PROGRAM EVALUATION REPORT

SC Department of Health and Human Services

Date of Submission: *June 2, 2020*

The contents of this report are considered sworn testimony from the agency director.

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Start Date: November 9, 2017
Number of Years as Agency Head: 2.5
Number of Years at Agency: 3.8
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Agency Online Resources
Website address: www.scdhhs.gov

Online Quick Links:

Please provide any links to the agency website agency representatives would like listed in the report for the benefit of the public.

https://www.scdhhs.gov/Getting-Started
https://apply.scdhhs.gov/CitizenPortal/application.do
https://www.scdhhs.gov/site-page/where-go-help
https://www.scdhhs.gov/Contact-Info

Table of Contents

I. Agency Snapshot

A. Glossary of Terms

1. Glossary of agency terms.

Term, Phrase or Acronym	Meaning of the Term, Phrase or Acronym
AA	Area Administrator
AAP	American Academy of Pediatrics
ABA	Applied Behavior Analysis
ABD	Aged, Blind or Disabled
ABTS	Applied Behavioral Therapy Services
AC	Assessment Consultant
ACA	Affordable Care Act
ACH	Adult Care Home
ADA	Americans with Disabilities Act
ADHC	Adult Day Health Care
ADHC-N	Adult Day Health Care Nursing
ADLS	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AG	Attorney General
AMA	American Medical Association
ANE	Abuse, Neglect and Exploitation
AO	Area Office
APCC	Adult Protection Coordinating Council
APS	Adult Protective Service
ARIES	Ad hoc Reporting Information Extract System
ARM	Alternative Reimbursement Methodology
ARP	Awaiting Residential Placement
ARR	Annual Resident Reviews
ASC	Ambulatory Surgical Centers
ASO	Administrative Services Organization
ATT	Attendant Care
AWP	Average Wholesale Price
BBA	Balance Budget Act
BCCP	Breast and Cervical Cancer Program
BCN	Best Chance Network
BHS	Behavioral Health Services
BVD	Based Value Bid
CAPS	Claims and Provider Services
CARC	Claim Adjustment Reason Code
CC	Community Choices
CCN	Claim Control Number
CDC	Centers for Disease Control and Prevention
CFAS	Children, Families, and Adult Services

CFR	Code of Federal Regulations
CGIS	Curam Global Income Support
CHIP	Children's Health Insurance Program
CI	Centralized Intake
CIL	Center for Independent Living
CIS	Client Information System
CLTC	Community Long Term Care
CM	Case Manager
CMC	Case Management Contact
CMS	Centers for Medicare and Medicaid Services
CMV	Case Management Visit
CO	Central Office
COA	Council on Aging
COMP	Companion
CPAS	Claims Processing Assessment
CPC	Children's Personal Care
CPDN	Children’s Private Duty Nursing Program
CPO	Chief Procurement Officer
CPS	Child Protective Services
CPT	Current Procedural Terminology
CRCF	Community Residential Care Facility
CRS	Children's Rehabilitation Services
CS	Community Supports Waiver
CSD	Client Status Document
DAODAS	South Carolina Department of Alcohol, Drug and Other Abuse Services
DCR	Detail Claims Report
DDI	Design, Development and Implementation
DME	Durable Medical Equipment
DOA	Department of Aging
DRGS	Diagnosis Related Groups
DSE	Designated State Entity
DSH	Disproportionate Share
EHR	Electronic Health Record
EM	Environmental Modification
EPMS	Employee Performance Management System
EPSDT	Early Periodic Screening, Diagnostic and Treatment
EVV	Electronic Visit Verification
FFS	Fee-for-Service
FMR	Facilities Management and Resources
FPB	Fixed Price Bid
FPL	Federal Poverty Level
FR	Federal Register
HA	Home Again
HASCI	Head and Spinal Cord Injury Waiver
HCBS	Home and Community-based Services

HCR	Health Care Reform
HDM	Home Delivered Meals
HH	Home Health
HHA	Home Health Aide
HHN	Home Health Nurse
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HSP	Hospice
IADLS	Instrumental Activities of Daily Living
ICF/ID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ID/RD	Intellectual Disabilities and Related Disabilities
IDEA	Individuals with Disabilities Education Act
IFB	Invitation for Bid
IFSP	Individualized Family Service Plan
ILOC	Intermediate Level of Care
IMD	Institute of Mental Disease
IS	Incontinence Supplies
IT	Information Technology
LOC	Level of Care
LTC	Long Term Care
LTCC	Long Term Care Coordinator
LTCM	Lead Team Case Manager
LTL	Long Term Living
LTNC	Lead Team Nurse Consultant
MCC	Medically Complex Children's Waiver
MCCS	Medicaid Claims Control System
MCO	Managed Care Organization
MEDS	Medicaid Eligibility Determination System
MES	Medicaid Enterprise Systems
MFCU	Medicaid Fraud Control Unit
MMO	Material Management Office
MMRP	Member Management Replacement Program
MRFU	Medicaid Recipient Fraud Unit
NEMT	Non-Emergency Medical Transportation
NS	Nutritional Supplement
OBRA	Omnibus Budget Reconciliation Act
OOS	Out-of-state
OSCAP	Optional Supplemental Care for Assisted Living Participants
OSS	Optional State Supplementation
P & P	Community Long Term Care Policy and Procedure
PACE	Program for All-inclusive Care for the Elderly
PASRR	Preadmission Screening and Resident Review
PC	Primary Contact

PC I	Personal Care I
PC II	Personal Care II
PDD	Pervasive Developmental Disorder
PDN	Private Duty Nursing
PERM	Payment Error Rate Measurement
PERS	Personal Emergency Response System
PHI	Protected Health Information
PHX	Phoenix
PII	Personally Identifiable Information
POA	Power of Attorney
POC	Plan of Care
PPD	Purified Protein Derivative (tuberculin skin test)
PRIME	Healthy Connections PRIME
PSC	Provider Service Center
QV	Quarterly Visit
RCF	Residential Care Facility
RFP	Request for Proposals
RFS	Request for Space
RMMIS	Replacement Medicaid Management Information System
RN	Registered Nurse
RP	Responsible Party
RSF	Rentable Square Feet
RSP	Recipient Special Programs
RV	Re-evaluation
SCDDSN	South Carolina Department of Disabilities and Special Needs
SCDHEC	South Carolina Department of Health and Environmental Control
SCDHHS	South Carolina Department of Health and Human Services
SCDJJ	South Carolina Department of Juvenile Justice
SCDOI	South Carolina Department of Insurance
SCEIS	South Carolina Enterprise Information System
SCDMH	South Carolina Department of Mental Health
SCDSS	South Carolina Department of Social Services
SILC	Statewide Independent Living Council
SLED	State Law Enforcement Division
SLOC	Skilled Level of Care
SP	Service Plan
SPIL	State Plan for Independent Living
SS	Satellite Supervisor
SSI	Social Security Income
SW	Social Worker
TAD	Turn Around Document
TC	Transition Coordinator
TCM	Targeted Case Management
TCO	Transition Coordinator Ongoing
TCV	Transition Coordinator Visit

TFC	Therapeutic Foster Care
TMP	Temporary Medical Personnel
UAP	University Affiliated Program
USF	Usable Square Feet
VA	Veterans Affairs
VENT	Mechanical Ventilator Dependent

B. History

2. **History of significant events related to the agency, from agency's origin to the present.** When reference is made to a significant legislative action, please cite to the applicable act, if known.	1965	The Medicaid program was authorized by Title XIX of the Social Security Act that was signed into law by the President on July 30, 1965.
	1967	Congress introduced the Medicaid benefit for children and adolescents, known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.
	1968	South Carolina began participation in the Medicaid program, including the EPSDT program, which was housed under the Department of Welfare (currently the Department of Social Services).
	1972	The Supplemental Security Income (SSI) program was created. This federally funded income assistance program for people with disabilities replaced the preceding federal-state aged, blind or disabled (ABD) cash assistance programs and Medicaid eligibility was linked to SSI eligibility.
	1983	In June 1983, the South Carolina Legislature enacted Act No. 83 of 1983 creating the State Health and Human Services Finance Commission which was to be operational effective July 1, 1984. The act establishes the State Health and Human Services Finance Commission's authority to administer Title XIX of the Social Security Act (Medicaid), including the EPSDT program and the community long term care (CLTC) system; Designates the commission as the South Carolina Center for Health Statistics to operate the Cooperative Health Statistics Program pursuant to the Public Health Services Act; and, prohibits the commission from engaging in the delivery of services. The State Health and Human Services Finance Commission later became the South Carolina Department of Health and Human Services (SCDHHS).
	1984	The Centers for Medicare and Medicaid Services (CMS) approved South Carolina's request for a home and community-based (HCBS) waiver for the elderly and disabled. In 2003 the name changed to Community Choices.
	1985	

	SC Legislature enacted Act No. 201 of 1985 creating the South Carolina Medically Indigent Assistance Program administered by the agency. The program is authorized to sponsor inpatient hospital care for which hospitals shall receive no reimbursement.
1986	
	Inpatient Hospital Prospective Payment Methodology
1987	
	The Omnibus Budget Reconciliation Act (OBRA) of 1987 developed the Preadmission Screening and Resident Review (PASRR) to screen individuals for serious mental illness or Intellectual Disability and Related Disability (ID/RD) prior to admission to a Title XIX certified nursing facility, ensuring appropriate placement and services.
1988	
	The Disproportionate Share (DSH) Program was created on or after July 1, 1988, with significant increases in DSH spending during FYs 1991-1994. CMS authorized South Carolina to provide services under a Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver to eligible persons with HIV/AIDS.
1989	
	The Medicaid Permit Day Law was enacted. Every nursing facility that desires to participate in the Medicaid program must obtain a Medicaid Patient Day permit from the South Carolina Department of Health and Environmental Control (SCDHEC) Certificate of Need specifying the number of Medicaid patient days the facility is authorized to use during a State Fiscal Year. Published May 26, 1989 in State Register (SCDHEC Regulation) CMS authorized Palmetto Senior Care. In 2003, this became a State Plan service. The Medicaid expansion fund was created. Coverage for pregnant women was added as a category of eligibility.
1990	
	The Children's Personal Care Aide (PCA) service was approved as a part of the Medicaid State Plan to provide PCA service to children under the EPSDT program.
1991	
	CMS authorized South Carolina to provide services under an ID/RD waiver to eligible persons.
1993	
	The Adult Protection Coordinating Council (APCC) was created under the auspices of SCDHHS. APCC was created by the SC General Assembly to foster coordination and cooperation among multiple entities involved in the adult protection system. This is part of the Omnibus Adult Protection Act.

The name commission was changed to department under Act No. 181 of 1993.
The SC Legislature enacted Act No. 181 of 1993 creating in the Office of the Governor, the Division of Aging. effective July 1, 1993.

1994

CMS authorized South Carolina to provide services under a Mechanical Ventilator Dependent (VENT) waiver to eligible persons.
South Carolina Governor Carroll Campbell initiated the Palmetto Health Initiative, a statewide research and demonstration project, which included restructuring the fee-for-service delivery system into a managed care delivery system.

1995

CMS authorized South Carolina to provide services to eligible persons with head and spinal cord injuries (HASCI) Waiver.
SCDHHS implemented coverage for severely disabled children who meet institutional level of care under the Katie Beckett/Tax Equity and Fiscal Responsibility Act (TEFRA) option.

1996

South Carolina began operating a comprehensive risk-based managed care organization (MCO) program, which served certain children, pregnant women and non-dual eligible adults with disabilities. The MCO program also covered acute, primary and some specialty care services and outpatient behavioral health. Initially, MCOs were available on a voluntary basis.
Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 Code of Federal Regulations [CFR], parts 160 and 164) was enacted to help simplify the flow of health information, standardize electronic transmission of health information, and ensure the privacy and security of health information.

1997

Program oversight of Optional State Supplementation (OSS) is transferred from the South Carolina Department of Social Services (SCDSS) to SCDHHS. OSS is designed to provide a monthly entitlement payment on behalf of an eligible aged, blind or disabled (ABD) individual who lives in a licensed community residential care facility (CRCF) that is enrolled with SCDHHS to participate in the OSS program.
The appeals procedure is amended by State Register Vol. 21, No. 3 detailing the necessary requirements. Effective March 28, 1997.

2000

The SC Legislature enacted Act No. 387 of 2000 prohibiting state or Medicaid funds to be expended to perform abortions, except for those abortions authorized by federal law under the Medicaid program.

2001

Implemented coverage for females under age 65 who were screened by SCDHEC's Best Chance Network and diagnosed with breast and/or cervical cancer.

2002

Statewide implementation of Medicaid Eligibility Determination System (MEDS).
Proviso 8.35 transfers Medicaid eligibility functions and staff from SCDSS to SCDHHS. It also, directs counties to continue to provide office space and facility service for this function as they do for SCDSS functions under Section 43-3-65.
The South Carolina Nurse Aide program is transferred from SCDHEC to SCDHHS.

2003

To help prevent fraud, waste, and abuse, the agency implemented electronic visit verification (EVV) for use by waiver providers rendering in-home care. CMS now requires EVV use by all states.
State Register Vol. 27, 2003 transferred administration of the Child Care Development Fund and the Social Services Block Grant to SCDSS and SCDHHS, effective Nov. 17, 2003.

2004

The agency enacted hearing procedures amended by State Register Vol. 28, No. 6 detailing the rights and representation in proceedings, effective June 25, 2004.

Proviso 8.17 of the 2003-04 Appropriations Act transferred the Division on Aging from the Office of the Governor to SCDHHS.

2006

Implemented the Gap Assistance Pharmacy Program for Seniors program and Deficit Reduction Act verification of citizenship and identity rules.

2007

SCDHHS introduced the Medical Homes Network (MHN) program, a statewide Enhanced Primary Care Case Management program (PCCM), that utilized networks of primary care providers to provide and arrange for most Medicaid acute, primary and specialty care and behavioral health services for eligible Medicaid participants (excluding those in another managed care program and those receiving home and community-based waiver services or residing in an institution).
Eligible individuals received applied behavior analysis (ABA) services through the Pervasive Developmental Disabilities (PDD) waiver, which was discontinued when the benefit became a state plan covered service.

	SCDHHS began providing Non-emergency Medical Transportation (NEMT) to its beneficiaries through the broker system.
2008	
	Proviso 89.112 (2008-09) is enacted, which prohibits SCDHHS from decreasing provider reimbursement rates from their current levels. On August 12, 2008, SCDHHS received notification from the SC Budget and Control Board that the agency's base budget of recurring General Funds must be reduced by 3%. The agency implemented reductions and policy changes accordingly effective October 1, 2008. SCDHHS instituted a name change for the state Medicaid program from "Partners for Health" to "Healthy Connections." SCDHHS implemented a separate Children's Health Insurance Program, called Healthy Connections Kids, for children in families with income between 150% and 200% of the federal poverty level (FPL) who do not have creditable health insurance, do not have access to coverage to health insurance as a State of South Carolina employee, and have not dropped health insurance in the previous three months. The Pharmacy & Therapeutic Committee was created consisting of 15 members including 11 physicians and four pharmacists under Act No. 353 of 2008. The Division on Aging transferred from SCDHHS to the Lieutenant Governor's Office on Aging. Proviso 57.2 (2007-08)
2009	
	The Medically Complex Children's Waiver (MCC) is implemented. A grant is received by Palmetto Health Richland from the Robert Wood Johnson Foundation in 1995 to develop a program for medically fragile children, resulting in the Medically Fragile Children program. The grant ended in 1999 and was replaced by SCDHHS 1915(c) Medically Fragile Children Program Waiver. CMS authorized South Carolina to provide services under a Community Supports (CS) waiver to eligible persons with ID/RD.
2010	
	South Carolina opted to change CHIP by eliminating the stand-alone option and increasing expanded coverage to 200% of the FPL. The Healthy Connections Kids (HCK) Program was terminated and replaced by Partners for Healthy Children (PHC). All active budget groups were converted to PHC.
2011	
	SCDHHS further expanded Healthy Connections Choices through mandatory enrollment of Medicaid beneficiaries formerly served in the fee-for-service (FFS) system in either the MCO program or the MHN program.

	The State Verification and Exchange System (SVES) was implemented to verify citizenship and identity (C&I). The system has been modified to automatically request C&I verification and process incoming responses from the Social Security Administration (SSA). SCDHHS implemented the Complex Care Program for nursing home residents. SCDHHS initiated an MCO carve-in, including inpatient behavioral health services. Act No. 77 of 2011 is enacted, which suspends provisos 21.11, 21.15, and 21.20 of Part 1B, Act 291 of 2010; the FY 2010-11 General Appropriations Bill; and, suspends a portion of proviso 89.87 of Part 1B, Act 291 of 2010. The act prohibits the agency from reducing provider rates and requires SCDHHS to provide estimates of the projected dollar cost savings by source of funds and the number of providers and clients impacted with all proposed changes in provider rates and produce certain reports reconciling actual savings in comparison to the estimates.
2012	
	The agency implements major program reductions to rates and services. SCDHHS automated a monthly data match with SCDSS to identify children not currently receiving Medicaid, but who are receiving Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Children who are not on Medicaid and receive SNAP and/or TANF, are automatically eligible for Medicaid under Partners for Healthy Children (PHC). This process is known as Express Lane Eligibility (ELE).
2013	
	SCDHHS transitioned from the PCCM program to an MCO service delivery system. Enrollment in the managed care program remained limited until 2006, when SCDHHS introduced the Healthy Connections Choices program. This program deployed enrollment counselors to help beneficiaries who were now required to choose one of the three Medicaid delivery models available in the state at that time: an MCO, the new PCCM program or the traditional FFS option. The agency implemented Optional Supplemental Care for Assisted Living Participants (OSCAP). OSCAP service provides an enhanced payment to the CRCF for providing additional services to OSS residents in need of physical and cognitive assistance, in order to complete activities of daily living and remain in the community.
2014	
	SCDHHS eliminated the PCCM model, or MHN program, and transitioned to a managed care model. SCDHHS still administers one MHN, SC Solutions, for individuals that are enrolled in the MCC program. Pursuant to proviso 33.30 of FY2014-15, a delay for

the Healthy Connections PRIME (PRIME) program implementation was requested by CMS with the requested date to begin enrollment no earlier than Jan. 1, 2015.
PRIME participation began in FY 2015-2016 with limited participation to individuals who affirmatively elected to participate until April 1, 2016, at which time the agency was permitted to begin passively enrolling participants.
The Affordable Care Act provides the state with the authority to expand Medicaid eligibility to individuals with income below 133% of the FPL and children in families up to 213% of the FPL and standardizes the rules for determining eligibility and providing benefits through Medicaid, CHIP, and the health insurance Marketplace.

2015

The agency covered autism services through its EPSDT authority beginning January 2015. The agency processed requests for services with a special team led by a licensed psychologist and in consultation with its medical directors.

2016

The Palmetto ABLE Savings program is created to authorize the establishment of savings accounts empowering individuals with a disability and their families to save private funds, which can be used to provide for disability-related expenses in a way that supplements, but does not supplant, benefits provided through private insurance, the Medicaid program under Title XIX of the Social Security Act, the supplemental security income program under Title XVI of the Social Security Act, the beneficiary's employment, and other sources; and to provide guidelines for the maintenance of these accounts.

The agency transitioned to a prospective payment system for Federally Qualified Health Centers (FQHCs).

2017

Pursuant to Executive Order 2016-20, lead agency designation for South Carolina's Individuals with Disabilities Education Act (IDEA) Part C program, known in South Carolina as "BabyNet" was transferred from South Carolina First Steps to School Readiness to SCDHHS, effective July 1, 2017.

Autism services, also known as ABA, became a state plan covered benefit on July 1, 2017. ABA services were paid both through FFS and our coordinated care benefit (i.e., managed care). Individuals in the PDD waiver transitioned to state plan services over the subsequent three months.

2018

Implemented a State Plan Amendment for the provision of full benefits for lawfully present pregnant women and children.

Submitted the Preconception Care 1115 Demonstration Waiver to CMS.

2019

In January 2019, SCDHHS began to enroll opioid treatment programs (OTPs) in the Medicaid provider network and began to reimburse for medication-assisted treatment (MAT) provided in OTPs. The addition of this benefit made the full spectrum of pharmacotherapies approved for the treatment of opioid use disorder (OUD) available to Medicaid members.

Completed agency-wide risk assessment for internal audit on August 30, 2019.

CMS approved the state's Healthy Connections Community Engagement Project by approving two Section 1115 demonstration waivers on Dec. 12, 2019.

2020

SCDHHS reintroduced podiatry benefits for adult Medicaid beneficiaries effective Jan. 1, 2020.

The agency issued 32 pieces of guidance, including 15 Medicaid bulletins in the Spring of 2020 extending flexibilities, with a focus on telehealth flexibilities, to providers to ensure access to care for Medicaid beneficiaries in preparation and response to the coronavirus disease 2019 (COVID-19) public health emergency and to comply with the Families First Coronavirus Response Act and the Coronavirus Aid Relief and Economic Security Act.

State Plan Amendment to establish new COVID-19 Testing eligibility group for uninsured South Carolina residents.

Submitted its Palmetto Coordinated System of Care waiver application, which will serve children and youth with serious behavioral health challenges who are in or most at risk of out of home placements, to CMS on May 1, 2020.

3.	Agency directors and time of service.	

Name of Director	Time of Service
Joshua Baker	2017-present
Deirdra T. Singleton (Acting)	2017
Christian Soura	2014-2017
Anthony E. Keck	2011-2014
Emma Forkner	2007-2011
Susan Bowling (Acting)	2007
William Wells (Acting)	2007
Robbie Kerr	2003-2007
Bob Toomey (Acting)	2002-2003
William Prince	2000-2002
Sam Griswold	1999-2000
Gwen Power	1996-1999
Eugene A. Laurent	1987-1996
Dennis Caldwell	1984-1987
James Solomon	1984
John A. Crosscope Jr.	1983
Virgil L. Conrad	1977-1983

C. Governing Body, Organizational Chart, and Related Entities

4.	Agency's governing body, as outlined in the enabling statute.	S. C. Code Ann. 44-6-10 Establishes the State Department of Health and Human Services which shall be headed by a Director appointed by the Governor, upon the advice and consent of the Senate. The director is subject to removal by the Governor pursuant to the provisions of S.C. Code Section 1-3-240.
5.	Qualifications and duties of the agency director and governing body, as specified in law.	S. C. Code Ann. 44-6-100 Establishes the Director as the chief administrative officer of the department responsible for executing policies, directives, and actions of the Department either personally or by issuing appropriate directives to the employees. Department employees have such general duties and receive such compensation as determined by the Director. The Director is responsible for administration of state personnel policies and general Department personnel policies. The Director has sole authority to employ and discharge employees subject to such personnel policies and funding available for that purpose. The goal of the provisions of S.C. Code Section 44-6-100 is to ensure that the Department's business is conducted according to sound administrative practice, without unnecessary interference with its internal affairs.
6.	(A) Organizational Units Details Chart.	See attached Excel chart.
	(B) Has the agency ever conducted an employee engagement, climate, or	Yes, Public Consulting Group (PCG) conducted an employee engagement survey in December 2018. Prior to PCG, the engagement survey had been

	similar survey? If yes, when was the last one and who conducted it?	performed annually by Leaders Edge 360. The agency intends to re-bid the survey in 2020. The agency performs internal and external climate surveys on an as-needed basis and includes staff feedback as part of program area reviews. Staff interviews were included in reviews of Program Integrity in 2016, Internal Audits and Finance in 2018.
	(C) Does the agency conduct employee engagement, climate, or similar surveys on a regular basis? If yes, what is the frequency?	As noted above, the agency re-procured the engagement survey in 2018 and was not satisfied with PCG. The agency issued a solicitation for a new contractor and received responses in Oct. 2019.
7.	Role and responsibilities of the agency compared to its counterpart entities, if any, at the federal and local levels.	<u>Federal counterparts</u> **Centers for Medicare and Medicaid Services** The Centers for Medicare and Medicaid Services (CMS) is the agency within the U.S. Department of Health and Human Services (HHS) that administers the nation's major health care programs. The CMS oversees health care programs such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the state and federal health insurance marketplaces. As a condition for receipt of federal funds under Title XIX of the Social Security Act the SCDHHS submits the State Plan for the medical assistance program and agrees to administer the program in accordance with the provision of this State Plan, the requirements of Titles XI and XIX of the Act, and all applicable federal regulations and other official issuances of the department. In accordance with and meeting all the requirements of 42 CFR 431.12, the SCDHHS has established an advisory committee, known as the Medical Care Advisory Committee (MCAC), to the Medicaid Director on health and medical care services. In accordance with Section 1902 (a) (73) of the Social Security Act, the SCDHHS seeks advise on an ongoing basis from the one federally recognized tribe in South Carolina, The Catawba Indian Nation, on matters related to Medicaid and CHIP programs. **Administration for Community Living** Another subdivision within U.S. HHS, the Administration for Community Living (ACL) coordinates efforts between entities serving individuals with intellectual and physical needs and promotes their integration into the community. South Carolina is a recipient of a grant to develop and support a state plan for independent living and operates these grants through Centers for Independent Living statewide. SCDHHS is the designated state administrator. **Office of Special Education Programs**

The office of Special Education Programs (OSEP) is a subdivision of the Office of Special Education and Rehabilitative Services (OSERS) within the U.S. Department of Education. OSEP is the primary grantmaking and oversight entity for the Individuals with Disabilities Education Act (IDEA), Part C program that focuses on identifying and screening children with developmental delays and referring them to needed services. SCDHHS is South Carolina's IDEA, Part C lead agency.

Cooperating State Agencies

South Carolina Department of Disabilities and Special Needs

The South Carolina Department of Disabilities and Special Needs (SCDDSN) is an entity established by the South Carolina General Assembly with the primary responsibility of administering home and community-based services (HCBS) waivers, authorized under section 1915(c) of the Social Security Act for individuals with intellectual and developmental disabilities, as well as those for individuals with head and spinal cord injuries. Although the General Assembly appropriates state match dollars directly to SCDDSN, and the number varies annually, consistently greater than 90% of SCDDSN's annual budget is associated with Medicaid Program Expenditures.

South Carolina Department of Health and Environmental Control

The South Carolina Department of Health and Environmental Control has varied cooperative responsibilities and authorities that interact with the Medicaid program. SCDHEC is a Medicaid provider, is CMS' survey and certification agency which licenses South Carolina's hospitals, nursing homes, and other facilities, and SCDHEC collects myriad data about disease and wellness that SCDHHS uses to evaluate program and vendor effectiveness.

South Carolina Department of Social Services

The South Carolina Department of Social Services operates the state's child protective safety programs and Title IV-E supportive adoption programs. Children under the care and auspices of these programs are categorically eligible for Medicaid coverage, making the data sharing and operational connections between the two agencies necessary for programmatic success.

State Agency Providers and Partners

SCDHHS has important relationships with state agencies that administer and fund provider networks, including the South Carolina Department of Alcohol, Drug and Other Abuse Services, the South Carolina Department of Mental Health, South Carolina Department of Education, South Carolina Office on Aging, Continuum of Care within the Office of the State Child Advocate, South Carolina Department of Corrections, among others. SCDHHS also plays a role in emergency management operations as a supporting agency for Emergency Support Function (ESF) 6 – Mass Care, and as a requesting entity for emergency waivers from U.S. HHS.

South Carolina Attorney General

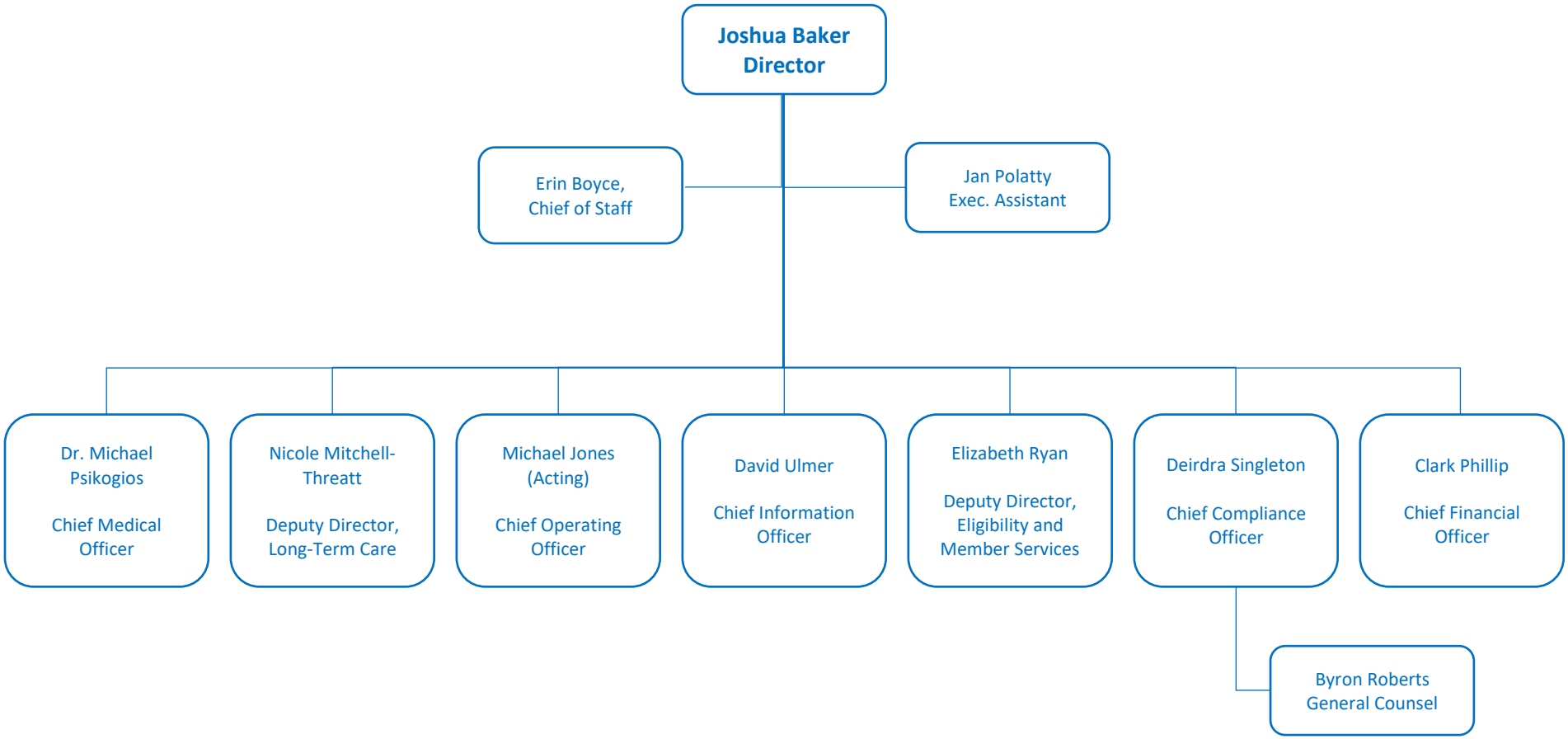
The South Carolina Attorney General operates the state-level prosecutorial arm of the agency's program integrity unity – the Medicaid Fraud Control Unit

(MFCU) and Medicaid Recipient Fraud Unit (MRFU). SCDHHS funds positions with the Office of the Attorney General to support these efforts, although MRFU and MFCU operate independently of SCDHHS.

Local counterparts

While the agency works with many partners in the state, there are no specific direct counterparts to the agency at the local level. Many political divisions, however, serve as providers eligible for reimbursement by the Medicaid and IDEA Part C programs. Such political subdivisions include local education agencies who must coordinate financing with Medicaid and their IDEA Part B (school-aged) programs, government-owned hospitals and nursing home, Act 301 local substance abuse authorities, local Disability and Special Needs (DSN) boards, and others.

8. Organizational Chart.



D. Successes and Issues

9. **3-4 agency successes.** Briefly describe 3-4 agency successes.	*Community Engagement Initiative* In December 2019, after more than a dozen public hearings and months of negotiations with federal officials, the Centers for Medicare and Medicaid Service (CMS) approved two section 1115 demonstration waivers – the Palmetto Pathways to Independence and SC Works waivers – that grant authority for SCDHHS to implement policies that incentivize Medicaid beneficiaries to engage in their communities. These efforts are aimed at: • Incentivizing employment, education, and volunteerism among able-bodied Medicaid beneficiaries. • Removing economic disincentives for employment created by the Affordable Care Act's (ACA) all-or-nothing Medicaid expansion and ensuring continuity of benefits for low-income parents of Medicaid beneficiaries. • Supporting the state's ongoing response to the opioid crisis by providing health coverage to targeted groups at highest risk of opioid use disorder and its disastrous consequences, including pregnant and postpartum women, parents of children in foster care, individuals with involvement in the justice system, and individuals facing chronic homelessness and mental health challenges. While the implementation of these waivers has been delayed as a result of congressional action and the healthcare system's response to COVID-19, SCDHHS will reinstate waiver efforts upon the conclusion of the COVID-19 public health emergency. *Benefit-Wide Rate Review* Upon appointment, Director Baker committed to conducting a cyclical, benefit-wide review of all provider reimbursement rates. This effort is focused on improving access to quality healthcare for Medicaid beneficiaries, aligning reimbursement strategies with other healthcare payers, and simplifying the manuals, fee schedules, and processes used by providers to seek reimbursement for providing care to Medicaid beneficiaries. Phase one of the reimbursement review included physicians, autism service, and durable medical equipment providers and was completed in July 2019. In 2019, SCDHHS engaged an external consultant to analyze the section 1915(c) home and community-based services (HCBS) waivers administered by the SCDDSN. The draft report has been delivered to SCDDSN for review and formal comment. Phase two of the reimbursement rate review, including pharmacy, waiver services, and several allied health providers, will be completed in July 2020. In addition, SCDHHS has taken the first steps toward simplifying the requirements for therapeutic foster families and providers, separating those benefits from the remainder of Rehabilitative Behavioral Health Services (RBHS).

Phase three of the reimbursement project will include a comprehensive redesign of the state's behavioral health benefit, with a special focus on:

- Rationalizing the RBHS benefit, including additional revisions to services available for children in foster care
- Consolidating and streamlining the department's 9 separate behavioral health provider manuals
- Aligning reimbursement rates and policies with other healthcare payers
- Identifying gaps in the continuum of behavioral health services, to include institutional step-down.
- Tiering inpatient psychiatric rates to improve network adequacy and pushing governmental providers – the South Carolina Department of Mental Health and local Disability and Special Needs Boards – to resume their traditional roles in the public safety-net.

While the final phase of the reimbursement rate review was to focus on institutional rate review, SCDHHS believes that the implementation of a hospital quality payment program, along with uncertain economic conditions will likely result in a delay of this phase.

Replacement and Certification of Information Systems

The day-to-day operation of the Medicaid program requires a significant information technology framework to manage Medicaid eligibility for more than 1 million South Carolinians, process over 29 million claims and capitation payments every year, and issue reimbursement and capitation payment to over 60,000 Medicaid providers. In 2010, SCDHHS began the modernization of the four decade-old system, hosted and operated by Clemson University. To date, CMS has certified the following three modules:

- Pharmacy benefits administration (PBA) - 2019
- Third-party liability (TPL) - 2020
- Business Intelligence Systems (BIS) - 2020

Additional modules in the implementation phase are

- Legacy Accounting System (LASRAI)
- Administrative Service Organization (ASO)
- Electronic Visit Verification (EVV)
- Medicaid Enterprise System (MES)

COVID-19 Response Effort

In response to the COVID-19 pandemic, SCDHHS initiated an aggressive strategy of modifying the Medicaid benefit with the aim of ensuring access to care for COVID-19, fostering social distancing in the delivery of care, and ensuring ongoing access to behavioral health in the environment of increased social isolation. These benefit modifications included the addition of new covered services, the removal of patient cost share and prior authorization requirements, and the introduction of unprecedented flexibilities in the delivery of care via telehealth.

In the first six weeks of the response, the department issued 32 pieces of guidance – bulletins, state plan and waiver amendments, alerts, memoranda,

and frequently asked questions – and operationalized them in the agency's 40-year-old billing system.

Addressing the Opioid Crisis

SCDHHS has engaged in an aggressive strategy to address the opioid crisis within South Carolina's Medicaid population. These policy changes and benefit enhancements, coordinated through the South Carolina Opioid Emergency Response Team, have contributed to improvements in opioid prescribing, but also highlighted the need for continued focus on ensuring that treatment for OUD is available. The number of opioid prescriptions funded through the Medicaid program has decreased steadily over the last several years. Despite these successes, the number of South Carolinians who suffer opioid overdose and opioid-related death continue to rise. In response, SCDHHS has refocused in efforts on:

- Ensuring access to treatment for OUD, including coverage of Opioid Treatment Centers (OTPs), standardization of coverage for medication assisted treatment (MAT) care of individuals with opioid use disorder, allowing telehealth in 301 centers, and allowing Medicaid managed care organizations to cover OUD treatment in intuitions of mental disease (IMDs)
- Provider education, including a campaign of provider education to address the inappropriate use of opioids, named Timely Information for Providers in South Carolina (tipSC)
- Investing in innovative treatment options, including the initiation of MAT in emergency departments, Managing Abstinence in Newborns (MAiN) program

Improving the Quality of Care of Children covered by Medicaid

Over 60 percent of South Carolina's children obtain healthcare coverage through Medicaid. To ensure the highest quality of care is provided for those children, SCDHHS has invested considerably through the Quality Through Innovation in Pediatrics (QTIP) program. This program provides learning collaboratives and in-office technical assistance to pediatric offices across the state, aimed at improving quality of care. These efforts have demonstrated significant improvements in rates of pediatric well visits, development screenings, and care for pediatric conditions such as ADHD and asthma.

Medical Cost Trend Management

Healthcare costs have increased considerably over recent decades and now represent 19 percent of gross domestic product (GDP) at the national level. Through a host of efforts to maintain a sustainable trend of medical costs, SCDHHS experienced an increase in 1.9% from SFY 2018 to SFY 2019. This is considerably less than the United States rate healthcare expenditure trend of 4.6% or the South Carolina State Health Plan trend of 2.3%.

10. 3-4 agency challenges. Briefly describe 3-4 agency	*Health System Accountability and Performance Measurement*

challenges and preparations, if any, to address these issues.	The cost of publicly funded healthcare continues to represent a considerable portion of the state's budget, resulting in consistent pressure to reduce the cost of care. The provision of healthcare also represents a considerable portion of the state's economy, creating a competing desire to maintain revenue and profitability to players in that economic segment- hospitals, insurance companies, and healthcare providers- who are increasingly depending upon government payment sources. Further, the broad entitlement programs operated by state and federal governments tend to prioritize access and prompt payment over the quality of services, and the rigor of the evidence supporting some services. SCDHHS must continue to aggressively implement quality systems that may have the net effect of reducing the total revenue paid to implementing vendors. This tension between SCDHHS and its provider community is further exacerbated by the fact that federal rules and regulations provide far more payment flexibility to states when the Medicaid program is executed through managed care. This model comes with some inherent opportunities, such as: • Provider network and contracting flexibility • Risk-sharing between the state and managed care vendor • Opportunities to implement alternate payment strategies without direct federal approval. • Offering benefits and services not otherwise provided for in the state plan for medical assistance. While this allows some measure of private-sector flexibility and opportunities for risk-sharing, it presents three important challenges: • The relationship between the primary payer (SCDHHS) and the ultimate healthcare provider becomes indirect • The managed care program requires a third-party administrator, of which the marketplace is largely for-profit, publicly traded insurers, which adds profit-motivated behaviors to a public health program • An additional layer of administrative expense and loss of some economies of scale with respect to network building, provider rate negotiations, and risk pooling Further, societal expectations that government entities meaningfully measure health – both individually and in the aggregate – outstrip the industry's ability to actually do so. Many measures are effective at the level of an individual patient or provider, particularly with respect to proxies such as immunization, antipsychotic use, and weight control; however, a single metric or approach to globally capture the health status of the Medicaid population is illusive. Finally, the Medicaid program is structured to attribute the success or failure of a healthcare intervention to a provider, and inherently lacks the ability to provide either positive or negative incentives to beneficiaries. While this may be effective in acute care settings, there are fundamental challenges to motivating individuals to take responsibility for and make effective personal lifestyle and health decisions through indirect economic incentives.

Replacement MMIS

While one of the greater opportunities for modernization, the failure to incrementally modernize the state's Medicaid Management Information System (MMIS) system has resulted in a dramatic platforming of every one of the department's major systems – from provider enrollment, to claims adjudication, member eligibility, provider payment, reporting, and others. This program puts several major stressors on the organization:

- Human capital
- Financial prioritization
- Change risk

In addition to the natural strain of change, the Medicaid Information Technology Infrastructure (MITA) version 3.0 modularity structure directs states to a modular technology approach, requiring multiple rounds of procurements, as opposed to a monolithic solution. While this will provide more opportunity for incremental modernization in the future, this compounds the complexity of the MMIS replacement as the state is not only replacing the system itself, it is also changing the entire architecture and design of how the system interacts with the agency, itself, and beneficiaries.

Although the availability of 90 percent federal match for many of these efforts has incentivized states to take on the significant investment of systems replacement, the financial incentive to information technology professionals and vendors has been significant. This leads to increased costs of implementation and widening disparities in workforce compensation. Procurements of this size and scope are also unusual for state governments, whose procurement codes are better suited for purchasing space, commodities, and consulting services than the hybrid configurations of software-as-a-service, or claims adjudication and data transfer truly unique to Medicaid programs.

Low-Evidence, Atypical Benefits and the Role of Advocacy

The role of Medicaid in providing care to disabled individuals, and especially disabled children, results in coverage of services that are outside the scope of traditional healthcare payer organizations. Services focused on behavioral health, life skills development, long-term services and supports, and social determinants of health often lack the robust evidence basis that is customary for more traditional healthcare services. Despite this lack of evidence, several interventions and disciplines have developed strong advocacy efforts. Advocacy-based coverage decisions often use compelling anecdotal personal narratives to create support for coverage as opposed to the more challenging and slower process of building a body of clinical evidence. Additionally, challenges to create unbiased evidence in support of or against coverage include the following:

- Funding for clinical research is most often made available by the businesses and industries supporting an intervention, procedure, or technology. Accordingly, interventions with limited evidence often do not have impartial evaluations
- Certain therapeutic interventions lack clear objective measures or have not been utilized in their current form for a sufficient duration to have created longitudinal studies. While high-intensity services are

	often measured with respect to avoided negative interventions – emergency room diversion, reduced pharmaceutical utilization, avoided death – low-intensity therapies often lack an effective comparison • There is a disincentive to study low-intensity interventions. Some studies of the difference between lay-administered and professionally administered therapies have shown little to no difference in effectiveness, and not all studies fully support differential outcomes for some interventions. In short, there is risk that if an intervention is robustly studied, it may be proven to be ineffective when implemented in uncontrolled settings The lack of evidence is often compounded by a total lack of provider licensure or regulation, requiring SCDHHS to serve not only in its customary role as payer, but also as regulator of provider qualification and quality. Medicaid's "any willing and qualified provider" standards often run counter to the agency exerting a regulator role on the network.
11. **3-4 emerging issues.** Briefly describe 3-4 emerging issues anticipated to have an impact on agency operations in the upcoming five years and preparations, if any, to address these issues.	*COVID-19* The COVID-19 pandemic has created new strains on the healthcare delivery system, and society's response to it has compounded issues from health network sustainability, delivery modality, economic and budgetary strain for governments, society's comfort with interacting with the healthcare apparatus, risk scoring and modeling, and many more. SCDHHS is continuing to work with stakeholders, peers in other states, the provider and beneficiary community, and state agencies to continue to adapt to a new normal of public health and healthcare delivery after COVID-19. *Telemedicine* South Carolina, as an early adopter of telemedicine, has experienced a rapid expansion of telemedicine in non-traditional ways to ensure access to care during periods of intense social distancing and isolation. While some of these flexibilities will not outlast the COVID-19 public health emergency, SCDHHS has already engaged academic partners to structure studies of its telemedicine benefit to ensure that the flexibilities remaining post COVID-19 are evidence-based and high-quality. As noted previously, telemedicine has a role in healthcare delivery and a strong advocacy. SCDHHS intends to work with the provider community to ensure that provider education is available to aid in proper adoption of telemedicine into provider practices and that services authorized for reimbursement are appropriately measured for value against the appropriate balance of access, quality, and cost. *Social Determinants of Health* Increasingly, the role of employment, education, housing, and cycles of violence and abuse are correlated to long-term measures of health and longevity. Although SCDHHS has clear limitations on interventions that can be supported with federal Medicaid funding – specific prohibitions on housing, for example – the department can nonetheless play an important role in collecting measurements of social determinants and investing in the information technology infrastructure necessary to undertake these public health efforts.

Data and Security

SCDHHS is increasingly a technology organization. As expectation of rapid claims and eligibility processing, higher standards for timeliness and accuracy of transactions, societal expectations of data analysis and the need to link claims data with other socially acquired data elements, SCDHHS has more data than ever before. There are also increased expectations that SCDHHS will leverage this data to analyze the Medicaid program and its operations. This creates the need to better access, secure, and share data in a disciplined and predictable manner, and govern that process in a consistent and transparent manner.

Workforce Preparedness

As SCDHHS continues to transition to the use of intermediaries – contract administrative service organizations, managed care organizations, contract case managers, and third-party consulting experts – to administer the state's Medicaid program, SCDHHS' workforce must adapt to match. The skills and expertise to manage providers indirectly, proactively identify trends in large data sets, create and enforce contract service levels, and research relevant and emerging public health trends are different from those traditionally sought by the organization. SCDHHS, as with other state agencies, struggles to compete for talent in what has been an ever-tightening labor market.

II. Agency Records, Policies, and Risk Mitigation Practices

A. Records and Policies Management

12. (A) Agency's records management policy and the position or division responsible for managing this policy.	SCDHHS has largely adopted the guidance set forth by the South Carolina Department of Archives and History for core records retention. In addition, the agency maintains fiscal records, including claims records, in compliance with 42 CFR 433.32. The agency occasionally places a litigation hold on records pursuant to discovery rules and court orders in ongoing litigation.
(B) Agency's status in regards to compliance with the records management policy and explanation for non-compliance, if the agency is non-compliant.	Agency is in compliance.
13. Agency's schedule for regularly reviewing and updating, as necessary, all agency policies and explanation for lack of a schedule, if the agency does not have a schedule.	General In general, SCDHHS updates externally focused member and provider policies on a near-continuous basis. Further, the pace of systems changes in the claims, enrollment, and financial systems, policies and training manuals have been updated during various implementations. As part of the change management process, SCDHHS, however, has identified a deficit in documentation and training for several internal processes and unit-level policies are not managed centrally. As part of SCDHHS' migration to cloud-based computing for core administrative functions, it intends to centralize document and policy management. Several postings for library manager in 2019 and documentation specialists produced insufficient candidates. SCDHHS will continue to pursue this effort in 2020 and welcomes any recommendations the committee with respect to these efforts. Administrative Policies The department has a variety of administrative procedures that are reviewed annually or that have been recently updated as a result of comprehensive review, including, facilities management, vehicle usage, internal audit, FOIA, program integrity, HIPAA and privacy policies, and information security. Health and Provider Policies

Due to the complexity of Health Programs' policy, the agency operates a policy governance process that promotes the routine review of benefits in addition to regular budgetary reviews. The agency's policymaking process follows a quarterly schedule, to coincide with quarterly Medical Care Advisory Committee (MCAC) meetings and public notice, and semi-annual managed care rate setting activities.

In 2018 and 2019, SCDHHS also engaged an independent consultant to aid the agency with a comprehensive redesign of its policy manuals and supplemental provider information.

Medicaid Eligibility Policies

Medicaid eligibility policies, as outlined in the Eligibility Policy and Procedure manual, are the implementation process for federal and state regulations and policies. Portions of the Policy and Procedure Manual is reviewed at least monthly by a policy implementation group. Monthly updates to policy implementation are released, as needed, on the first business day of the month based on nature of the changes, leadership prioritization, and the impacts on timely and accurate eligibility processing. Updates may be annual requirement or based on federal, state or agency policy changes.

Managed Care

Managed Care rates are set annually in July and subject to a limited mid-year review for risk scoring in January. MCO contracts and Policy and Procedures Manuals are reviewed annually. New MCO contracts are presented to CMS every 2 years.

14. (A) Agency's status in regards to compliance with S.C. Code Ann. §1-23-120(J) that requires agencies to conduct a formal review of its regulations every five years.	The agency is in compliance with S.C. Code Ann §1-23-120(J).
(B) Last time the agency conducted a formal review of its regulations.	September 2016
(C) Last time the agency submitted new or revised regulations to the General Assembly.	The agency submitted new/revised regulations to the General Assembly on May 4, 2017. The new/revised regulations were approved and became effective May 25, 2018.

15. How the agency collaborates with other agencies to seek funding (e.g. grant and federal funding).	As the single state agency administering South Carolina's Title XIX Medicaid, Title XXI CHIP, and IDEA Part C programs, greater than 99% of agency funds come from either state general funds, statutorily defined fund sources, and federal funds matched against state expenditures either in SCDHHS or other certified public entities. While SCDHHS coordinates with other state agencies in the formulation of programs and services, and often supports smaller individual grants and efforts, there is relatively little funding from non-core activities.

16. Does the agency receive data from other state agencies, which require manual entry? If so, identify the state agencies and the associated data received.	• SC Department on Aging (SCDOA): Consent Form HIP02 allows SCDOA to gather information on the services an individual is receiving through Community Long Term Care. Data is entered in Phoenix.
	• SC Department of Mental Health (SCDMH): Submission of information relative to Level II Preadmission Screening and Resident Review (PASRR) to determine appropriate placement of participants in nursing facilities. Data is entered in Phoenix.
	• SC Department of Social Services/Adult Protection Services (SCDSS/APS):
	  o Consent Form 921 LTL is used to give authorization to release health information. Data is entered in Phoenix.
	  o Foster care and adopted children demographic information
	• SC Department of Disabilities and Special Needs (SCDDSN):
	  o Waiver enrollment and disenrollment forms (SCDHHS Form 118a) for Intellectually Disabled and Related Disabilities (ID/RD), Community Supports (CS) and Head and Spinal Cord Injury (HASCI) waiver participants. Data is entered in the Medicaid Management Information System (MMIS).
	  o Eligibility information for SCDDSN clients who need Medicaid eligibility determinations
	  o Submission of information relative to Level II Preadmission Screening and Resident Review (PASRR) to determine appropriate placement of participants in nursing facilities. Data is entered in Phoenix.
	  o Children's Services Case Management Hierarchy form is used to obtain the assessment and service plan from other agencies to better serve the participants' needs. Data is entered in Phoenix.
	• SC Department of Health and Environmental Control (SCDHEC):
	  o SCDHEC emails Consent Orders to terminate providers. Termination date is entered in MMIS.
	  o Dates of death, paper applications for Family Planning, Breast and Cervical Cancer Program, Tuberculosis
	• SC Vocational Rehabilitation (SCVR): Disability determinations
	• USC University Affiliated Programs (UAP): Enrollment data
	• SC Department of Corrections: A perpetual agreement was signed in 2016.

B. Internal Audit and/or Other Risk Mitigation Practices

17. (A) Agency's internal audit process and/or other risk mitigation practices.

The Division of Internal Audits provides independent and objective assurance and consulting services regarding risk management, control, and governance processes in all areas of the Agency including financial, operational, and information technology areas, in order to assist management and employees in the effective discharge of their responsibilities by furnishing them with analyses, appraisals, recommendations, and pertinent comments concerning the activities reviewed.

The authorized scope of the Division of Internal Audits' activities encompasses (1) the examination and evaluation of the adequacy and effectiveness of the Agency's risk management, internal control, and governance processes, and (2) the quality of performance in carrying out assigned responsibilities.

This can include the following activities:

- Reviewing and appraising the soundness of risk management, internal controls, and the reliability and integrity of financial, managerial, and operating data
- Ascertaining compliance with the Agency's policies and procedures
- Evaluating asset safeguards and accountability
- Evaluating the economy and efficiency with which resources are employed
- Reviewing operations or programs to assess whether they are being carried out as planned and whether results are consistent with established objectives

The authority and responsibilities of the Division of Internal Audits are established by the audit committee on behalf of the Agency's Director. The Director of the Division of Internal Audits serves as the chief audit executive, reports functionally to the audit committee and administratively to the chief compliance officer, and has full and independent access to the Agency Director and the audit committee. The CAE is responsible to ensure that all Division of Internal Audits operations are carried out in conformance with the Code of Ethics as promulgated by the Institute of Internal Auditors. The Division of Internal Audits also adheres to Generally Accepted Government Auditing Standards (GAGAS) as established by the U.S. Government Accountability Office.

The Division of Internal Audits has a responsibility to inform and advise management and the audit committee as to significant deficiencies or other substantive issues noted in the course of its activities.

The Division of Program Integrity supports the agency's Mission by fulfilling the Federally Mandated Utilization Review process; to safeguard against unnecessary, inappropriate, excessive and/or fraudulent use of Medicaid services; to ensure compliance with applicable Medicaid laws, regulations and policies; to assess the quality of services and refer to the appropriate licensing board as warranted and to perform preliminary investigations of all credible allegations of fraud.

A significant group of authorized external program integrity entities, including two Federal and State recovery audit contractors and the Department's many MCO Special Investigative Unit partners, also supplement the Division's efforts by performing provider reviews. The Division of

Program Integrity or its authorized entities may perform post-payment reviews of any health care provider type or specialty.
The SC Medicaid *Provider Administrative and Billing Manual* contains additional information on activities conducted by the Division of Program Integrity/SUR.
PI identifies and recovers state and federal funds from both providers and members lost through:

- Fraud
- Waste
- Abuse
- Improper Payments
- Overpayments

The Division of Program Integrity/SUR has a dedicated team of staff having diverse professional credentials, skills and backgrounds who work performing both beneficiary and provider reviews to detect and prevent fraud, waste and abuse in the SC Medicaid Program. Program Integrity expertise includes datamining experts, and varied career professionals with experience in law enforcement investigations, nursing, dental, pharmacy, social work, paralegal training, auditing, healthcare administration, etc. Many PI staff hold one or more professional certifications such as Certified Professional Coder (CPC), Certified Fraud Examiner (CFE), Accredited Healthcare Fraud Investigator (AHFI), and Certified Medicaid Integrity Professional (CPIP).
PI consists of the following units:

- Medical Services Review
- Ancillary Services Review
- Surveillance Utilization and Review Services (SURS)
- Department of Recipient Utilization (DRU)
- Operations and Managed Care Oversight

The Office of Compliance (OC) supports agency program areas in their commitment to comply with governing laws and regulations to include internal procedures. The OC collaborates with program areas to establish an agency culture that positively encourages risk factor identification and education along with design and implementation controls.

1. It provides an in-house service that effectively supports program areas in their duty to satisfy external and internal guidelines. It operates and functions to satisfy two regulatory levels.
   - External rules, laws, and regulations imposed upon the agency.
   - Internal systems of control developed to achieve compliance with external rules.

2. Provides guidance/recommendations to other areas within the agency as they begin new initiatives or have concerns with current and existing program activities.

3. Functions within the Office of Compliance includes but are not limited to the following:
   - Assessment – a review to determine policy or process compliance.
   - Identification – Identify agency risks.
   - Prevention - Design and implement controls.
   - Evaluation and Detection - Monitor and report on the effectiveness of controls.
   - Resolution – Assist with resolving compliance issues.

The Office of Compliance in partnership with agency program areas promotes proactive actions to minimize and prevent potential risks and problems.

(B) List of areas reviewed in agency internal audits during the last five years.

Audit Project Number	*Description*	*Area*	*Report Date*
1414	Federally Qualified Health Centers	Cost Reports	1/13/2016
1501	Provider Enrollment	Provider Enrollment	2/20/2015
1502	Enhanced Physicians Payments Audit	Provider Payment	8/29/2016
1503	United Way Call Center MOA Review	Member Services-Contracting	3/1/2017
1504	BCBS Med Ops Contract	Contract Service Provider	8/23/2016
1506	Medicaid Drug Rebate	Provider Payment/ Finance	5/12/2015
1507	Carriage House Residential Care Facilities OSS	Provider Review	10/31/2016
1602	Clemson Contracts	Contract Service Provider	Report not issued* (FY 2016)
1603	Langit Residential Care Facility OSS	Provider Review	11/30/2016
1604	Medicaid Drug Rebate	Provider Payment/ Finance	6/3/2016
1606	MAPPS Circle of Friends Audit	Provider Payment	Report not issued* (FY 2016)
1701	MAPPS Orangeburg District 3	Provider Payment	Report not issued* (FY 2017)
1704	MAPPS Orangeburg District Five	Provider Payment	Report not issued* (FY 2017)
1706	Select Health Managed Care Organization	Contract Service Provider	Report not issued* (FY 2017)
1709	Enhanced Physician Payments Recoupment Project	Provider Payment	Report not issued* (FY2017)
1711	False Claims Act	Provider Payment	Report not issued* (FY 2017)
1712	Medicaid Drug Rebate Audit	Provider Payment/ Finance	6/5/2017
1715	Emergency Ambulance Services	Claims Processing	Report not issued* (FY 2017)
1717	Anderson DSN Board	Repayment	Report not issued* (FY 2017)
1801	BCBS TPL Verification Review	Contract Service Provider	Report not issued* (FY 2018)
1802	Review of SCDHHS Policies and Procedures	Policy Maintenance	Report not issued* (FY 2018)
1803	USC Contracts	Contract Service Provider	11/13/2018
1804	Email Account Controls	IT Security	10/21/2019
1901	P Card Audit	Procurement	9/8/2019
2001	Fee Schedule	Provider Payment/ Finance	In Process**
2002	Procurement Methods	Procurement	In Process**
2005	Grants Administration	Contract Service Provider	In Process**
2006	Reasonable Compatibility	Eligibility	In Process**
2007	EFT Payment Issue	Provider Payment/ Finance	In Process**

* Area reviewed but no audit report issued

** Current audit enegement in process

18. Issues or recommendations from external reviews or audits conducted of the agency during the last five years, which the agency has not yet fully addressed or implemented.

Issue or Recommendation	Agency's Status in Addressing or Implementing	Date External Review or Audit completed	Entity Conducting the Audit or Review
Annual Eligibility Reviews Condition: The Department did not perform annual eligibility reviews for Medicaid and CHIP recipients in accordance with Section 101.10 of the South Carolina Medicaid Policies and Procedure Manual. Recommendation: The Department should ensure that eligibility reviews are performed annually in accordance with the South Carolina Medicaid Policies and Procedures Manual Finding: 2015-005, 2016-017, 2017-007, 2018-006	Note: due to provisions of the Families First Coronavirus Response Act (FFCRA), SCDHHS may not perform annual reviews at this time. Corrective action plans are suspended. Beginning with a failed eligibility system implementation in 2014, SCDHHS accumulated an eligibility application and redetermination backlog. The agency has since implemented successive mitigation and corrective action plans to address the deficiency. 2015-16: System stabilization, improvement, operational and staffing controls, and targeted efforts at escalation so that the most vulnerable populations are prioritized. 2016-17: Systems updates to incorporate third party data sources to validate identity and income so that automated ex parte determinations reduces the number of worker-dependent redeterminations. 2018-20: Centralize and regionalize eligibility staffing and improving accountability systems to measure eligibility staff performance against two primary measures: timeliness and accuracy. Implementation of systems updates to limit the number of workarounds that eligibility staff can use to force case outcomes. Promotion of rules-based determinations. Reinstatement of annual reviews for nearly 100,000 beneficiaries that had not received periodic reviews since 2014.	2015-005: 3/30/16 2016-017: 3/22/17 2017-007:3/22/18 2018-006: 3/8/2019	Clifton Larson Allen LLP, OSA

Activities allowed or unallowed costs and allowable costs/cost principles criteria: Funds allocated for the CHIP program may only be used for individuals eligible for the CHIP program. The agency allocated $39 attributable to a Medicaid beneficiary to the CHIP grant. The auditor recommends that SCDHHS only use funds in accordance with a grant's allowable purpose. Finding: 2018-002	South Carolina operates the CHIP program as an extension of the Medicaid program, and not a standalone program. A root cause analysis of this finding concluded that beneficiaries in question are eligible for the department's healthcare subsidy, but untimely eligibility redeterminations resulted in the misclassification of a beneficiary into the CHIP program, and the allocation of unallowable costs to the grant. The annual eligibility redetermination finding is listed above, along with SCDHHS' mitigation strategy.	3/8/2019	Clifton Larson Allen LLP, OSA
Discontinuation of Medicaid Benefits: The department must, in a timely manner, discontinue benefits for ineligible beneficiaries. The auditor recommends that SCDHHS discontinue benefits in a timely manner. Finding: 2016-016, 2017-006, 2018-005	As with the two previous sets of findings, a root cause analysis of this finding conclude that the untimely discontinuation of benefits is attributable to untimely eligibility determinations as opposed to incorrect or inaccurate determinations. The annual eligibility redetermination finding is listed above, along with SCDHHS' mitigation strategy.	2016-016: 3/22/17 2017-006: 3/22/18 2018-005: 3/8/19	Clifton Larson Allen LLP, OSA
Eligibility Condition: Documentation SCDHHS did not maintain adequate documentation for a portion of sampled eligibility determination cases. The auditor recommends that SCDHHS maintain documentation supporting eligibility determinations. Finding: 2015-016, 2016-015, 2017-005,2018-004	In 2014, SCDHHS implemented a centralized document management system and has continued scanning paper documents distributed among over 60 county and regional offices. In some instances, individuals with initial eligibility determinations prior to 2014 – particularly those with disability determinations from that time – will not have documentation in SCDHHS' document management system. This finding will continue to be mitigated by SCDHHS' strategy of paperless determinations, improvements to the annual review cycle, and the natural entry and exit of beneficiaries.	2015-006: 3/30/16 2016-015: 3/22/17 2017-005: 3/22/18 2018-004: 3/8/19	Clifton Larson Allen LLP, OSA

Matching, Level of Effort, Earmarking Criteria: Federal participation for family planning services is 90 percent in accordance with section 1905(a)(5) of the Social Security Act. The department has misclassified claims both claiming 90 percent federal match in an unallowed manner, and claiming standard federal participation for claims eligible for 90 percent federal match. The auditor recommends SCDHHS make appropriate system and process changes to ensure proper classification of claims for federal matching purposes. Finding: 2016-014, 2017-004, 2018-003	SCDHHS currently uses a claims system initially deployed in 1981 to implement medical claims adjudication rules for its various programs. While in a replacement cycle for all major systems, SCDHHS still relies on an antiquated structure of hard-coded rules and funding codes, and functional areas to ensure match compliance. An initial root cause analysis of this finding indicated that claims adjudication rules were inappropriately routing expenditures to a fund code associated with 90 percent federal financial participation for family planning. While the primary system errors have been retified, the persistence of this finding has uncovered both additional adjudication logic errors and opportunities for provider education. The provider education elements involve the proper application of billing codes and modifiers to ensure that medical visits for family planning purposes are differentiated from medical visits that do not include family planning or reproductive health counseling, evaluation, and management.	2016-014: 3/22/17 2017-004: 3/22/18 2018-003: 3/8/19	Clifton Larson Allen LLP, OSA
The DHHS should consider requiring prior to significant policy changes, a formal risk assessment and corresponding management control fraud, waste, and abuse risk mitigation strategies, which could be enhanced by examining other states' best practices and DHHS using its internal audit function to consult with management, particularly managers with technical healthcare expertise without a corresponding depth of organizational management skills.	Although the agency has formalized its policy governance process, to include impact analyses and benchmarking to other states, agencies, and payers, the agency's internal auditor is not formally a part of the policy development process.	8/25/2016	State OIG
SCDHHS should consider the use of a subject matter expert consultant in planning its contact monitoring function to leverage lessons learned and best practices from other states' experiences, in	We continue to utilize our State partners, Milliman our Actuaries and the Institute for Families in Society (IFS). Our partners are key in EQI validation and ensuring MCO Network Adequacy.	6/4/2015	State OIG

particular establishing the appropriate mix of relying on external consultants versus in-house expertise.	SCDHHS has posted for a managed care procurement specialist and has not received satisfactory applications. Consulting entities have been engaged as part of the dual Medicare-Medicaid eligible managed care carve-in, but to date, the agency has not engaged an external consultant to review its managed care contract.		
SCDHHS should seek opportunities to reinforce the culture change in the MCO model to proactively orchestrate and coordinate an entire system of care and extricate SCDHHS personnel from reactive customer service or provider issues which are more appropriately addressed by MCOs.	SCDHHS has made substantive changes to the manner in which state staff interacts with MCO personnel, to include better integration with clinical staff, program integrity, and policy staff during benefit changes. Although the agency believes that steps have been taken to satisfy the intent of this recommendation, its nature is that of an ongoing recommendation, so it is included here.	6/4/2015	State OIG
Legislative Audit Council Review of SCDHHS Children's Behavioral Health Program	The Legislative Audit Council conducted a limited review of Children's Behavioral health programs from 2017-2019. The agency's response to the audit is attached as an appendix.	September 2019	South Carolina Legislative Audit Council.
The S.C. Department of Health and Human Services should give providers of Medicaid formal training on telemedicine documentation requirements.	SCDHHS, in concert with the Medical University of South Carolina, will conduct cyclic and as needed training on telemedicine documentation requirements. SCDHHS will monitor results of training quarterly.	January 2020	Federal OIG
The S.C. Department of Health and Human Services should enhance the monitoring of provider compliance by conducting periodic reviews of telemedicine.	Through SCDHHS' Division of Program Integrity, enhanced monitoring will be conducted to ensure provider compliance with telemedicine policy.	January 2020	Federal OIG
Policies and procedures that are reasonably designed to ensure the accuracy of SCDHHS' payments to its early intervention service or EIS providers. Those policies and procedures must include a review of EIS provider claims for early intervention services and ensure that EIS providers are not submitting multiple claims or receiving duplicate payments.	All appropriate changes have been made to address this finding and have been submitted to OSEP. The response submission is under review. A draft of the contract was sent to SCDDSN on Nov. 27, 2019. The contract was sent back to SCDHHS with suggested edits on April 2, 2020. Changes are being incorporated into the contract for final review by both agencies.	2020	United States Department of Education, Office of Special Education Programs (OSEP)

Policies and procedures that are reasonably designed to ensure the accuracy of SCDHHS' payments to its early intervention service or EIS providers. Those policies and procedures must include a review of EIS provider claims for early intervention services and ensure that EIS providers are not submitting multiple claims or receiving duplicate payments. A review of the policies and procedures must also examine MCO practices to ensure that their relationship with EIS providers does not negatively impact IDEA's payor of last resort requirement in 34 C.F.R. § 303.510 or the requirement to serve traditionally underserved groups (including rural populations) in 34 C.F. R. § 303.227	The state believes that this requirement has been satisfied in practice and is engaged in an exchange of documentation with OSEP to satisfy the finding. The response outlines trainings conducted, includes links to websites and includes additional work being conducted within the agency that address the fiscal findings. A request for additional information was received on May 28, 2020, and staff are working to provide the additional information requested.	Letter received Aug. 29, 2019	OSEP

III. Agency Spending

19. Finance Overview Chart.	

IV. Agency Deliverables

20. Deliverables Chart.	See attached Excel chart.

V. Performance

21. Performance Measures Chart.	See attached Excel chart.

VI. Agency Ideas and Recommendations for Law Changes

22. Recommendations for changes in law.

LAW CHANGE # 1			
Law	Summary of Current Law(s) and Recommended Change(s)	Basis for Recommendation	Approval and Others Impacted
SC Code Sections 44-6-132 through 155 (Medically Indigent Assistance Act), including Section 44-6-140 (Medicaid Hospital Prospective Payment System)	Current Law: Assure care for the largest possible number of SC's medically indigent citizens within funds available by: (a) expanding the number of persons eligible for Medicaid services, using additional state and county funds to take advantage of matching federal funds; (b) creating a fund based on provider and local government contributions to provide medical assistance to those citizens who do not qualify for Medicaid or any other government assistance and who do not have the means to pay for hospital care; and (c) mandating access to emergency medical care for all state residents in need of the care; Provide incentives for cost containment to providers of care to indigent patients by implementing a prospective payment system in the Medicaid and Medically Indigent Assistance Fund programs; Recommendation: Amend some parts of the Act	Funding mechanism is outdated. Program is not fully operational today as provided in the Act.	Presented and approved by agency's governing body: N/A Other entities potentially impacted: Hospitals, county governments If the law is a regulation, where agency is in the process of finalizing it and providing it to the General Assembly: N/A

Current Law Wording	Proposed Revisions to Law Wording
SECTION 44-6-140. Medicaid hospital prospective payment system; cost containment measures. (A) To provide cost containment incentives for providers of care to Medicaid recipients, the department shall convert the Medicaid hospital reimbursement system from a retrospective payment system to a prospective payment system by October 1, 1985. The prospective payment system includes, at a minimum, the following elements:	Repeal Section 44-6-140 to account for substantial changes made to hospital prospective payment system. State statutory authority is not needed to maintain a prospective payment standard, but the prescriptive nature of the statute may prohibit future alternate payment methodologies. Amend section 44-6-146 to allow the Department to set a formula in regulation, as opposed to a defined statutory formula. The current formula was created based upon the existence of a county-by-county federated hospital system that is no longer exists in South Carolina – either through hospital closure, population movements, or system consolidation.

(1) a maximum allowable payment amount established for individual hospital products, services, patient diagnoses, patient day, patient admission, or per patient, or any combination thereof. This payment must be based on hospital costs rather than hospital charges and must be adjusted at least every two years to reflect the most recent audited cost data available. The department shall set by regulation those circumstances under which a hospital may seek an exception. The maximum allowable payment amount must be weighted to allow for the costs of medical education and primary, secondary, or tertiary care considerations; (2) payment on a timely basis to the hospital by the commission or patient or both, of the maximum allowable payment amount determined by the commission; and (3) acceptance by the hospital of the maximum payment amount as payment in full, which includes any deductible or copayment provided for in the state Medicaid program. (B) The department shall at the same time implement other cost containment measures which include, but are not limited to: (1) utilization reviews for appropriateness of treatment and length of stay; (2) preadmission certification of nonemergency admissions; (3) mandatory outpatient surgery in appropriate cases; (4) a second surgical opinion pilot study; and (5) procedures for encouraging the use of outpatient services. The department, to the fullest extent possible, shall utilize information required in this subsection in the form hospitals are presently submitting the information to other governmental agencies or in the form hospitals are presently utilizing the information within the hospital. HISTORY: 1985 Act No. 201, Part II, Section 19C; 1989 Act No. 189, Part II, Section 35A; 1993 Act No. 181, Section 1048. SECTION 44-6-146. County assessments for indigent medical care; penalties for failure to pay assessments in timely manner. (A) Every fiscal year the State Treasurer shall withhold from the portion of the Local Government Fund allotted to the counties a sum equal to fifty cents per capita based	Additional conforming amendments may be necessary at the interest or discretion of the committee.

on the population of the several counties as shown by the latest official census of the United States. The money withheld by the State Treasurer must be placed to the credit of the commission and used to provide Title XIX (Medicaid) services.

(B) County governments are assessed an additional thirteen million dollars annually for use as matching funds for Medicaid services. Of these funds, seven and a half million dollars must be deposited into the Medicaid Expansion Fund created by Section 44-6-155.

The department shall assess each county its share of the thirteen million dollars based on a formula which equally weighs the following factors in each county: property value, personal income, net taxable sales, and the previous two years of claims against the medically indigent assistance fund or program against county residents. If a trust fund has been established in a county to fund indigent care in the county, contributions on behalf of the county must be credited against the county assessment.

(C) Within thirty days of the first day of the state's fiscal year, and on the first day of the other three quarters, each county shall remit one-fourth of its total assessment to the department. The department shall allow a brief grace period during which late payments are not subject to interest or penalty.

Any county which fails to pay its assessment within the time allotted must pay, in addition to the assessment, a penalty of five percent of the assessment and interest at one and one-half percent per month from the date the assessment was originally due to the date of the payment of the assessment and penalty. The department may in its discretion waive or reduce the penalty or interest or any part thereof.

HISTORY: 1989 Act No. 189, Part II, Section 35B; 1991 Act No. 171, Part II, Section 22K; 1993 Act No. 181, Section 1049.

SECTION 44-6-150. Medically Indigent Assistance Program; reporting of charges for sponsored patients; duties of commission; duty to provide unreimbursed medical care to indigent persons.

(A) There is created the South Carolina Medically Indigent Assistance Program administered by the department. The program is authorized to sponsor inpatient hospital care for which hospitals shall receive no reimbursement. A general hospital equipped to provide the necessary treatment shall:

(1) admit a patient sponsored by the program; and

(2) accept the transfer of a patient sponsored by the program from a hospital which is not equipped to provide the necessary treatment. In addition to or in lieu of an action taken affecting the license of the hospital, when it is established that an officer, employee, or member of the hospital medical staff has violated this section, the South Carolina Department of Health and Environmental Control shall require the hospital to pay a civil penalty of up to ten thousand dollars. (B) Hospital charges for patients sponsored by the Medically Indigent Assistance Program must be reported to the Revenue and Fiscal Affairs Office pursuant to Section 44-6-170. (C) In administering the Medically Indigent Assistance Program, the department shall determine: (1) the method of administration including the specific procedures and materials to be used statewide in determining eligibility for the program; (a) In a nonemergency, the patient shall submit the necessary documentation to the patient's county of residence or its designee to determine eligibility before admission to the hospital. (b) In an emergency, the hospital shall admit the patient pursuant to Section 44-7-260. If a hospital holds the patient financially responsible for all or a portion of the inpatient hospital bill, and if the hospital determines that the patient could be eligible for the program, it shall forward the necessary documentation along with the patient's bill and other supporting information to the patient's county of residence or its designee for processing. A county may request that all hospital bills incurred by its residents sponsored by the program be submitted to the county or its designee for review. (2) the population to be served, including eligibility criteria based on family income and resources. Eligibility is determined on an episodic basis for a given spell of illness. Eligibility criteria must be uniform statewide and may include only those persons who meet the program's definition of medically indigent; (3) the health care services covered; (4) a process by which an eligibility determination can be contested and appealed; and	

(5) the program may not sponsor a patient until all other means of paying for or providing services have been exhausted. This includes Medicaid, Medicare, health insurance, employee benefit plans, or other persons or agencies required by law to provide medical care for the person. Hospitals may require eligible patients whose gross family income is between one hundred percent and two hundred percent of the federal poverty guidelines, to make a copayment based on a sliding payment scale developed by the department based on income and family size. (D) Nothing in this section may be construed as relieving hospitals of their Hill-Burton obligation to provide unreimbursed medical care to indigent persons. HISTORY: 1985 Act No. 201, Part II, Section 19C; 1986 Act No. 335, Section 1; 1989 Act No. 189, Part II, Section 35C; 1993 Act No. 130, Section 1; 1993 Act No. 181, Section 1050.	

LAW CHANGE # 2			
Law	Summary of Current Law(s) and Recommended Change(s)	Basis for Recommendation	Approval and Others Impacted
SC Code Sections 44-6-300 through 320 (Child Development Services)	Current Law: Established child development services in certain counties throughout the state. Recommendation: Remove from DHHS' enabling legislation	Language should be deleted as this program is no longer operated by DHHS	Presented and approved by agency's governing body: N/A Other entities potentially impacted: If the law is a regulation, where agency is in the process of finalizing it and providing it to the General Assembly:

Current Law Wording	Proposed Revisions to Law Wording
SECTION 44-6-300. Child development services to be established. The Department of Health and Human Services shall establish child development services in the following counties: Allendale, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Chesterfield, Fairfield, Jasper, Lexington, Newberry, and Orangeburg. The services established in each county must provide at least thirty slots for the children of that county. HISTORY: 1989 Act No. 189, Part II, Section 43 sub 3; 1993 Act No. 181, Section 1057.	Repeal the language as this program is no longer administered by SCDHHS.

Editor's Note 1989 Act No. 189, Part II, subsection 1, subdivision I, Section 43, eff June 8, 1989, provides that Section 43 is known and may be cited as the "South Carolina Initiative for Child Care Act". SECTION 44-6-310. Expansion of existing child development services. The Department of Health and Human Services shall expand existing child development services in the following counties: Beaufort, Charleston, Florence, Greenville, Hampton, and Richland. The services in each county must be expanded to provide at least twenty new slots but no more than sixty new slots for the children of each county. HISTORY: 1989 Act No. 189, Part II, Section 43 sub 4; 1993 Act No. 181, Section 1058. SECTION 44-6-320. Appropriations. The establishment and expansion of the child development services mandated by Sections 44-6-300 and 44-6-310 must be accomplished within the limits of the appropriations provided by the General Assembly in the annual General Appropriations Act for this purpose and in accordance with the Department of Health and Human Services policies for child development services funded through Title XX. HISTORY: 1989 Act No. 189, Part II, Section 43 sub 5; 1993 Act No. 181, Section 1059.	

VII. Feedback (Optional)

Agency feedback

23. (A) Other questions that may help the Committee and public understand how the agency operates, budgets, and performs	Many of the resources invested by the agency are into full-benefit entitlement programs for which there are defined network adequacy, national standard metrics, and a variety of stakeholders involved in the investment and distribution of funds. Although the agency may control categorical allocation of funds, the agency often does not have the ability to control individual expenditures. Rather, it has to formulate and seek approval for categorical changes and methodologies to shift expenditures.
(B) Best ways for the Committee to compare the specific results the agency obtained with the resources the agency invested	The agency will be providing a series of presentations that it believes will be valuable in informing investment and expenditure decisions.
(C) Changes to the report questions, format, etc., agency representatives would recommend.	The templates are particularly well-suited for regulatory and licensing agencies that perform many of the same type of transaction or issue commodity items. Given the number of services reimbursed and different methodologies listed, the averages in many of the deliverables are either too aggregated to provide insight, or the number of deliverables to provide individual detail would be unwieldy.
(D) Benefits agency representatives see in the public having access to the information in this report.	I think the report highlights well the varied services and activated covered by the agency, and also provides good perspective on the degree of cost associated with benefit payments versus expenditures on agency activities.
(E) Two to three things agency representatives could do differently next time (or it could advise other agencies to do) to complete the report in less time and at a lower cost to the agency.	The agency feels that the final reports and templates may be better submitted in the middle or at the end of the presentation process, so that context and mutual understanding can be achieved prior to the submission of detailed documents.
(F) Other comments or suggestions from the agency.	

Organizational Unit Details

	A	B	C	D
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5	**Name of organizational unit**			Administration
6				
7	**Purpose of organizational unit**			Serves as administrative support to assist the Agency in accomplishing its core mission.
8				
9	**Exit interviews or surveys performed?**			
10	2018-19			Yes
11	2017-18			Yes
12	2016-17			Yes
13				
14	**Employee satisfaction tracked?**			
15	2018-19			Yes
16	2017-18			Yes
17	2016-17			Yes
18				
19	**Anonymous employee feedback allowed?**			
20	2018-19			Yes
21	2017-18			Yes
22	2016-17			Yes
23				
24	**Number of employees (all types) in the unit**			
25	Start of fiscal year			
26	2018-19			54.00
27	2017-18			50.00
28	2016-17			49.00
29	End of fiscal year			
30	2018-19			55.00
31	2017-18			55.00
32	2016-17			51.00
33	Leave the unit during fiscal year			
34	2018-19			8.00
35	2017-18			8.00
36	2016-17			11.00
37				
38	**Turnover rate**			
39	2018-19			14.68%
40	2017-18			15.24%
41	2016-17			22.00%
42				
43	**Agency Comments (Optional)**			Administration includes Compliance, Communications, Contracts & Procurement, HR, Facilities Management, Civil Rights Division, and Legal.

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	E
1	**Agency**	
2	Department of Health and Human Services	
3	**Accurate as of**	
4		
5	**Name of organizational unit**	Program Integrity
6		
7	**Purpose of organizational unit**	To prevent and identify fraud, waste, and abuse in the Medicaid program and to recover the funds lost due to fraudulent and wasteful practices on the part of healthcare providers and beneficiaries; to operate a system to detect fraud and to conduct post-payment reviews of provider records; to conduct preliminary fraud investigations and when appropriate make referrals to law enforcement; to operate the pharmacy lock-in program; to impose sanctions on providers, and to provide oversight of managed care program integrity activities.
8		
9	**Exit interviews or surveys performed?**	
10	2018-19	Yes
11	2017-18	Yes
12	2016-17	Yes
13		
14	**Employee satisfaction tracked?**	
15	2018-19	Yes
16	2017-18	Yes
17	2016-17	Yes
18		
19	**Anonymous employee feedback allowed?**	
20	2018-19	Yes
21	2017-18	Yes
22	2016-17	Yes
23		
24	**Number of employees (all types) in the unit**	
25	Start of fiscal year	
26	2018-19	25.00
27	2017-18	26.00
28	2016-17	25.00
29	End of fiscal year	
30	2018-19	25.00
31	2017-18	25.00
32	2016-17	26.00
33	Leave the unit during fiscal year	
34	2018-19	1.00
35	2017-18	6.00
36	2016-17	0.00
37		
38	**Turnover rate**	
39	2018-19	4.00%
40	2017-18	23.53%
41	2016-17	0.00%
42		
43	**Agency Comments (Optional)**	

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	F
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Fair Hearing and Appeals
6			
7	**Purpose of organizational unit**		To provide an opportunity for a fair hearing to any person whose claim for Medicaid assistance is denied or not acted upon promptly.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		8.00
27	2017-18		6.00
28	2016-17		6.00
29	End of fiscal year		
30	2018-19		7.00
31	2017-18		8.00
32	2016-17		6.00
33	Leave the unit during fiscal year		
34	2018-19		1.00
35	2017-18		0.00
36	2016-17		0.00
37			
38	**Turnover rate**		
39	2018-19		13.33%
40	2017-18		0.00%
41	2016-17		0.00%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	G
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Internal Audits
6			
7	**Purpose of organizational unit**		To provide independent and objective assurance and consulting services regarding risk management, control, and governance processes to assist management and employees in the effective discharge of their responsibilities.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		5.00
27	2017-18		5.00
28	2016-17		11.00
29	End of fiscal year		
30	2018-19		3.00
31	2017-18		7.00
32	2016-17		9.00
33	Leave the unit during fiscal year		
34	2018-19		3.00
35	2017-18		4.00
36	2016-17		3.00
37			
38	**Turnover rate**		
39	2018-19		75.00%
40	2017-18		66.67%
41	2016-17		30.00%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	H
1	**Agency**	
2	Department of Health and Human Services	
3	**Accurate as of**	
4		
5	**Name of organizational unit**	Finance (budget, controller, reinbursement, federal contract and vendor management)
6		
7	**Purpose of organizational unit**	Budgets administers the development of the budget and variance analysis. Controller's office carries out financial operations and CMS reporting. Reimbursement performs provider rate analysis and non-claim reimbursement. Federal contracts provides oversight to the CMS contract and administers the Advanced Planning Document process. Vendor management monitors vendor contract compliance and service level agreements.
8		
9	**Exit interviews or surveys performed?**	
10	2018-19	Yes
11	2017-18	Yes
12	2016-17	Yes
13		
14	**Employee satisfaction tracked?**	
15	2018-19	Yes
16	2017-18	Yes
17	2016-17	Yes
18		
19	**Anonymous employee feedback allowed?**	
20	2018-19	Yes
21	2017-18	Yes
22	2016-17	Yes
23		
24	**Number of employees (all types) in the unit**	
25	Start of fiscal year	
26	2018-19	56.00
27	2017-18	62.00
28	2016-17	62.00
29	End of fiscal year	
30	2018-19	55.00
31	2017-18	59.00
32	2016-17	47.00
33	Leave the unit during fiscal year	
34	2018-19	11.00
35	2017-18	8.00
36	2016-17	8.00
37		
38	**Turnover rate**	
39	2018-19	19.82%
40	2017-18	13.22%
41	2016-17	14.68%
42		
43	**Agency Comments (Optional)**	

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	I
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Reporting
6			
7	**Purpose of organizational unit**		Reporting provides data analysis on a recurring and ad hoc basis and functions as a source of training and assistance for the development of dash boards.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		0.00
27	2017-18		0.00
28	2016-17		4.00
29	End of fiscal year		
30	2018-19		0.00
31	2017-18		0.00
32	2016-17		5.00
33	Leave the unit during fiscal year		
34	2018-19		0.00
35	2017-18		0.00
36	2016-17		0.00
37			
38	**Turnover rate**		
39	2018-19		Agency did not have employees in this unit
40	2017-18		Agency did not have employees in this unit
41	2016-17		0.00%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	J
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Eligibilty (Central Office, County Offices and Processing Centers)
6			
7	**Purpose of organizational unit**		The eligibility central office provides operational and technical support to ensure timely and accurate eligibility determinations are made for Medicaid and BabyNet applicants. Eligibility processing makes timely and accurate eligibility determinations for Medicaid and BabyNet applicants and provides customer support.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		594.00
27	2017-18		558.00
28	2016-17		504.00
29	End of fiscal year		
30	2018-19		650.00
31	2017-18		592.00
32	2016-17		561.00
33	Leave the unit during fiscal year		
34	2018-19		104.00
35	2017-18		104.00
36	2016-17		83.00
37			
38	**Turnover rate**		
39	2018-19		16.72%
40	2017-18		18.09%
41	2016-17		15.59%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	K
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Long Term Care Program Support (CLTC, NH, OSS/OSCAP, Home Health, Hospice)
6			
7	**Purpose of organizational unit**		Responsible for administering and operating the programs for long term care support. (Four home and community-based waivers, home health,nursing facilities, hospice and OSS programs)
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		216.00
27	2017-18		213.00
28	2016-17		213.00
29	End of fiscal year		
30	2018-19		221.00
31	2017-18		214.00
32	2016-17		220.00
33	Leave the unit during fiscal year		
34	2018-19		34.00
35	2017-18		51.00
36	2016-17		30.00
37			
38	**Turnover rate**		
39	2018-19		15.56%
40	2017-18		23.89%
41	2016-17		13.86%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	L
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		DDSN Program Support
6			
7	**Purpose of organizational unit**		Responsible for administering three home and community-based waivers and ensure that the operating agency, SCDDSN, performs assigned waiver operational and administrative functions in accordance with waiver requirements.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		11.00
27	2017-18		9.00
28	2016-17		9.00
29	End of fiscal year		
30	2018-19		2.00
31	2017-18		11.00
32	2016-17		9.00
33	Leave the unit during fiscal year		
34	2018-19		2.00
35	2017-18		1.00
36	2016-17		0.00
37			
38	**Turnover rate**		
39	2018-19		30.77%
40	2017-18		10.00%
41	2016-17		0.00%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	M
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Health Programs (Behavioral Health, Pharmacy, Dental, coverage and benefit design, etc.)
6			
7	**Purpose of organizational unit**		Health Programs oversees both the managed care and the medical services sections of the agency including physicians, hospitals, pharmacy, durable medical equipment, dental, transportation, managed care and medical support services. Health Programs focuses on health outcomes, quality patient care, contract management and the development of innovative programs and policies that improve the overall health or our beneficiaries and the citizens of South Carolina.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		68.00
27	2017-18		86.00
28	2016-17		83.00
29	End of fiscal year		
30	2018-19		60.00
31	2017-18		78.00
32	2016-17		78.00
33	Leave the unit during fiscal year		
34	2018-19		9.00
35	2017-18		24.00
36	2016-17		15.00
37			
38	**Turnover rate**		
39	2018-19		14.06%
40	2017-18		29.27%
41	2016-17		18.63%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	N
1	**Agency**	
2	Department of Health and Human Services	
3	**Accurate as of**	
4		
5	**Name of organizational unit**	Medical Management
6		
7	**Purpose of organizational unit**	Medical Management is responsible for the management and execution of the Department's clinical strategy. Medical management also provides medical expertise and consultation across the organization. Additionally, the medical management division provides guidance and clinical leadership across the enterprise, advising the executive staff on clinical matters.
8		
9	**Exit interviews or surveys performed?**	
10	2018-19	Yes
11	2017-18	Yes
12	2016-17	Yes
13		
14	**Employee satisfaction tracked?**	
15	2018-19	Yes
16	2017-18	Yes
17	2016-17	Yes
18		
19	**Anonymous employee feedback allowed?**	
20	2018-19	Yes
21	2017-18	Yes
22	2016-17	Yes
23		
24	**Number of employees (all types) in the unit**	
25	Start of fiscal year	
26	2018-19	Agency did not have employees in this unit
27	2017-18	Agency did not have employees in this unit
28	2016-17	Agency did not have employees in this unit
29	End of fiscal year	
30	2018-19	Agency did not have employees in this unit
31	2017-18	Agency did not have employees in this unit
32	2016-17	Agency did not have employees in this unit
33	Leave the unit during fiscal year	
34	2018-19	Agency did not have employees in this unit
35	2017-18	Agency did not have employees in this unit
36	2016-17	Agency did not have employees in this unit
37		
38	**Turnover rate**	
39	2018-19	Agency did not have employees in this unit
40	2017-18	Agency did not have employees in this unit
41	2016-17	Agency did not have employees in this unit
42		
43	**Agency Comments (Optional)**	

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	O
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Managed Care
6			
7	**Purpose of organizational unit**		The Managed Care area is responsible for mananging the Healthy Connections Choices care coordination program. This program supports establishing a medical home for Medicaid beneficiaries and requires eligible beneficiaries to enroll with and receive their Medicaid health benefits via their medical home.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		2.00
27	2017-18		7.00
28	2016-17		10.00
29	End of fiscal year		
30	2018-19		2.00
31	2017-18		2.00
32	2016-17		7.00
33	Leave the unit during fiscal year		
34	2018-19		0.00
35	2017-18		1.00
36	2016-17		1.00
37			
38	**Turnover rate**		
39	2018-19		0.00%
40	2017-18		22.22%
41	2016-17		11.76%
42			
43	**Agency Comments (Optional)**		

The contents of this chart are considered sworn testimony from the agency director.

Organizational Unit Details

	A	B	P
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		Agency Operations (claims processing, PMO, provider enrollment, etc)
6			
7	**Purpose of organizational unit**		Claims and Provider Services provides operational support to providers enrolled, or seeking information on enrolling, in South Carolina's Medicaid Program. Services include enrollment application and processing, claims submission and customer service, prior-authorization requests and administrative appeals, and ancillary services such as Non-Emergency Medical Transportation and Out-of-State Placements.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		24.00
27	2017-18		26.00
28	2016-17		31.00
29	End of fiscal year		
30	2018-19		15.00
31	2017-18		15.00
32	2016-17		30.00
33	Leave the unit during fiscal year		
34	2018-19		2.00
35	2017-18		6.00
36	2016-17		3.00
37			
38	**Turnover rate**		
39	2018-19		10.26%
40	2017-18		29.27%
41	2016-17		9.84%
42			
43	**Agency Comments (Optional)**		

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Organizational Unit Details

	A	B	Q
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		IT Operations
6			help desk, hardware/sofware, etc.
7	**Purpose of organizational unit**		The mission of the Information Technology Operations is to provide both strategic IT vision and enterprising solutions to the Department of Health and Human Services, so they can meet their goals, deliver results and enhance the agency's goals and objectives. The Information Technology department provides the information technology required for fulfillment of the Agency's mission in an efficient, effective and secure manner. The Information Technology Operations assists in the technical analysis, design, procurement, implementation, operation and support of the computing infrastructure and services. In addition the organization provides security that includes a Governance Foundation, an Information Security Charter, and Strategic Security plan as well as policy and governance lifecycle.
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		134.00
27	2017-18		132.00
28	2016-17		55.00
29	End of fiscal year		
30	2018-19		174.00
31	2017-18		152.00
32	2016-17		67.00
33	Leave the unit during fiscal year		
34	2018-19		23.00
35	2017-18		26.00
36	2016-17		17.00
37			
38	**Turnover rate**		
39	2018-19		14.94%
40	2017-18		18.31%
41	2016-17		27.87%
42			
43	**Agency Comments (Optional)**		

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Organizational Unit Details

	A	B	R
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5	**Name of organizational unit**		IT Development
6			MMRP, RMMIS
7	**Purpose of organizational unit**		The IT Development organizational unit consists of the Member Management Replacement Program, the Replacement Medicaid Management Information System, and the Medicaid Enterprise System. Member Management Replacement Program Operations and Maintenance supports the continued operation of the Cúram Health Care Reform and Global Income Support modules including software maintenance, enhancements, and defect resolution. The Eligibility and Enrollment Helpdesk provide support to the eligibility workers. The Member Management Replacement Program Design, Development and Implementation supports the implementation of the Cúram Health Care Reform and Global Income Support modules. The Replacement Medicaid Management Information System Program provides information technology design, development, and
8			
9	**Exit interviews or surveys performed?**		
10	2018-19		Yes
11	2017-18		Yes
12	2016-17		Yes
13			
14	**Employee satisfaction tracked?**		
15	2018-19		Yes
16	2017-18		Yes
17	2016-17		Yes
18			
19	**Anonymous employee feedback allowed?**		
20	2018-19		Yes
21	2017-18		Yes
22	2016-17		Yes
23			
24	**Number of employees (all types) in the unit**		
25	Start of fiscal year		
26	2018-19		24.00
27	2017-18		18.00
28	2016-17		26.00
29	End of fiscal year		
30	2018-19		27.00
31	2017-18		21.00
32	2016-17		24.00
33	Leave the unit during fiscal year		
34	2018-19		6.00
35	2017-18		9.00
36	2016-17		4.00
37			
38	**Turnover rate**		
39	2018-19		23.53%
40	2017-18		46.15%
41	2016-17		16.00%
42			
43	**Agency Comments (Optional)**		The Member Management Replacement Program is a support function to the Eligibility Central Office and Eligibility Processing. These organizational units are responsible for determining Medicaid Eligibility for SC citizens whether they

Finance Overview

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	**Agency**														
2	Department of Health and Human Services														
3	**Accurate as of**														
4															
5															
6		**2018-19**					**2017-18**					**2016-17**			
7		**General Funds**	**Other Funds**	**Federal Funds**	**Total**		**General Funds**	**Other Funds**	**Federal Funds**	**Total**		**General Funds**	**Other Funds**	**Federal Funds**	**Total**
8	**How much was the agency appropriated and authorized to spend during the fiscal year?**	$1,365,653,053	$985,081,306	$5,380,311,338	$7,731,045,697		$1,317,414,661	$997,097,870	$5,308,622,236	$7,623,134,767		$1,271,015,600	$974,142,716	$5,109,118,837	$7,354,277,153
9	**Enter any additional other or federal funds authorization received during the fiscal year.**	$0	$0	$0	$0		$0	$0	$0	$0		$0	$0	$0	$0
10	**Enter the total actual expenditures during the fiscal year.**	$1,347,679,764	$900,596,746	$5,209,021,671	$7,457,298,181		$1,292,566,097	$842,938,385	$5,051,291,100	$7,186,795,583		$1,274,500,766	$869,823,131	$4,959,607,198	$7,103,931,095
11	**How much did the agency carry forward? (Total amount)**	$97,339,036	$0	$0	$97,339,036		$106,598,506	$0	$0	$106,598,506		$100,523,191	$0	$0	$100,523,191
12	**10% Carry forward (General Carry Forwards)**	$9	$0	$0	$9		$0	$0	$0	$0		$0	$0	$0	$0
13	**Special Carry forward**	$97,339,052	$0	$0	$97,339,052		$106,599,304	$0	$0	$106,599,304		$100,523,173	$0	$0	$100,523,173
14	**How much cash did the agency have at the end of the fiscal year that it was not authorized to spend?**	$0	$558,018,439	$0	$558,018,439		$0	$525,705,358	$0	$525,705,358		$0	$462,873,591	$0	$462,873,591
15															
16	**If the agency received additional federal funds authorization, please note why and when the request was made.**	N/A					N/A					N/A			
17	**If the agency received additional other funds authorization, please note why and when the request was made.**	N/A					N/A					N/A			
18	**Please provide detail regarding why the agency has cash balances. Does the agency expect to spend down these balances?**														

The contents of this chart are considered sworn testimony from the agency director.

Deliverables

	B	C	E	F
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		1	2
8	Associated laws		S.C. Code § 44-6-50(1) - Contracts with other agencies; program monitoring S.C. Code of Reg. Article 3 Medicaid, Subarticle 2 Eligibility for the Medical Assistance (Medicaid) Program 42 U.S. Code § 1396a. State plans for medical assistance • (a)(8) – eligibility applications • (a)(10) – eligibility categories • (a)(17) – eligibility standards • (a)(34) – three (3) month retroactive eligibility • (a)(46) – Income and Eligibility Verification System; Citizenship • (a)(47) – presumptive eligibility • (a)(55) – outstationed eligibility locations • (a)(63) – coverage for certain low-income families • (a)(66) – special provisions relating to Medicare prescription drug benefit • (e)(13) – express lane eligibility • (e)(14) – modified adjusted gross income (MAGI) 42 U.S. Code § 1383c. – Social Security Administration determinations of eligibility in the case of aged, blind, or disabled individuals 42 C.F.R. Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa	S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care 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 • Co payment • Service limits S.C. Code of Reg. Article 9 Optional State Supplementation Program • State-funded program that provides a cash benefit payment that supplements an eligible individual's countable income up to the net income limitation 42 U.S. Code § 1396a. State plans for medical assistance • (a)(30) – utilization management • (a)(43) – early and periodic screening, diagnostic, and treatment (EPSDT) services and vaccines • (a)(62)- pediatric vaccine distribution program • (a)(67) – 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
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		Provide for an eligibility system that allows citizens to apply for Medicaid, processes that application, and determines which citizens are eligible for Medicaid benefits.	Design and provide reimbursement for evidence-based, high value health benefits to Medicaid beneficiaries, based on medical necessity.
11	Responsible organizational unit (primary)		Eligibility	Health Programs/Long Term Living
12				
13	**Results Sought**			
14	Does the legislature state intent, findings, or purpose?		Yes	Yes
15	Purpose of the service/why it is provided (as written in statute/enabling act OR, if not in law, as understood by agency, subject to clarification from the legislature)?			
16	Associated performance measure item numbers from the Performance Measures Chart, if any		9, 10, 29, 30, 31	1,4,20,22,23,26,27
18	**Customer Details**			
19	Customer description		Medicaid Beneficiaries	Medicaid/BabyNet Providers
20	Does the agency evaluate customer satisfaction?	2018-19	Yes	No
21	Counties served in last completed fiscal year	2018-19	46	46
22	Number of customers served	2018-19	1,466,110	63,787
23		2017-18	1,464,593	58,438
24		2016-17	1,452,178	58,281
25				
26	**Units Provided and Amounts Charged to Customers**			
27	Description of a single deliverable unit		Medicaid Eligibilility Determinations	Claims and Capitation Payments
28	Number of units provided	2018-19	600,701	29,539,011
29		2017-18	550,084	29,169,588
30		2016-17	609,230	28,557,422
31	Does law prohibit charging the customer for the deliverable?	2018-19	No	No
32	If yes, provide law			
33		2017-18	No	No
34	If yes, provide law			
35		2016-17	No	No
36	If yes, provide law			
37	Amount charged to customer per deliverable unit	2018-19	$0.00	$0.00

Deliverables

	B	C	E	F
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		1	2
8	Associated laws		S.C. Code § 44-6-50(1) - Contracts with other agencies; program monitoring S.C. Code of Reg. Article 3 Medicaid, Subarticle 2 Eligibility for the Medical Assistance (Medicaid) Program 42 U.S. Code § 1396a. State plans for medical assistance • (a)(8) – eligibility applications • (a)(10) – eligibility categories • (a)(17) – eligibility standards • (a)(34) – three (3) month retroactive eligibility • (a)(46) – Income and Eligibility Verification System; Citizenship • (a)(47) – presumptive eligibility • (a)(55) – outstationed eligibility locations • (a)(63) – coverage for certain low-income families • (a)(66) – special provisions relating to Medicare prescription drug benefit • (e)(13) – express lane eligibility • (e)(14) – modified adjusted gross income (MAGI) 42 U.S. Code § 1383c. – Social Security Administration determinations of eligibility in the case of aged, blind, or disabled individuals 42 C.F.R. Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa	S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care 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 • Co payment • Service limits S.C. Code of Reg. Article 9 Optional State Supplementation Program • State-funded program that provides a cash benefit payment that supplements an eligible individual's countable income up to the net income limitation 42 U.S. Code § 1396a. State plans for medical assistance • (a)(30) – utilization management • (a)(43) – early and periodic screening, diagnostic, and treatment (EPSDT) services and vaccines • (a)(62)- pediatric vaccine distribution program • (a)(67) – 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
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		Provide for an eligibility system that allows citizens to apply for Medicaid, processes that application, and determines which citizens are eligible for Medicaid benefits.	Design and provide reimbursement for evidence-based, high value health benefits to Medicaid beneficiaries, based on medical necessity.
11	Responsible organizational unit (primary)		Eligibility	Health Programs/Long Term Living
38		2017-18	$0.00	$0.00
39		2016-17	$0.00	$0.00
40				
41	**Costs**			
42	Total employee equivalents required (37.5 hour per week units)	2018-19	1,136.00	136.00
43		2017-18	902.00	157.00
44		2016-17	877.00	160.00
45	Total deliverable expenditures each year (operational and employee salary/fringe)			
46		2018-19	$155,323,518.00	$7,146,405,058.00
47		2017-18	$134,859,486.00	$6,933,547,007.00
48		2016-17	$66,612,335.00	$6,874,889,743.00
49	Total deliverable expenditures as a percentage of total agency expenditures			
50		2018-19	2.08%	95.83%
51		2017-18	1.88%	96.48%
52		2016-17	0.94%	96.78%
53	Agency expenditures per unit of the deliverable			
54		2018-19	$258.57	$241.93
55		2017-18	$245.16	$237.70
56		2016-17	$109.34	$240.74
57				
58	**Amount collected from providing deliverable**			
59	Total collected from charging customers	2018-19	$0.00	$0.00
60		2017-18	$0.00	$0.00
61		2016-17	$0.00	$0.00
62	Total collected from non-state sources as a result of providing the	2018-19	$113,982,915.00	$4,987,245,921.00
63	deliverable (including federal and other grants awarded to agency to	2017-18	$103,436,105.00	$4,868,945,633.00
64	provide deliverable)	2016-17	$39,977,322.00	$4,800,436,577.00
65	Total collected from charging customers and non-state sources	2018-19	$113,982,915.00	$4,987,245,921.00
66		2017-18	$103,436,105.00	$4,868,945,633.00
67		2016-17	$39,977,322.00	$4,800,436,577.00
68				
69	**Agency Comments**			
70	Additional comments from agency (optional)			

Deliverables

	B	C	G	H
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		3	4
8	Associated laws		S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care System 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 S.C. Code § 44-6-910 - Recognition and Designation of Federally Qualified Health Centers, Rural Health Clinics, and Rural Hospitals 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 42 U.S.C. 1320a–3 – Disclosure of ownership and related information 42 U.S. Code 1396u–2 – Provisions related to Managed Care 42 C.F.R. Part 431 Subpart C – Administrative Requirements: Provider Relations 42 C.F.R. Part 438 – Managed Care	S.C. Code § 44-6-190 - Applicability of Administrative Procedures Act; compliance with Medicaid disclosure rules. S.C. Code of Reg. Article 1 Administration, Subarticle 3 Appeals and Hearings 42 U.S. Code § 1396a. State plans for medical assistance •(a)(3) – beneficiary/applicant appeals and hearings •(a)(28)(D) – state appeals process for transfers and discharges 42 C.F.R. Part 431 Subpart D – Appeals process for Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities 42 C.F.R. Part 431 Subpart F – Fair Hearings for Applicants and Beneficiaries
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		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.	Provide and operate a process for member and provider appeals.
11	Responsible organizational unit (primary)		Agency Operations	Fair Hearings and Appeals
12				
13	**Results Sought**			
14	Does the legislature state intent, findings, or purpose?		Yes	Yes
15	Purpose of the service/why it is provided (as written in statute/enabling act OR, if not in law, as understood by agency, subject to clarification from the legislature)?			
16	Associated performance measure item numbers from the Performance Measures Chart, if any		3,5,6,11,14,15,16	
18	**Customer Details**			
19	Customer description		Medicaid Providers	Medicaid Beneficiaries
20	Does the agency evaluate customer satisfaction?	2018-19	No	Yes
21	Counties served in last completed fiscal year	2018-19	46	46
22	Number of customers served	2018-19	63,787	1,466,110
23		2017-18	58,438	1,464,593
24		2016-17	58,281	1,452,178
25				
26	**Units Provided and Amounts Charged to Customers**			
27	Description of a single deliverable unit		Providers Enrollment Determinations	Appeal Decisions
28	Number of units provided	2018-19	12,960	3,024
29		2017-18	10,345	2,610
30		2016-17	15,472	1,948
31	Does law prohibit charging the customer for the deliverable?	2018-19	No	No
32	If yes, provide law			
33		2017-18	No	No
34	If yes, provide law			
35		2016-17	No	No
36	If yes, provide law			
37	Amount charged to customer per deliverable unit	2018-19	$598.00	$0.00

Deliverables

	B	C	G	H
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		3	4
8	Associated laws		S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care System 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 S.C. Code § 44-6-910 - Recognition and Designation of Federally Qualified Health Centers, Rural Health Clinics, and Rural Hospitals 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 42 U.S.C. 1320a–3 – Disclosure of ownership and related information 42 U.S. Code 1396u–2 – Provisions related to Managed Care 42 C.F.R. Part 431 Subpart C – Administrative Requirements: Provider Relations 42 C.F.R. Part 438 – Managed Care	S.C. Code § 44-6-190 - Applicability of Administrative Procedures Act; compliance with Medicaid disclosure rules. S.C. Code of Reg. Article 1 Administration, Subarticle 3 Appeals and Hearings 42 U.S. Code § 1396a. State plans for medical assistance •(a)(3) – beneficiary/applicant appeals and hearings •(a)(28)(D) – state appeals process for transfers and discharges 42 C.F.R. Part 431 Subpart D – Appeals process for Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities 42 C.F.R. Part 431 Subpart F – Fair Hearings for Applicants and Beneficiaries
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		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.	Provide and operate a process for member and provider appeals.
11	Responsible organizational unit (primary)		Agency Operations	Fair Hearings and Appeals
38		2017-18	$598.00	$0.00
39		2016-17	$598.00	$0.00
40				
41	**Costs**			
42	Total employee equivalents required (37.5 hour per week units)	2018-19	33.00	8.00
43		2017-18	32.00	8.00
44		2016-17	38.00	6.00
45	Total deliverable expenditures each year (operational and employee salary/fringe)			
46		2018-19	$18,877,525.00	$765,745.00
47		2017-18	$15,529,992.00	$714,876.00
48		2016-17	$15,123,794.00	$669,191.00
49	Total deliverable expenditures as a percentage of total agency expenditures			
50		2018-19	0.25%	0.01%
51		2017-18	0.22%	0.01%
52		2016-17	0.21%	0.01%
53	Agency expenditures per unit of the deliverable			
54		2018-19	$1,456.60	$253.22
55		2017-18	$1,501.21	$273.90
56		2016-17	$977.49	$343.53
57				
58	**Amount collected from providing deliverable**			
59	Total collected from charging customers	2018-19	$88,799.00	$0.00
60		2017-18	$164,290.00	$0.00
61		2016-17	$211,208.00	$0.00
62	Total collected from non-state sources as a result of providing the	2018-19	$12,893,343.00	$466,095.00
63	deliverable (including federal and other grants awarded to agency to	2017-18	$10,640,892.00	$435,462.00
64	provide deliverable)	2016-17	$9,942,727.00	$401,223.00
65	Total collected from charging customers and non-state sources	2018-19	$12,982,142.00	$466,095.00
66		2017-18	$10,805,182.00	$435,462.00
67		2016-17	$10,153,935.00	$401,223.00
68				
69	**Agency Comments**			
70	Additional comments from agency (optional)			

Deliverables

	B	C	I	J
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		5	6
8	Associated laws		S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care 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 § 44-6-40(3) - Continuously review and evaluate 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 of Reg. Article 4 Program Evaluation, Subarticle 1 Administrative Sanctions Against Medicaid Providers, Subarticle 2 Program Integrity 42 U.S. Code § 1396a. State plans for medical assistance: • (a)(35) & (38) – ownership and disclosure requirements • (a)(39) – provider exclusion and termination • (a)(41) – notification requirements regarding certain provider sanctions • (a)(42) – recovery audit contractors • (a)(49) – Information concerning sanctions taken by State licensing authorities against health care practitioners and providers • (a)(61) – Medicaid Fraud Control Unit • (a)(64) – fraud hotline • (a)(69) – CMS Medicaid Integrity Program • (a)(77) – provider screening and enrollment • (p) – provider exclusion • (kk)- Provider and Supplier Screening, Oversight, and Reporting Requirements • (ll)- Termination Notification Database 42 U.S. Code § 1396u-6 – CMS Medicaid Integrity Program 42 U.S.C. 1320a–3 – Disclosure of Ownership and Related Information	S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care System S.C. Code § 44-6-40 – duties of the Department S.C. Code § 44-6-70 - Preparation of state plan and resource allocation recommendations S.C. Code § 44-6-190 - Applicability of Administrative Procedures Act; compliance with Medicaid disclosure rules S.C. Code of Reg. Article 1 Administration, Subarticle 2 Nondiscriminatory Practices S.C. Code of Reg. Article 1 Administration, Subarticle 4, Safeguarding of Client Information 42 U.S. Code § 1396a. State plans for medical assistance: • (a)(4) – proper and efficient administration of the Medicaid program • (a)(5) – Designation of single state agency to administer Medicaid program • (a)(7)(A) – safeguarding beneficiary/applicant information Title VI of The Civil Rights Act of 1964, 42 U.S.C. § 2000d Et Seq. - prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		Safeguard taxpayer resources against fraud, waste, and abuse.	Administer the Medicaid program in a manner that is consistent with state and federal law.
11	Responsible organizational unit (primary)		Program Integrity/Internal Audit	Administration
12				
13	**Results Sought**			
14	Does the legislature state intent, findings, or purpose?		Yes	Yes
15	Purpose of the service/why it is provided (as written in statute/enabling act OR, if not in law, as understood by agency, subject to clarification from the legislature)?			
16	Associated performance measure item numbers from the Performance Measures Chart, if any			
18	**Customer Details**			
19	Customer description		Medicaid Providers	Medicaid Beneficaries
20	Does the agency evaluate customer satisfaction?	2018-19	No	Yes
21	Counties served in last completed fiscal year	2018-19	46	46
22	Number of customers served	2018-19	63,787	1,466,110
23		2017-18	58,438	1,464,593
24		2016-17	58,281	1,452,178
25				
26	**Units Provided and Amounts Charged to Customers**			
27	Description of a single deliverable unit		Program Integrity and Internal Audit Investigations	N/A
28	Number of units provided	2018-19	604	0
29		2017-18	591	0
30		2016-17	764	0
31	Does law prohibit charging the customer for the deliverable?	2018-19	No	No
32	If yes, provide law			
33		2017-18	No	No
34	If yes, provide law			
35		2016-17	No	No
36	If yes, provide law			
37	Amount charged to customer per deliverable unit	2018-19	$0.00	$0.00

Deliverables

	B	C	I	J
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		5	6
8	Associated laws		S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care 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 § 44-6-40(3) - Continuously review and evaluate 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 of Reg. Article 4 Program Evaluation, Subarticle 1 Administrative Sanctions Against Medicaid Providers, Subarticle 2 Program Integrity 42 U.S. Code § 1396a. State plans for medical assistance: • (a)(35) & (38) – ownership and disclosure requirements • (a)(39) – provider exclusion and termination • (a)(41) – notification requirements regarding certain provider sanctions • (a)(42) – recovery audit contractors • (a)(49) – Information concerning sanctions taken by State licensing authorities against health care practitioners and providers • (a)(61) – Medicaid Fraud Control Unit • (a)(64) – fraud hotline • (a)(69) – CMS Medicaid Integrity Program • (a)(77) – provider screening and enrollment • (p) – provider exclusion • (kk)- Provider and Supplier Screening, Oversight, and Reporting Requirements • (ll)- Termination Notification Database 42 U.S. Code § 1396u-6 – CMS Medicaid Integrity Program 42 U.S.C. 1320a–3 – Disclosure of Ownership and Related Information	S.C. Code § 44-6-30(1) - administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care System S.C. Code § 44-6-40 – duties of the Department S.C. Code § 44-6-70 - Preparation of state plan and resource allocation recommendations S.C. Code § 44-6-190 - Applicability of Administrative Procedures Act; compliance with Medicaid disclosure rules S.C. Code of Reg. Article 1 Administration, Subarticle 2 Nondiscriminatory Practices S.C. Code of Reg. Article 1 Administration, Subarticle 4, Safeguarding of Client Information 42 U.S. Code § 1396a. State plans for medical assistance: • (a)(4) – proper and efficient administration of the Medicaid program • (a)(5) – Designation of single state agency to administer Medicaid program • (a)(7)(A) – safeguarding beneficiary/applicant information Title VI of The Civil Rights Act of 1964, 42 U.S.C. § 2000d Et Seq. - prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		Safeguard taxpayer resources against fraud, waste, and abuse.	Administer the Medicaid program in a manner that is consistent with state and federal law.
11	Responsible organizational unit (primary)		Program Integrity/Internal Audit	Administration
38		2017-18	$0.00	$0.00
39		2016-17	$0.00	$0.00
40				
41	**Costs**			
42	Total employee equivalents required (37.5 hour per week units)	2018-19	28.00	278.00
43		2017-18	32.00	188.00
44		2016-17	35.00	146.00
45	Total deliverable expenditures each year (operational and employee salary/fringe)			
46		2018-19	$2,750,901.00	$114,646,247.00
47		2017-18	$2,991,521.00	$77,388,545.00
48		2016-17	$3,302,187.00	$120,304,146.00
49	Total deliverable expenditures as a percentage of total agency expenditures			
50		2018-19	0.04%	1.54%
51		2017-18	0.04%	1.08%
52		2016-17	0.05%	1.69%
53	Agency expenditures per unit of the deliverable			
54		2018-19	$4,554.47	Insufficient data provided.
55		2017-18	$5,061.80	Insufficient data provided.
56		2016-17	$4,322.23	Insufficient data provided.
57				
58	**Amount collected from providing deliverable**			
59	Total collected from charging customers	2018-19	$0.00	$3,101.95
60		2017-18	$0.00	$2,661.37
61		2016-17	$0.00	$2,775.09
62	Total collected from non-state sources as a result of providing the	2018-19	$1,629,888.00	$82,901,056.00
63	deliverable (including federal and other grants awarded to agency to	2017-18	$1,789,104.00	$53,675,421.00
64	provide deliverable)	2016-17	$1,956,014.00	$93,645,771.00
65	Total collected from charging customers and non-state sources	2018-19	$1,629,888.00	$82,904,157.95
66		2017-18	$1,789,104.00	$53,678,082.37
67		2016-17	$1,956,014.00	$93,648,546.09
68				
69	**Agency Comments**			
70	Additional comments from agency (optional)			

Deliverables

	B	C	K	L
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		7	8
8	Associated laws		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 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	Executive Order 2016-20 2019-2020 Appropriation Act, Part 1B Section 33.23. (DHHS: BabyNet Compliance)20 U.S. Code § 1400 et seq.- Individuals with Disabilities Education Act (IDEA), Subchapter III (Infants and Toddlers with Disabilities)
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		Exercise fiscal responsibility in the use of taxpayer resources.	Lead Agency for South Carolina's Individuals with Disabilities Education Act (IDEA) Part C Program, known locally as "BabyNet"
11	Responsible organizational unit (primary)		Finance	Health Programs
12				
13	**Results Sought**			
14	Does the legislature state intent, findings, or purpose?		Yes	Yes
15	Purpose of the service/why it is provided (as written in statute/enabling act OR, if not in law, as understood by agency, subject to clarification from the legislature)?			
16	Associated performance measure item numbers from the Performance Measures Chart, if any		17,18,19,21,24,32,33,34	
18	**Customer Details**			
19	Customer description		Medicaid Providers	BabyNet Beneficiaries
20	Does the agency evaluate customer satisfaction?	2018-19	No	Yes
21	Counties served in last completed fiscal year	2018-19	46	46
22	Number of customers served	2018-19	63,787	5,481
23		2017-18	58,438	4,952
24		2016-17	58,281	4,376
25				
26	**Units Provided and Amounts Charged to Customers**			
27	Description of a single deliverable unit		N/A	BabyNet Eligibility Determinations
28	Number of units provided	2018-19	0	7,004
29		2017-18	0	5,687
30		2016-17	0	0
31	Does law prohibit charging the customer for the deliverable?	2018-19	No	Yes
32	If yes, provide law			IDEA Part C Section 303.521
33		2017-18	No	Yes
34	If yes, provide law			IDEA Part C Section 303.521
35		2016-17	No	Yes
36	If yes, provide law			IDEA Part C Section 303.521
37	Amount charged to customer per deliverable unit	2018-19	$0.00	$0.00

Deliverables

	B	C	K	L
1	**Agency**			
2	Department of Health and Human Services			
3	**Accurate as of**			
4				
5				
6	**Deliverable**			
7	Item number		7	8
8	Associated laws		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 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	Executive Order 2016-20 2019-2020 Appropriation Act, Part 1B Section 33.23. (DHHS: BabyNet Compliance)20 U.S. Code § 1400 et seq.- Individuals with Disabilities Education Act (IDEA), Subchapter III (Infants and Toddlers with Disabilities)
9	Does state or federal law specifically require this deliverable?		Yes	Yes
10	Deliverable description		Exercise fiscal responsibility in the use of taxpayer resources.	Lead Agency for South Carolina's Individuals with Disabilities Education Act (IDEA) Part C Program, known locally as "BabyNet"
11	Responsible organizational unit (primary)		Finance	Health Programs
38		2017-18	$0.00	$0.00
39		2016-17	$0.00	$0.00
40				
41	**Costs**			
42	Total employee equivalents required (37.5 hour per week units)	2018-19	64.00	80.00
43		2017-18	72.00	67.00
44		2016-17	60.00	0.00
45	Total deliverable expenditures each year (operational and employee salary/fringe)			
46		2018-19	$13,837,397.00	$4,691,790.00
47		2017-18	$17,823,501.00	$3,940,655.00
48		2016-17	$23,029,699.00	$0.00
49	Total deliverable expenditures as a percentage of total agency expenditures			
50		2018-19	0.19%	0.06%
51		2017-18	0.25%	0.05%
52		2016-17	0.32%	0.00%
53	Agency expenditures per unit of the deliverable			
54		2018-19	Insufficient data provided.	$669.87
55		2017-18	Insufficient data provided.	$692.92
56		2016-17	Insufficient data provided.	Insufficient data provided.
57				
58	**Amount collected from providing deliverable**			
59	Total collected from charging customers	2018-19	$0.00	$0.00
60		2017-18	$0.00	$0.00
61		2016-17	$0.00	$0.00
62	Total collected from non-state sources as a result of providing the deliverable (including federal and other grants awarded to agency to provide deliverable)	2018-19	$7,685,590.00	$2,216,863.00
63		2017-18	$10,525,154.00	$1,843,329.00
64		2016-17	$13,247,564.00	$0.00
65	Total collected from charging customers and non-state sources	2018-19	$7,685,590.00	$2,216,863.00
66		2017-18	$10,525,154.00	$1,843,329.00
67		2016-17	$13,247,564.00	$0.00
68				
69	**Agency Comments**			
70	Additional comments from agency (optional)			

Performance Measures

	A	C	D
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	1	2
8	Description	Ensure performance at or above the regional average for targeted HEDIS measures	Implement social determinants of health screenings in 10% of high needs communities
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	1	10
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	E	F
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	3	4
8	Description	Maintain 100% monthly production submission to CMS	Reduce avoidable Emergency Department visits by 5% in one year
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet	Obtain lower value
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	100	328023
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	G	H
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	5	6
8	Description	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)	Maintain performance at or above the regional Medicaid standard for Consumer Assessment of Healthcare Providers and Systems (CAHPS) measurements of access to care (Adult measure)
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	77.65%	61.38%
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	I	J
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	7	8
8	Description	Maintain an opioid prescribing rate for Medicaid beneficiaries of no more than the statewide average	Increase the percentage of beneficiaries diagnosed with substance use disorder who are receiving treatment by 10%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	709	57.8
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	K	L
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	9	10
8	Description	Increase the number of applications completed in a timely manner by 5%	Decrease the number of applications and reviews aged over 180 days by 20%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or obtain lower value
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	89.25%	93343
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	M	N
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	11	12
8	Description	Process 99% of provider applications within 30 days	Process 99% of all electronic claims submissions within 30 days
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	Yes	There was no target
16	2018	Yes	There was no target
17	2017	Yes	There was no target
18	2016	Yes	There was no target
19	2015	No	There was no target
20			
21	**Changes in target**		
22	2020	Same as prior year	No prior year target
23	2019	Same as prior year	No prior year target
24	2018	Same as prior year	No prior year target
25	2017	Same as prior year	No prior year target
26	2016	Same as prior year	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	99%	99%
31			
32	**2019**		
33	Target	99%	
34	Actual	99%	
35			
36	**2018**		
37	Target	99%	
38	Actual	100%	
39			
40	**2017**		
41	Target	99%	
42	Actual	100%	
43			
44	**2016**		
45	Target	99%	
46	Actual	100%	
47			
48	**2015**		
49	Target	99%	
50	Actual	98%	
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	O	P
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	13	14
8	Description	Achieve 97% of claims adjudicated on the provider's first submission	Ensure that 95% of beneficiaries receive primary care services within 10 miles and 15 days
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending...**		
29	**2020**		
30	Target	97%	95%
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	Q	R
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	15	16
8	Description	Ensure that 95% of beneficiaries receive specialty care services within 40 miles and 45 days	Increase the number of providers participating in telehealth by 5%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	95%	189
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	S	T
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	17	18
8	Description	Keep per-member cost increases below national benchmarks (PMPM Growth)	Keep per-member cost increases below national benchmarks (HC Cost Growth)
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Obtain lower value	Obtain lower value
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	1.9%	2.1%
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	U	V
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	19	20
8	Description	Maintain or decrease the department's percent share of the state's general funds appropriation over a three year period	Increase the relative share of long-term care beneficiaries in community settings by 3%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or obtain lower value	Exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending...**		
29	**2020**		
30	Target	16.46	61.22
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	W	X
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	21	22
8	Description	Maintain general fund expenditures within 3% of forecast	Ensure MCO performance, based on National Committee for Quality Assurance (NCQA) health plan rankings, at or above the southeastern average (Child measure)
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or obtain lower value	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	3%	86.27%
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	Y	Z
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	23	24
8	Description	Ensure MCO performance, based on National Committee for Quality Assurance (NCQA) health plan rankings, at or above the southeastern average (Adult measure)	Maintain medical loss ratio (MLR) at or above 86%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	There was no target
16	2018	There was no target	There was no target
17	2017	There was no target	There was no target
18	2016	There was no target	There was no target
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	No prior year target
23	2019	No prior year target	No prior year target
24	2018	No prior year target	No prior year target
25	2017	No prior year target	No prior year target
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	85.95%	86%
31			
32	**2019**		
33	Target		
34	Actual		
35			
36	**2018**		
37	Target		
38	Actual		
39			
40	**2017**		
41	Target		
42	Actual		
43			
44	**2016**		
45	Target		
46	Actual		
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	AA	AB
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	25	26
8	Description	Implement metric-driven planning documents for 60% of the agency's staff by June 30, 2020	Provide at least 20% of managed care payments using a value-based approach
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	Yes
16	2018	There was no target	Yes
17	2017	There was no target	Yes
18	2016	There was no target	Yes
19	2015	There was no target	No
20			
21	**Changes in target**		
22	2020	No prior year target	Decreased from prior year
23	2019	No prior year target	Increased from prior year
24	2018	No prior year target	Same as prior year
25	2017	No prior year target	Increased from prior year
26	2016	No prior year target	Same as prior year
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target	60%	
31			
32	**2019**		
33	Target		30%
34	Actual		33.7%
35			
36	**2018**		
37	Target		20%
38	Actual		32%
39			
40	**2017**		
41	Target		20%
42	Actual		26%
43			
44	**2016**		
45	Target		12%
46	Actual		19%
47			
48	**2015**		
49	Target		12%
50	Actual		5%
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	AC	AD
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	27	28
8	Description	Increase the percentage of HEDIS withhold metrics at or above the 50th percentile by 2% annually	Reduce the rate of low birth weight babies by 3%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	No	No
16	2018	Yes	Yes
17	2017	Yes	Yes
18	2016	Yes	No
19	2015	There was no target	Yes
20			
21	**Changes in target**		
22	2020	Decreased from prior year	Decreased from prior year
23	2019	Increased from prior year	Increased from prior year
24	2018	Increased from prior year	Increased from prior year
25	2017	Increased from prior year	Decreased from prior year
26	2016	No prior year target	Decreased from prior year
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target		
31			
32	**2019**		
33	Target	94%	9.02%
34	Actual	75%	5.79%
35			
36	**2018**		
37	Target	85%	8.50%
38	Actual	92%	10.77%
39			
40	**2017**		
41	Target	56%	7.68%
42	Actual	83%	8.76%
43			
44	**2016**		
45	Target	47%	8.68%
46	Actual	55%	7.46%
47			
48	**2015**		
49	Target		10.58%
50	Actual		10.91%
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	AE	AF
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	29	30
8	Description	Increase the number of online applications by 10%	Increase the rate of one-hour resolution for walk-in services by 10%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	Yes	No
16	2018	No	No
17	2017	No	No
18	2016	No	Yes
19	2015	No	There was no target
20			
21	**Changes in target**		
22	2020	Decreased from prior year	Decreased from prior year
23	2019	Increased from prior year	Decreased from prior year
24	2018	Decreased from prior year	Decreased from prior year
25	2017	Decreased from prior year	Increased from prior year
26	2016	Increased from prior year	No prior year target
27			
28	**Result details for year ending...**		
29	**2020**		
30	Target		
31			
32	**2019**		
33	Target	43959	0.776215
34	Actual	44218	0.69273
35			
36	**2018**		
37	Target	43415	0.80796495
38	Actual	34027	0.70565
39			
40	**2017**		
41	Target	46005	86%
42	Actual	39468	73%
43			
44	**2016**		
45	Target	74526	10%
46	Actual	54923	78%
47			
48	**2015**		
49	Target	67115	
50	Actual	61014	
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	AG	AH
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	31	32
8	Description	Increase the rates of single-touch case resolutions for applications and reviews by 10%	Maintain General Fund expenditures within 3% of forecast
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or obtain lower value
13			
14	**Did the agency achieve its goal?**		
15	2019	No	Yes
16	2018	No	Yes
17	2017	No	Yes
18	2016	Yes	No
19	2015	There was no target	Yes
20			
21	**Changes in target**		
22	2020	Decreased from prior year	Decreased from prior year
23	2019	Increased from prior year	Same as prior year
24	2018	Increased from prior year	Same as prior year
25	2017	Increased from prior year	Same as prior year
26	2016	No prior year target	Same as prior year
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target		
31			
32	**2019**		
33	Target	0.8767	3%
34	Actual	0.806	1%
35			
36	**2018**		
37	Target	0.806714042	3%
38	Actual	0.70311	2%
39			
40	**2017**		
41	Target	78%	3%
42	Actual	73%	1%
43			
44	**2016**		
45	Target	10%	3%
46	Actual	71%	3.5%
47			
48	**2015**		
49	Target		3%
50	Actual		2.31%
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	AI	AJ
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	33	34
8	Description	Keep per-member cost increases below national benchmarks	Increase the percentage of expenditures analyzed for third-party liability by 5%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or obtain lower value	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	There was no target	No
16	2018	There was no target	No
17	2017	There was no target	No
18	2016	There was no target	No
19	2015	There was no target	There was no target
20			
21	**Changes in target**		
22	2020	No prior year target	Decreased from prior year
23	2019	No prior year target	Same as prior year
24	2018	No prior year target	Increased from prior year
25	2017	No prior year target	Same as prior year
26	2016	No prior year target	No prior year target
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target		
31			
32	**2019**		
33	Target		0.903
34	Actual		0.84
35			
36	**2018**		
37	Target		0.903
38	Actual		0.86
39			
40	**2017**		
41	Target		89%
42	Actual		86%
43			
44	**2016**		
45	Target		89%
46	Actual		86%
47			
48	**2015**		
49	Target		
50	Actual		
51			
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.

Performance Measures

	A	AK	AL
1	**Agency**		
2	Department of Health and Human Services		
3	**Accurate as of**		
4			
5			
6	**Performance Measure**		
7	Item #	35	36
8	Description	Process 99% of electronic claims submissions within 14 days	Improve employee engagement scores by 5%
9	Time applicable	State Fiscal Year (July - June)	State Fiscal Year (July - June)
10			
11	**Results Summary**		
12	**Is the goal to meet, exceed, or obtain a lower value than the target?**	Meet or exceed	Meet or exceed
13			
14	**Did the agency achieve its goal?**		
15	2019	Yes	No
16	2018	Yes	No
17	2017	Yes	Yes
18	2016	Yes	No
19	2015	Yes	No
20			
21	**Changes in target**		
22	2020	Decreased from prior year	Decreased from prior year
23	2019	Same as prior year	Increased from prior year
24	2018	Same as prior year	Increased from prior year
25	2017	Same as prior year	Decreased from prior year
26	2016	Same as prior year	Same as prior year
27			
28	**Result details for year ending…**		
29	**2020**		
30	Target		
31			
32	**2019**		
33	Target	99%	0.525
34	Actual	99%	
35			
36	**2018**		
37	Target	99%	0.5145
38	Actual	99.83%	0.5
39			
40	**2017**		
41	Target	99%	49%
42	Actual	99.85%	49%
43			
44	**2016**		
45	Target	99%	49.4%
46	Actual	99.91%	47%
47			
48	**2015**		
49	Target	99%	49.4%
50	Actual	99.8%	47%
51			n
52	**Agency Comments**		
53	Additional comments from agency (optional)		

The contents of this chart are considered sworn testimony from the agency director.