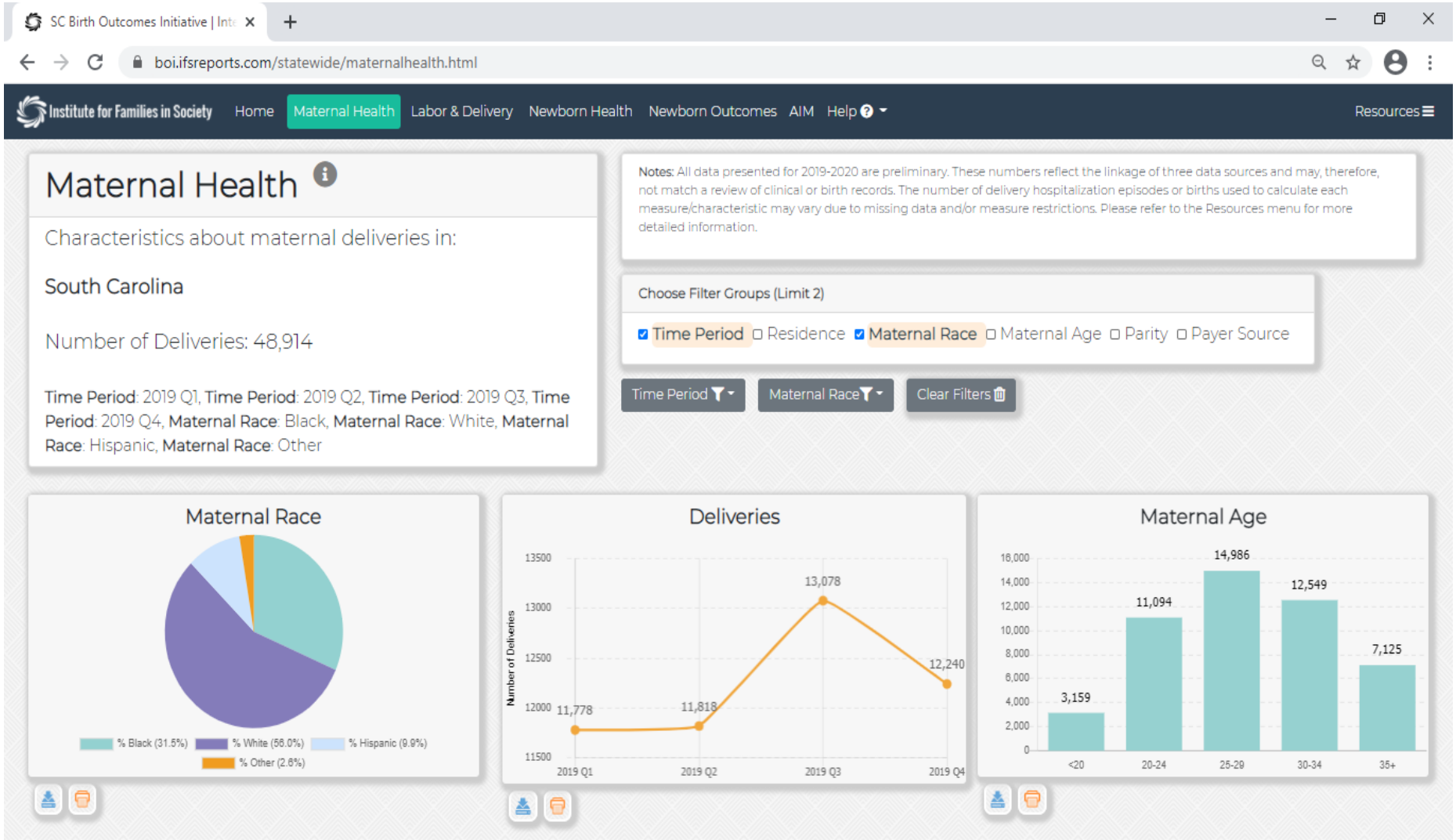
South Carolina Birth Outcomes Initiative (SCBOI) Overview

- Leverages the **collective impact model** to identify a common agenda and provide for continuous communication
- Collaborative of SCDHHS, the South Carolina Department of Health and Environmental Control, South Carolina Hospital Association, March of Dimes, Blue Cross Blue Shield of South Carolina and more than 100 stakeholders

South Carolina Birth Outcomes Initiative (SCBOI) Successes

- Eliminating Early Elective Inductions
- Reducing NICU Admissions and Preventing Pre-term Births
- Supporting Screening and Support for Environmental Factors
- Promoting Breastfeeding
- Encouraging the Use of Long-acting Reversible Contraceptives (LARCs)
- Ensuring Safe Sleep Habits for Children
- Using Data and Best Practices to Improve Maternal Health Outcomes

South Carolina Birth Outcomes Initiative (SCBOI) Dashboard



The Future of South Carolina Birth Outcomes Initiative (SCBOI)

- Improving Postpartum Care Affinity Group
- Continued monitoring and sundowning of achieved established goals
- Establishing goals and objectives for next decade of SCBOI

Quality Through Technology and Innovation in Pediatrics (QTIP) Overview

- Started in 2010 as a federal Children's Health Insurance Program Reauthorization Act (CHIPRA) demonstration grant designed to build a learning community for pediatric primary care practices across South Carolina
- Improves 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.

The Value of QTIP

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Children	Providers	SCDHHS
• Increase evidence-based clinical care and quality of care • Increase screening and preventative services • Increase focus on mental health, well-visit compliance, oral health, caregiver smoking cessation and vaccinations	• Open dialogue with SCDHHS • Increased capacity for system changes • Additional trainings, community resources, pilot programs and assistance in transformation to a patient-centered medical home	• Open dialogue with South Carolina chapter of American Academy of Pediatrics (AAP) • Quality improvement projects to improve health outcomes for South Carolina's children • Focus on specific state initiatives designed to improve public health

How QTIP Works

- Leverages the **collective impact** model; structurally very similar to SCBOI
- QTIP is designed to work directly with pediatric practices by supporting their office's quality improvement team
- Collaborative learning sessions are held twice per year
- Technical assistance is provided via on-site visits, monthly calls and workshops
- Quality improvement (QI) techniques are taught and data is gathered on select children's measures

QTIP Data

QTIP practices score higher than non-QTIP practices and the state average in all tracked Well Child Care (WCC) HEDIS-like categories.

Since 2011:	6+ visits in the first 15 months	3 – 6 years	Adolescents
QTIP practices have shown:	a 53.7% increase	a 17.5% increase	a 37.7% increase
The state rate has:	increased 15.4%	increased 13.5%	increased 15.9%

- Data reflects QTIP practices as a group and shows percentage of change from 2011 to 2019.
- Data provided by Medicaid Policy Research at the USC Institute for Families in Society.

QTIP Preventative Health Claims Data

- QTIP has worked to promote targeted preventative health areas. The number of Medicaid-enrolled children receiving preventative services is shown below:
  - **1,606% increase** in the fluoride varnish in a non-dental setting since 2011
  - **351% increase** in developmental screenings since 2011
  - **429% increase** in emotional/behavioral health screenings since 2015
  - **1,666% increase** in environment and risk assessments since 2011

QTIP Provider Feedback

"QTIP has shown me that pediatricians are stronger, and our practices provide better and more efficient care, when we work together and learn from one another....and all of our young patients are better off for it."

Deborah Greenhouse, MD
Palmetto Pediatrics and Adolescent Clinic

"QTIP gave us the focus we needed. It helped put us ahead and position our practice to where it needed to be."

Kevin Wessinger, MD
Sandhills Pediatrics

"QTIP got us thinking in terms of quality."

Bill Basco, MD
Director, Division of General Pediatrics,
Medical University of South Carolina

"SCDHHS and QTIP provide an invaluable resource for the pediatricians of South Carolina via the SC Chapter of the AAP. Through a strong liaison/working relationship, both organizations can and do deliver innovative and substantial programs to our children and families. We are the envy of many AAP chapters in the country."

Dr. Robert Saul, president of the South Carolina Chapter of the American Academy of Pediatrics

Individuals with Disabilities Education Act (IDEA) Part C (BabyNet)

BabyNet

- IDEA is a federal law ensuring services to children with disabilities throughout the nation.
- IDEA governs how states and public agencies provide early intervention, special education and related services to infants, toddlers, children and youth with disabilities.
- At the federal level, the IDEA Part C program, which serves children under the age of three, is overseen by the Office of Special Education Programs (OSEP) within the U.S. Department of Education.
- The BabyNet program is not a Medicaid program. SCDHHS assumed lead agency responsibilities for South Carolina's IDEA Part C program, commonly known as BabyNet, effective July 1, 2017.

BabyNet Services

- BabyNet provides families with the services and information they need to support their infant or toddler with developmental delays or disabilities.
  - Services are provided at no cost to the family.
  - The amount or type of services provided vary depending upon the individualized needs of the child and family. Services may include: therapies, service coordination and family training.
  - Services are provided in natural environments or settings that are natural or typical for same-aged children without a disability.
  - IDEA Part C service coordinators assist in transitioning children to Part B of IDEA (school-based services) or other settings such as preschool programs, etc.
  - Children exit IDEA Part C for one of three reasons; the child meets their outcomes, the family chooses to end services or the child turns three.

BabyNet Eligibility Criteria

Established Risk Condition

Has a diagnosed physical or mental condition that:

- Has a high probability of resulting in developmental delay, and
- Includes conditions such as chromosomal abnormalities, genetic disorders, sensory impairments and congenital disorders

OR

Developmental Delay

Is experiencing a developmental delay, as measured by appropriate diagnostic instruments and procedures, in one or more areas:

- Cognitive development, physical development (including vision and hearing), communication, social or emotional development or adaptive development

South Carolina's Eligibility Criteria

- 2 standard deviations (approximately 40%) below in one area of development
- 1.5 standard deviations (approximately 25%) below in two areas of development

BabyNet Program Data

- Referrals received between July 1, 2020 - April 29, 2021: **14,987**
- Currently serving 7,534 children with Individualized Family Service Plans (IFSPs)
- Top Referral Sources:
  - Physicians: 4,401
  - Parent/Relative: 2,458
  - Child Abuse Prevention & Treatment Act (CAPTA): 4,059

BabyNet Accomplishments

- Streamlined referral and intake processes and increased staffing to reduce wait time for families from referral to eligibility
- Federally approved IDEA Part C policy and procedure manual
- Integration of provider enrollment
- Coordination of benefits with MCOs
- Integration of the BabyNet Reporting & Integration Data Gathering Electronic System (BRIDGES) case management platform with the Medicaid Management Information System (MMIS) for improved payment coordination and reporting
- Conducted program monitoring and issued findings for the first time in the program's history

Behavioral Health Benefit

Behavioral Health Benefit-Covered Services

- SCDHHS Behavioral Health Benefit covers the spectrum of behavioral services spanning a total of nine provider manuals. Services range from:
  - Outpatient [Rehabilitative Behavioral Health Services (RBHS), Licensed Independent Provider (LIP) services, Early Intervention services, Autism Spectrum Disorder (ASD) services]
  - Clinic-based [Community Mental Health Services, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Opioid Treatment Programs (OTPs)]
  - Inpatient services [Psychiatric Rehabilitative Treatment Facilities (PRTFs), Acute Inpatient Psychiatric Services]

Behavioral Health Benefit-Covered Services *(cont.)*

- SCDHHS covers a continuum of behavioral health care including:
  - Community-based Services
    - Early Intervention
    - Community Support Services
    - Core Services
    - ASD Services
    - Substance Use Disorder (SUD) Services
  - Psychiatric Residential Treatment Facilities (PRTF) Services
  - Acute Inpatient Psychiatric Services
  - Medicaid Targeted Case Management (MTCM)

Behavioral Health and Managed Care Carve-in Timeline

- 2010 → Core therapies via LIPs
- 2013 → Substance use disorders
- 2016 → All outpatient behavioral health services
- 2017 → PRTFs and ASD services
- 2019 → Acute inpatient psychiatric services and OTPs

South Carolina Mobile Crisis Services

- SCDHHS contracts with the South Carolina Department of Mental Health (SCDMH) to provide crisis intervention to all South Carolina citizens regardless of insurance or ability to pay.
- This is paid for 100% by state dollars and the budget has been and continues to be $3.6 million annually.
- The Mobile Crisis Services act as the frontline defense keeping children and youth with significant behavioral health challenges and adults with persistent mental illnesses from frequenting emergency departments, inpatient psychiatric facilities and the judicial system.
- FY21 2Q Outcomes
  - 55% stayed in community
  - 23% went to emergency department
  - 8% went to hospital
  - 1% went to jail
  - 13% other

Autism Spectrum Disorder (ASD) Treatment Services Benefit

- Before ASD was added to the State Plan in 2017, services were provided via a waiver and limited to a total of three years and to individuals 3-11 years old.
- State Plan ASD services are now available for beneficiaries with an ASD diagnosis 0-21 years.
- Individual provider capacity has increased 166% since 2017.
- SCDHHS contracts with UofSC and Clemson to provide grants to grow ASD provider community.
- SCDHHS has increased rates twice since 2017 to incentivize enrollment.
- SCDHHS actively recruits providers through several outreach efforts.
- Since April 2018, 1,554 Medicaid beneficiaries have applied for ASD services and 1,454 (94%) have been approved

Therapeutic Foster Care (TFC)

- On July 1, 2020, SCDHHS added TFC to the State Plan under the RBHS authority.
- TFC eligibility is determined by the South Carolina Department of Social Services (DSS).
- TFC was created for children and youth whose behavioral health needs require them to be placed with specially trained foster parents who can provide appropriate interventions to address the child's needs.
- TFC simplifies documentation requirements for providers.

Opioid Crisis Strategies

Opioid Crisis—Actions to Combat

- Controlling the supply
- Limits of naïve opioid prescriptions and dosing best practices
- Prescription drug monitoring program (PDMP) mandate
- Provider education and drug utilization review (DUR)
- Steering demand
- Pharmacy lock-in program
- Non-opioid pain management (OTC drugs, physical therapy)
- Identification and treatment options
- Screening, Brief Intervention and Referral to Treatment focused on preventing Neonatal Abstinence Syndrome
- Managing Abstinence in Newborns
- Drug Addiction Treatment Act-waived medication-assisted treatment (MAT) physicians – naltrexone, buprenorphine
- Naloxone/Narcan® for overdose reversal
- Telemedicine and emergency room-initiated MAT
- Managed care: Institution for Mental Disease (IMD) 'in-lieu-of' and MAT prior authorization alignment
- Substance use disorder (SUD) treatment in state's first 1115 waiver

Opioid Crisis—Expanding Treatment Options

- Since Jan. 1, 2018, SCDHHS has provided reimbursement to local county SUD treatment centers for the provision of MAT provided through telemedicine.
- In Jan. 2019, enrollment began for opioid treatment programs (OTPs) in the Medicaid provider network.
- Beginning in July 2019, the benefit for services provided in OTP clinics was expanded to the coordinated care benefit provided by South Carolina's contracted MCOs.
- On July 1, 2020, Naltrexone and long-acting injectable Buprenorphine were added to the OTP service along with options for monthly bundling and bundling without specific medication. This took place several months before CMS issued guidance to states requiring three medications (Methadone, Buprenorphine and Naltrexone) be made available for MAT (December 2020).

COVID-19 Impact

COVID-19 Preparation and Response Priorities

- Ensure access to care for beneficiaries with suspected and confirmed COVID-19 cases
- Facilitate appropriate hospital discharges to maximize South Carolina's inpatient capacity
- Stabilize access to services that meet urgent and emergent needs during the initial response
- Modify Medicaid reimbursement to promote social distancing without deferring care, when such deferrals are inappropriate

COVID-19 Actions

- Requested and received approval for a blanket emergency waiver from CMS in March 2020
- Issued 32 pieces of guidance for providers in first six weeks of the declared public health emergency
  - Majority of guidance focused on ensuring access to care by extending the telehealth program that was already in place
- Created website dedicated to the COVID-19 response with guidance, FAQs, fee schedules, resources for providers and a shared email account to triage incoming questions and identify themes
- Webinars
  - Held webinars for legislators and providers in April 2020

SCDHHS COVID-19 Policy Modifications

- Expanded reimbursement for telehealth
  - Coordinated with the South Carolina Department of Labor, Licensing and Regulation (LLR) on Practice Act and independence issues
- Removed prior authorization requirements
- Waived administrative and financial requirements
- Provided new pathways to seek care and eligibility
- Modified benefit design

COVID-19 Impact

- Initial increase in telehealth visits for routine care
- Elective surgeries (non-life-threatening) were postponed
- Provided valuable data to continue to evaluate potential permanent changes to the agency's existing telehealth benefit

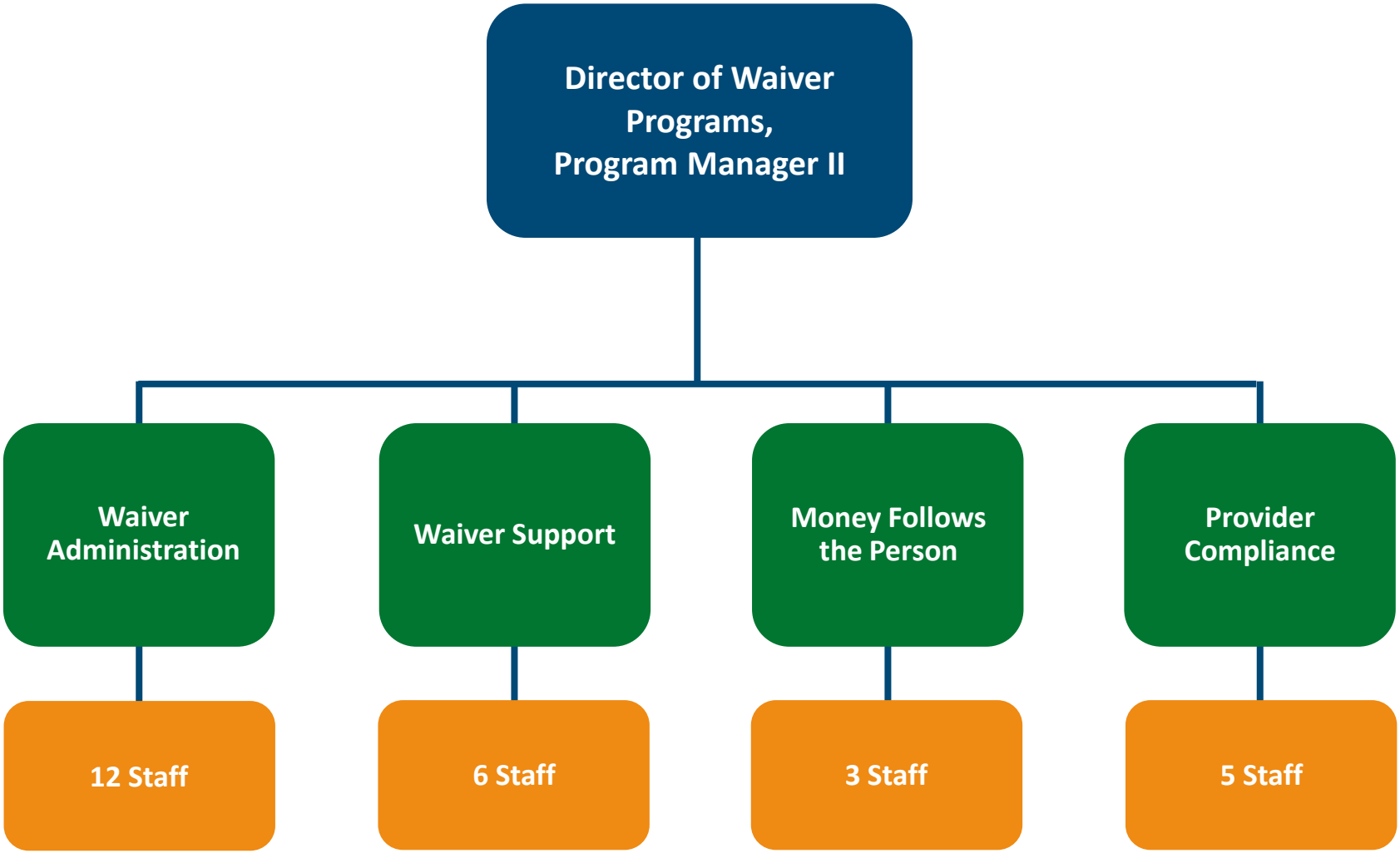
South Carolina Home and Community-Based Services Waiver Programs Overview

Home and Community-Based Services Waivers Agenda

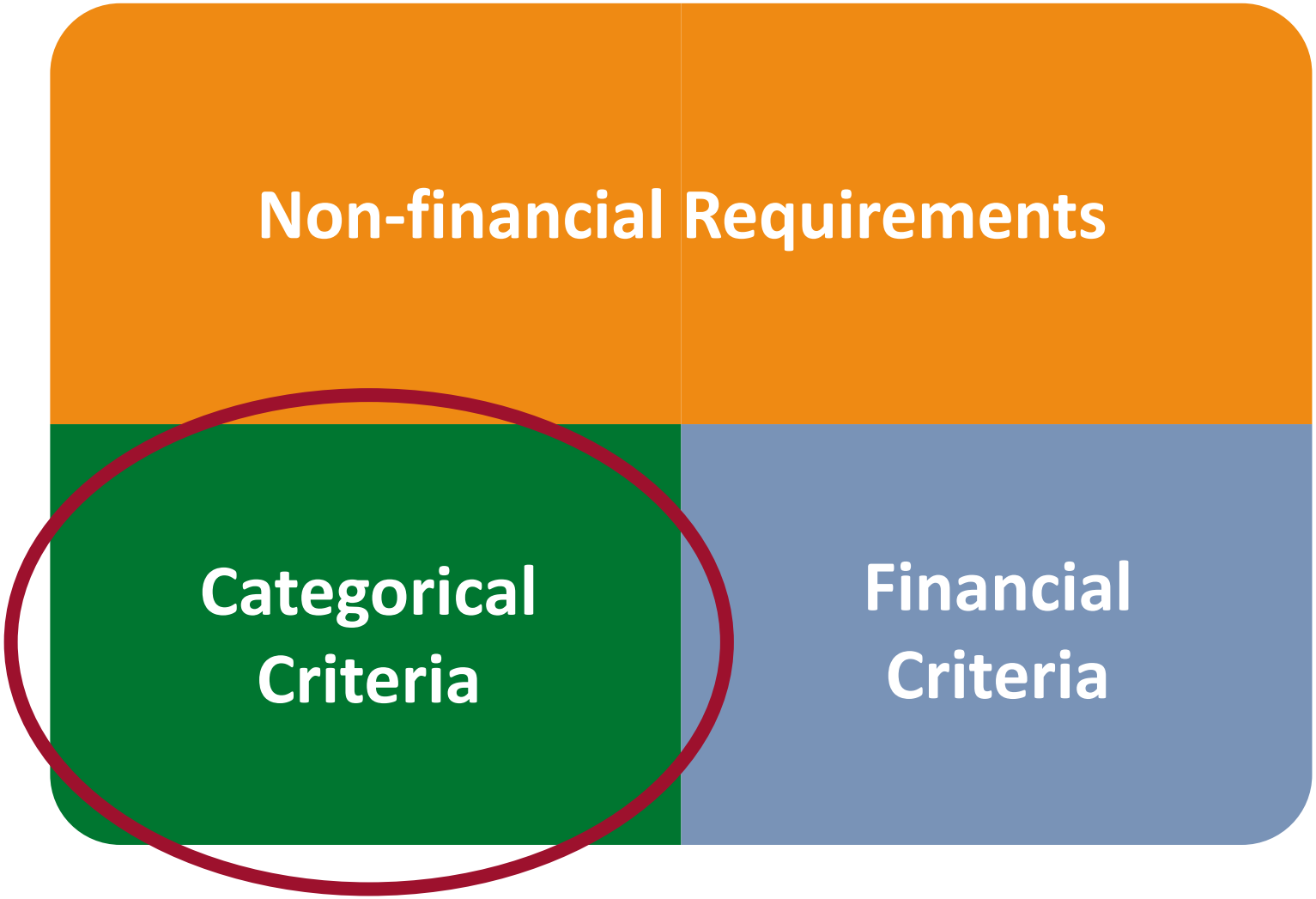
- Waiver Programs Structure and Scope
- SCDHHS Administered and Operated Waivers
- External Agency Operated Waivers
- Waiver Enrollment
- COVID-19 Impact
- Waiver Renewals and Outlook

Waiver Programs Structure and Scope

Waiver Programs - Organizational Chart



What Makes You Eligible?



Home and Community-Based Services (HCBS) Waivers Overview

- CMS allows states to provide services to those who need care in their home or communities.
  - Encourages Healthy Connections Medicaid members to receive care in "least restrictive" environment possible, generally, their home
- Under a waiver program, a state can waive certain Medicaid program requirements.
  - Allows the state to provide care for people who might not otherwise be eligible under Medicaid
- Through waivers, states can tailor services to people who need long-term services and supports.

Authorities and Program Requirements

- HCBS waivers operate under Section 1915(c) authority.
- HCBS waiver programs must:
  - Demonstrate that providing waiver services will not cost more than providing these services in an institution
  - Ensure the protection of people's health and welfare
  - Provide adequate and reasonable provider standards to meet the needs of the target population
  - Ensure that services follow an individualized and person-centered plan of care

HCBS Waivers Accountability and Renewals

- Waivers are generally approved for a five-year period.
- Waivers must have systems in place to measure and improve its performance in meeting the following assurances:
  - Administrative authority
  - Level of care
  - Qualified providers
  - Service plan
  - Health and welfare
  - Financial accountability
- The state must report annually on service utilization, costs, and quality improvement related to the waiver assurances.
- When performance measures are below threshold, a remediation plan is required.

HCBS Waivers Accountability and Renewals *(cont.)*

- A waiver renewal application must be submitted to CMS at least 90 but preferably 180 days prior to the end of the waiver period.
- Two conditions must be met for consideration of a waiver renewal application:
  - State must submit, and CMS accept, required annual financial and statistical reports
    - Includes demonstration of cost neutrality and information on quality of services
  - CMS must determine the waiver has been operated in accordance with the approved waiver, all applicable federal requirements, and the waiver assurances

State Plan Services

- Medicaid State Plan services are available to all full-benefit beneficiaries including:
  - Primary care
  - Behavioral health and autism spectrum disorder services
  - Specialty care
  - Pharmaceuticals
  - Surgery
  - Therapies (e.g., speech, occupational, physical)
  - Home health
  - Incontinence supplies
  - Durable medical equipment
  - Hospitals, intermediate care facilities, nursing homes

Waiver Services

- Waiver programs provide additional services that are tailored to meet the needs of a particular target group and can include a combination of standard medical services and non-medical services.
- Standard waiver service examples include:
  - Case management
  - Personal care (assistance with activities of daily living)
  - Adult day health care
  - Habilitation (day and residential)
- HCBS waiver participants are enrolled in fee-for-service Medicaid.

South Carolina HCBS Waivers

- South Carolina administers the following 1915(c) waivers:
  - Community Choices (CC) Waiver
  - HIV/AIDS Waiver
  - Mechanical Ventilator Dependent (Vent) Waiver
  - Medically Complex Children (MCC) Waiver
  - Head and Spinal Cord Injury (HASCI) Waiver
  - Intellectual Disability/Related Disability (ID/RD) Waiver
  - Community Supports (CS) Waiver
  - Palmetto Coordinated System of Care (PCSC) for Children Waiver

Eligibility Determination

- Categorical and financial eligibility are determined by SCDHHS staff for the following waivers:
  - Community Choices (CC) Waiver
  - HIV/AIDS Waiver
  - Mechanical Ventilator Dependent (Vent) Waiver
  - Head and Spinal Cord Injury (HASCI) Waiver

- This process includes:
  - Medicaid determination for financial eligibility is completed by Medicaid eligibility staff; and,
  - Initial assessments completed by agency nurses to determine if applicants meet level of care criteria.

Eligibility Determination *(cont.)*

- For ID/RD and CS waivers, the South Carolina Department of Disabilities and Special Needs (SCDDSN) completes assessment of waiver eligibility.
- For the MCC waiver, contracted providers complete preadmission screening.
- For the PCSC waiver, the South Carolina Continuum of Care (COC) completes screening and assessment of waiver eligibility.
- Medicaid determination for financial eligibility is completed by Medicaid eligibility staff.

SCDHHS Administered and Operated Waivers

Community Choices (CC) Waiver

- Serves the frail elderly and persons with physical disabilities who meet the nursing facility level of care criteria
- Offers a continuum of service options capable of meeting the needs of all waiver participants
  - Agency-directed services
  - Self-directed services

Community Choices (CC) Waiver Eligibility

- To participate in the CC waiver a person must:
  - Receive Healthy Connections Medicaid
  - Be 18 years old or older
  - Meet nursing home level of care (skilled or intermediate)

CC Waiver Covered Services

- Case management
- Personal care I/II
- Attendant care
- Companion care
- Home delivered meals
- Nutritional supplements
- Adult day health care
- Adult day health care transportation
- Adult day health care nursing
- Respite care
- Personal emergency response system
- Telemonitoring
- Pest control
- Enhanced pest control
- Home accessibility adaptations
- Specialized medical equipment and supplies

HIV/AIDS Waiver

- Serves participants who meet level of care criteria and have an HIV/AIDS diagnosis
- Offers a continuum of service options capable of meeting the needs of all waiver participants
  - Agency-directed services
  - Self-directed services

HIV/AIDS Waiver Eligibility

- For those six years and older, a person must:
  - Receive Healthy Connections Medicaid
  - Be diagnosed as having AIDS **or** diagnosed as being HIV positive and have had two or more episodes of specific related conditions
  - Have CD4 levels equal to or less than 500
  - Be at-risk for hospitalization

HIV/AIDS Waiver Covered Services

- Case management
- Personal care I/II
- Attendant care
- Companion
- Home delivered meals
- Nutritional supplements
- Pest control
- Enhanced pest control
- Private duty nursing
- Home accessibility adaptations
- Specialized medical equipment supplies

Vent Waiver

- Serves the frail elderly and persons with physical disabilities who require mechanical ventilation and meet the nursing facility level of care criteria
  - Provides participant-directed options for supervision of services
  - Offers a continuum of service options capable of meeting the needs of all waiver participants

Vent Waiver Eligibility

- To participate in the Vent waiver, a person must:
  - Receive Healthy Connections Medicaid
  - Be 21 years-old or older
  - Meet nursing home level of care (skilled or intermediate)
  - Be dependent upon life sustaining or supporting mechanical ventilation at least six hours a day

Vent Waiver Covered Services

- Case management
- Personal care I/II
- Attendant care
- Private duty nursing
- Specialized medical equipment and supplies
- Respite care
- Personal emergency response system
- Home accessibility adaptations
- Pest control
- Enhanced pet control
- Home delivered meals
- Nutritional supplements

Medically Complex Children (MCC) Waiver

- Designed to serve children with a serious illness or condition expected to last at least 12 months
  - Dependent upon medications, hospitalizations, skilled nursing services, specialists and ancillary services
  - Services approved in this waiver are pediatric medical day care and care coordination

Medically Complex Children (MCC) Waiver Eligibility

- To participate in the MCC waiver, a person must:
  - Receive Healthy Connections Medicaid
  - Be age birth to age 18
  - Meet the hospital level of care requirements
  - Have a chronic physical/health condition that is expected to last at least 12 months
  - Meet the state-defined medical eligibility criteria

Medically Complex Children (MCC) Waiver Covered Services

- Care coordination
- Pediatric medical day care

**Children under 21 may also receive Early and Periodic Screening, Diagnostic, and Treatment services and additional Medicaid State Plan services such as private duty nursing and/or children's personal care.*

External Agency Operated Waivers

Head and Spinal Cord Injury (HASCI) Waiver

- Joint effort between SCDHHS and SCDDSN
- Provides a broad range of HCBS waiver services to Medicaid-eligible individuals with the most severe physical impairments involving head and spinal cord injuries
- Designed to help clients who would otherwise require services in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) to remain independent in the community

Head and Spinal Cord Injury (HASCI) Waiver Eligibility

- To participate in the HASCI waiver, a person must:
  - Receive Healthy Connections Medicaid
  - Be 64 years old or younger
  - Meet diagnostic criteria (traumatic brain injury, spinal cord injury or similar disability)
  - Have urgent circumstances affecting his or her health or functional status

Head and Spinal Cord Injury (HASCI) Waiver Covered Services

- Career preparation services
- Day activity
- Employment services
- Attendant care/personal assistant services
- Health education for participant-directed care
- Peer guidance for participant-directed care
- Residential habitation
- Supplies, equipment and assistive technology
- Incontinence supplies
- Respite care
- Personal emergency response system
- Physical therapy
- Occupational therapy
- Psychological services
- Behavior support services
- Nursing services
- Speech and hearing
- Private vehicle modifications
- Environmental modifications
- Assistive technology consultation
- Private vehicle modification
- Pest control
- Waiver case management

Intellectual Disability/Related Disability (ID/RD) Waiver

- Joint effort between SCDHHS and SCDDSN for those with an ID/RD who meet ICF/IID level of care criteria
- Provides a broad range of services based on identified needs of the participant and the appropriateness of the service to meet the need
  - Services may be limited due to provider availability
- Children under age three apply through the Individuals with Disabilities Education Act Part C Program (BabyNet)
- Individuals age three and older apply through the University of South Carolina Center for Disability Resources

Intellectual Disability/Related Disability (ID/RD) Waiver Eligibility

- To participate in the ID/RD waiver, a person must:
  - Receive Healthy Connections Medicaid
  - Be diagnosed with an ID or an RD
  - Be allocated a waiver slot
  - Be given the option of receiving services in his/her home and community or in an ICF/IID and choose to receive services in his/her home and community

Intellectual Disability/Related Disability (ID/RD) Waiver Covered Services

- Personal care I/II
- Residential habitation
- Environmental modifications
- Private vehicle modifications
- Private vehicle assessment/consultation
- Specialized medical equipment and assistive technology
- Specialized medical equipment and assistive technology assessment/consultation
- Incontinence supplies
- Respite care
- Audiology services
- Adult companion services
- Nursing services
- Adult dental
- Adult vision
- Adult day health care
- Adult day health care nursing
- Adult day health care transportation
- Adult attendant care
- Behavior support services
- Career preparation
- Employment services
- Day activity
- Community services
- Support center services
- Personal emergency response system
- Pest control
- Waiver case management

Community Supports (CS) Waiver

- Allows persons, age three and older, with an Intellectual Disability/Related Disability (ID/RD) to choose to receive care at home rather than in an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Participants may choose to receive care at home, but they must require the degree of care that would be provided in the ICF/IID
- Has an individual cost limit for services

Community Supports (CS) Waiver

- To participate in the CS waiver, an individual must:
  - Receive Healthy Connections Medicaid
  - Be diagnosed with an ID or an RD
  - Be allocated a waiver slot
  - Maintain services within the individual cost limit
- There is no age maximum for the CS waiver

Community Supports (CS) Waiver Covered Services

- Personal care I/II
- Adult day health care
- Adult day health care nursing
- Adult day health care transportation
- Respite care
- Environmental modifications
- Assistive technology and appliances
- Assistive technology and appliances/consultation
- Incontinence supplies
- Private vehicle modifications
- Private vehicle assessment/consultation
- Behavior support services
- Day activity services
- Career preparation services
- Community services
- Employment services
- Support center services
- In-home support
- Personal emergency response system
- Waiver case management

Palmetto Coordinated System of Care (PCSC) for Children Waiver

- The PCSC waiver is operated through the South Carolina Continuum of Care (COC) and serves children and youth with significant behavioral health challenges or co-occurring conditions in or at imminent risk of out-of-home placement
- PCSC services are provided using a system of care approach
- High Fidelity Wraparound services provide participants and families intensive care coordination, advocacy and support

Palmetto Coordinated System of Care (PCSC) for Children Waiver Eligibility

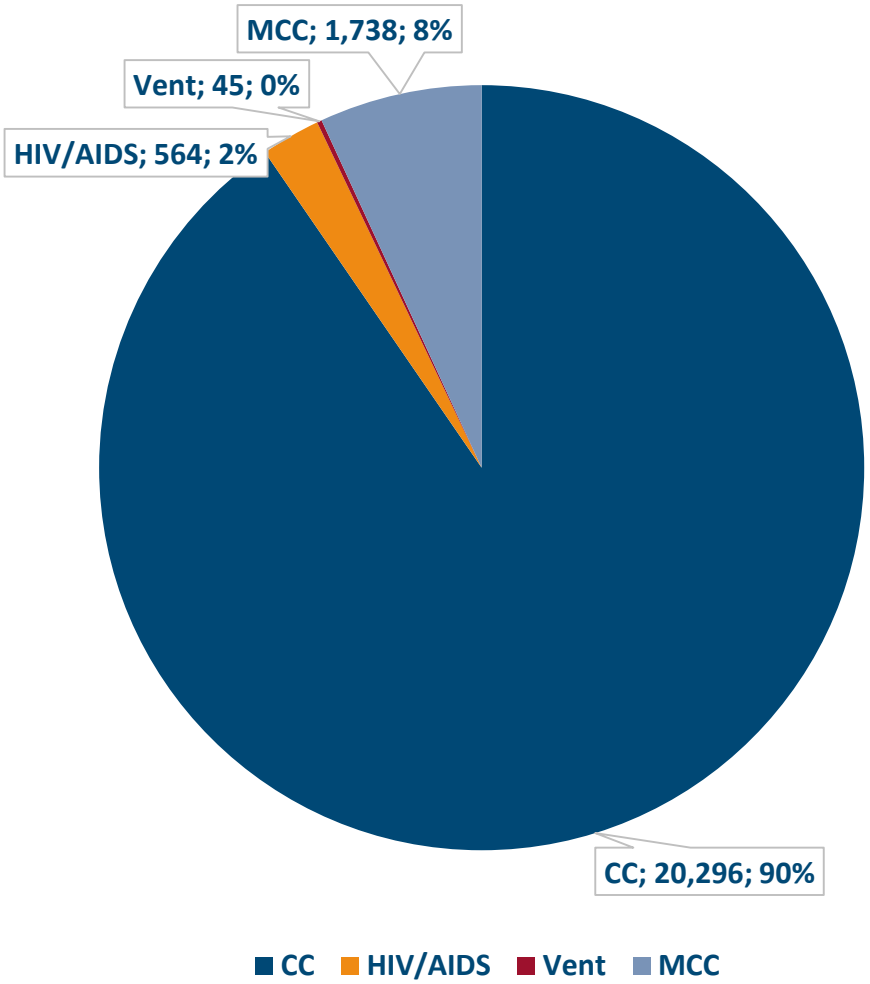
- To participate in the PCSC waiver, an individual must:
  - Receive Healthy Connections Medicaid
  - Be age 21 or younger
  - Have a primary mental health diagnosis meeting the target criteria
  - Meet minimum scores for hospital level of care

Palmetto Coordinated System of Care (PCSC) for Children Waiver Covered Services

- High Fidelity Wraparound
- Respite
- Individual directed goods and services

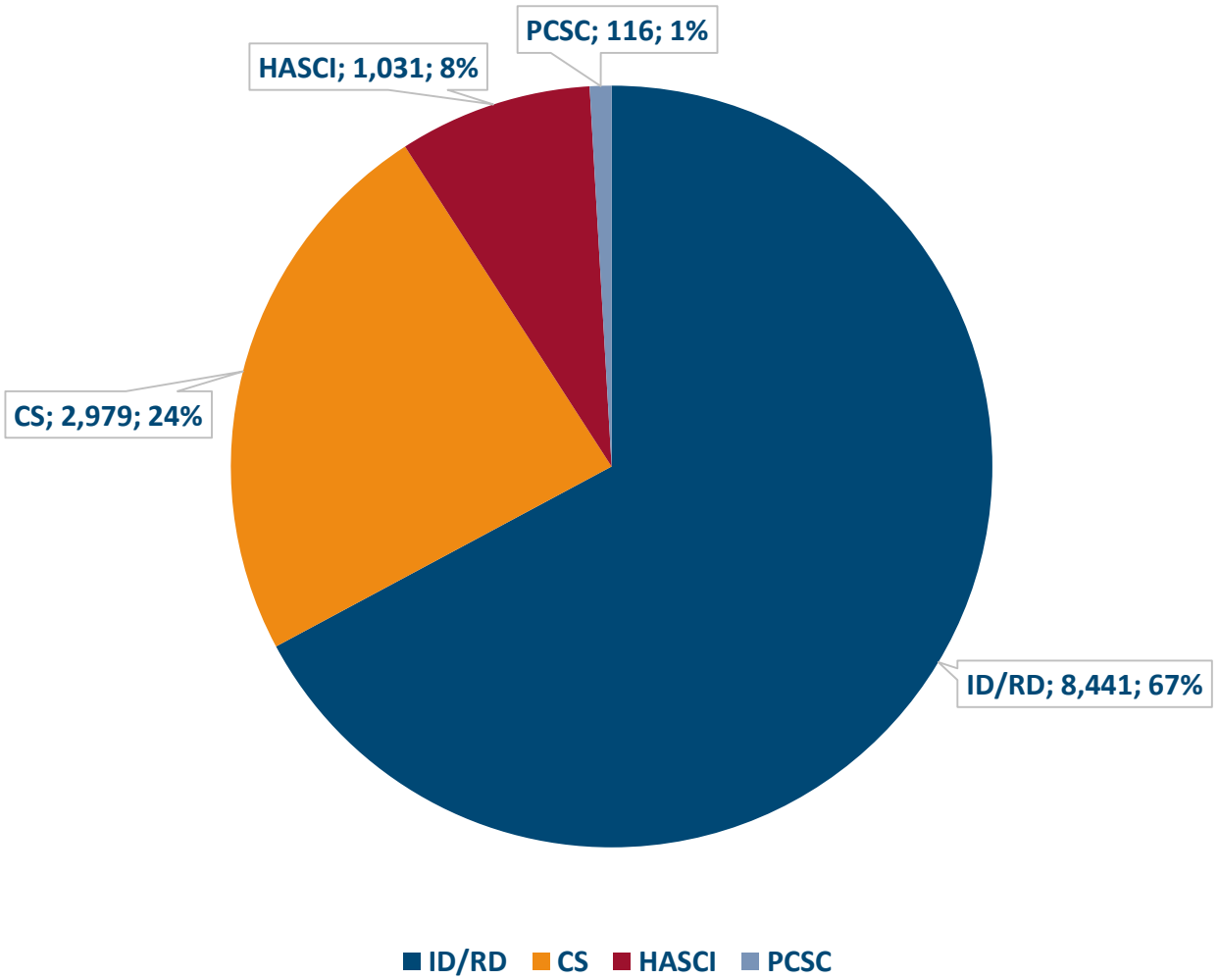
Waiver Enrollment

SCDHHS Administered Waiver Enrollment



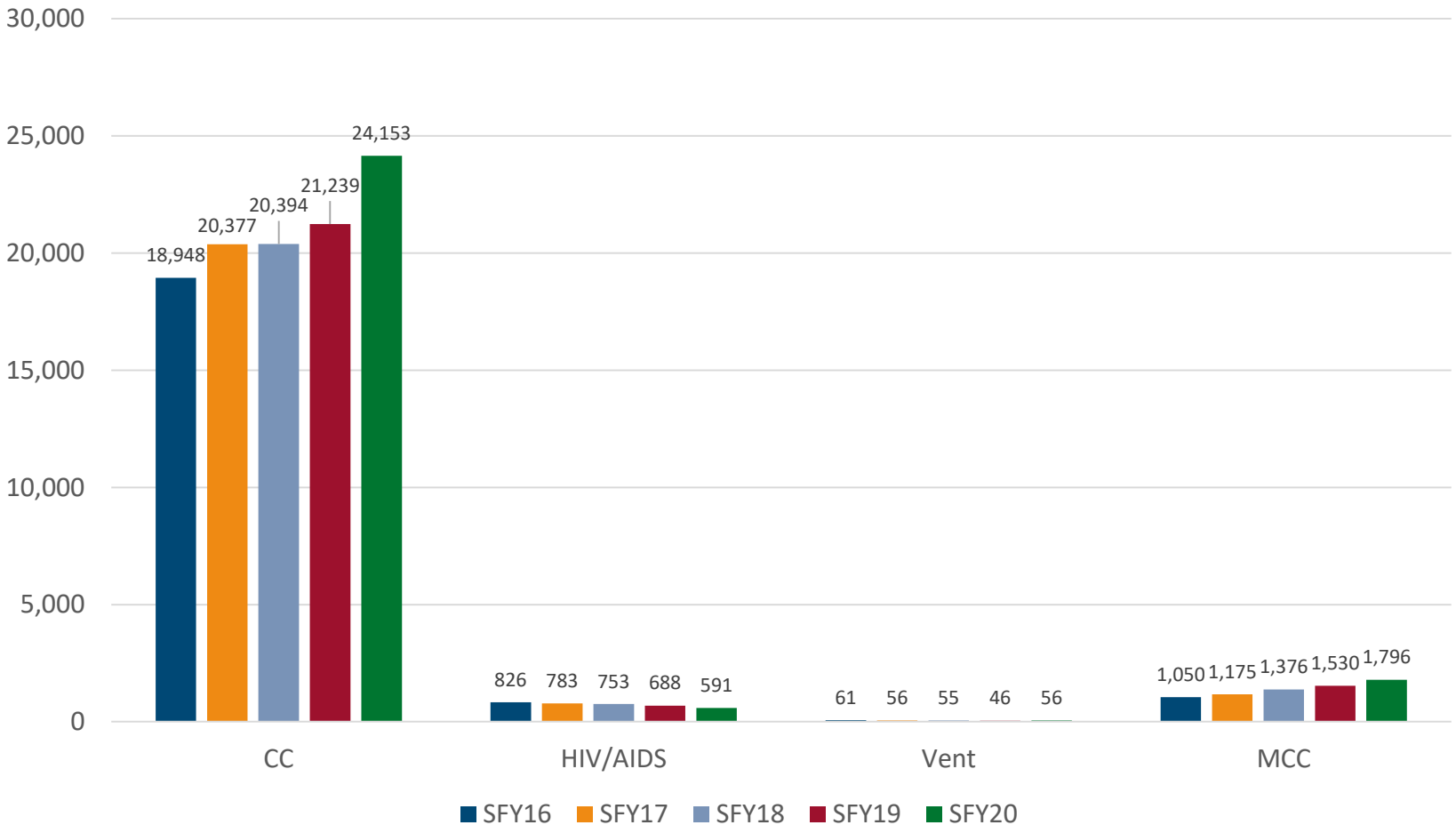
Enrollment as of April 24, 2021

External Agency Operated Waiver Enrollment



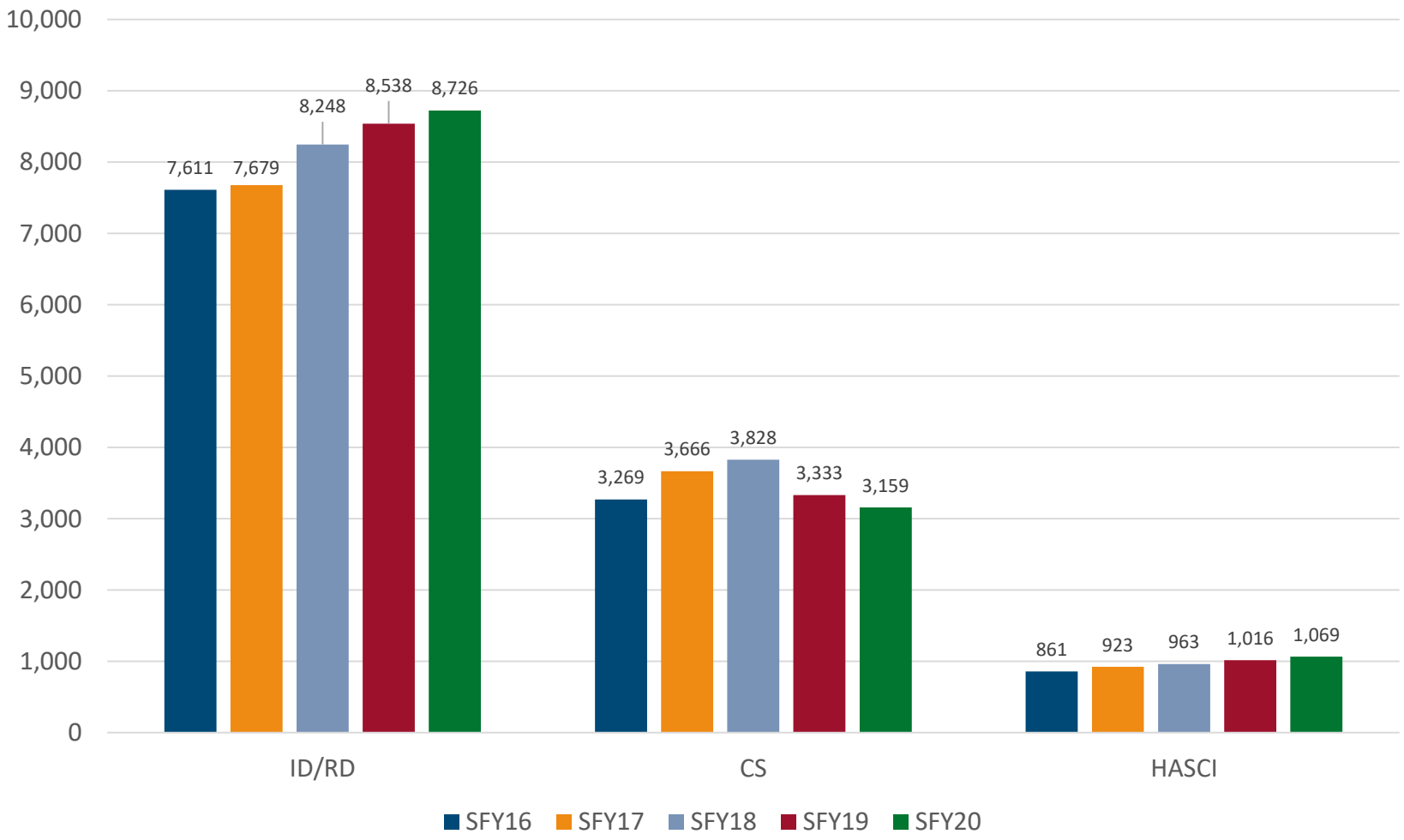
Enrollment as of April 30, 2021

SCDHHS Administered Waiver Enrollment Five-year Trend



Enrollment for SFY20 as of April 30, 2021

External Agency Operated Waiver Enrollment Five-year Trend



Enrollment for SFY20 as of April 30, 2021

COVID-19 Impact

COVID-19 Actions

- On April 21, 2020, CMS approved South Carolina's first stand-alone Appendix K document.
- Appendix K may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers.
- Appendix K advised CMS of expected changes to waiver operations, such as:
  - Changes to certain service provisions
  - Provision of remote monitoring of participants health, safety and welfare
  - Added flexibilities for substitution of services and delivery of services in alternate settings

COVID-19 Actions *(cont.)*

- On September 22, 2020, CMS approved South Carolina's second Appendix K document.
- The second Appendix K document advised CMS of expected changes to waiver operations, such as:
  - Flexibility to issue temporary retainer payments to certain providers who render personal care services
  - Flexibility in submission of federal reports due to circumstances of the pandemic
- A third Appendix K document allowed for continuation of the flexibilities to extend to up to six months after the federal public health emergency.

COVID-19 Impact—Increased Census

- The Families First Coronavirus Response Act, enacted on March 20, 2020, provides health provisions in response to the COVID-19 national public health emergency. This legislation provides provisions for coverage of testing for COVID-19 for uninsured individuals, as well as eligibility protections for the duration of the emergency.

Waiver Renewals and Outlook

HCBS Waivers Renewals and Outlook

- Waiver renewals currently in process
  - CC (submitted to CMS March 30, 2021)
  - HIV/AIDS (submitted to CMS March 30, 2021)
  - MCC (waiver renewal submission targeted for July 2021)
  - ID/RD (waiver renewal submission targeted for July 2021)
- Priorities for waiver renewals
  - Opportunities for modernization
  - Enhancing quality improvement strategies and performance measures
  - Review and revision of service arrays and definitions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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Healthy Connections Medicaid Replacement Medicaid Management Information System (RMMIS) Program Overview

Rhonda Morrison

Deputy Director of Systems Development & Acting CIO

South Carolina Department of Health and Human Services

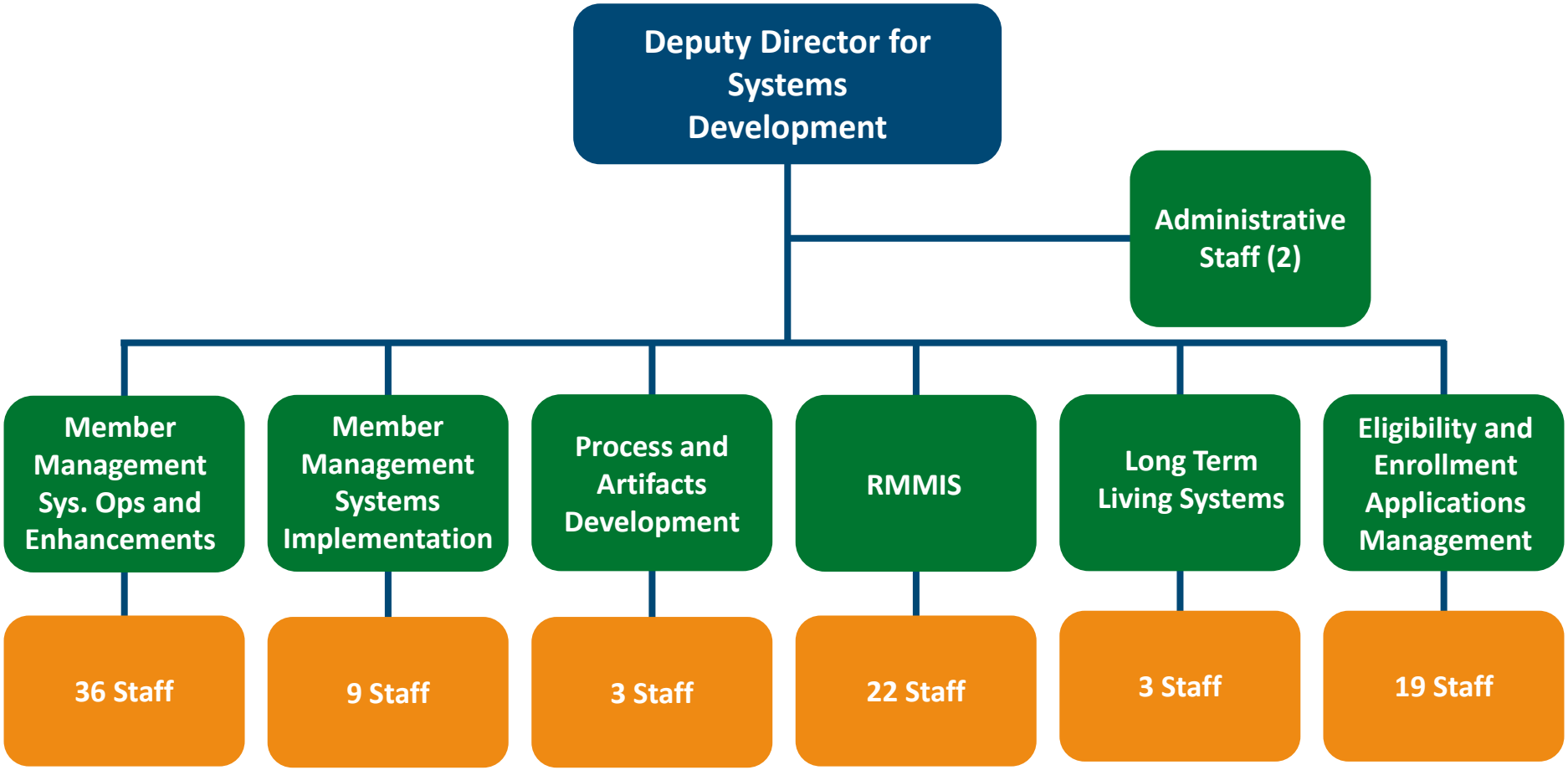
RMMIS Agenda

- PER Information and Organizational Charts
- Background
- Vision and Objectives
- Overview of Modules
- COVID-19 Impact
- Outlook

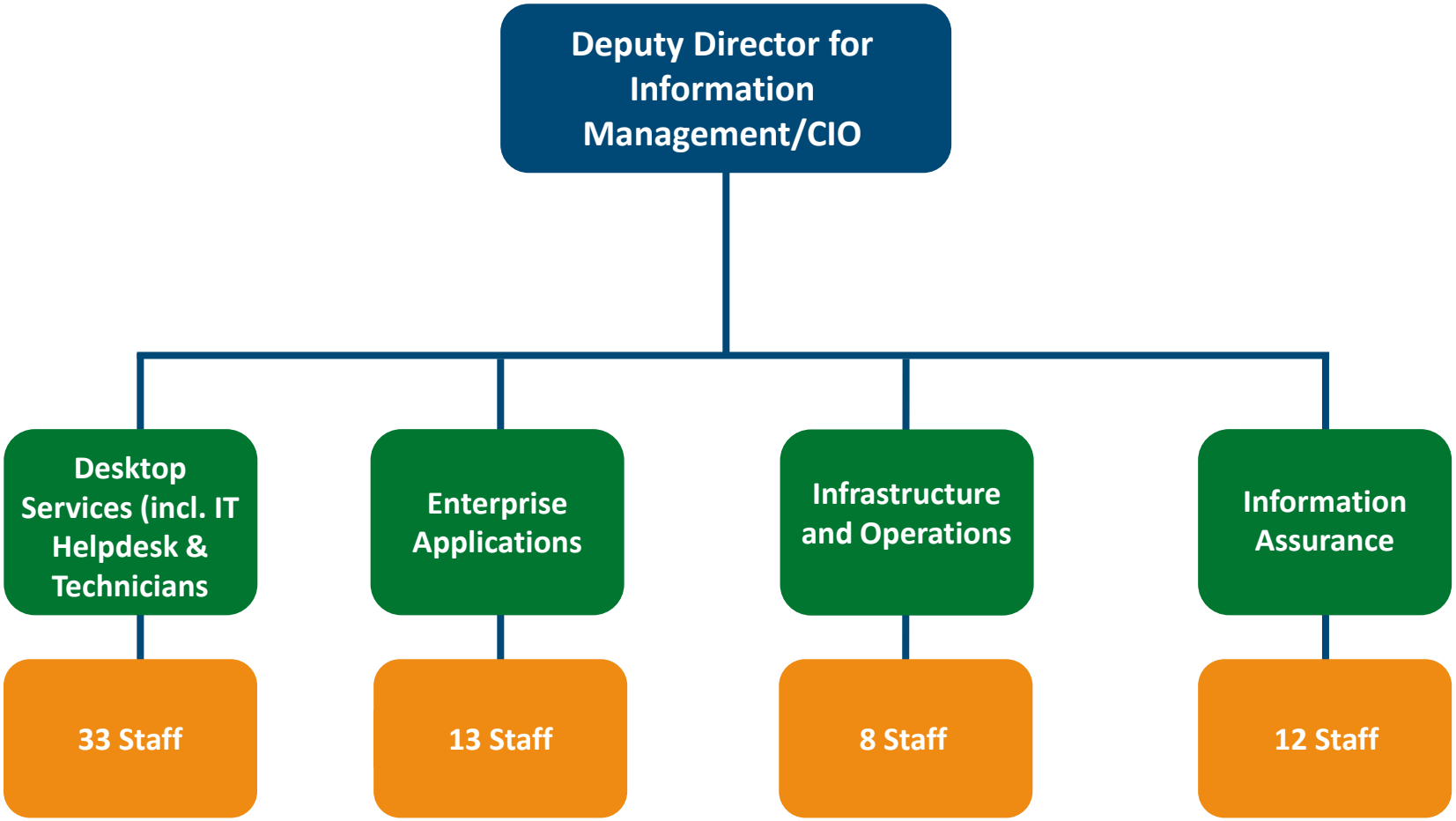
Turnover Data

- IT Development
  - FY19-20: 8.89%
  - FY18-19: 23.53%
  - FY17-18: 46.15%
  - FY16-17: 16.00%

Office of Systems Development (OSD) Organizational Chart



Office of Information Management (OIM) Organizational Chart



Background

Medicaid Management Information System (MMIS)

- The Medicaid Management Information System (MMIS) is an integrated group of procedures and computer processing modules whose purpose is to control Medicaid business functions, such as:
  - Providing data for management reporting for planning and control
  - Beneficiary and provider inquiries and services
  - Operations of claims control and computer capabilities

Federal Financial Participation (FFP)

- States may receive FFP from the Centers for Medicare and Medicaid Services (CMS) for state mechanized claims processing and information retrieval systems
  - 90% FFP for design, development or installation; and,
  - 75% FFP for operation
- Requires extensive process of submitting Advance Planning Documents (APD) to CMS for review and approval
- CMS must certify the system based on specific outcome measures

Current System Limitations

- The existing core of MMIS is a monolithic system based on aging COBOL/mainframe technology that has not benefited from modernization
- Changes to the system are expensive and time-consuming resulting in manual processes to replace system functionality
- Batch processing versus real-time processing
- Without substantially replacing the underlying technology, improving business processes is difficult and slow

Vision and Objectives

RMMIS Vision & Objectives

- Implement best-of-industry solutions from multiple vendors using a modular approach
- Integrate the solutions at the Medicaid Enterprise System (MES)
- Utilize a Multi-vendor Integrator (MVI) to coordinate activities
- Commit to a strong governance structure
- Meet CMS standards and conditions
- Minimize impact to providers and stakeholders

Overview of Modules

RMMIS Modules

- Three Administrative Modules
  - Medical Administrative Services Organization (MASO) – **Active Project**
  - Pharmacy Benefit Administrator (PBA)
  - Dental ASO (DASO)
- Support Modules for RMMIS
  - Multi-vendor Integrator (MVI) - **Active Project**
  - Accounting and Finance (A&F)
  - Third Party Liability (TPL)
  - Business Intelligence System (BIS)
- Medicaid Enterprise System (MES) - **Active Project**

Medical Administrative Services Organization (MASO)

- **Started Dec. 11, 2019**
- Supports:
  - Claims processing & resolution
  - Reference file maintenance
  - National Correct Coding Initiative (NCCI)
  - QIO/prior authorization
  - Provider call center, outreach, training and enrollment
- Optum is the vendor

Pharmacy Benefits Administration (PBA)

- **Implemented November 2017**
- Supports:
  - Pharmacy Claims adjudication
  - Prior Authorization
  - Retrospective Drug Use Review
  - Benefit Plan support
  - Drug Rebate
  - Maximum Allowable Cost (MAC) Administration
  - Trend Analysis and Reporting
- Magellan is the vendor

Dental Administrative Service Organization (DASO)

- **Implemented/Awarded:** 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
- Supports:
  - Dental claims adjudication
  - Prior authorization
  - Claims payment
  - Benefit plan support
  - Coordination of benefits
  - Grievance and appeals
  - Utilization management and program integrity
- DentaQuest is the vendor

Multi-vendor Integrator (MVI)

- **Started April 2018**
- Responsible for:
  - Project management
  - Coordination of RMMIS vendors including schedules, risks, issues, deliverables, quality assurance, training, testing and organizational change management
- NTT Services is the vendor

Accounting and Finance (A&F)

- **Implemented July 2019**
- Supports:
  - Provider payments and disbursement
  - Claims remittance and adjustments
  - 1099 reporting
  - Medicaid bank account
  - Reporting and analytics
- A&F functions are carried out by the South Carolina Enterprise Information System (SCEIS)

Third Party Liability (TPL)

- **Implemented August 2018**
- Supports:
  - The legal obligation of third-party insurers to pay all or part of the Medicaid expenditures
  - Insurance policy identification, verification and maintenance
  - Health Insurance TPL
  - Casualty Related TPL
  - Estate Recovery TPL
  - Health Insurance Premium Payment (HIPP) Program
  - Retro Health
  - Retro Medicare
  - Special Needs Trust
- Blue Cross Blue Shield of South Carolina (BCBSSC) is the vendor

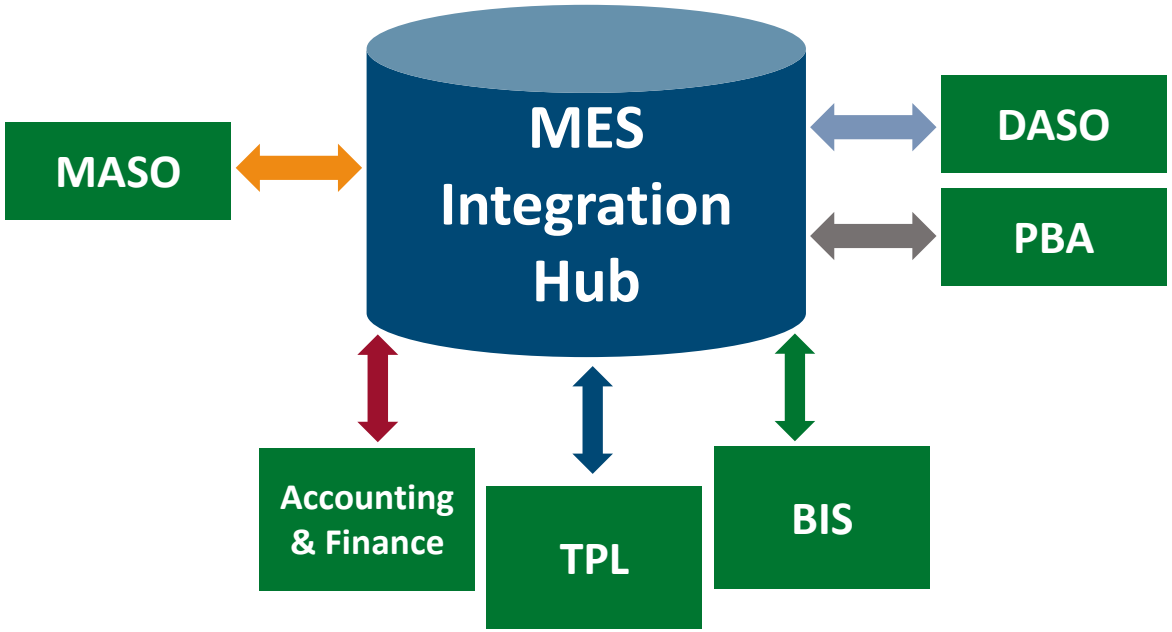
Business Intelligence System (BIS)

- **Implemented Nov. 30, 2018**
- Supports:
  - Program planning and evaluation through financial reporting
  - Utilization management
  - Detection and investigation of fraudulent, abusive or otherwise inappropriate reimbursements made to a Medicaid provider, in violation of South Carolina Medicaid's policies, MCO policies and state and federal laws and regulations
  - Federal reporting requirements
- SAS is the vendor

Medicaid Enterprise System (MES)

- **Implemented in the Amazon Web Services (AWS) Cloud January 2021**
- Supports:
  - 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
  - Allows SCDHHS to incrementally retire legacy components without impacting other components
- Contracted through Department of Administration Cloud Broker

Target State



Each module becomes independent of the other modules with the MES as the integration point.

COVID-19 Impact

COVID-19 Impact

- The implementation phase of the MASO was originally projected to last 18 months with a targeted operational start date in June 2021.
- This timeline is being redeveloped due to the impact of the pandemic on allocating resources to Model Office sessions.

Outlook

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- **2021 activities include:**
  - Restarted MASO Model Office sessions
  - New Integrated Project Schedule for MASO
  - Development of a DASO RFP
  - Further development of the MES


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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Healthy Connections Medicaid Communications

Jeff Leieritz

Director of External Affairs

South Carolina Department of Health and Human Services

Main Audiences and Vehicles

- Providers
  - Provider Service Center
  - Provider bulletins
  - Provider alerts
  - Trainings and webinars
  - Social media
  - Website and microsites
- Members
  - Member Contact Center
  - Member Relations team
  - Local offices
  - Website and microsites
  - E-newsletter
  - Social media
  - Community-based organizations
  - Managed care organizations

Refocus on Social Media

- Social media content resumed Sept. 2019
- Development of editorial calendar
- Current social media platforms

Proactive Provider Communications

- Goal: Concise, consistent and timely guidance and resources
- Provider-specific vehicles:
  - Bulletins—provider communications that communicate policy changes
  - Alerts—provider communications that include:
    - Important date reminders
    - SCDHHS/federal/state/other available resources
    - Policy clarifications
    - Operational updates
  - Webinars/trainings

Proactive Member Communications

- Goal: Provide timely and accurate assistance to members and applicants; connect individuals to resources and benefits that help them live healthier lives
- Member-specific vehicles:
  - Community-based organizations
  - E-newsletters

Oversight Presentation Series Topics

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


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Legislative Oversight Committee

South Carolina House of Representatives

Committee Mission

Determine if agency laws and programs are being implemented and carried out in accordance with the intent of the General Assembly and whether they should be continued, curtailed or eliminated. Inform the public about state agencies.

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