

**Medical Care Advisory Committee (MCAC)
February 9, 2016
SCDHHS, 1801 Main Street, Columbia, South Carolina 29202
10:00AM-12:00PM**

I. Welcome by Agency Director

II. Advisements

- Supplemental Teaching Payments
- FQHC Prospective Payment System
Jeff Saxon, Program Manager, Finance and Administration
- RBHS Inclusion in the Coordinated Care Benefit
- Rehabilitative Behavioral Health Providers-Provider Qualifications State Plan Amendment (SPA)
- Community Integration Services (CIS) and Therapeutic Childcare Centers (TCC)
- Palmetto Coordinated System of Care 1915(c) Waiver
Peter Liggett, Deputy Director, Long Term Care and Behavioral Health Services

III. SCDHHS Deputy Updates

Kelly Eifert, Program Manager, Long Term Care and Behavioral Health Services

- Statewide Transition Plan

Stephen Boucher, Program Manager, Health Programs

- Opioids

Jim Coursey, Chief Information Officer, Information Management

- Provider Revalidation Process

Beth Hutto, Deputy Director, Eligibility, Enrollment, and Member Services

- Eligibility, Enrollment, and Member Services (EEMS)

Adriana Day, Deputy Director, Finance and Administration

- 2016 Year to Date Budget

IV. Public Comment

V. Closing Comments

VI. Adjournment



**Medical Care Advisory Committee
November 17, 2015 Meeting Minutes**

Present

*Susan Alford
John Barber
Sue Berkowitz
Cindy Carron
Richard D'Albarto
Diane Flashnick
Dr. Tom Gailey
Tysha Holmes
Lea Kerrison
Bill Lindsey
J.T. McLawhorn
Melanie Matney
Maggie Michael
Gloria Prevost
Dr. Jennifer Root
Dr. Keith Shealy

Not Present

William Bilton
Chief Bill Harris
Amy Holbert
Dr. Kashyap Patel
Dr. Amy Picklesimer
Crystal Ray
Dr. Lynn Wilson
Lathran Woodard

Ms. Joan Meacham attended on behalf of Ms. Susan Alford

The Chief of Staff stated SCDHHS made revisions to the packet that was mailed November 12th and that the revised documents would be e-mailed after the meeting.

The Director welcomed members. He stated the new MCAC member list is online and asked members to notify SCDHHS if there are any discrepancies. The Director explained the purpose of staggering the expiration dates of new MCAC members.

Jeff Saxon (Program Manager, Office of Finance and Administration) presented on the advisement regarding South Carolina Department of Mental Health (SCDMH) Rate Effective December 1, 2015. There were no questions regarding this advisement.

Roy Smith (Program Manager, Office of Community Long Term Care) presented on the advisement regarding Renewal of two Waiver Programs. The following questions were asked:

1) Do you know why Adult Care Home Services is not being utilized?

Answer: The individuals using the service do not have the family support system which makes it difficult to maintain the setting and providers did not get enough referrals to maintain the service.

2) Have services been coordinated with the Department of Social Services?

Answer: Yes, referrals were targeted from Adult Protective Services

3) What's the alternative to this service?

Answer: Nursing homes; however if Community Residential Care Facilities (CRCFs) can meet the final rule requirements this is an alternative.

4) What are the licensing requirements for adults?

Answer: There are no licensing requirements until the 4th person enters the home. Standards can be put in place through a contract.

5) Why did SCDHHS move from 15 minute billing to monthly fixed rate?

Answer: 15 minute units can vary the individual's needs. Also there was a lot of burden placed on doing the 15 minute unit billing.

6) What sort of quality measurement and routine will be put in place for case management?

Answer: The Waiver has a lot of regulations. Case Manager must make contact once a month and there will be staff to do quality assurance.

7) How will quality assurance ensure that individual's needs are met?

Answer: It has always been the focus to ensure that the individual's needs are being met; this will remain the focus.

Megan Old, Project Manager, Project Management Office presented on the advisement regarding **Enhanced Prenatal & Postpartum Home Visitation Services**. The following questions were asked:

1) Why do we focus on first time mothers?

Answer: The Nurse-Family Partnership model focuses exclusively on first-time moms. The Department did select NFP to work with based upon the program's past performance in randomized control trials. We weren't specifically looking to target first-time moms - we just wound up with that focus once we picked NFP.

Jim Coursey (Chief Information Officer, Information Management) gave an update on ICD-10. There were no questions.

Bryan Amick (Pharmacy Director, Health Programs) gave an update on the Hospital Re-admission policy.

The following questions were asked:

1) What impact will there be to reduce readmission?

Answer: SCDHHS cannot determine this until a thorough data analysis has been completed.

2) Who will consult family with end of life planning?

Answer: This issue impacts other payers more than Medicaid, largely due to our demographics. At some point, it may be appropriate for Medicaid programs to consider implementing benefits such as those recently implemented by Medicare.

3) What kind of penalties and when do you anticipate penalties?

Answer: Current system looks for discharges; failures through utilization process. July 1 timeframe moving retrospective process to prospective process; however we need to clean up

data.

- 4) Will there be links to HOPs and has SCDHHS fully vetted the factors of readmissions?

Answer: SCDHHS is looking at the diagnosis that are denied readmission and from that data we will be able to determine some of the factors.

- 5) Will MCOs be penalized?

Answer: This is built into MCO model.

Comment: SCDHHS needs to make sure this is fully vetted through hospital system as well as the other providers.

- 6) Is there communication to family members to further delay re-admits?

Answer: It is up to each MCO plan to develop this communication.

Beth Hutto (Deputy Director, Office of Eligibility, Enrollment and Member Services) gave an update on Eligibility, Enrollment, and Member Services (EEMS). The following questions were asked:

- 1) Has there been any increase in enrollment due to the flooding?

Answer: Not that we are aware of.

- 2) Is SCDHHS adding manpower to complete applications and reviews?

Answer: Yes.

- 3) What kind of backlog is there on applications and reviews?

Answer: yes, there is a backlog due to access implementation.

- 4) Can we get by category a break out of enrollment? Would like to know if we are losing children vs adults.

Answer: Yes.

- 5) What has been the impact of the decrease in enrollment on the quality of care in ER?

Answer: SCDHHS does not have access to this data on individuals who drop out of the system.

- 6) What is the difference between the old rules and the new rules?

Answer: The old rules were linked to AFDC income that allowed certain disregards. The new rules are linked to tax filer status including the individuals that claim dependents on their tax returns. There are no more income disregards under the new rules but there are higher income levels to make up for the loss of disregards.

Adriana Day (Deputy Director, Office of Finance and Administration) gave an update on the 2016 Year to date budget. The following questions were asked:

- 1) What are you saying with shift in Hep C drug expenditures to FFS that they are built into coordinated care and shifted?

Answer: The utilization rate is the same, but the expenditures moved to FFS. The Rate of approval has stayed the same. There is a high rebate on these drugs that flows back to the State.

- 2) So this is not as bad as it looks?

Answer: No, the percentages don't reflect the true reality. Rebates are not shown on this report.

- 3) All high priced Hep C Drugs managed as carve out, is this a better way to manage it?

Answer: The State gets rebates for medications provide through either the FFS or MCO programs. There are instances where the State can leverage competition to increase rebate dollars. These opportunities have to be evaluated on a case-by-case basis.

4) What is the annual or quarterly spend of Checkup?

Answer: There is not a lot of utilization of Checkup enhanced screenings. The spend is minimal.

5) Is checkup going away?

Answer: There is no intentions to take Checkup enhanced screenings away.

6) Are individuals still utilizing Family Planning services?

Answer: Family Planning expenditures are about the same as prior years.

7) Is there any following up for screenings when the outcome is positive?

Answer: There are different paths to take if positive screenings but there is limited treatment.

8) Can we get a quarterly CEO update on a high level?

Answer: Yes

Meeting Adjourned

Next Meeting scheduled for February 9, 2016 10:00 a.m. to 12:00 p.m.

**South Carolina Department of Health and Human Services
Medical Care Advisory Committee
Item for Committee Advisement**

PREPARED BY: Jeff Saxon, Program Manager, Office of Finance and Administration

PRESENTED BY: Jeff Saxon, Program Manager, Office of Finance and Administration

DATE: January 22, 2016

SUBJECT: The South Carolina Medicaid Supplemental Teaching Physician (STP) Payment Program

OBJECTIVE: To replace the current STP payment methodology based upon 35% of billed charges with the average commercial rate (ACR) payment methodology.

BACKGROUND: CMS has asked the state to adjust its current STP payment methodology in order to come into compliance with one of three approvable payment methodologies as prescribed by CMS. While SCDHHS has successfully obtained three extensions of the current payment methodology from CMS, we are now required to submit a state plan amendment that changes this methodology with an effective date of April 1, 2016.

In accordance with the January 2014 report titled "Leveraging Graduate Medical Education (GME) to Increase Primary Care and Rural Physician Capacity in South Carolina", the South Carolina GME Advisory Group recommended that the SCDHHS "develop a state Medicaid plan amendment to change the methodology for obtaining federal matching funds for the supplemental teaching physicians' payment program, using the average commercial rate payment methodology. The average commercial rate is based on what commercial payers reimburse for services as a percentage of charges for these services. As part of the state plan amendment process, SCDHHS should determine whether CMS would allow a common commercial payer rate that is equal in rate and applied across all STP participants".

The SCDHHS has completed its analysis of eligible teaching physician STP payments using the ACR payment methodology based upon average commercial rates and Medicaid fee for service claims experience applicable to service dates of October 1, 2013 through September 30, 2014. The analysis was completed on an individual provider basis and was shared with members of the Medical Education Advisory Council on January 20, 2016.

BUDGETARY IMPACT: Annual aggregate Medicaid fee for service STP expenditures are projected to increase by approximately \$1.2 million (total dollars) based upon provider specific ACR calculations. No state match will be incurred by SCDHHS since the state matching funds required for these payments are provided via intergovernmental transfers from the Medical Universities, a non-state owned governmental hospital, or from the South Carolina Area Health Education Consortium (AHEC). However it should be noted that of the eight STP providers, all but one will receive payment reductions under the ACR payment methodology.

EXPECTED OUTCOMES: Medicaid recipient access to STP providers is expected to be maintained.

EXTERNAL GROUPS AFFECTED: STP providers and Medicaid recipients.

RECOMMENDATION: Move to amend the current state plan to incorporate the use of the ACR payment methodology for STP providers on a facility specific basis.

EFFECTIVE DATE: For services provided on and after April 1, 2016

**South Carolina Department of Health and Human Services
Medical Care Advisory Committee
Item for Committee Advisement**

PREPARED BY: Jeff Saxon, Program Manager, Office of Finance and Administration

PRESENTED BY: Jeff Saxon, Program Manager, Office of Finance and Administration

DATE: January 22, 2016

SUBJECT: Federally Qualified Health Centers (FQHCs) Payment Methodology Changes

OBJECTIVE: To replace the current FQHC payment methodology with a prospective payment system.

BACKGROUND: Under the Benefits Improvement and Protection Act (BIPA) of 2000, Medicaid agencies were required to establish Medicaid payment rates to FQHCs and Rural Health Clinics (RHCs) using an alternate payment methodology or a prospective payment system (PPS) methodology. The minimum baseline PPS rate for each FQHC effective January 1, 2001 was established based upon “100% of the reasonable costs incurred during fiscal year 1999 and fiscal year 2000” for each provider. For FQHC PPS rates effective on and after January 1, 2002, the baseline PPS rate would be trended by the annual Medicare Economic trend rate and adjusted upward or downward for changes in scope of services.

Currently all but one of the FQHC providers are reimbursed under an “alternate payment methodology” which provides for reimbursement at 100% of direct care service costs and 30% of overhead costs based upon the submission of annual cost reports. This method was chosen by most FQHC providers since it allowed for actual recoupment of Medicaid’s share of direct care service costs and easily accounts for any scope of service changes. One FQHC provider is currently being reimbursed under a prospective payment rate as allowed under the Benefits Improvement and Protection Act (BIPA) 2000.

In order to promote provider efficiency, decrease administrative burden, and assist in the SCDHHS budgeting process, the SCDHHS proposes to establish prospective payment rates for all contracting FQHCs that are currently being reimbursed under the alternate payment methodology. This change will become effective for services provided on and after July 1, 2016. The providers’ fiscal year end 2014 Medicaid cost report will serve as the base period. The SCDHHS will develop scope of service criteria that will be used to adjust rates accordingly.

By moving to PPS rates for all contracting FQHCs, it is anticipated that 100% of the FQHC PPS rates effective July 1, 2016 can be built into the Medicaid managed care rates. Assuming CMS approval of this change, the SCDHHS will no longer be required to prepare “WRAP” payment adjustments relating to FQHC services provided to a Medicaid recipient enrolled in a managed care organization.

BUDGETARY IMPACT: The change effective July 1, 2016 is expected to be budget neutral.

EXPECTED OUTCOMES: Prospective payments will improve cash flow to the FQHCs due to the elimination of retrospective cost settlements, in addition to easing the administrative burden on

both the FQHCs and the SCDHHS. Medicaid recipient access to FQHC providers is expected to be maintained.

EXTERNAL GROUPS AFFECTED: FQHC providers and Medicaid recipients.

RECOMMENDATION: Move to amend the current state plan to provide for PPS rates to all contracting FQHC providers.

EFFECTIVE DATE: For services provided on and after July 1, 2016

**South Carolina Department of Health and Human Services
Medical Care Advisory Committee
Item for Committee Advisement**

PREPARED BY: Pete Liggett

PRESENTED BY: Pete Liggett

DATE: 2/9/16

SUBJECT: Rehabilitative Behavioral Health Services (RBHS) inclusion in the Coordinated Care Benefit.

OBJECTIVE: To include the Rehabilitative Behavioral Health Services array and its providers in the Coordinated Care benefit provided by SCDHHS' contracted Managed Care Organizations. MCO members will access RBHS through the MCO plan to which they are assigned. Individuals not assigned to an MCO will continue to access RBHS through the SCDHHS Medicaid fee-for-service benefit.

BACKGROUND: The Rehabilitative Behavioral Health Services (RBHS) program was launched in 2010 as a result of CMS determining that many behavioral health service bundles were disqualified from eligibility for Federal Financial Participation. The RBHS array – created alongside the Licensed Independent Practitioners (LIPs) service array – included the same core therapy services and added a number of Community Support Services. The LIPs array was included in the Coordinated Care benefit, but RBHS remained a fee-for-service benefit only. In 2012, RBHS was expanded to include services for individuals with substance use issues, and this benefit was included in the Coordinated Care benefit; RBHS for mental health issues remained out of the MCO array.

After more than 18 months of work and through the participation of over 60 stakeholder organizations, the South Carolina Institute of Medicine and Public Health released a report in 2015 entitled, “Hope for Tomorrow: The Collective Approach for Transforming South Carolina’s Behavioral Health Systems.” This well-received and widely-endorsed report compiled background on many current behavioral health issues and issued a set of recommendations that drew upon the expertise of the relevant state agencies, private providers, advocacy groups, university-based researchers, and many others. This report identified the failure to meaningfully address individuals’ physical and behavioral health needs in a coordinated way as a key flaw of South Carolina’s healthcare delivery system. As the IMPH report stated:

“Challenges in transitioning to a more integrated care delivery system are numerous. The most significant, perhaps, is the existing financial framework of fee-for-service and volume-based reimbursement” (p. 22).

The inclusion of RBHS in Coordinated Care is an important step toward an integrated care model for children, adolescents, and adults with serious behavioral health issues. The existing model effectively deters this integrated approach, since MCOs have a short-term financial incentive to see their beneficiaries receive RBHS on a fee-for-service basis (paid by SCDHHS directly) instead of obtaining comparable care through the LIPs array, in which case the MCO would be financially responsible.

BUDGETARY IMPACT: Exact budgetary impact projections are currently being developed by Milliman – SCDHHS’ actuary firm. It is expected that the “carve-in” of the RBHS array will initially be budget neutral, but will ultimately lead to cost savings through increases in coordination of care, better utilization management and review, and reduced institutional costs.

EXPECTED OUTCOMES: The proposed action is expected to improve the coordination of services that address our beneficiaries’ physical and behavioral health needs. In addition to providing appropriate utilization management, it is expected that the MCOs will be able to construct networks that only include the most responsible and qualified providers. This will improve health outcomes and mitigate the risk of fraud and abuse.

EXTERNAL GROUPS AFFECTED: Providers of Rehabilitative Behavioral Health Services including private RBHS providers, the South Carolina Department of Mental Health, local drug and alcohol abuse agencies that deliver RBHS outside of substance use services, Local Educational Authorities enrolled as RBHS providers, and any other RBHS provider. These providers will need to contract with participating MCOs in order to be eligible for reimbursement for services provided to MCO members.

RECOMMENDATION: It is recommended that Rehabilitative Behavioral Health Services be included in the Coordinated Care benefit, and that the State Plan be amended accordingly.

EFFECTIVE DATE: On or after July, 1, 2016

**South Carolina Department of Health and Human Services
Medical Care Advisory Committee
Item for Committee Advisement**

PREPARED BY: Ann-Marie Dwyer

PRESENTED BY: Pete Liggett

DATE: February 9, 2016

SUBJECT: Rehabilitative Behavioral Health Providers – Provider Qualifications SPA.

OBJECTIVE: To modify the RBHS policy to more clearly require compliance with South Carolina health practice acts, ensure consumer protection, and improve utilization and quality of services provided to beneficiaries.

BACKGROUND: The state's behavioral health practice acts generally require that providers of core therapeutic services be licensed, be pursuing a license during a supervised period of clinical practice, or be exempt as an employee of a governmental agency.

Currently the State Plan could be misinterpreted to allow for providers who are not professionally licensed to render core therapeutic services. The SPA would clearly require providers not employed by governmental entities who render core treatment services to possess a license to practice in psychology, social work, professional counseling, marriage and family therapy, medicine, or pharmacy and to practice within the licensing requirements. This would improve oversight and overall quality of services.

BUDGETARY IMPACT: The proposed action is expected to result in a nominal reduction in total expenditures that cannot be readily quantified because the modifiers that are associated with these codes do not currently differentiate between licensed and unlicensed providers.

EXPECTED OUTCOMES: Improved quality of behavioral health therapy services to beneficiaries, increased consumer protection, and clearer consistency between the State Plan, the state's practice acts.

EXTERNAL GROUPS AFFECTED: Eligible beneficiaries and their families, private RBHS providers, referring agents to RBHS services.

RECOMMENDATION: To submit a State Plan Amendment requiring licensing at the independent level for private RBHS providers.

EFFECTIVE DATE: On or after April 1, 2016

**South Carolina Department of Health and Human Services
Medical Care Advisory Committee
Item for Committee Advisement**

PREPARED BY: Ann-Marie Dwyer

PRESENTED BY: Pete Liggett

DATE: February 9, 2016

SUBJECT: Community Integration Services and Therapeutic Childcare Centers

OBJECTIVE: To establish specified, targeted treatment services for adults with serious and persistent mental illnesses and pre-K children who have experienced trauma, neglect, and abuse. These services will fall under the Rehabilitative Behavioral Health Services authority.

BACKGROUND: Both of the target populations have specialized needs that are best served with a focused treatment approach.

- A. Adults with serious and persistent mental illness who will be served by Community Integration Services (CIS) are at risk for inpatient hospitalizations, emergency department visits, social isolation, and potential interaction with law enforcement.
- B. Children (birth to kindergarten) who have experienced trauma, neglect, and abuse and require early focused treatment will be served by Therapeutic Childcare Centers (TCCs).

BUDGETARY IMPACT: The fiscal impact is estimated to be approximately budget neutral as these populations are currently being served via RBHS Community Support Services. Anticipated expenditures for FY17 are \$3,835,735 (total dollars).

EXPECTED OUTCOMES: CIS are designed to keep these beneficiaries in their homes and communities, reduce utilization of emergency departments, ensure continuity of services, and provide meaningful social engagement in a structured, facility-based program.

TCCs are designed to keep children at home with their families by using evidence-based practices in a licensed and accredited childcare facility to build family supports, enhance the child-parent bond, and potentially mitigate the need for future treatment interventions.

EXTERNAL GROUPS AFFECTED: Eligible beneficiaries and their families, public and private service providers.

RECOMMENDATION: To submit a State Plan Amendment to add CIS for beneficiaries 18 and older and TCCs for beneficiaries age 0-6.

EFFECTIVE DATE: On or after July 1, 2016

**South Carolina Department of Health and Human Services
Medical Care Advisory Committee
Item for Committee Advisement**

PREPARED BY: Gwynne Goodlett

PRESENTED BY: Pete Liggett

DATE: 1/15/16

SUBJECT: Palmetto Coordinated System of Care 1915(c) Waiver

OBJECTIVE: To provide an array of home and community-based services that assist children and youth up to age 21 to live in the community who experience significant behavioral health challenges or co-occurring conditions and would otherwise be in inpatient general or psychiatric hospitals.

BACKGROUND: State agencies, providers, and family members have been working for over two years to create a statewide coordinated system of care through various workgroups. South Carolina is developing the Palmetto Coordinated System of Care (PCSC) for children and youth with significant behavioral health challenges or co-occurring conditions in or at imminent risk of out-of-home placement. PCSC is an evidence-based approach that is part of a national movement to develop family-driven and youth-guided care, and keep children at home, in school, and out of the child welfare and juvenile justice systems. The State's goal is for children and families of South Carolina to receive services when needed and designed to achieve safe, healthy, and functional lives as successful, responsible, and productive citizens.

The purpose of this waiver is to provide home and community-based supports and services to children with significant behavioral health challenges or co-occurring conditions who would otherwise be served in inpatient general and psychiatric hospitals. Families and youths will be offered the choice of behavioral health services and supports to permit the youths to remain in, or return to, the least restrictive environment that is appropriate. To be eligible, a potential waiver participant must meet the inpatient level of care and meet all Medicaid financial requirements.

BUDGETARY IMPACT: Waivers under Section 1915(c) must be budget-neutral, although the precise budgetary impact will not be known until the schedule of waiver services has been finalized and the number of waiver slots and the per-participant costs have been determined.

EXPECTED OUTCOMES: Two workgroups have met and made recommendations.

Improved Clinical and Functional Outcomes for Youth

The CANS Workgroup, comprised of family members and clinicians representing seven child-serving public agencies, has proposed improved clinical and functioning for the child or youth, as measured by the Child Adolescent Needs and Strengths tool. The Child and Adolescent Level of Care Utilization System (CALOCUS) and Child and Adolescent Functional Assessment Scale (CAFAS) is also being considered as a possible measurement tool.

Improved Family and Youth Satisfaction

The Outcome Measures Workgroup, comprised of family members, providers, and public agency

representatives, has recommended that satisfaction be measured by a satisfaction survey. To minimize the burden on families and youth, seven questions are planned to be added to an evaluation of the high-fidelity wraparound process, called the WFI-EZ.

Reduced Caregiver Strain

The Outcome Measures Workgroup has recommended that family stress, a major predictor of out-of-home placement, be measured with the Caregiver Strain Questionnaire.

Improved Functioning and Access to Services

The Outcome Measures Workgroup has reviewed an administrative dashboard which include data for new clients such as number of referrals for screening, number of screenings, percent of youth eligible at screening, number of assessments completed, percent of assessments compliant with service level agreement, percent of children and youth eligible at assessment, number of plans of care, percent plans of care compliant with service level agreement. Data collected for existing clients would include number of children and youth served, percent of child and family meetings compliant with service level agreement, number of referrals to informal services, percent of children and youth with at least one community-based informal service on the plan of care, number of referrals to state Medicaid behavioral health services, number of referrals to out-of-home placements, number of children and youth in psychiatric residential treatment facilities, number of children and youth in group homes (IMD and non-IMD), number of children and youth with DJJ referral, number of children and youth on probation, number of children and youth in secure facility detention/DJJ long-term institution, number of children and youth with school disciplinary referral, number of children and youth suspended from school, and number of children and youth expelled from school.

EXTERNAL GROUPS AFFECTED: Family Service Organizations--NAMI, Federation of Families, Family Connection, PRO-Parents, and FamilyCorps; Public Agencies—DJJ, DSS, DMH, DAODAS, Continuum of Care, DDSN, local school districts; public providers; private providers; and children, youth, and their families. Judges, solicitors, public defenders, and child welfare attorneys have also contributed to the discussion of services needed for youth. Representatives from various groups have been a part of the planning process in 170 meetings over the last two years.

RECOMMENDATION: To develop and submit a waiver application.

EFFECTIVE DATE: On or about January 1, 2017 or upon CMS approval.

Home and Community-Based Services (HCBS) Rule – South Carolina Statewide Transition Plan

Kelly Eifert, Ph.D.

Project Manager, Long Term Care & Behavioral Health

February 9, 2016



- Status Update
 - Feb. 26, 2015: SC Statewide Transition Plan submitted to CMS
 - Aug. 11, 2015: CMS provided written feedback on plan, required revision
 - Sept. 25, 2015: Revised Statewide Transition Plan submitted to CMS
 - No public notice required per CMS
 - Nov. 6, 2015: CMS provided additional written feedback on plan, required second revision
 - Dec. 9, 2015: CMS SOTA Webinar added required deadlines and public notice not previously required
 - Second revision will be sent to CMS by Feb. 3, 2016, to be reviewed as a “draft” prior to public notice and comment
 - Public notice will be Feb. 24, 2016 – Mar. 25, 2016

Information Management

Jim Coursey

Chief Information Officer, Information Management

February 9, 2016



Provider Revalidation

- CMS updates to provider revalidation process
 - On target to complete revalidation by 03/26/16
 - New guidance on fingerprint-based criminal background checks (SLED will provide service)
- Total statuses as of 01/29/16
 - ~ 47,300 providers in SC Medicaid program
 - 19,264 applied for revalidation
 - 18,475 have not yet responded
 - 1,566 voluntary terminations
 - 8,053 letters are undeliverable
- Non-responsive provider outreach strategy established
 - Claims volume analysis starting this month
 - February – first round of outreach
 - Outreach based on location and utilization
 - March – finalizing validation

Eligibility, Enrollment, & Member Services

Beth Hutto

Deputy Director, Eligibility, Enrollment and Member Services

February 9, 2016



Case Processing

Increased staffing at county offices

130 new staff postings since July 1, 2015

300 temps in case processing and support roles

5 new supervisor positions posted

9 Long Term Care Coordinators

Processing Centers with Multiple Shifts

24 hours of operation

Charleston: Two Processing Centers

Columbia: Seven Processing Centers, 1st, 2nd, 3rd shifts

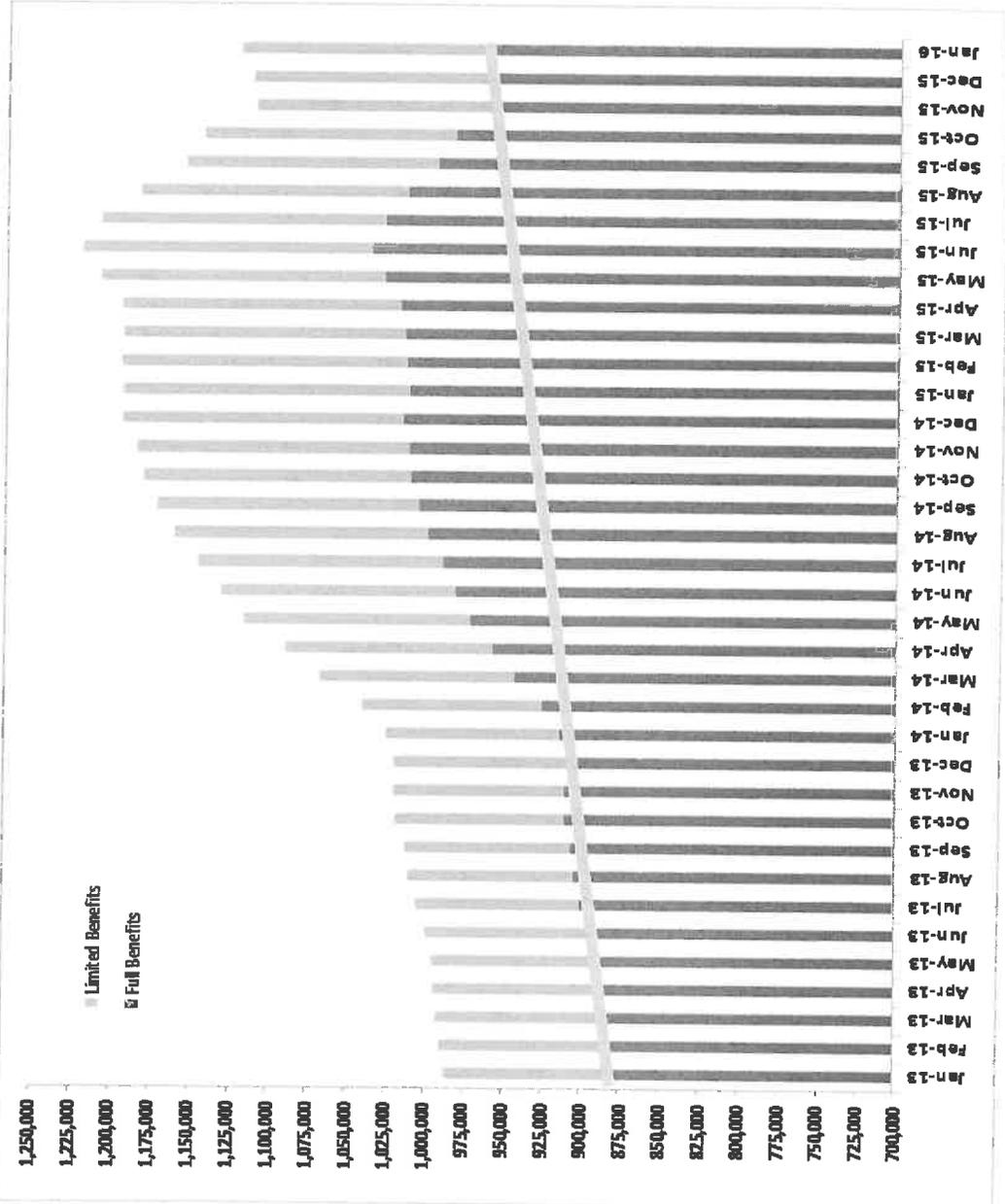
Greenville: Two Processing Centers

Spartanburg: Processing Centers, 1st and 2nd shifts

Additional Future Processing Centers

Columbia, Charleston 2nd shift, Lancaster, Oconee, Horry

Trends in Medicaid Enrollment



October 2015 enrollment (final): 1,144,000

January 2016 enrollment (prelim): 1,121,000.

Full Benefit Enrollment

In line with growth trend prior to delayed reviews

Annual Review Impact

July and August consisted of doubled months of >60,000 reviews each month

Nearly 50% Annual Review match rate

Finance and Administration

Adriana Day

Deputy Director, Finance and Administration

February 9, 2016



Budget by Major Program and Spending Purpose

FY 2016 Appropriation/Authorization

FY 2016 YTD as of 12/31/15

Remaining from Approp./Auth.

% Expended

SCDHHS Medicaid Assistance

Coordinated Care	2,919,593,633	1,302,482,841	1,617,110,793	45%	Per member capitated rates below projection; enrollment decreased due to redetermination restart
Hospital Services	498,422,994	274,999,161	223,423,833	55%	Timing of supplemental payments
Disproportionate Share	550,002,538	254,451,829	295,550,709	46%	
Nursing Facilities	558,675,837	276,210,677	282,465,160	49%	
Pharmaceutical Services	72,527,229	47,019,679	25,507,550	65%	Shift in Hep C drug expenditures to FFS
Physician Services	89,240,781	43,959,847	45,280,934	49%	
Community Long-term Care (CLTC)	151,788,479	92,754,014	59,034,465	61%	Community Choices census higher than budget
Dental Services	154,492,726	65,461,558	89,031,168	42%	Lower utilization of adult dental services than projected
Clinical Services	36,858,789	30,534,240	6,324,549	83%	Cost settlements from prior years paid this FY
Transportation Services	95,905,759	37,396,837	58,508,922	39%	New broker contract still undergoing evaluation
Medical Professional Services	20,691,967	12,078,228	8,613,739	58%	Utilization higher than projected
Durable Medical Equipment	23,763,350	12,822,387	10,940,963	54%	
Lab & X-Ray Services	12,787,691	5,774,023	7,013,668	45%	Utilization lower than projected
Family Planning	62,825,713	7,807,980	55,017,733	12%	Traditional FP services on-budget; Checkup utilization limited
Hospice	14,733,783	6,553,098	8,180,685	44%	Lower than projected enrollment
Program of All-Inclusive Care (PACE)	17,057,506	6,400,525	10,656,981	38%	Fewer recipients due to delay in new PACE site
EPSDT	2,823,379	1,990,075	833,304	70%	Higher utilization partially relating to Autism screenings
Home Health Services	12,992,989	6,178,467	6,814,522	48%	
OSCAP	10,695,773	3,848,636	6,847,137	36%	Lower than projected enrollment
Optional State Supplement (OSS)	22,607,703	9,494,944	13,112,759	42%	Lower than projected enrollment
Premiums Matched	180,000,000	88,880,964	91,119,036	49%	
MMA Phased Down Contributions	80,237,248	40,019,464	40,217,784	50%	
Premiums 100% State	17,381,975	7,058,462	10,323,513	41%	Lower than projected enrollment
Children's Community Care	19,907,516	8,490,625	11,416,891	43%	Utilization less than projected
Behavioral Health	147,562,230	79,425,025	68,137,205	54%	
Total SCDHHS Medicaid Assistance	\$ 5,773,577,588	\$ 2,722,093,586	\$ 3,051,484,002	47%	

SCDHHS Other Health Programs

Disabilities & Special Needs (DDSN)	597,762,223	274,502,213	323,260,010	46%	State agency claims tend to come in late in FY
Education (DOE)	51,693,998	19,438,177	32,255,821	38%	State agency claims tend to come in late in FY
Health & Environmental Control (DHEC)	7,390,368	2,581,544	4,808,824	35%	Timing of Supplemental Teaching Payments
Medical University of SC (MUSC)	43,348,419	26,104,262	17,244,157	60%	State agency claims tend to come in late in FY
Mental Health (DMH)	125,774,007	56,422,711	69,351,296	45%	Timing of Supplemental Teaching Payments
University of South Carolina (USC)	7,150,176	9,360	7,140,816	0%	Timing of Supplemental Teaching Payments
Other Entities Funding	35,855,745	34,364,356	1,491,389	96%	
State Agencies & Other Entities	\$ 868,974,936	\$ 413,422,624	\$ 455,552,312	48%	

SCDHHS Operating Expenditures

Personnel & Benefits	68,458,064	33,361,450	35,096,614	49%	
Medical Contracts	252,785,590	61,787,933	190,997,657	24%	Contracts issued annually; spend weighted towards end of year
Other Operating Costs	58,019,577	11,178,746	46,840,831	19%	Projecting to spend less than budgeted
Total SCDHHS Operating Expenditures	\$ 379,263,231	\$ 106,328,128	\$ 272,935,103	28%	

*Variances explained when 5% points above or below 50% of annual appropriation.

Funded Program	Description of Services
Coordinated Care	Provides coordinated services for beneficiaries through managed care organizations which are paid through capitated rates
Hospital	Provides inpatient and outpatient hospital services for our fee for service beneficiaries
DSH (Disproportionate share)	Provides payment to qualifying hospitals for the unreimbursed cost of providing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals
Nursing Home	Provides nursing facility services including complex care and hospice room and board
Pharmacy	Provides prescription medications in the outpatient setting for our fee for service beneficiaries
Physicians	Provides physician services including primary care, preventative care and specialty care for our fee for service beneficiaries
Community Long-Term Care (CLTC)	Provides services in the home and community settings for beneficiaries as an alternative to nursing home placement – includes Community Choices, HIV/AIDS, Mechanical Vent, and Children’s Personal Care waivers.
Dental	Provides dental services for our beneficiaries
Clinics	Provides services in FQHCs, RHCs, and other clinic settings for our fee for service beneficiaries
Transportation	Provides non-emergency transportation for the entire Medicaid population and emergency transportation services for our fee for service beneficiaries
Medical Professionals	Provides therapy, vision, and other medical professional services to our fee for service beneficiaries
Durable Medical Equipment (DME)	Provides durable medical equipment including wheel chairs and oxygen supplies for our fee for service beneficiaries
Lab & X-Ray	Provides lab and x-ray services including CT scans and MRIs for our fee for service beneficiaries
Family Planning	Provides family planning services including contraceptives and STD testing for our fee for service and Checkup beneficiaries
Hospice	Provides hospice services for terminally ill Medicaid beneficiaries
Program of All Inclusive Care for the Elderly (PACE)	Provides a comprehensive array of services for beneficiaries in home and community-based settings who would otherwise qualify for nursing home placement
Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	Provides well-child, comprehensive and preventive health care screenings and services for children under the age of 21
Home Health	Provides home health services and incontinence supplies for our fee for service beneficiaries
Optional State Supplement (OSS)	Program for those residing in licensed community residential care facilities who meet SSI eligibility requirements except for income (100% state funding)
Optional Supplemental Care for Assisted Living Program (OSCAP)	Entitlement program and state supplement to SSI for enrolled CRCFs to provide room and board for eligible consumers and a degree of personal care (100% state funding)
Premiums Matched	Pays for Medicare premiums for dual eligible individuals who meet certain income requirements
Medicare Modernization Act (MMA) Phasedown	Federal “clawback” for state’s portion of Medicare Part D prescription drug benefit (100% state funding)
Premiums 100% State	100% state funded program that covers Medicare premiums for specific Medicaid eligibility categories (Nursing Home, General Hospital, HCBS, ABD, QI, Refugee Assistance)
Children’s Community Care Behavioral Health	Includes children’s nursing services and medically complex children’s waiver Provides behavioral health services for beneficiaries including inpatient psych, rehabilitative behavioral health services, targeted case management, private residential treatment facilities, and autism services amongst many others