AGENCY NAME:	Department of Health and Human Services		
AGENCY CODE:	J020	SECTION:	033

Fiscal Year 2015-16
Accountability Report

SUBMISSION FORM

AGENCY MISSION	To purchase the most health for our citizens in need at the least possible cost for taxpayers.

AGENCY VISION	The vision of the South Carolina Department of Health and Human Services is to be a responsive and innovative organization that continuously improves the health of South Carolina.

Please state yes or no if the agency has any major or minor (internal or external) recommendations that would allow the agency to operate more effectively and efficiently.

RESTRUCTURING RECOMMENDATIONS:	Yes

Please identify your agency's preferred contacts for this year's accountability report.

	Name	*Phone*	*Email*
PRIMARY CONTACT:	Jenny Stirling	803-898-3965	lynchjen@scdhhs.gov
SECONDARY CONTACT:	Bryan Kost	803-898-2580	kostbr@scdhhs.gov

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I have reviewed and approved the enclosed FY 2015-16 Accountability Report, which is complete and accurate to the extent of my knowledge.

AGENCY DIRECTOR ***(SIGN AND DATE)*:**	 August 22, 2016
***(TYPE/PRINT NAME)*:**	Christian L. Soura

BOARD/CMSN CHAIR ***(SIGN AND DATE)*:**	N/A
***(TYPE/PRINT NAME)*:**	

AGENCY'S DISCUSSION AND ANALYSIS

Leadership

The vision of the South Carolina Department of Health and Human Services is to be a responsive and innovative organization that continuously improves the health of South Carolina. Values and performance expectations are defined and communicated through several mechanisms, the centerpiece of which is the agency's Balanced Scorecard.

This tool highlights a dozen key goals for the upcoming year, with three items assigned to each of the four following categories: Better Health, Outstanding Member Services, Sound Fiscal Stewardship, and Responsive and Responsible Management.

Although these headings were overhauled in 2015, many of the themes and the individual performance measures were preserved in concept, if not in specific form. For instance, several measures were changed for 2015-16 to conform to the "SMART" criteria required by the Accountability Report. Not only are these performance measures incorporated into the agency's annual Accountability Report; they are also discussed at three meetings of agency managers and supervisors each year (Leadership Development Reviews) and updated on intranet sites available to agency employees.

Values and performance expectations are further disseminated through personal interaction with agency employees (in group and/or individual settings) and through the performance management process. Upon his appointment in November 2014, the Director began to visit each of the agency's nearly 60 offices in order to establish this relationship.

- Objective 1A: Complete the revision of the Balanced Scorecard and communicate it to the agency.
    - Success Factor 1A1: Complete the annual revision of the Balanced Scorecard by September 15th. (Annual since September 2015)
    - Success Factor 1A2: Explain the changes during the November 2016 Leadership Development Retreat and ensure that regular updates are provided through subsequent LDRs and other agency-wide communications.
- Objective 1B: Establish personal contact with all of the Department's offices to further communicate the agency's vision, values, and performance expectations.
    - Success Factor 1B1: Maintain a schedule by which all departmental offices will be visited no later than December 31, 2016.

Strategic Planning

The Department's strategic objectives are derived from its legal obligations as enshrined in state and federal law, regulation, and other administrative issuances. These obligations are operationalized into more specific workplans based upon shorter-term priorities established through proviso or other budgetary instrument or in order to ensure compliance with the ever-evolving body of federal regulations and other policy guidance from the Centers for Medicare and Medicaid Services, among other legal authorities.

Against this legal backdrop, the Department strives to develop and implement plans in a manner that is consistent with the Institute for Healthcare Improvement's "Triple Aim," which seeks to improve the health of the population, enhance the patient experience of care, and reduce the per-capita cost of care.

Plans are developed and implemented through the normal operations of the agency; information is shared among agency leadership, managers, and rank-and-file employees through standing and ad hoc meetings, informal discussions, and through intranet sites (such as SharePoint) and other media. Meetings are established with a goal being to ensure that the appropriate staff and program areas are consulted and have an opportunity to participate in the decision-making process, while being spaced so that each meeting has a specific purpose and to prevent "meeting creep" from consuming so much time that employees are left without hours in which to actually execute on these plans.

The agency's plans can be revised through several of these settings, and will be escalated to a level within the agency that is commensurate with the sensitivity and importance of the matter at hand. Sufficiently disruptive changes may require additional consultation with the Governor's Office, the General Assembly, or various federal authorities. Matters such as these are likely to rise to the level that they would need to be addressed in future iterations of the Balanced Scorecard, the Accountability Report, or subsequent budgets.

Accomplishments are measured and sustained through each of these mechanisms and venues described above and also, for more "micro-level" accomplishments, through the employee performance management process.

- Objective 2A: Complete the revision of the Balanced Scorecard and communicate it to the agency.
    - Success Factor 2A1: Complete the annual revision of the Balanced Scorecard by September 15th. (Annual since September 2015)
    - Success Factor 2A2: Explain the changes during the November 2016 Leadership Development Retreat and ensure that regular updates are provided through subsequent LDRs and other agency-wide communications.

[Note: Objective 2A is identical to Objective 1A, since these same activities and success factors are associated with both Leadership and Strategic Planning.]

<u>Customer Focus</u>

In the purest sense, the Department's customers are South Carolina's one million Medicaid beneficiaries. Applicants and the authorized representatives of our applicants and beneficiaries are in a similar position. Certainly the Department has other stakeholders, such as the state's hospital and healthcare systems, the provider community, the managed care plans, and the friends, families, and caregivers of those we serve. Other parties, such as the Department's vendors and other health-related state agencies are also part of the same ecosystem.

The needs and requirements of these entities are in some cases defined in the Medicaid state plan and/or in one or more federally-approved waivers. They are also communicated through in-person meetings or through the platforms or requests presented by various trade associations or advocacy groups. The expectations of this individuals and associations are also presented in these same ways.

The Department's performance against these expectations is measured through several items that are presented on the Balanced Scorecard. We also use performance-based contract reports and various dashboards to monitor these trends.

- Objective 3A: Provide outstanding service to our members and applicants.
    - Success Factor 3A1: Increase the rates of single-touch case resolutions for applications and reviews by 10%.
    - Success Factor 3A2: Increase the number of online applications by 10%.
    - Success Factor 3A3: Increase the one-hour resolution rate for walk-in services by 10%.
- Objective 3B: Demonstrate responsiveness to Medicaid providers and vendors through prompt processing.
    - Success Factor 3B1: Process 99% of electronic claims submissions within 14 days.
    - Success Factor 3B2: Process 99% of provider applications within 30 days.

Workforce Focus/Human Resources

On an individual level, employee performance is assessed and directed through an annual review process that is similar to that which is carried out all across state government. At a higher level, the Department has created some unique training and development opportunities that were custom-tailored in order to provide the Medicaid workforce with multiple paths to grow and to actively participate in the agency's planning and execution.

Every fall, all HHS employees are invited to participate in the Annual Engagement Survey, which allows employees to anonymously comment on their connection to the agency, their immediate supervisors, and the agency's leadership. They may also provide additional comments on what is and what is not perceived to be working within HHS. This survey is enormously helpful to setting the Department's direction for the upcoming year, for enabling employees to feel valued and appreciated, and for developing ideas for future workforce development initiatives.

The Department also recently launched the Leadership Academy program, which offers a series of modules that help the agency's supervisors make the transition from being managers to becoming leaders.

Finally, as noted in the discussion of other objectives, the Leadership Development Reviews have a workforce development focus and are also used as opportunities to remind managers of the agency's priorities and of recent progress against the Balanced Scorecard.

- Objective 4A: Keep employees actively involved in and attached to the agency's work by conducting an Annual Engagement Survey and ensuring that leadership's decisions are informed by the survey results.
    - Success Factor 4A1: Improve employee engagement scores by 5%.

Process Management/Continuous Improvement

Although agency head evaluation materials treat "process management and continuous improvement" as a distinct objective, if these priorities are being afforded the attention they deserve, then they should be treated more as a cross-cutting theme that should be present in the discussion of all other objectives. We should be asking how do we continuously improve our financial management, workforce planning, customer focus, etc.? These questions are thoroughly and repeatedly explored by the agency's senior management at each discussion of the Balanced Scorecard, where we ask whether we are measuring the things that truly matter, whether we have operationalized them correctly, and whether we are potentially misinterpreting the results we have seen so far.

To ensure that this spirit is communicated throughout the organization, HHS has the Leadership Development Retreats, the Annual Engagement Survey, and the "Bright Ideas" program through which employees can offer suggestions for quality improvement that are promptly vetted by the relevant staff. We also announced a Spot Bonus program to help attract and reward additional suggestions.

- Objective 5A: Provide outstanding service to our members and applicants.
    - Success Factor 5A1: Increase the rates of single-touch case resolutions for applications and reviews by 10%.
    - Success Factor 5A2: Increase the number of online applications by 10%.
    - Success Factor 5A3: Increase the one-hour resolution rate for walk-in services by 10%.
- Objective 5B: Demonstrate responsiveness to Medicaid providers and vendors through prompt processing.
    - Success Factor 5B1: Process 99% of electronic claims submissions within 14 days.
    - Success Factor 5B2: Process 99% of provider applications within 30 days.

[Note: Objectives 5A and 5B are identical to Objectives 3A and 3B, since our current process management and continuous improvement efforts are so strongly connected to the ongoing transition to a new eligibility system.]

Financial Management

The South Carolina Department of Health and Human Services is ultimately a healthcare policy and financing agency; without sound financial management, the Department will be unable to meet its commitments to its one million beneficiaries.

The Department must ensure that it retains adequate working capital in order to pay its bills in a timely manner. Similarly, cost growth must be contained so that Medicaid expenditures don't force the Governor and the General Assembly to sacrifice whatever additional investments may be required in the education, infrastructure, or other policy arenas.

Finally, the Department must also develop a series of policies, controls, and investigative/recovery mechanisms that deter or otherwise combat waste, fraud, and abuse.

- Objective 6A: Demonstrate sound fiscal stewardship of the Medicaid program.
    - Success Factor 6A1: Maintain General Fund expenditures within 3% of forecast.
    - Success Factor 6A2: Keep per-member cost increases below national benchmarks.
    - Success Factor 6A3: Increase the percentage of expenditures analyzed for third-party liability by 5%.

Risk Assessment and Mitigation Strategies

In this section, the Department is required to "identify the potential most negative impact on the public as a result of the agency's failure in accomplishing its goals and objectives", then "explain the nature and level of outside help it may need to mitigate such negative impact on the public", and finally "list three options for what the General Assembly could do to help resolve the issue before it became a crisis." Ultimately, the greatest negative impact that could result from the Department's failure to accomplish its goals and objectives would be a loss of access to healthcare services for our one million beneficiaries. A systematic failure like this is exceedingly unlikely. The most likely major threat would be the fiscal impact of the next recession, when revenues will fall and the agency's budget will likely be cut. This is particularly challenging for Medicaid, which is

a countercyclical program, meaning that more people become financially eligible and therefore the demand for Medicaid spending increases just as funding will start to be pulled away.

In terms of outside help, maintaining healthy reserve accounts for the Medicaid program itself and for the government as a whole is essential. Other threats to the program are technological (IT systems failure, cyberattack) or related to waste, fraud, and abuse. The Department has a multifaceted defense against many of these threats, but has taken a number of additional steps in the past year, including hiring specialists in key areas, gaining access to certain consultants, and increasing collaboration with the Department of Administration's technology and information security staff.

The General Assembly has already taken some of the actions needed to help avoid a crisis. Key provisos have been amended in recent years to allow the Department to maintain a responsible reserve balance, despite the repeated efforts of other parties to raid those funds. The deficit monitoring mechanism has been tightened to raise the likelihood that the legislature would be recalled in the event of a major shortfall between sessions. It is also important to continue to resist the temptation to use budget provisos to alter rates for certain classes of providers and/or to limit the Department's ability to manage the program in a responsive and responsible way.

Restructuring Recommendations

The Department is in the process of reviewing all of its regulations, as required under §1-23-270(F)(1), and will have recommendations relating to those in a few months. There may also be statutory recommendations that arise from that review.

As noted in this year's House Oversight Report, we believe that the General Assembly should explore a merger of SCDHHS and DAODAS. Bob Toomey, who held leadership positions in both agencies during his career, was a vocal advocate for this position. During the past several years, SCDHHS has financed many of DAODAS' service enhancements. We have also worked together to begin transitioning some substance use treatment services into the managed care model. The two agencies have a great deal in common, in the sense that they are both healthcare policy and financing organizations. A formal merger would help us to ensure that Medicaid participants may benefit from a carefully designed integrated care model that addresses both their physical and behavioral health needs. It would also streamline the process of evaluating and launching appropriate substance use treatment services.

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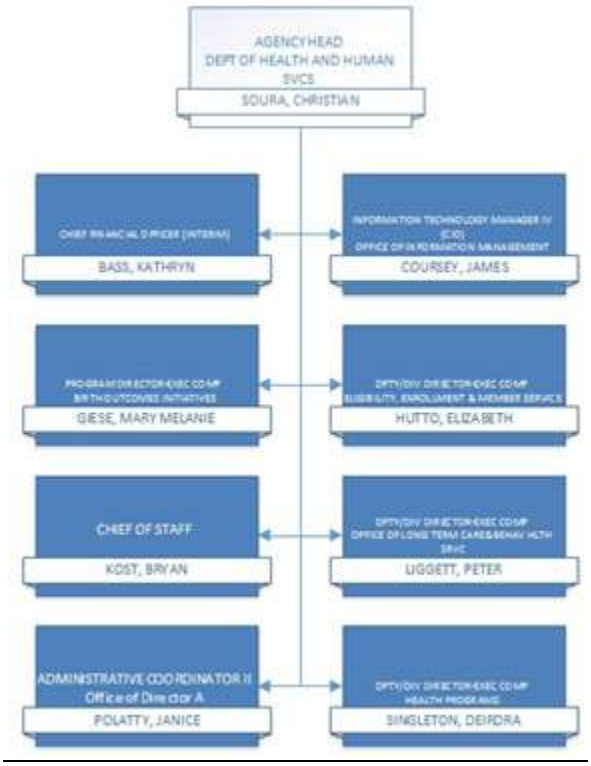
#	Accountability Report – Objective	Discussion
1.1.1	Provide at least 12% of managed care payment using a value-based approach	Achieved.
1.1.2	Increase the percentage of HEDIS withhold metrics at or above the 50th percentile by 2% annually	Achieved.
1.2.1	Reduce the rate of low birth weight babies by 3%	Achieved.
2.1.1	Increase the number of online applications by 10%	Applicants were asked not to use the online application for a period because it was creating duplicate applications.
2.2.1	Increase the rate of one-hour resolution for walk-in services by 10%	Achieved.
2.2.2	Increase the rates of single-touch case resolutions for applications and reviews by 10%	Achieved.
3.1.1	Maintain General Fund expenditures within 3% of forecast	Ended the year at 96.5% of forecast expenditures, due largely to more aggressive MCO rates than initially forecast.
3.2.1	Keep per-member cost increases below national benchmarks	Achieved.
3.3.1	Increase the percentage of expenditures analyzed for third-party liability by 5%	Increased the amount of spending analyzed, but the percentage fell slightly because of growth in CLTC services.
4.1.1	Process 99% of provider applications within 30 days	Achieved.
4.1.2	Process 99% of electronic claims submissions within 14 days	Achieved.
4.2.1	Improve employee engagement scores by 5%	Short this year, but was up 8% last year. Still above baseline.

Agency's Organization Chart – Three Levels



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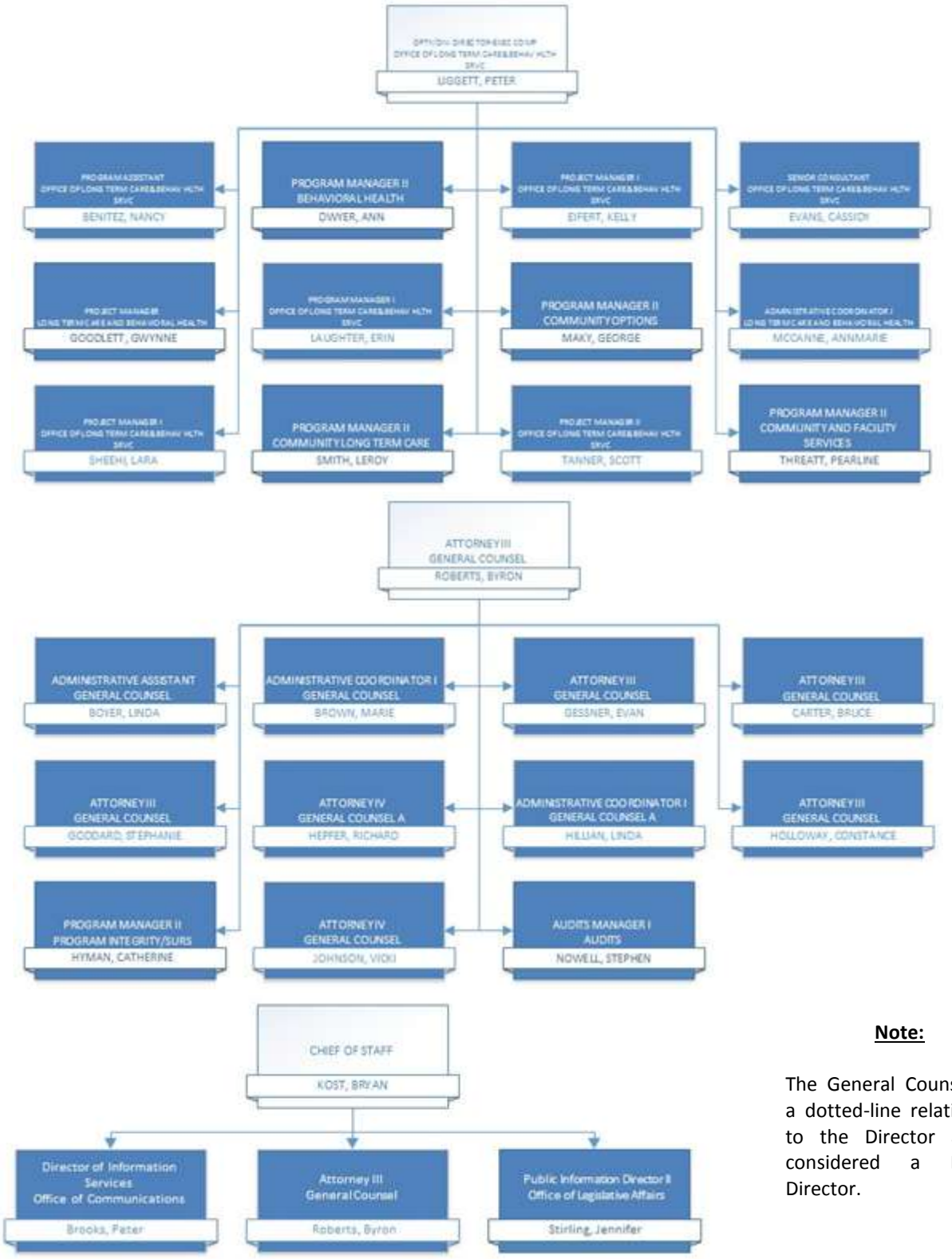

Note:

The General Counsel has a dotted-line relationship to the Director and is considered a Deputy Director.

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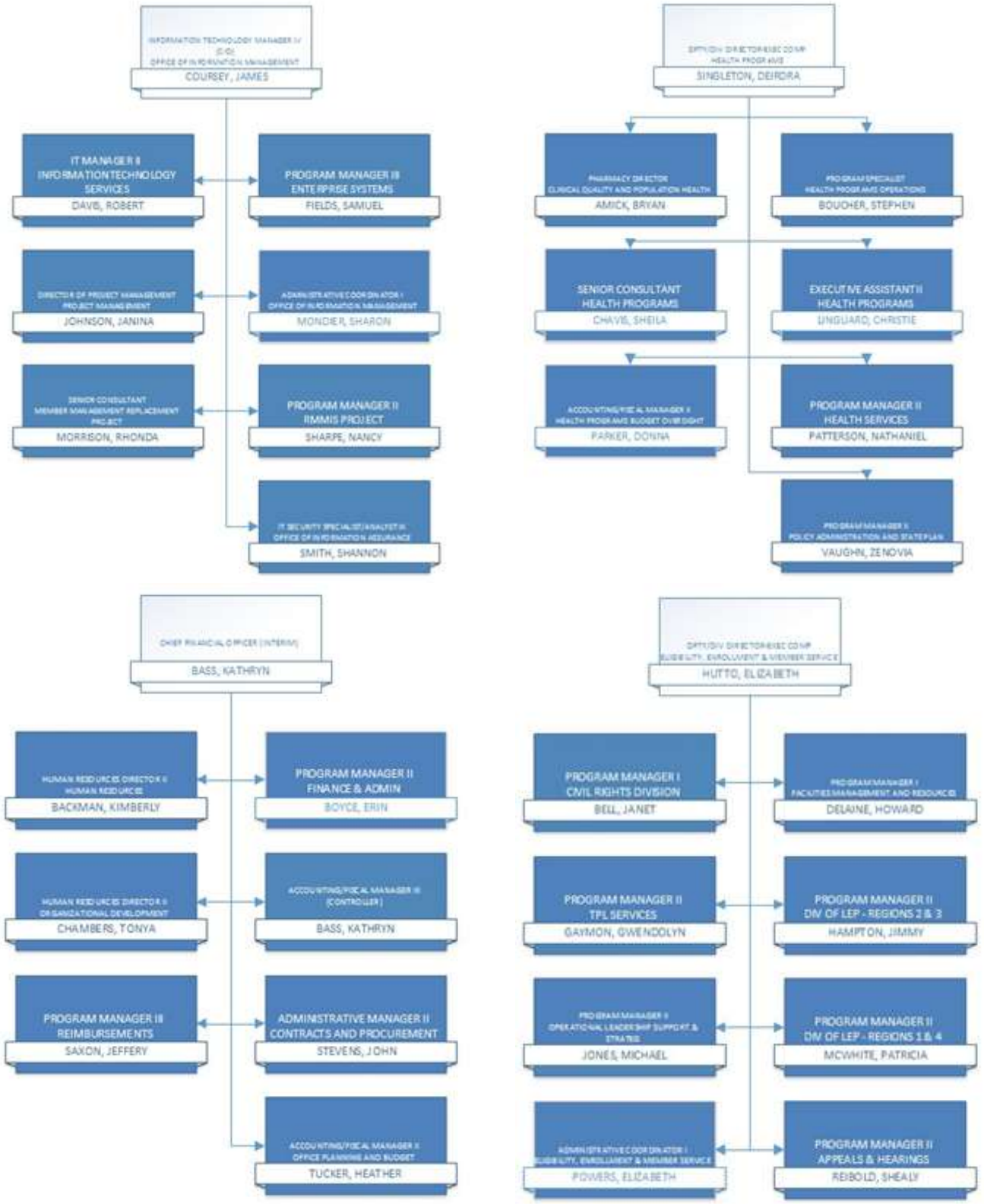

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Strategic Planning Template

Type	Goal	Item # Strat	Object	Associated Enterprise Objective	Description
G	1			Healthy and Safe Families	Provide better health outcomes for Medicaid beneficiaries
S		1.1		Healthy and Safe Families	Expand the use of value-based payment methodologies
O			1.1.1	Healthy and Safe Families	Provide at least 20% of managed care payment using a value-based approach
O			1.1.2	Healthy and Safe Families	Increase the percentage of HEDIS withhold metrics at or above the 50th percentile by 2% annually
S		1.2		Healthy and Safe Families	Build upon the success of the Birth Outcomes Initiative
O			1.2.1	Healthy and Safe Families	Reduce the rate of low birth weight babies by 3%
G	2			Government and Citizens	Provide outstanding member services
S		2.1		Government and Citizens	Use new technologies to improve the member service experience
O			2.1.1	Government and Citizens	Increase the number of online applications by 10%
S		2.2		Government and Citizens	Improve processing time and resolution rates for applications and reviews
O			2.2.1	Government and Citizens	Increase the rate of one-hour resolution for walk-in services by 10%
O			2.2.2	Government and Citizens	Increase the rates of single-touch case resolutions for applications and reviews by 10%
G	3			Government and Citizens	Promote sound fiscal stewardship
S		3.1		Government and Citizens	Develop reliable budget forecasts and mid-year correction mechanisms
O			3.1.1	Government and Citizens	Maintain General Fund expenditures within 3% of forecast
S		3.2		Government and Citizens	Control increases in healthcare spending
O			3.2.1	Government and Citizens	Keep per-member cost increases below national benchmarks
S		3.3		Government and Citizens	Prevent waste, fraud and abuse
O			3.3.1	Government and Citizens	Increase the percentage of expenditures analyzed for third-party liability by 5%
G	4			Government and Citizens	Provide responsive and responsible management of health and human service programs
S		4.1		Government and Citizens	Ensure timely handling of provider relations
O			4.1.1	Government and Citizens	Process 99% of provider applications within 30 days
O			4.1.2	Government and Citizens	Process 99% of electronic claims submissions within 14 days
S		4.2		Government and Citizens	Develop and maintain a committed and engaged workforce
O			4.2.1	Government and Citizens	Improve employee engagement scores by 5%

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Performance Measurement Template

Item	Performance Measure	FY 2015-16 Target Value	FY 2015-16 YTD Actual Value	Future Target Value	Time Applicable	Data Source and Availability	Calculation Method	Associated Objective(s)
1	Maintain General Fund Expenditures within 3% of forecast	<3%	3.50%	<3%	7/1/2015-6/30/2016	Business Objects - Monthly	((Appropriation - Actuals)/forecast)*100	3.1.1
2	Keep per-member cost increases below national benchmarks	Less than health care cost growth	PMPM Growth: 2.20% HC Cost Growth: 3.53%	Less than health care cost growth	7/1/2015-6/30/2016	Expenses from Business Objects, Eligibility from Document Direct - Monthly	PMPM - #enrolled/expenses PMPM growth = (PMPM FY16-PMPM FY1)/PMPM FY14)	3.2.1
3	Increase the percentage of expenditures analyzed for third-party liability by 5%	+5% FY 2014-15: 86%	-1% FY 2015-16: 85%	89%	7/1/2015-6/30/2016	Truven Analytics - Advantage Suite	(Expenditures Reviewed by TPL)/(Total TPL Potential)	3.3.1
4	Provide at least X% of managed care payments using value-based approach	12%	19%	20%	1/1/2015-12/31/2015 (measurements will not be available until April 2017)	MCO Attestation	Percentage of MCO claims dollars paid subject to VOC contract.	1.1.1
5	Increase the percentage of HEDIS withhold metrics at or above the 50th percentile by 2% annually	47%	55%	57%	7/1/2015-6/30/2016	MCO HEDIS submission	Number of measure above 50%/total number of measures	1.1.2
6	Reduce the rate of low birth weight babies by 3%	8.68%	7.46%	7.24%	1/1/2015-12/31/2015	Truven Analytics - Advantage Suite	Percentage of live birth deliveries with diagnosis of birth weight below 2,500 mg	1.2.1
7	Increase the rate of single-touch case resolutions for applications and reviews by 10%	10%	71%	78%	7/1/2015-6/30/2016	Pathos	Number of single-touch resolutions/total resolutions	2.2.2
8	Increase the number of online applications by 10%	74,526	54,923	60,415	7/1/2015-6/30/2016	Electronic Document Management System	Total Online Apps Submitted	2.1.1
9	Increase rate of one-hour resolution for walk-in services by 10%	+10%	78%	86%	7/1/2015-6/30/2016	Pathos	Number of one-hour resolutions/total resolutions	2.2.1
10	Process 99% of electronic claims submissions within 14 days	99+%	99.91%	99+%	7/1/2015-6/30/2016	MMIS; Document Direct	Document Direct (CLM4710R01 - Monthly Prompt Payment Compliance Report); Average of 30 Day Period % column	4.1.2
11	Process 99% of provider applications within 30 days	99+%	100.00%	99+%	7/1/2015-6/30/2016	iFlow	Applications over 30 days / Total applications	4.1.1
12	Improve employee engagement scores by 5%	49.4%	47.0%	49.4%	7/1/2015-6/30/2016	Third party engagement survey administered in fall	Calculated as part of third party engagement survey that generates an "Overall Engagement Score"	4.2.1

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Program Template

Program/Title	Purpose	FY 2015-16 Expenditures (Actual) General	Other	Federal	TOTAL	FY 2016-17 Expenditures (Projected) General	Other	Federal	TOTAL	Associated Objective(s)
I. Administration	Provides administrative support and other shared operating services for the agency.				$ -				$ -	Objective 3.1.1 - Maintain General Fund expenditures within 3% of forecast
I. Administration	Provides administrative support and other shared operating services for the agency.				$ -				$ -	Objective 3.2.1 - Keep per-member cost increases below national benchmarks
I. Administration	Provides administrative support and other shared operating services for the agency.				$ -				$ -	Objective 3.3.1 - Increase the percentage of expenditures analyzed for third-party liability by 5%
I. Administration	Provides administrative support and other shared operating services for the agency.	$ 10,062,450	$ 691,931	$ 11,638,253	$ **22,392,634**	$ 11,994,335	$ 1,474,227	$ 17,263,229	$ **30,731,791**	Objective 4.2.1 - Improve employee engagement scores by 5%
II. Programs and Services A. Health Services 1. Medical Administration	Provides administrative support and other shared operating services for the agency.				$ -				$ -	Objective 3.1.1 - Maintain General Fund expenditures within 3% of forecast
II. Programs and Services A. Health Services 1. Medical Administration	Provides administrative support and other shared operating services for the agency.	$ 10,582,251	$ 1,018,316	$ 18,359,396	$ **29,959,963**	$ 9,493,887	$ 1,449,879	$ 19,159,566	$ **30,103,332**	Objective 3.2.1 - Keep per-member cost increases below national benchmarks
II. Programs and Services A. Health Services 2. Medical Contracts	Provides contract development and management services for the Department's nursing home, Community Long Term Care, eligibility, telemedicine, clams payment, and other provider-facing programs.				$ -				$ -	Objective 2.2.1 - Increase the rate of one-hour resolution for walk-in services by 10%
II. Programs and Services A. Health Services 2. Medical Contracts	Provides contract development and management services for the Department's nursing home, Community Long Term Care, eligibility, telemedicine, clams payment, and other provider-facing programs.				$ -				$ -	Objective 2.2.2 - Increase the rates of single-touch case resolutions for applications and reviews by 10%
II. Programs and Services A. Health Services 2. Medical Contracts	Provides contract development and management services for the Department's nursing home, Community Long Term Care, eligibility, telemedicine, clams payment, and other provider-facing programs.				$ -				$ -	Objective 4.1.1 - Process 99% of provider applications within 30 days
II. Programs and Services A. Health Services 2. Medical Contracts	Provides contract development and management services for the Department's nursing home, Community Long Term Care, eligibility, telemedicine, claims payment, and other provider-facing programs.	$ 89,291,231	$ 26,376,883	$ 129,704,758	$ **245,372,872**	$ 63,027,792	$ 65,737,407	$ 179,008,826	$ **307,774,025**	Objective 4.1.2 - Process 99% of electronic claims submissions within 14 days

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Program Template

Program/Title	Purpose	FY 2015-16 Expenditures (Actual) General	Other	Federal	TOTAL	FY 2016-17 Expenditures (Projected) General	Other	Federal	TOTAL	Associated Objective(s)
II. Programs and Services A. Health Services 3. Medical Assistance Payment - Case Services	Finances a broad range of inpatient and outpatient services through both the fee-for-service and managed care programs, including for nursing homes, pharmaceuticals, hospital and physician services, dental, Community Long Term Care, home health, EPSDT, medical professionals, transportation, laboratory and radiology, family planning, Medicare premium matching/payments, hospice, clinical, durable medical equipment, behavioral health, and other related services.				$ -				$ -	Objective 1.1.1 - Provide at least 12% of managed care payments using a value-based approach
II. Programs and Services A. Health Services 3. Medical Assistance Payment - Case Services	Finances a broad range of inpatient and outpatient services through both the fee-for-service and managed care programs, including for nursing homes, pharmaceuticals, hospital and physician services, dental, Community Long Term Care, home health, EPSDT, medical professionals, transportation, laboratory and radiology, family planning, Medicare premium matching/payments, hospice, clinical, durable medical equipment, behavioral health, and other related services.				$ -				$ -	Objective 1.1.2 - Increase the percentage of HEDIS withhold metrics at or above the 50th percentile by 2% annually
II. Programs and Services A. Health Services 3. Medical Assistance Payment - Case Services	Finances a broad range of inpatient and outpatient services through both the fee-for-service and managed care programs, including for nursing homes, pharmaceuticals, hospital and physician services, dental, Community Long Term Care, home health, EPSDT, medical professionals, transportation, laboratory and radiology, family planning, Medicare premium matching/payments, hospice, clinical, durable medical equipment, behavioral health, and other related services.	$ 1,069,868,700	$ 449,562,392	$ 3,554,765,692	**$ 5,074,265,984**	$ 1,146,303,610	$ 468,495,577	$ 3,798,382,670	**$ 5,413,181,857**	Objective 1.2.1 - Reduce the rate of low birth weight babies by 3%

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Program Template

Program/Title	Purpose	FY 2015-16 Expenditures (Actual) General	Other	Federal	TOTAL	FY 2016-17 Expenditures (Projected) General	Other	Federal	TOTAL	Associated Objective(s)
II. Programs and Services A. Health Services 4. Assistance Payments - State Agencies	Finances services that are provided by or through other state agencies, such as to the disabled and special needs population, for child health, chronic disease control, STI treatment, women's health, emergency medical services, outpatient and rehabilitative behavioral health, case management and clinical services, alcohol and other substance use treatment, school-based services, etc.	$ 225,086	$ 236,086,478	$ 583,138,090	**$ 819,449,654**	$ 225,086	$ 263,986,154	$ 651,757,692	**$ 915,968,932**	Objective 1.2.1 - Reduce the rate of low birth weight babies by 3%
II. Programs and Services* A. Health Services 6. Other Entities - Assistance Payments	Provides payment to qualifying hospitals for the unreimbursed cost of providing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals (DSH Program).		$ 157,894,910	$ 385,974,607	**$ 543,869,517**	$ 18,628,621	$ 166,808,737	$ 411,484,684	**$ 596,922,042**	None
II. Programs and Services A. Health Services 7. Medicaid Eligibility	Process applications, annual reviews, and other eligibility changes and member services for the program's applicants and beneficiaries.				**$ -**				**$ -**	Objective 2.1.1 - Increase the number of online applications by 10%
II. Programs and Services A. Health Services 7. Medicaid Eligibility	Process applications, annual reviews, and other eligibility changes and member services for the program's applicants and beneficiaries.				**$ -**				**$ -**	Objective 2.2.1 - Increase the rate of one-hour resolution for walk-in services by 10%
II. Programs and Services A. Health Services 7. Medicaid Eligibility	Process applications, annual reviews, and other eligibility changes and member services for the program's applicants and beneficiaries.	$ 5,460,934	$ 2,050,727	$ 15,746,072	**$ 23,257,733**	$ 14,816,850	$ 4,512,197	$ 22,541,330	**$ 41,870,377**	Objective 2.2.2 - Increase the rates of single-touch case resolutions for applications and reviews by 10%
III. Employee Benefits C. State Employer Contributions	Provide fringe & benefits for SCDHHS employees.	$ 5,397,087	$ 757,951	$ 11,230,591	**$ 17,385,629**	$ 6,525,419	$ 1,678,538	$ 9,520,840	**$ 17,724,797**	Objective 4.2.1 - Improve employee engagement scores by 5%

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Item #	Law Number	Jurisdiction	Type of Law	Statuary Requirement and/or Authority Granted	Associated Program(s)
1	44-6-5; 44-6-10	State	Statute	Establishes the State Department of Health and Human Services which shall be headed by a Director appointed by the	I. Administration
2	44-6-30	State	Statute	Establishes DHHS' authority to administer Title XIX of the Social Security Act (Medicaid), including the EPSDT Program and	I. Administration
3	44-6-35	State	Statute	Establishes Medicaid waiver protections for eligible family members of a member of the armed services who maintains his South Carolina state residence, regardless of where the service member is stationed.	II. A. 7. Medicaid Eligibility
4	44-6-40	State	Statute	Establishes the Department's duties for all health and human services interagency programs.	II. A. 4. Assistance Payments - State Agencies
5	44-6-45	State	Statute	Establishes the authority of DHHS to collect administrative fees associated with accounts receivable for those individuals or	I. Administration
6	44-6-50	State	Statute	Establishes that the Department will carry out certain duties through contracts in accordance with the South Carolina Consolidated Procurement Code.	I. Administration; II. A. 2. Medical Contracts
7	44-6-70	State	Statute	Requires DHHS to prepare a state plan for each program assigned to it and prepare resource allocation recommendations	I. Administration
8	44-6-80	State	Statute	Requires the Department to submit to the Governor, the State Budget and Control Board, and the General Assembly an	I. Administration
9	44-6-90	State	Statute	Authorizes the Department to promulgate regulations to carry out its duties. Requires all state and local agencies whose responsibilities include administration or delivery of services which are covered by Title 44, Chapter 6 to cooperate with the Department and comply with its regulations.	I. Administration; II. A. 4. Assistance Payments - State Agencies
10	44-6-100	State	Statute	Establishes the Director as the chief administrative officer of the department responsible for executing policies, directives,	I. Administration
11	44-6-132; 44-6-135	State	Statute	Medically Indigent Assistance Act; Legislative Intent and Findings.	I. Administration
12	44-6-140	State	Statute	Establishes the Medicaid hospital prospective payment system and cost containment measures.	Administration; II. A. 6. Other Entities - Assistance Payments
13	44-6-146	State	Statute	Establishes County assessments for indigent medical care and penalties for failure to pay assessments in timely manner.	Administration; II. A. 6. Other Entities - Assistance Payments
14	44-6-150	State	Statute	Creates the Medically Indigent Assistance Program to be administered by the Department. The program is authorized to sponsor inpatient hospital care for which hospitals shall receive no reimbursement.	Administration; II. A. 6. Other Entities - Assistance Payments
15	44-6-155	State	Statute	Creates the Medicaid Expansion Fund. Monies in the fund must be used to: (1) provide Medicaid coverage to pregnant women and infants with family incomes above one hundred percent but below one hundred eighty-five percent of the	Administration; II. A. 7. Medicaid Eligibility
16	44-6-160	State	Statute	Requires the Department, by August first of each year, to compute and publish the annual target rate of increase for net	I. Administration
17	44-6-180	State	Statute	Patient records received by the Department, as well as counties and other entities involved in the administration of the	I. Administration
18	44-6-190	State	Statute	Establishes that the Department may promulgate regulations pursuant to the Administrative Procedures Act and appeals	I. Administration
19	44-6-200	State	Statute	Criminal penalties for falsification of information regarding MIAP.	I. Administration
20	44-6-220	State	Statute	Establishes notice requirements on nursing home admission applications regarding eligibility for Medicaid-sponsored long-term care services.	II. A. 7. Medicaid Eligibility
21	44-6-300	State	Statute	Requires the Department to establish child development services in certain counties.	I. Administration
22	44-6-310	State	Statute	Requires the Department to expand child development services in certain counties.	I. Administration
23	44-6-320	State	Statute	Requires the establishment and expansion of the child development services to be accomplished within the limits of the	I. Administration

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24	44-6-400	State	Statute	Definitions for the Intermediate Sanctions For Medicaid Certified Nursing Home Act.	I. Administration
25	44-6-420	State	Statute	Authorizes the Department to take certain enforcement action when it is notified by DHEC that a nursing home is in	I. Administration
26	44-6-470	State	Statute	Specifies the use of funds collected by the department as a result of the imposition of civil monetary penalties or other	I. Administration
27	44-6-530	State	Statute	Before instituting an action against a nursing home, requires the Department to determine if the Secretary of the United	I. Administration
28	44-6-540	State	Statute	Authorizes the Department to promulgate regulations, pursuant to the Administrative Procedures Act, to administer	I. Administration
29	44-6-630	State	Statute	Creates within the Department the Gap Assistance Pharmacy Program for Seniors (GAPS) program. The purpose of this program is to coordinate, beginning January 1, 2006, with Medicare Part D Prescription Drug Plans to provide to low-	I. Administration; II. A. 7. Medicaid Eligibility
30	44-6-640	State	Statute	Establishes that the Department may designate, or enter into contracts with, other entities including, but not limited to,	I. Administration
31	44-6-650	State	Statute	Establishes the eligibility requirements and benefits available under the GAPS program.	I. Administration
32	44-6-660	State	Statute	Requires the Department to maintain data to allow evaluation of the cost effectiveness of the GAPS program and to	I. Administration
33	44-6-710	State	Statute	Requires the Medicaid application for nursing home care of a person deemed ineligible because of Medicaid qualifying trust to be treated as an undue hardship case.	I. Administration; II. A. 7. Medicaid Eligibility
34	44-6-720	State	Statute	Establishes requirements for qualifying for undue hardship waiver.	I. Administration; II. A. 7. Medicaid Eligibility
35	44-6-725	State	Statute	Establishes that certain promissory notes received by a Medicaid applicant or recipient or the spouse of a Medicaid applicant or recipient shall, for Medicaid eligibility purposes, be deemed to be fully negotiable under the laws of this State	I. Administration; II. A. 7. Medicaid Eligibility
36	44-6-730	State	Statute	Authorizes the Department to promulgate regulations to implement the article and comply with federal law and amend the state Medicaid plan consistent with article ("Trusts and Medicaid Eligibility").	I. Administration; II. A. 7. Medicaid Eligibility
37	44-6-610 to 630	State	Statute	Definitions and creation of the GAPS program.	I. Administration; II. A. 7. Medicaid Eligibility
38	44-6-910	State	Statute	Recognition of FQHCs, RHCs and Rural Hospitals.	I. Administration; II. A. Health Services
39	44-6-1010	State	Statute	Establishes the Pharmacy and Therapeutics Committee within the Department of Health and Human Services and describes	I. Administration
40	44-6-1020	State	Statute	Requires the P&T Committee to adopt bylaws, elect a chairman and vice chairman; establishes rules regarding	I. Administration
41	44-6-1030	State	Statute	Requires the P&T committee to recommend to the Department therapeutic classes of drugs that should be included on a	I. Administration
42	44-6-1040	State	Statute	Establishes certain procedures to be included in any preferred drug list program administered by the Department.	I. Administration; II. A. Health Services
43	44-6-1050	State	Statute	Establishes rules regarding the granting of prior authorization for a drug and establishes that a Medicaid recipient who has been denied prior authorization for a prescribed drug is entitled to appeal this decision through the Department's appeals	I. Administration; II. A. Health Services
44	43-7-50	State	Statute	Establishes that payments for professional services under the State Medicaid Program shall be uniform within the State.	I. Administration; II. A. Health Services
45	43-7-60	State	Statute	Establishes that a false claim, statement, or representation by a medical provider is a misdemeanor and sets out penalties for violations.	I. Administration; II. A. Health Services
46	43-7-70	State	Statute	Establishes that a false statement or representation on application for assistance under the Medicaid program is a misdemeanor and sets out penalties for violations.	I. Administration; II. A. 7. Medicaid Eligibility
47	43-7-80	State	Statute	Establishes that Medicaid providers are required to keep separate accounts for patient funds and maintain records of such	I. Administration

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48	43-7-410	State	Statute	Assignment and subrogation of claims for reimbursement for Medicaid services; definitions.	I. Administration; II. A. Health Services
49	43-7-420	State	Statute	Establishes that Medicaid applicants and recipients are considered to have assigned their right to recover an amount paid by Medicaid from a third party or private insurer to the department. Also that the receipt of medical assistance by an	I. Administration; II. A. 7. Medicaid Eligibility
50	43-7-430	State	Statute	Establishes the subrogation of rights to the Department. The Department automatically is subrogated, only to the extent	I. Administration
51	43-7-440	State	Statute	Establishes the enforcement and superiority of the Department's subrogation rights. Requires provider assistance in identification of third parties liable for medical costs. Renders ineffective certain insurance provisions.	I. Administration; II. A. Health Services
52	43-7-450	State	Statute	Assignment and subrogation of claims for reimbursement for Medicaid services; claims or actions pending or brought	I. Administration
53	43-7-460	State	Statute	Establishes the Department's obligation to recovery of medical assistance paid under the Title XIX State Plan for Medical Assistance from estates of certain individuals.	I. Administration; II. A. 7. Medicaid Eligibility
54	43-7-465	State	Statute	Establishes requirements for insurers doing business in the State that provide coverage to persons receiving Medicaid	I. Administration
55	44-7-80 through 44-7-90	State	Statute	Establishes the Medicaid Nursing Home Permits rules.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services
56	1-1-1035	State	Statute	Establishes that no state funds or Medicaid funds shall be expended to perform abortions, except for those abortions	I. Administration
57	12-23-840	State	Statute	Revenues derived under Article 11 (Indigent Health Care) of Title 12 of Chapter 23 of the Code must be deposited in the Medicaid Expansion Fund created by Section 44-6-155. In addition to the purposes specified in Section 44-6-155, monies in	I. Administration; II. A. 7. Medicaid Eligibility
58	9-1-1870	State	Statute	With one exception, retirees and beneficiaries under the State Retirement Systems receiving Medicaid (Title XIX) sponsored nursing home care as of June thirtieth of the prior fiscal year shall receive no increase in retirement benefits during the current fiscal year. The exception is for a retired employee who is discharged from the nursing home and does not require admission to a hospital or nursing home within six months.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services
59	9-11-315	State	Statute	With one exception, retirees and beneficiaries under the Police Officers Retirement System receiving Medicaid (Title XIX) sponsored nursing home care as of June thirtieth of the prior fiscal year shall receive no increase in retirement benefits during the current fiscal year. The exception is for a retired employee who is discharged from the nursing home and does not require admission to a hospital or nursing home within six months.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services
60	40-43-86(H)(6)	State	Statute	A Medicaid recipient whose prescription is reimbursed by the South Carolina Medicaid Program is deemed to have consented to the substitution of a less costly equivalent generic drug product.	I. Administration; II. A. Health Services
61	62-7-503	State	Statute	Makes the spendthrift exception unenforceable against a special needs trust, supplemental needs trust, or similar trust established for a disabled person if the applicability of such a provision could invalidate such a trust's exemption from	I. Administration; II. A. 7. Medicaid Eligibility
62	11-7-40	State	Statute	Establishes that the Department is responsible for fifty percent of the costs incurred by the State Auditor in conducting the medical assistance audit. The amount billed by the State Auditor must include those appropriated salary adjustments and	I. Administration; II. A. Health Services
63	12-21-625	State	Statute	Describes the portion of the cigarette tax to be deposited in the South Carolina Medicaid Reserve Fund created pursuant to	I. Administration
64	59-123-60	State	Statute	Requires certain state appropriations to the Department to be used as match funds for the disproportionate share for the MUSC's federal program. Any excess funding may be used for hospital base rate increases. The Department must pay to the Medical University of South Carolina Hospital Authority an amount equal to the amount appropriated for its	I. Administration; II. A. 6. Other Entities - Assistance Payments
65	44-6-110 (effective Jan. 1, 2017)	State	Statute	A Medicaid provider, outside of the geographical boundary of South Carolina but within the South Carolina Medicaid	I. Administration

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66	38-71-2110(B)	State	Statute	Exempts the Department from Article 20, Chapter 71 of Title 38 of the SC Code, which provides procedures governing the maximum allowable cost reimbursements for generic prescription drugs by pharmacy benefit managers.	I. Administration; II. A. Health Services
67	58-23-1610	State	Statute	A transportation network company does not include transportation services provided pursuant to Articles 1 through 15, Chapter 23, Title 58, or arranging nonemergency medical transportation for individuals qualifying for Medicaid or Medicare	I. Administration; II. A. Health Services
68	11-5-400; 11-5-440(F)(2)	State	Statute	Establishes the 'South Carolina ABLE Savings Program'. The purpose of the South Carolina ABLE Savings Program is to authorize the establishment of savings accounts empowering individuals with a disability and their families to save private	I. Administration; II. A. 7. Medicaid Eligibility
69	Reg. 126-125	State	Regulation	Requires the Department to administer its programs without discrimination.	I. Administration
70	Regs. 126-150 through 126-158	State	Regulation	Establishes rules for the Department's appeals and hearings.	I. Administration
71	Regs. 126-170 through 126-175	State	Regulation	Establishes rules for the safeguarding and disclosure of Department-held client information.	I. Administration
72	Regs. 126-300 through 126-335	State	Regulation	Establishes the scope of the Medicaid program including services available under the program.	I. Administration
73	Regs. 126-350 through 126-399	State	Regulation	Establishes the application procedures and the general requirements for Medicaid eligibility.	I. Administration; II. A. 7. Medicaid Eligibility
74	Regs. 126-400 through 126-405	State	Regulation	Describes the administrative sanctions that may be invoked by the Department against Medicaid providers.	I. Administration
75	Reg. 126-425	State	Regulation	Establishes program integrity rules designed to safeguard against unnecessary, harmful, wasteful, and uncoordinated	I. Administration
76	Regs. 126-500 through 126-515	State	Regulation	Describes eligibility requirements for the Medically Indigent Assistance Program (MIAP).	I. Administration; II. A. 7. Medicaid Eligibility
77	Regs. 126-530 through 126-540	State	Regulation	Describes the services covered by the Medically Indigent Assistance Program (MIAP).	I. Administration; II. A. Health Services
78	Reg. 126-560	State	Regulation	Establishes the payment process to reimburse hospitals for inpatient services provided to Medically Indigent recipients.	I. Administration; II. A. 6. Other Entities - Assistance Payments
79	Reg. 126-570	State	Regulation	Establishes the grace period for County assessments for indigent medical care in accordance with the provisions of 44-6-146(C).	I. Administration; II. A. 6. Other Entities - Assistance Payments
80	Regs. 126-710 through 126-799	State	Regulation	Establishes rules regarding the administration of Social Services Block Grants under Title XX of the Social Security Act.	I. Administration
81	Regs. 126-800 through 126-850	State	Regulation	Establishes intermediate sanctions for Medicaid certified nursing facilities. Establishes that the Administrator, or his designee, of the State Medicaid Agency may invoke certain sanctions against a Medicaid nursing facility which has failed to correct deficiencies or make acceptable progress toward correction of deficiencies.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services
82	Regs. 126-910 through 126-940	State	Regulation	Establishes eligibility rules for individuals to participate in the Optional State Supplementation (OSS) program as well as rules for the Department in administering the OSS program.	I. Administration; II. A. 7. Medicaid Eligibility
83	Proviso 33.1 (Recoupment/Restricted Fund)	State	Proviso	Establishes a restricted fund for recoupments and overpayments and specifies the allowable uses of that fund.	I. Administration
84	Proviso 33.2 (Long Term Care Facility Reimbursement Rate)	State	Proviso	Establishes procedures for calculating reimbursements for long-term care facilities.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services

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85	Proviso 33.3 (Medical Assistance Audit Program Remittance)	State	Proviso	Directs the Department to make monthly remittances to the State Auditor's Office to support Medical Assistance audits.	I. Administration
86	Proviso 33.4 (Third Party Liability Collection)	State	Proviso	Allows the Department to fund Third Party Liability and Drug Rebate collection efforts from the monies collected in those efforts.	I. Administration
87	Proviso 33.5 (Medicaid State Plan)	State	Proviso	Establishes the circumstances under which the Department may bill other state agencies for state matching funds.	I. Administration; II. A. 4. Assistance Payments - State Agencies
88	Proviso 33.6 (Medically Indigent Assistance Fund)	State	Proviso	Makes DSH-receiving hospitals liable for any audit exceptions relating to their receipt or expenditure of DSH funds.	I. Administration: II. A. 6. Other Entities - Assistance Payments
89	Proviso 33.7 (Registration Fees)	State	Proviso	Authorizes the Department to receive and expend registration fees for educational, training, and certification programs.	I. Administration
90	Proviso 33.8 (Fraud and Abuse Collections)	State	Proviso	Authorizes the Department to offset the administrative costs associated with controlling fraud and abuse.	I. Administration
91	Proviso 33.9 (Medicaid Eligibility Transfer)	State	Proviso	Transfers responsibility for Medicaid eligibility from DSS to HHS and requires that counties provide facilities for this work, as they do for DSS.	I. Administration: II. A. 7. Medicaid Eligibility
92	Proviso 33.10 (Franchise Fees Suspension)	State	Proviso	Suspends franchise fees imposed on nursing home beds.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services
93	Proviso 33.11 (Program Integrity Efforts)	State	Proviso	Directs the Department to expand its program integrity efforts by utilizing resources both within and external to the agency including, but not limited to, the ability to contract with other entities for the purpose of maximizing the	I. Administration
94	Proviso 33.12 (Post Payment Review)	State	Proviso	Requires post-payment reviews to ensure compliance with the Hyde Amendment.	I. Administration; II. A. Health Services
95	Proviso 33.13 (Long Term Care Facility Reimbursement Rates)	State	Proviso	Requires that HHS submit its long-term care facility reimbursement state plan amendment to CMS by August 15th each year.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services
96	Proviso 33.14 (Nursing Services to High Risk/High Tech Children)	State	Proviso	Requires a separate classification and compensation plan for Registered Nurses (RN) and Licensed Practical Nurses (LPN) who provide services to Medically Fragile Children and others.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services
97	Proviso 33.15 (SCHIP Enrollment and Recertification)	State	Proviso	Directs the Department to enroll and recertify eligible children for the Children's Health Insurance Program (CHIP) using various sources of information from other state agencies.	I. Administration; II. A. 7. Medicaid Eligibility
98	Proviso 33.16 (Carry Forward)	State	Proviso	Allows the Department to carry forward funds from earmarked and restricted sources and establishes relevant reporting	I. Administration
99	Proviso 33.17 (Medicaid Provider Fraud)	State	Proviso	Directs the Department to expand and increase its effort to identify, report, and combat Medicaid provider fraud and requires annual reporting.	I. Administration
100	Proviso 33.18 (GAPS)	State	Proviso	Suspends the GAPS program.	I. Administration

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101	Proviso 33.20 (Contract Authority)	State	Proviso	Authorizes the Department to contract with community-based not-for-profit organizations for local projects that further the objectives of the Department's programs.	I. Administration; II. A. 2. Medical Contracts
102	Proviso 33.21 (Medicaid Accountability and Quality Improvement Initiative)	State	Proviso	Establishes the Healthy Outcomes Initiative, increases DSH payments to rural hospitals, promotes telemedicine, and directs expenditures to safety net and other providers.	I. Administration; II. A. 6. Other Entities - Assistance Payments
103	Proviso 33.22 (Medicaid Healthcare Initiatives Outcomes)	State	Proviso	Requires that the Director of the Department of Health and Human Services present to the House Ways and Means Healthcare Budget Subcommittee on the outcomes of Medicaid healthcare initiatives by February 15th.	I. Administration
104	Proviso 33.23 (Carry Forward Authorization)	State	Proviso	Allows the Department to carry-forward General Fund balances.	I. Administration
105	Proviso 33.27 (Rural Health Initiative)	State	Proviso	Establishes a Rural Health Initiative to promote rural healthcare and education, along with workforce development for rural medicine.	I. Administration; II. A. 6. Other Entities - Assistance Payments
106	Proviso 117.9 (Transfers of Appropriations)	State	Proviso	Sets rules for transferring appropriations within programs.	I. Administration
107	Proviso 117.10 (Federal Funds - DHEC, DSS, DHHS - Disallowances)	State	Proviso	Allows DSS, DHEC, and HHS to use current-year funds for certain prior-year purposes.	I. Administration
108	Proviso 117.13 (Discrimination Policy)	State	Proviso	Agencies must submit employment reports to the State Human Affairs Commission by October 31st.	I. Administration
109	Proviso 117.14 (Personal Service Reconciliation)	State	Proviso	Defines the process through which FTEs are tracked and allocated.	I. Administration
110	Proviso 117.18 (Business Expense Reimbursement)	State	Proviso	DOA to promulgate regulations governing business travel expenses for department heads and deputies.	I. Administration
111	Proviso 117.20 (Travel - Subsistence Expenses and Mileage)	State	Proviso	Outlines state employee travel reimbursement policies.	I. Administration
112	Proviso 117.23 (Carry Forward)	State	Proviso	Allows agencies to carry-forward 10% of their General Fund appropriations; sets procedures for sweeping these accounts, if necessary in a recession.	I. Administration
113	Proviso 117.24 (TEFRA)	State	Proviso	Directs HHS to amend the State Plan to exercise the TEFRA eligibility option and other agencies to identify potential sources of state match.	I. Administration; II. A. 4. Assistance Payments - State Agencies
114	Proviso 117.29 (Base Budget Analysis)	State	Proviso	Agencies must submit accountability reports by September 15th.	I. Administration
115	Proviso 117.30 (Collection on Dishonored Payments)	State	Proviso	Agencies may collect service charges for payments dishonored for insufficient funds.	I. Administration
116	Proviso 117.32 (Voluntary Separation Incentive Program)	State	Proviso	Sets parameters through which agencies may establish voluntary separation incentives, subject to DOA approval.	I. Administration; III. Employee Benefits

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117	Proviso 117.34 (Debt Collection Reports)	State	Proviso	Agencies must submit debt collection reports by the end of February.	I. Administration
118	Proviso 117.36 (Tobacco Settlement Funds Carry Forward)	State	Proviso	Agencies may carry-forward Tobacco Settlement Agreement funds.	I. Administration
119	Proviso 117.45 (Parking Fees)	State	Proviso	Agencies may not increase or impose new parking fees for employees.	I. Administration
120	Proviso 117.47 (Insurance Claims)	State	Proviso	Agencies may use insurance reimbursements to offset expenses related to the claim and may carry-forward these funds.	I. Administration
121	Proviso 117.48 (Organizational Charts)	State	Proviso	Agencies must file organization charts by September 1st and when making changes that affect grievance rights.	I. Administration
122	Proviso 117.49 (Agencies Affected by Restructuring)	State	Proviso	Defines the process for making accounting changes when agencies are restructured.	I. Administration
123	Proviso 117.50 (Agency Administrative Support Collaboration)	State	Proviso	Agencies should pursue cost savings through shared services efforts.	I. Administration
124	Proviso 117.55 (Employee Bonuses)	State	Proviso	Sets limits on employee bonuses and sets reporting requirements.	I. Administration; III. C. State Employer Contributions
125	Proviso 117.58 (Year-End Financial Statements - Penalties)	State	Proviso	Sets deadlines for agencies to submit financial statements to the Comptroller General.	I. Administration
126	Proviso 117.59 (Purchase Card Incentives)	State	Proviso	Agencies that receive incentive rebate premiums for using the purchasing card may retain those funds.	I. Administration
127	Proviso 117.64 (Attorney Dues)	State	Proviso	Agencies employing attorneys may use their funds to pay SC Bar Association dues.	I. Administration
128	Proviso 117.65 (Healthcare Employee Recruitment and Retention)	State	Proviso	Allows certain agencies to pay bonuses, educational leave, loan repayments, and tuition for healthcare workers under specific conditions.	I. Administration; III. C. State Employer Contributions
129	Proviso 117.68 (Voluntary Furlough)	State	Proviso	Agencies may create voluntary furlough programs	I. Administration; III. C. State Employer Contributions
130	Proviso 117.70 (Reduction in Force Antidiscrimination)	State	Proviso	Agencies can't discriminate when applying reductions in force.	I. Administration
131	Proviso 117.71 (Reduction in Force/Agency Head Furlough)	State	Proviso	Agency heads must take a five-day furlough in fiscal years when they apply reductions in force, with certain exceptions.	I. Administration
132	Proviso 117.73 (IMD Operations)	State	Proviso	Funds used prior to 2006 for behavioral health services for children in group homes and other institutional settings must still be used for out-of-home placements; creates associated reporting requirements.	I. Administration

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133	Proviso 117.75 (Mandatory Furlough)	State	Proviso	Defines the rules governing mandatory employee furloughs.	I. Administration; III. C. State Employer Contributions
134	Proviso 117.76 (Reduction in Force)	State	Proviso	When RIFs occur, agencies should focus on letting contractors, TERI, and post-TERI employees go first.	I. Administration
135	Proviso 117.77 (Cost Saving When Filling Vacancies Created by Retirements)	State	Proviso	Agencies should eliminate 1/4 of the cost associated with positions made vacant by retirement.	I. Administration
136	Proviso 117.78 (Information Technology for Health Care)	State	Proviso	Establishes the intended use of funds awarded to HHS under the HITECH Act.	I. Administration
137	Proviso 117.80 (Reduction in Compensation)	State	Proviso	Agencies can't discpline or give pay reductions to employees solely for providing sworn testimony to legislative committees.	I. Administration; III. C. State Employer Contributions
138	Proviso 117.81 (Deficit Monitoring)	State	Proviso	Defines the Executive Budget Office's quarterly deficit monitoring program.	I. Administration
139	Proviso 117.82 (Commuting Costs)	State	Proviso	Provides restrictions on the use of state vehicles for employees' commuting purposes.	I. Administration
140	Proviso 117.83 (Bank Account Transparency and Accountability)	State	Proviso	Agencies must provide detailed reports on non-SCEIS bank accounts by October 1st.	I. Administration
141	Proviso 117.84 (Websites)	State	Proviso	Agency websites must link to another agency's website that posts procurement card spending reports?	I. Administration
142	Proviso 117.85 (Regulations)	State	Proviso	Joint Resolutions for regulations that raise or establish fees must state this in their titles.	I. Administration
143	Proviso 118.88 (Recovery Audits)	State	Proviso	Requires state agencies to participate in recovery audit program and cooperate and provide necessary information in a timely manner.	I. Administration
144	Proviso 117.90 (Opt out of Affordable Care Act)	State	Proviso	Opts-out of specific provisions of the Patient Protection and Affordable Care Act, where permissible.	I. Administration
145	Proviso 117.91 (Means Test)	State	Proviso	Agencies providing healthcare services are to apply means tests and report on these criteria and collections by January 1st.	I. Administration
146	Proviso 117.92 (Agency Reduction Management)	State	Proviso	In the event of a base reduction, agencies are to realize savings through furloughs, reductions in employee compensation, hiring freezes, elimination of administrative overhead, and as a final option, reductions to programmatic funding.	I. Administration; III. 3. State Employer Contributions
147	Proviso 117.98 (First Steps - Baby Net)	State	Proviso	Imposes reporting requirements on First Steps, largely related to compliance with recent LAC reports.	I. Administration
148	Proviso 117.107 (Data Breach Notification)	State	Proviso	Creates notification requirements in the event of a data breach.	I. Administration
149	Proviso 117.114 (Information Technology and Information Security Plans)	State	Proviso	Agencies must file IT and information security plans by October 1st.	I. Administration

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Legal Standards Template

Item #	Law Number	Jurisdiction	Type of Law	Statuary Requirement and/or Authority Granted	Associated Program(s)
150	Proviso 117.118 (Employee Compensation)	State	Proviso	Directs employee pay raise of 3.25% for FY 2016-17.	I. Administration; III. Employee Benefits
151	Proviso 117.133 (Statewide Strategic Information Technology Plan Implementation)	State	Proviso	Directs state agencies to provide information/comply with the Statewide Strategic Information Technology Plan Implementation.	I. Administration
152	Proviso 117.137 (State Employee Leave Donation)	State	Proviso	Replaces previous rules for donating annual and sick leave.	I. Administration; III. Employee Benefits
153	Proviso 118.1 (Year End Cutoff)	State	Proviso	Sets accounting rules for fiscal year-end.	I. Administration
154	Proviso 118.5 (Health Care Maintenance of Effort Funding)	State	Proviso	Directs the proceeds of the $0.50 cigarette surcharge and applies those funds to Medicaid.	I. Administration
155	Proviso 118.6 (Prohibits Public Funded Lobbyists)	State	Proviso	Agencies may not use General Funds to pay lobbyists.	I. Administration
156	Proviso 118.11 (Tobacco Settlement)	State	Proviso	Allocates funds received through the Tobacco Master Settlement Agreement.	I. Administration
157	Proviso 118.16 (Non-recurring Revenue)	State	Proviso	Appropriates non-recurring revenues.	I. Administration
158	Title XIX and XXI of the Social Security Act	Federal	Statute	Authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed	I. Administration
159	42 CFR 430.0 - 430.104	Federal	Regulation	Establishes regulations regarding the Medicaid State Plan, federal deferrals and disallowances, reduction of Federal	I. Administration
160	42 CFR 431.1 - 431.1002	Federal	Regulation	Establishes regulations regarding State organization and general administration of the Medicaid program including rules on	I. Administration
161	42 CFR 432.1 - 432.55	Federal	Regulation	Establishes regulations regarding the Department's personnel administration including available federal financial participation for staffing and training.	I. Administration; III. Employee Benefits
162	42 CFR 433.1 - 433.322	Federal	Regulation	Establishes regulations regarding the Department's fiscal administration of the Medicaid program including matching	I. Administration
163	42 CFR 434.1 - 434.78	Federal	Regulation	Establishes general provisions regarding Department contracts including conditions for federal financial participation.	I. Administration; II. A. 2. Medical Contracts
164	42 CFR 435.2 - 435.1205	Federal	Regulation	Establishes regulations regarding eligibility to participate in the Medicaid program including mandatory and optional coverage groups, general financial eligibility requirements, certain post-eligibility financial requirements, and federal financial participation available for expenditures in determining eligibility and providing services.	I. Administration; II. A. Health Services; II. A. 7. Medicaid Eligibility
165	42 CFR 438.1 - 438.812	Federal	Regulation	Establishes regulations regarding the administration of the Medicaid program through managed care entities.	I. Administration; II. A. Health Services
166	42 CFR 440.1 - 440.390	Federal	Regulation	Establishes regulations regarding the services available under the Medicaid program including definitions, requirements	I. Administration
167	42 CFR 441.1 - 441.745	Federal	Regulation	Establishes requirements and limits applicable to specific services.	I. Administration; II. A. Health Services
168	42 CFR 442.1 - 442.119	Federal	Regulation	Establishes standards for payment to nursing facilities and intermediate care facilities for individuals with intellectual disabilities.	I. Administration; II. A. 3. Medical Assistance Payment - Case Services

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Item #	Law Number	Jurisdiction	Type of Law	Statuary Requirement and/or Authority Granted	Associated Program(s)
169	42 CFR 447.1 - 447.520	Federal	Regulation	Establishes regulations regarding the Department's payment for services including payment methods, payment for inpatient hospital and long term care facility services, payment adjustments for hospitals that serve a disproportionate number of low-income patients, payment methods for other institutional and non-institutional services, payments for primary care services provided by physicians, and payment for drugs.	I. Administration; II. A. 2. Medical Contracts; II. A. 6. Other Entities - Assistance Payments
170	42 CFR 455.1 - 455.516	Federal	Regulation	Establishes regulations regarding Medicaid program integrity including the Medicaid agency fraud detection and	I. Administration
171	42 CFR 456.1 - 456.725	Federal	Regulation	Establishes regulations regarding utilization control measures for Medicaid services.	I. Administration; II. A. Health Services
172	42 CFR 460.1 - 460.210	Federal	Regulation	Establishes regulations for the administration of the Program of All-inclusive Care for the Elderly (PACE).	I. Administration; II. A. 3. Medical Assistance Payment - Case Services

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Customer Template

Divisions or Major Programs	Description	Service/Product Provided to Customers	Customer Segments	*Specify only for the following Segments:* (1) Industry: Name; (2) Professional Organization: Name; (3) Public: Demographics.
Eligibility and Health Services	Medicaid members and/or applicants	Health coverage for members	**Public**	Low-income and/or **disabled residents** who meet categorical requirements.

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Partner Template

Name of Partner Entity	Type of Partner Entity	Description of Partnership	Associated Objective(s)
Department of Disabilities and Special Needs	State Government	DDSN administers certain waiver programs on behalf of HHS; DDSN is primarily financed through HHS.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Department of Mental Health	State Government	DMH is a major provider of behavioral health services for Medicaid beneficiaries.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Department of Education	State Government	SCDE has traditionally served as an intermediary between HHS and the school districts that provide Medicaid-funded services.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Department of Social Services	State Government	Many Medicaid beneficiaries also receive some form of services through DSS (SNAP, TANF, foster care, etc.). The agencies collaborate on eligibility and to serve certain populations.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Lt. Governor's Office	State Government	The agencies collaborate on enrollment and eligibility data for elderly and vulnerable adults pursuing Medicaid eligibility to receive long-term care or nursing facility services.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Department of Health and Environmental Control	State Government	DHEC is an important service provider and information source for Medicaid beneficiaries.	1.2.1 Reduce the rate of low birth weight babies by 3%; 3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks

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Partner Template

Name of Partner Entity	Type of Partner Entity	Description of Partnership	Associated Objective(s)
Department of Alcohol and Other Drug Abuse Services	State Government	DAODAS receives significant funding from HHS and the agencies collaborate to discuss/design Medicaid service offerings.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Continuum of Care	State Government	Continuum manages services for children needing the most intensive behavioral health assistance; these services are often Medicaid-funded.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Medical University of South Carolina	State Government	MUSC administers the statewide telemedicine system that is funded with resources from HHS.	3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks
Managed Care Organizations	Private Company	The program's five managed care organizations are responsible for coordinating care and controlling costs for most Medicaid beneficiaries.	1.1.1 Provide at least 20% of managed care payment using a value-based approach; 1.1.2 Increase the percentage of HEDIS withhold metrics at or above the 50th percentile by 2% annually; 3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks

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Name of Partner Entity	Type of Partner Entity	Description of Partnership	Associated Objective(s)
Providers	State Government, Private Company, Individuals, Non-profits	Roughly 48,000 individuals and organizations are currently enrolled to provide services to Medicaid beneficiaries, including physicians, dentists, and countless other classes.	1.1.1 Provide at least 20% of managed care payment using a value-based approach; 1.1.2 Increase the percentage of HEDIS withhold metrics at or above the 50th percentile by 2% annually; 3.1.1 Maintain General Fund expenditures within 3% of forecast; 3.2.1 Keep per-member cost increases below national benchmarks

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Report Template

Item	Report Name	Name of Entity Requesting the Report	Type of Entity	Reporting Frequency	Submission Date (MM/DD/YYYY)	Summary of Information Requested in the Report	Method to Access the Report
1	Restructuring Report	House Legislative Oversight Committee	State	Annually	January 12, 2016	Assure that agency programs are rooted in an organized hierarchy of goals, strategies, and objectives; assess agency performance.	www.scstatehouse.gov
2	Accountability Report	Executive Budget Office	State	Annually	September 15, 2015	Assure that agency programs are rooted in an organized hierarchy of goals, strategies, and objectives; assess agency performance.	www.budget.sc.gov
3	Restructuring Report	Senate's committees of jurisdiction	State	Annually	January 13, 2015	Assure that agency programs are rooted in an organized hierarchy of goals, strategies, and objectives; assess agency performance.	www.scstatehouse.gov
4	Carry Forward Report	General Assembly, through appropriations bill	State	Annually	August 10, 2015	Provide additional information on funds carried forward from one fiscal year to the next.	www.scstatehouse.gov
5	Medicaid Provider Fraud	General Assembly, through appropriations bill	State	Annually	April 1, 2016	Confirm the Department is taking appropriate steps to combat waste, fraud, and abuse.	www.scdhhs.gov
6	Medicaid Accountability and Quality Improvement Initiative	General Assembly, through appropriations bill	State	Quarterly	Various (Quarterly)	Monitor the impact of a variety of recently introduced programs.	www.scdhhs.gov
7	Medicaid Healthcare Initiatives Outcomes	General Assembly, through appropriations bill	State	Annually	December 8, 2015; February 3, 2016	Ensure the House Ways and Means Healthcare Subcommittee has an opportunity to discuss budget and policy matters with the Department's Director early in each legislative session.	www.scdhhs.gov
8	Carry Forward Authorization	General Assembly, through appropriations bill	State	Annually	August 10, 2015	Provide appropriations committees with information on funds carried forward from one year to the next.	www.scstatehouse.gov
9	Discrimination Policy	General Assembly, through appropriations bill	State	Annually	October 21, 2015	Ensure that agencies are appropriately applying anti-discrimination laws in their hiring and promotion practices.	By request
10	Travel Report	General Assembly, through appropriations bill	State	Annually	September 18, 2015	Monitor agency travel expenses.	By request
11	Debt Collection Report	General Assembly, through appropriations bill	State	Annually	March 1, 2016	Ensure that agencies recover funds that are due to the state.	By request
12	IMD Operations	General Assembly, through appropriations bill	State	Annually	February 23, 2016	Monitor the impact of funding changes made by the state in recent years due to changes in federal guidance.	www.scstatehouse.gov
13	Bank Account Transparency and Accountability	General Assembly, through appropriations bill	State	Annually	September 28, 2015	Provide information on fund balances and accounts not managed through the SCEIS system.	By request
14	Means Test	General Assembly, through appropriations bill	State	Annually	December 15, 2015	Ensure that recipients of public services are those in the greatest need.	www.scstatehouse.gov
15	First Steps/BabyNet	General Assembly, through appropriations bill	State	Quarterly	April 14, 2016	Track BabyNet's progress in implementing various recommendations from past audit reports.	By request
16	Information Technology and Information Security Plans	General Assembly, through appropriations bill	State	Annually	October 1, 2015	Track agencies' progress in implementing IT and information security plans; ensure adherence to government-wide initiatives.	By request
17	Medicaid Transportation Advisory Committee Reports	General Assembly through Joint Resolution	State	Quarterly	March 10, 20116	Ensure the Department's management of transportation services is informed by public comment.	www.scstatehouse.gov

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Item	Report Name	Name of Entity Requesting the Report	Type of Entity	Reporting Frequency	Submission Date (MM/DD/YYYY)	Summary of Information Requested in the Report	Method to Access the Report
18	PAPD/IAPD/IAPD-U/OPAD Reports	Federal requirement	Federal	Annually or as Needed	Various	Request enhanced federal funds from Centers for Medicare and Medicaid Services (CMS); update CMS on changes to previously approved planning documents.	By request
19	Supplemental; 64 Report	Federal requirement	Federal	Quarterly	April 30, 2016	Update CMS on enhanced federal spending at a detailed level	By request
20	The Annual Report of the Children's Health Insurance Plans Under Title XXI of the Social Security Act	Federal requirement	Federal	Annually	December 31, 2015	Measure quality of healthcare for children in Medicaid and CHIP programs.	CARTS
21	Sole Sources and Emergencies	SFAA - Division of Procurement Services	State	Quarterly	May 3, 2016	Monitor use of select source selection methods.	http://procurement.sc.gov/PS/general/PS-general-audit-reports.phtm
22	Trade-In Sales	SFAA - Division of Procurement Services	State	Quarterly	No activity	Monitor instances in which agencies trade-in items instead of selling them outright.	By request
23	Unauthorized (Illegal) Procurements	SFAA - Division of Procurement Services	State	Quarterly	January 15, 2016	Monitor procurement exceptions.	http://procurement.sc.gov/PS/general/PS-general-audit-reports.phtm
24	Preferences and 10% Rule	SFAA - Division of Procurement Services	State	Quarterly	No activity	Provide information on agencies' procurement activities.	By request
25	Quarterly Reporting of Indefinite Delivery Contract Activity	SFAA - Division of Procurement Services	State	Quarterly	No activity	Provide information on agencies' procurement activities.	By request
26	Minority Business Utilization Plan	Governor's Office of Small and Minority Business Assistance	State	Annually	September 14, 2015	Provide information on agencies' procurement activities.	By request
27	MBE Progress Report	Governor's Office of Small and Minority Business Assistance	State	Quarterly	April 30, 2016	Provide information on agencies' procurement activities.	By request
28	Federal Expenditure Reports CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program), CMS-21 (Quarterly Children's Health Insurance Program Statement of Expenditures for Title XXI)	Federal requirement.	Federal	Quarterly	April 29, 2016	These reports are the State's accounting of actual recorded expenditures for the federal grant programs.	By request
29	Federal Budget Reports CMS-37 (Medicaid Program Budget Report), CMS-21B (Children's Health Insurance Program Budget Report)	Federal requirement.	Federal	Quarterly	May 16, 2016	These reports provide a statement of the state's Medicaid and CHIP funding requirements for a certified quarter and estimates and underlying assumptions for two fiscal years (FYs).	By request
30	Federal Financial Report (FFR)	Federal requirement.	Federal	Quarterly	April 6, 2016	This report allows the agency to report cash disbursements back to (i.e., reconcile to) Payment Management System, the central system responsible for paying most Federal assistance grants and contracts.	By request

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Report Template

Item	Report Name	Name of Entity Requesting the Report	Type of Entity	Reporting Frequency	Submission Date (MM/DD/YYYY)	Summary of Information Requested in the Report	Method to Access the Report
31	CHIP Statistical Enrollment Data Reports	Federal requirement.	Federal	Quarterly	April 28, 2016	The 64.21E report collects data on children enrolled in Medicaid expansion CHIP Title XXI funded coverage. The 64.EC report collects data on children enrolled in the Medical assistance program Title XIX, traditional Medicaid.	By request
32	Schedule of Expenditures of Federal Awards (SEFA/SFFA)	Federal requirement; State of SC Proviso 117.105 of the 2015-2016 Appropriation Act requires the schedule be completed and submitted to the SC Office of the State Auditor.	Federal	Annually	August 15, 2015	The schedule is prepared each year and lists the expenditures for each grant during the fiscal year. The schedule is also the basis for the major programs audited in accordance with OMB Circular A-133.	By request
33	CMS-R-199 (Survey of Medicaid Payables and Receivables) CMS-10180 (Survey of CHIP Payables & Receivables)	Federal requirement.	Federal	Annually	April 28, 2016	These reports and the accompanying questionnaires identify/estimate the accounts payable for services rendered by both Medicaid and CHIP providers which have not been reported on the quarterly CMS-64/CMS-21. The reports also identify all amounts due to the states from various sources, excluding the federal government.	By request

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Oversight Review Template

Item	Name of Entity Conducted Oversight Review	Type of Entity	Oversight Review Timeline (MM/DD/YYYY to MM/DD/YYYY)	Method to Access the Oversight Review Report
1	CMS	Federal	10/01/2011-09/30/2015	Contact SCDHHS Program Integrity (final report pending)
2	SC Office of Inspector General	State	7/1/2014-11/30/2015	Office of the State Inspector General
3	CAFR Audit (Office of State Auditor and CPA Firm)	State	7/1/2014-6/30/2015	http://www.cg.sc.gov/publicationsandreports/Pages/CAFRFY20142015.aspx
4	Agreed Upon Procedures Audit (Hobbs Group)	State	7/1/2014-6/30/2015	By request
5	Statewide Single Audit (Office of State Auditor)	State	7/1/2014-6/30/2015	By request