SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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The Honorable Jay West
Chairman, Healthcare and Regulatory Subcommittee
House of Representatives Legislative Oversight Committee
404A Blatt Building
Columbia, South Carolina 29201

Dear Representative West and Members of the Subcommittee,

Thank you for your recent inquiry regarding South Carolina Department of Health and Human Services' (SCDHHS) response to the coronavirus disease 2019 (COVID-19) epidemic and state and federally declared public health emergency. With this unprecedented event, Medicaid agencies, private providers, and commercial insurers are reacting not just to the virus and the human response, but to a rapidly evolving regulatory environment at both the state and federal levels. To provide perspective on this, as of the time of this correspondence, South Carolina is only 12 days from the Presidential disaster declaration and 14 days since the first Gubernatorial Executive Order regarding the COVID-19 epidemic. In that period, the Centers for Medicare and Medicaid Services (CMS), state licensing authorities, the Governor's Office, and SCDHHS have offered previously unprecedented flexibilities. SCDHHS is approaching these flexibilities with the following principles in-mind:

1. Continue to deliver the Medicaid benefit that finances healthcare for more than 1 million South Carolinians and maintain the daily operations of SCDHHS.
2. Respond in a manner thematically consistent with federal and state directives with respect to social distancing.
3. Ensure continuity of care, to the extent possible, prioritizing care that addresses urgent or emergent clinical needs.

These principles create natural tensions and necessitate decisions that individuals, parents, and healthcare providers must make to minimize the risk of COVID-19 infection for themselves, their staff, and their family members, while also continuing to provide and receive clinically appropriate services.

SCDHHS Initial Response Period Priorities

Throughout the initial response period, SCDHHS has prioritized life, physical health, and safety. Accordingly, the flexibilities offered in Medicaid bulletins issued the week of March 16, 2020, have focused on medication maintenance; removing barriers to care including suspending cost sharing and visit limits for ambulatory care; and making infusion centers more available for individuals receiving a variety of treatments, including outpatient chemotherapy. SCDHHS issued subsequent bulletins that allowed for brief diagnostic screenings, check-ins and evaluations by various behavioral health providers, remote acute care visits for new and established patients in primary care settings, and durable medical equipment (DME) flexibilities to ensure access to needed supplies and to support hospital discharges.

Future bulletins and actions in draft form to be released the week of March 23, 2020 include:

- Concurrent action on skilled nursing facility flexibilities by SCDHHS the South Carolina Department of Health and Environmental Control (SCDHEC);
- Financial support for nursing homes experiencing strain during the COVID-19 response;
- Cooperative action with South Carolina's hospitals to expedite medically necessary discharges, create inpatient capacity, and provide financial support during the initial response period;
- Submitting South Carolina's phase I Section 1135 disaster response waiver to CMS;
- Supplemental telemedicine guidance to government-owned mental health providers through the South Carolina Department of Mental Health (SCDMH);
- Supplemental telemedicine guidance to government-owned addiction service providers through the "301" system;
- Appendix K emergency response services under section 1915(c) Home and Community-Based Services waivers, relevant to SCDHHS' community long-term care program and waiver services administered by the South Carolina Department of Disabilities and Special Needs (SCDDSN); and
- Medication assisted addiction treatment services.

Several disciplines and services being monitored by SCDHHS, but have not yet been considered for full flexibility at this time, include:

- Speech Therapy;
- Physical Therapy;
- Occupational Therapy;
- Applied Behavioral Analysis;
- Early Intervention; and
- Unlicensed Rehabilitative Behavioral Health Services.

SCDHHS has offered flexibilities under the first principle of maintaining a consistent and dependable program for more than one-fifth of South Carolina's population. This means providing measured flexibilities to support the priorities of the initial response and simple guidance to providers that improves access to care. The remainder of this correspondence addresses the Committee's specific request about which provider groups are subject to telemedicine flexibilities, and the impact on beneficiary groups of the presence or absence of such an allowance. In brief, SCDHHS evaluates the baseline benefit and has added flexibilities in consultation with provider disciplines – largely through their professional associations and clinical leaders, staff physicians, other insurers, other state Medicaid programs, medical literature, and practice act standards to assemble the basis for flexibilities that have been offered.

Medicaid Telemedicine Benefit

In December 2019, SCDHHS produced a brief report to the General Assembly on the evolution of the Medicaid program's telemedicine benefit, which was virtually non-existent a mere five years ago. While I will not restate all of the findings and recommendations of that report here, it is worth noting that SCDHHS' existing telemedicine benefit is focused predominantly on pairing beneficiaries and clinicians with specialty services and consultation not available in the healthcare settings available in their community. Unlike some commercial insurers, SCDHHS has not offered a direct-to-consumer benefit, again with a rationale more thoroughly developed in the referenced report. In addition to these benefits, SCDHHS has traditionally offered psychological evaluation, crisis stabilization, and case management as telephonic services covered under the Medicaid State Plan. Some providers and advocates believe that

our approach to the public health response should default to telemedicine for all disciplines, but there are several reasons to moderate this approach.

First, where there are clear indications and evidence for the appropriate use of telemedicine, SCDHHS has either already incorporated them into the base benefit or offered flexibility as part of the COVID-19 public health response. There are interventions that are obviously ill-suited for telemedicine, such as surgical interventions, where the virtue of in-person interaction is self-evident. Other interventions, such as technician-delivered applied behavior analysis or behavior modification, are also not appropriate for telemedicine. This is because the training and expertise of the line technician is limited, and the industry-standard training and practice is based upon in-person interactions. SCDHHS is considering additional flexibilities for provider disciplines where there is some evidence that telemedicine can be delivered in a clinically effective manner and clear guidelines for these practices may be documented and published.

Second, SCDHHS is communicating with other payers in the market to ensure that agency guidance on telemedicine is consistent, though not identical, to guidance being offered by other governmental and commercial payers. Most payers in the market have opened telemedicine services to physicians, advanced practice nurses, physician assistants, and some classes of behavioral health providers as SCDHHS has already announced or intends to announce this month. Consistency across the payer industry is important to give providers a common sense of the payer landscape and predictability, if not full flexibility.

Third, SCDHHS notes that almost all CMS guidance regarding telemedicine in recent days is focused entirely on providing states flexibility to promote access. Such guidance carries the underlying assumption of clinical efficacy, which SCDHHS feels it must address as an explicit factor in its decision-making for the purpose of this response. South Carolina has made significant investments in telemedicine in recent years, but several disciplines, particularly those administered by non-physician providers, still lack evidence to support the efficacy of providing the full benefit though that mode. In its telemedicine report to the General Assembly, SCDHHS notes that the three key considerations of employing telemedicine are quality, cost, and access. Accordingly, SCDHHS must balance the considerations of quality and access, as well as balance the three principles of the pandemic response noted earlier in this letter to provide flexibility of services, but also must consider the evidence and maturity of any clinical discipline with respect to telemedicine.

Fourth, we are witnessing an unprecedented contraction of social interaction, service utilization, and commerce. Individuals are deferring services for a variety of reasons, weighing the risk of receiving services in alternate settings against the risks of social interaction. One recent example the department has been evaluating is chemotherapy, which must be administered through infusion and supervised by trained clinicians. While SCDHHS has loosened physician oversight of infusion centers during the public health response to COVID-19 to improve access and reduce strain on physician capacity, it has not supported the full transition to home-based infusion so it can ensure appropriate clinical supervision of the administration of chemotherapy drugs. Daily, individuals and their clinical teams are evaluating interventions not just through the lens of payer actions, but through clinical appropriateness and risk to the beneficiary. While SCDHHS will likely, and retrospectively, see a contraction of utilization during the initial response period, it is not appropriate to assign or quantify the motivation for deferred services to anything other than the tremendous public effort to engage in social distancing.

Fifth, certain services are simply deferrable in the short-term, and SCDHHS is constantly consulting with physicians and other clinicians to gauge the tradeoffs between deferral and service delivery flexibility. Governor McMaster has requested that citizens defer actions and services, ranging from business activity and elective surgeries to in-person education, in order to prioritize social distancing. While the deferral of services is not ideal, wholesale restructuring of components of an $8 billion public benefit in the initial

weeks of an emergency response is also not advisable. SCDHHS intends to employ incremental, progressive, and evidence-based flexibilities for beneficiaries and providers as the period of publicly directed social distancing and self-quarantine prolongs.

Summation

The state's response to the COVID-19 pandemic is rapid and evolving, and SCDHHS will continue to offer incremental flexibilities based upon clinical judgement, market conditions, and beneficiary data as it becomes available. Now, two weeks into the statewide response, little actual data is available about the impact on services, beneficiaries, and providers. SCDHHS is monitoring the market and receiving input from providers, beneficiaries, and elected officials to adapt and respond to conditions as they evolve. Thank you for your support of SCDHHS and ongoing legislative efforts during this unprecedented time. I may be reached at joshua.baker@schddhs.gov or 803.898.2504.

Best,

Joshua D. Baker