October 5, 2011

The Honorable Nikki R. Haley  
Office of the Governor  
1205 Pendleton Street  
Columbia, SC 29201  

Dear Governor Haley:

On behalf of the South Carolina Department of Health and Human Services (SCDHHS or the Department), I am pleased to submit the FY 2012-13 proposed budget request. The budget submission reflects funding needs and program priorities as we know them at this time, given our best projection of enrollment and inflationary growth and incorporates the effects of our policy initiatives. We recognize that this is the first step in the production of your Executive Budget which must consider the needs of all State agencies and reflect your overall goals and direction for the State. With this in mind, we stand ready to answer any questions and make modifications based on your review and your priorities.

Attached you will find an overview of the SCDHHS budget submission that identifies the major budget assumptions and spending priorities for the upcoming fiscal year. This material is supplemental to the detailed budget submission documentation being submitted to your office. We expect summaries in this format for the overall program as well as our individual programs to be distributed to the public and the legislature once you have finalized and submitted your Executive Budget prior to the start of the legislative session.

As always, thank you for your support and the hard work of your staff.

Respectfully,

[Signature]

Anthony E. Keck  
Director
# Agency Certification and Transmittal Sheet

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<tr>
<th>Code:</th>
<th>J02</th>
<th>Name:</th>
<th>Department of Health and Human Services</th>
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Mission Statement: The mission of the South Carolina Department of Health and Human Services is to purchase the most health for our citizens in need at the least possible cost to taxpayers.

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To the Office of State Budget

This, and accompanying statements, schedules, and explanatory sheets consisting of 162 pages constitute the operating budget estimates of this agency for all proposed expenditures for the 2012-2013 fiscal year.

All statements and explanations contained in the estimates submitted herewith are true and correct to the best of my knowledge.

Signed: ________________________  Date: ____________

(Agency Head)  Oct. 5, 2011
I. EXECUTIVE SUMMARY

A. Agency Section/Code/Name:
   Section 21/02/Department of Health and Human Services

B. Summary Description of Strategic or Long-Term Goals:
   The mission of the South Carolina Department of Health and Human Services is to reverse the trend of higher
   spending without accountability and instead begin purchasing the most health for those in need at the least possible
   cost to taxpayers. Bringing costs to a sustainable level requires a fundamental realignment of incentives with a
   renewed focus on health outcomes, not just the number of services delivered. Simply cutting costs without regard to
   changing how health care is delivered will not achieve the long-term goal of improving health.

C. 2011-2012 Agency Recurring Base Appropriation:
   State $ 917,337,816
   Federal $3,948,059,197
   Other $ 763,689,143

D. Number of Budget Categories:
   8

E. Agency-wide Vacant FTEs
   Vacant FTEs as of July 31, 2011: 191
   % Vacant 16%

F. Efficiency Measures:
   The major organizational objectives to satisfy shareholders of Medicaid are as follows:

   1. To achieve the vision of greater beneficiary health through measurable improvements and through
      meaningful health outcomes such as decreasing low birth weight deliveries.

   2. To become a high performing organization through the evaluation of key internal business processes,
      planning for change and uncertainty and motivating the workforce to excel toward a common goal. The
      organization must be able to sustain change while demonstrating the ability to grow and innovate.

   3. To succeed financially through adjusted spending methodologies clearly recognizing that deficit spending
      is as an unacceptable practice, continued assessment of cost saving through reduced administrative costs as
      well as methods and standards of Medicaid service reimbursement rates, comprehensive expenditure
      reporting and decreasing fraud, abuse and waste from the Medicaid program.

   Next steps include establishing meaningful performance metrics to demonstrate a cause and effect relationship of
   each objective, mapping the objectives to the accurate organizational units, establishing baselines and benchmarks to
   measure success and progress, supporting the strategic objectives by building accountability throughout the
   organization and finally evaluating upon completion and implementing necessary strategy adjustments.

G. Number of Provisos:
   51
## SUMMARY OF OPERATING BUDGET PROGRAMS FOR FY 2012-13

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## SUMMARY OF OPERATING BUDGET PROGRAMS FOR FY 2012-13

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<td>Commission for the Blind</td>
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<td>Wil Lou Gray Opportunity School Medicaid</td>
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## SUMMARY OF OPERATING BUDGET PROGRAMS FOR FY 2012-13

### OPERATING BUDGET PROGRAMS

<table>
<thead>
<tr>
<th>Title</th>
<th>Activity Name</th>
<th>Activity No.</th>
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<th>Other</th>
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<td>Medicaid Eligibility Support</td>
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For additional rows, place cursor in this gray box and press "Ctrl" + "b". (You need to start in this gray box for each row needed or the formulas will not copy properly.)

**TOTAL OF ALL OPERATING BUDGET PROGRAMS**

| 0 | 1,264,024,450 | 4,044,497,099 | 615,129,975 | 5,923,651,524 | 0.00 | 0.00 | 0.00 | 0.00 |
### SUMMARY OF CAPITAL BUDGET/NON-RECURRING REQUESTS FOR FY 2012-13

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<th>Project No.*</th>
<th>Project Name</th>
<th>Activity Name</th>
<th>Activity No.</th>
<th>Additional State Funds</th>
<th>Previously Authorized State Funds</th>
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<td>30,353,993</td>
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</table>

For additional rows, place cursor in this gray box and press "Ctrl" + "c". (You need to start in this gray box for each row needed or the formulas will not copy properly.)

| TOTAL OF ALL CAPITAL BUDGET/NON-RECURRING REQUESTS | 7,157,264 | 0 | 30,353,993 | 37,511,257 |

*if applicable
A. **Summary description of programs and how they relate to the mission of the Agency:**

946 **Audits/Compliance:**

The Bureau of Compliance and Performance Review consists of three divisions: Program Integrity, Surveillance and Utilization Review (SUR) and Audit. The Division of Program Integrity, with a staff of nurses, pharmacy technicians, a dental hygienist, and licensed master social workers, performs investigations and reviews of providers and beneficiaries suspected of fraud, abuse, or inappropriate utilization of Medicaid benefits. The Division also manages the Agency’s fraud hotline. The division fulfills the federal Medicaid requirements for Program Integrity and utilization, and conducts post-payment reviews on all provider types. The Division also operates a pharmacy lock-in program for beneficiaries who show patterns of prescription drug seeking. The Division also manages the provider exclusion process and is responsible for oversight of the Recovery Audit Contractor program. The Division works closely with the South Carolina (SC) Attorney General’s Office and makes referrals of providers and recipients suspected of Medicaid fraud. The Surveillance and Utilization Review (SUR) division is a key component of the bureau, and works closely with both Program Integrity and Audits. SUR staff conducts on-going data analysis to identify patterns in Medicaid claims data indicating waste, fraud, and abuse. Using various analytical tools, fraud algorithms, and a database with seven years worth of claims data, the division looks for aberrant billing trends among providers or for beneficiaries with a large volume of claims or prescriptions but no diagnoses of serious illness or injury.

The Bureau Chief is also the Internal Auditor for the Agency and can report the results of internal audits directly to the Agency Director. The Division of Audits follows generally accepted governmental auditing standards and performs periodic audits of managed care organizations under contract with SCDHHS to provide Medicaid benefits to members. The division also performs audits of cost reports and the Medicaid programs of other State agencies which received federal Medicaid funds through SCDHHS. The division also audits internal operations of the department for compliance with certain federal and state requirements and Agency policies and procedures, and also will be auditing recipients of Electronic Health Records incentive payments.

The Bureau does not provide services to beneficiaries but rather is responsible for key oversight, audit, and integrity functions within the Agency. Internal customers include provider program and policy divisions; beneficiary eligibility divisions; the Office of General Counsel; the Division of Appeals and Hearing; Bureau of Financial Affairs; the Managed Care division; Reimbursement Methodology and Policy divisions; and the Director’s Office including legislative liaison and public information offices. External stakeholders include the SC Attorney General’s Office, other state agencies that deliver Medicaid funded services, managed care organizations, providers, beneficiaries, and tax payers.

This program generates significant income; in SFY 2011 more than $27 million was collected for overpayments due to waste, fraud and abuse. (See key performance indicators below.)

As part of the Bureau for Compliance and Performance Review, Audits, SUR, and Program Integrity activities are overseen by the Bureau Chief. The Division Director for Program Integrity reports directly to her. The Director for SURs also reports directly to the Bureau Chief. There are three program integrity departments (review teams) each with a supervisor who reports directly to the PI division director. Due to a recent reorganization of staff, the SURs director now functions as a senior consultant and no longer supervises staff; they have been moved to a program integrity team. In addition, the Division Director for Audits reports directly to the Bureau Chief and supervises 6 auditors, who usually work in teams of 2-3 auditors.

The Divisions of Program Integrity/SURs were formulated in response to federal requirements that the Medicaid Agency must have methods and criteria for identifying suspected fraud and abuse; must conduct preliminary investigations; and must refer cases to the Medicaid Fraud Control Unit in the SC State Attorney General’s Office. (42 CFR, §455 et. Seq.) The Agency must also have a state program of control for the utilization of all Medicaid services and a post payment review process that allows state personnel to develop and review recipient utilization profiles, provider service profiles, and exceptions criteria, and that identifies exceptions so that unnecessary utilization practices of beneficiaries and providers can be corrected (42 CFR, §456. 1-23)

The South Carolina (SC) Code of Laws, §44-6-30, mandates that SCDHHS administer the Medicaid program (Title XIX of the Social Security Act). The Division of Audits was formed to assist the Agency in the management, assessment, and improvement of Agency programs, services, and operations. The Division of Audits accomplishes
these goals by reviewing and evaluating programs and contracts administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost effective manner.

The Bureau is responsible for ensuring compliance with multiple other federal requirements in addition to the 42 CFR §455 and §456, including:

- 42 CFR §433.116 (e) through (h): Operation of Mechanized Claims Processing and Information Retrieval Systems
- 42 CFR §433.304: Definitions of Abuse, Fraud and Overpayments. 42 CFR, §433.312, Basic Requirements for Refunds:
- 42 CFR §433.316: Discovery of Overpayments
- 42 CFR §455.20: Recipient Verification Procedures
- 42 CFR §1002 et.: Seq., State Initiated Exclusions from Medicaid
- 42 CFR §447.45: Timely claims payment
- 42 CFR §447.202 and 206 (e): Audit of records if payment is based on cost of services
- 42 CFR §438.608: Program integrity requirements of managed care organizations.

The Bureau also primarily responsible for implementing other federal activities such as Medicaid Integrity Program (42 CFR, §455.200); the Recovery Audit Contractors Program (42 CFR, §455.500); the Payment Error Rate Measurement Program (PERM) (42 CFR §431.950); and the provisions of the Deficit Reduction Act of 2005 regarding Employee Education about False Claims Act.

The appropriation request for the Divisions of Program Integrity / SURs includes increases for staff expansion and other resources in order to increase recoveries and the identification/prevention of fraud and abuse. The appropriate request for the Division of Audits anticipates replacing TGE positions with FTE positions but no expansion of staff.

947 Internal Information Technology:
Support the internal Agency information technology infrastructure; Information Technology Helpdesk; PC Software applications; Document imaging; Network support and Security.

Advance the effective and efficient utilization of Information Technology in support of the Agency mission; Resolution of user requests in a timely manner relative to the size and complexity of the problem; duration of development in days within applicable security policies and user satisfaction; Ensure quality, security, verification, and storage of designated Agency documentation through electronic imaging services; Maintain network availability during normal hours of operation; Ensure the policy and procedures relative to data security and integrity are published and maintained.

948 Agency Administration:

- Financial Management develops, implements, and manages the Agency budget; directs all aspects of the Agency's financial accounting operations; provides financial and fiscal impact analysis and consultation on Medicaid issues Agency director, staff, Governor's Office, General Assembly, State Budget Office, and other external entities.

- Rate Setting develops and adjusts reimbursement rates for health care providers.

- Human Resources manage the personnel functions of the Agency in the areas of classification, compensation, recruitment, benefits, employee relations, training, and development.

- Public Information provides answers to questions presented to the Agency by the general public, the news media, and elected officials. It provides legislative liaison, assures Agency compliance with the Freedom of Information Act, and helps the Agency meet federal mandates that all Medicaid policy changes receive a recommendation from the South Carolina Medical Care Advisory Committee. It accomplishes its activities in person, over the telephone, by letter, through the news media, and via the Internet.
• Procurement and Support Services is responsible for coordinating and evaluating procurements and contractual arrangements for the Agency. It also administers the Agency policies related to postal, supply, fleet, and property management.

• Contracts Management directs the solicitation, development and management of contracts and Medicaid Services that legally bind SCDHHS and the provider based upon state and federal regulations.

• Appeals and Hearings Division provides fair hearings to Medicaid applicants and recipients who have received a negative decision from the Department that they believe is the result of error of fact or law. This Division provides fair hearings to providers who have a dispute with the Department over payment of claims, contract termination, nursing home reimbursement rates, etc. The Division also provides fair hearings to any resident of a Title XIX facility that has proposed transfer or discharge of the resident.

• The General Counsel Office/Legal Services advises the Agency on all legal matters. This includes handling litigation in multiple areas such as contract awards, audit recoveries, estate recovery, integrity sanctions, and denial of eligibility for Medicaid benefits. The Office of General Counsel ensures that contracts which bind the Agency are legally sound and are in compliance with state and federal laws and regulations. The Office also provides legal advice to the various departments within the Agency, handles all Freedom of Information Act requests and HIPAA privacy concerns, and represents the Agency before administrative, state and federal courts.

• The Deputy Director’s Office serves as the Chief Financial Officer and the overall business and administrative manager for the state Medicaid Agency. Specifically, the Deputy Director:
  ▪ Develops, implements, and manages the Agency budget.
  ▪ Directs all aspects of the Agency’s financial accounting operations.
  ▪ Directs all aspects of the Agency’s administrative support functions including procurement, contracts, administrative appeals, building services, physical inventory, security, mail, supplies, etc.
  ▪ Provides oversight of all aspects of the Agency’s human resources function, including recruitment, compensation, benefits, leave, EPMS, progressive discipline, employee relations, and training.
  ▪ Provides oversight of the Agency’s reimbursement methodology (rate setting) functions for health care providers.
  ▪ Provides financial and fiscal impact analysis and consultation on Medicaid issues to the Agency director, other Agency managers and staff, the Governor’s Office, General Assembly, State Budget Office, and other external entities.

Budget Program Number and Name:

I. Administration

B. Agency Activity Number and Name:

Note: If more than one activity maps to this program; provide all activity numbers, names, and approximate funding amounts.

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<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
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C. Performance Measures:

**946 Audits/Compliance:**

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<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
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<tbody>
<tr>
<td>Actual</td>
<td>Target</td>
<td>Target</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Program Integrity**

- Provider fraud/abuse cases opened: 585/305/320/336
- Provider fraud/abuse cases closed: 250/472/496/519
- Provider fraud/abuse cases in progress: 530/181/NA/NA
- Recipient fraud/abuse cases opened: 272/426/447/468
- Recipient fraud/abuse cases closed: 116/98/103/107
- Recipient fraud/abuse cases in progress: 273/601/NA/NA
- RAC Cases In Progress: NA/276/300/325
- Fraud hotline calls: 4542/2198/2200/3000
- Complaints from all sources: 1154/1297/1427/1569
- Provider Recoveries: $3,833,584/$10,675,998/$15,480,197
- Recipient Recoveries: $444,214/$500,000/$600,000
- RAC Recoveries: NA/$4,298,189/$5,000,000/$7,250,000
- All Recoveries Including Globals: $41,140,383/$41,384,717/$50,000,000
- Provider Fraud Referrals: 12/15/25/25
- Recipient Fraud Referrals: 242/230/288/300
- Beneficiary Lock-in: 100/200/400/400
- Return on Investment: NA/$7.49 to $1

**Division of Audits**

- # of Audit Reports Published: 3/2/5/6
- # of Audit Recommendation: 16/18/NA/NA
- $ Value of Programs Reviewed: $3,966,638/$120,187,213/NA/NA
- $ Value of Errors Identified: $1,181,326/$429,985/NA/NA
- Recoupment recommended: $10,356/$429,985/NA/NA
- EHR Audits: NA/NA/25/25

Notes: Could not calculate Return on Investment in 2010 due to unavailability of management reports from SCEIS.

**947 Internal Information Technology:**

Key performance indicators include the number of help desk tickets resolved and average time of resolution, network uptime statistics, number of workstations replaced.
948 Agency Administration:
The Agency maintains appropriate levels of accountability and control over the financial assets, pays bills promptly, and complies with applicable laws, regulations and policies. Prompt and accurate responses to financial data requests provided in a clear and understandable format.

- Rate Setting:
  - To develop fair and equitable Medicaid reimbursement rates for all non-institutional Medicaid services based upon a federally approved rate setting methodology, as well as review budgets for Agency administrative contracts for compliance with state and federal regulations concerning allowable costs.
  - To oversee the development of fair and equitable Medicaid reimbursement methodologies that adequately reimburses Medicaid providers, comply with applicable state and federal regulations, and limit expenditures within the appropriated dollars.

- Human Resources comply with all State and Federal human resources laws and regulations. Procurement and Support Services:

- Procurements will be completed in accordance with SC Consolidated Procurement Code. Responsible for the accountability of property management, postage, and supplies.

- Contracts Management ensures that Medicaid contracts are completed based upon the SC Consolidated Procurement Code, state and federal regulations.

- Appeals and Hearings provide fair hearings in accordance with the federal and state laws and regulations and to render decisions based on the facts and applicable law/policy to ensure eligible citizens receive the services they are entitled to and providers are reimbursed correctly.

D. Program Interaction:

946 Audits/Compliance:
As noted in the Program Description, the Bureau coordinates and interacts with other divisions within the Agency to:

- Enforce Medicaid policy and coverage standards
- Identify waste, fraud, abuse, and inappropriate payments
- Collect overpayments and remit to financial department to offset Agency operations
- Develop provider and beneficiary utilization reports to aide in cost avoidance and policy decisions
- Identify aberrant providers and change provider behavior through education, sanctions, or termination from the program
- Make recommendations for improvements in Agency operating policies
- Review internal controls for effectiveness
- Ensure Agency compliance with findings and recommendations from federal and state audits
- Manage the State Exclusion list to ensure that FFP is not claimed for excluded providers
- Manage beneficiary Pharmacy Lock-in to help control use of prescription drugs
- Carry out federally-mandated audit and integrity activities

If the Bureau’s programs were terminated, it would be impossible to provide the required oversight of the Medicaid program. Identification and prevention of fraud and abuse would be severely hampered, and expenditures to abusive providers would result in increased program costs without a corresponding increase in health care outcomes. The Agency would risk the loss of federal funds if the required Program Integrity/SUR/Audit functions were not in place.

947 Internal Information Technology:
Staff in Technology Services interacts with all other organizations within the Agency at all levels. Staffing levels directly affect the timeliness and quality of support.

948 Agency Administration:
Administrative staff interacts with all areas of the Agency to ensure payments are processed timely, assisting in budgeting, establishing financial codes to ensure proper payment methodologies and that federal and state regulations are
followed. Administration also communicates with external staff within other organizations to ensure proper payment and distribution of funds and federal and state regulations are followed.

E. Change Management:

946 Audits/Compliance:
The mission and focus of the Bureau have not changed. An ongoing goal is to increase identification of and recoveries from waste, non-compliance, improper payments, fraud and abuse. New areas of focus include:

- Direct program integrity auditing of providers in a managed care network. This will require increased coordination with managed care SIU / compliance officers as well as new approaches to using managed care encounter (claims) data. This may also require changes in managed care contracts and operating procedures.

- Development of a beneficiary fraud prevention unit. The number of individuals eligible for Medicaid will increase (as anticipated by the Affordable Care Act), and the majority of the new beneficiaries will be enrolled in the Medicaid managed care program. The Agency faces an increased risk of paying premiums for ineligible members. A “pre-eligibility intervention” is needed to divert applicants (that meet certain risk criteria) from the eligibility approval process for investigation and review. Significant cost avoidance (millions of dollars) is assured. (Note: Not in budget request at this time).

947 Internal Information Technology:
Budget constraints in the past several years have caused Technology Services to extend the use of hardware beyond the life cycle that was planned, resulting in increased maintenance and repair costs. The FY 2013 budget request includes funds to resume hardware replacement. Server virtualization was begun in the past 2 years, reducing the need for server hardware. Migration to “the cloud” for email and other server-based products will reduce costs and increase redundancy and disaster preparedness.

948 Agency Administration:
Economic and financial issues continue to be a challenge for the Agency.

F. Detailed Funding Information:

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<tr>
<th>FY 2012-13 Cost Estimates:</th>
<th>State</th>
<th>State</th>
<th>Federal</th>
<th>Other</th>
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<td>$12,230,977</td>
<td>$1,624,414</td>
<td>$20,590,394</td>
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</table>

* If new FTEs are needed, please complete Section G (Detailed Justification for FTEs) below.

Is this budget category or program associated with a Capital Budget Priority? No
If yes, state Capital Budget Priority Number and Project Name:

Please List proviso numbers that relate to this budget category or programs funded by this category.
G. Changes to the Appropriation:
Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

Funding:

<table>
<thead>
<tr>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012 Act</td>
<td>$6,735,003</td>
<td>$12,230,977</td>
<td>$1,624,414</td>
<td></td>
</tr>
<tr>
<td>2012-2013 Act</td>
<td>$6,735,003</td>
<td>$12,230,977</td>
<td>$1,624,414</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>% Difference</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Explanation of Changes: No changes.

H. Revenue Estimates:
Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Federal</th>
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</thead>
<tbody>
<tr>
<td>34420000</td>
<td>Special Grants</td>
<td></td>
<td></td>
<td>$1,624,414</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50000000</td>
<td>Federal Funds</td>
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<td></td>
<td></td>
<td></td>
<td>$12,230,977</td>
</tr>
</tbody>
</table>

If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

Please detail the long-term sustainability of this program if cash reserves are needed to operate.

If there is federal fund or other fund spending authority requested above the revenue streams detailed above, please indicate the amount and explanation for each.

I. FTE Positions:
Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other-Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
<th>Temporary, Temporary Grant, Time-limited</th>
</tr>
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<tbody>
<tr>
<td>2012-2013 (A)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>2011-2012 (A)</td>
<td>57.40</td>
<td>10.35</td>
<td>73.25</td>
<td>141.00</td>
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</tr>
<tr>
<td>2010-2011 (F)</td>
<td>52.46</td>
<td>7.81</td>
<td>69.52</td>
<td>126.00</td>
<td></td>
</tr>
<tr>
<td>2010-2011 (A)</td>
<td>57.40</td>
<td>10.35</td>
<td>73.25</td>
<td>141.00</td>
<td></td>
</tr>
<tr>
<td>2009-2010 (F)</td>
<td>53.31</td>
<td>8.09</td>
<td>65.50</td>
<td>126.90</td>
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<tr>
<td>2009-2010 (A)</td>
<td>57.40</td>
<td>73.25</td>
<td>10.35</td>
<td>141.00</td>
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<tr>
<td>2008-2009 (F)</td>
<td>58.10</td>
<td>7.98</td>
<td>69.92</td>
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<tr>
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<td>57.40</td>
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<td>141.00</td>
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<tr>
<td>2007-2008 (F)</td>
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<td>8.54</td>
<td>65.52</td>
<td>135.00</td>
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<tr>
<td>2007-2008 (A)</td>
<td>57.40</td>
<td>10.35</td>
<td>73.25</td>
<td>141.00</td>
<td></td>
</tr>
</tbody>
</table>

J. Detailed Justification for FTEs:
(1) Justification for New FTEs
(a) Justification:
(b) Future Impact on Operating Expenses or Facility Requirements:

(2) **Position Details:**

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
III. Budget

Category Justification Sheet

A. Summary description of programs and how they relate to the mission of the Agency:

887 Integrated Personal Care Administration:
Provides field supervision and coordinates the flow of information to nursing staff responsible for assessing residents in CRCF to determine eligibility for participation in the Integrated Personal Care (IPC) Program. Coordinates, monitors, and evaluates implementation of program policies to assure consistency in the statewide application of provider participation requirements; provides technical assistance to CRCFs interested in enrolling as providers of IPC services; collaborated with other state agencies, advocacy, and provider groups to ensure efficient working relationships and effective use of resources.

889 Clinic Services Administration:
Provide support to providers including Outpatient Pediatric Aids Clinics, End Stage Renal Disease Clinics, Infusion Centers and Ambulatory Surgery Centers through claim resolution and processing, policy, development, interpretation and clarification, rate setting and assisting with budget management.

- Hospitals: FY 2011 - Total number of recipients - 5,061 and Total paid claims - $11,951,280
- ASC: FY 2011 - Total number of recipients - 8,147 and Total paid claims - $4,430,958
- IC: FY 2011 - Total number of recipients – 401 and Total paid claims - $3,516,301

891 Durable Medical Equipment Administration:
Establish policy, procedures, and guidelines for provision of Durable Medical Equipment and supplies. Conduct prior authorization for equipment and supplies.

- FY 2011 Total number of recipients - 69,067
- FY 2011 Total paid claims - $47,728,973

893 Coordinated Care Administration:
Provides oversight and support to current Medicaid Managed Care Organizations (MCO), Medical Home Networks (MHN), and the Medically Complex Children’s Waiver Program (MCCW). The program conducts a continual quality improvement initiative with the MCOs and PPCM Networks in support of improved health outcomes for enrolled members in accordance with Federal regulations (42 CFR 438).

Healthcare outcomes are based on current Healthcare Effectiveness Data and Information Set (HEDIS) measures.

HEDIS measures are a required deliverable to SCDHHS for both MCOs and MHNs. External quality review of both MCOs and MHNs are conducted by a third party vendor. Quality review focuses on compliance with federal regulations (42 CFR 438) and SCDHHS contractual requirements. The program contracts with an independent research group to measure cost effectiveness and quality, perform annual member satisfaction survey, and publish the annual Managed Care report card.

902 Hospital Services Administration:
Establishes policies, procedures, and guidelines for delivery of services in acute care hospitals. Conducts prior authorization and prepayment medical reviews for hospital services. Support hospital providers through claims resolution and processing, policy development, interpretation and clarification. Manages the Quality Improvement Organization (QIO) contract.

- FY 2011 Total number of recipients - 71,955
- FY 2011 Total paid claims - $702,610,806

Outpatient hospital services provides diagnostic, therapeutic, rehabilitative or palliative items or services generally not to exceed a 24-hour period.

- FY 2011 Total number of recipients - 267,755
- FY 2011 Total amount paid claims - $220,782,828

904 Nursing Facility Administration:
Coordinates, manages and monitors statewide activities for nursing facilities, hospital swing beds and other facility based long term care programs; oversees the survey and certification process for long term care facilities, the South Carolina Nurse Aide Testing and Training Program, South Carolina Paid Feeding Assistant Program and claims processing and
resolution functions; oversees administrative contracts and memorandums of agreement; responsibilities include contract
negotiations and renewal, budgeting, encumbrances, monitoring for compliance and budgetary restraints and payment;
develops and maintains program related policies, procedures, manuals, Medicaid Bulletins, and forms which are in accordance with state and federal regulations; maintains policy manuals in accordance with Agency policy and regulation changes; compiles and analyzes information, conducts research activities, proposes long range and short-term strategies, and advises Agency on program policy changes required based on information researched. Performs research analysis activities and conducts training. Directs or assists in program evaluation as needed. Collaborates with other state agencies, advocacy, and provider groups to ensure efficient working relationships and effective use of resources.

906 Pharmaceutical Services Administration:
Provides support to providers participating in the Medicaid program through claims resolution/processing, policy
development, and interpretation/clarification. Administers the Pharmacy Benefits Manager contract, and supports the
Pharmacy and Therapeutics Committee.

908 Physician Services Administration:
Provides support to primary care physicians and over 40 different practice specialty physicians and associated health
groups participating in the Medicaid program through claims resolution and processing, policy development,
interpretation and clarification, rate setting, and assisting with budget management. This department also manages
contracts and programs designed to provide/encourage immunizations, rural health care, and health screenings for
children

910 Dental Services Administration:
Provides support to dental providers participating in the Medicaid program through claims resolutions and processing,
policy development, interpretation and clarification. Provide oversight of the contracted Dental Services
Administrative Service Organization. Monitors contracts for State Agency services (DHEC) and Maxillofacial
Surgeries.

912 Community Long Term Care Administration:
Manages statewide operation of the Community Long Term Care Programs (CLTC). These programs include four
home and community-based waivers and children’s personal care services with a daily census of approximately 14,000
recipients.

CLTC Administration oversees 13 regional offices staffed with approximately 170 Agency employees. The area
administration screens Medicaid nursing facility applicants and determines whether each individual’s medical necessity
criteria are met. The administration also oversees provider contracting, compliance and technical assistance and
training for over 3,000 CLTC providers. They provide quality monitoring for contracted providers. Budget analyses
and fiscal impact statements for CLTC budgeted activities are conducted by the CLTC Administration.

CLTC also prepares federally mandated reports on CLTC activities and work with developers to implement and support
the Care Call and Phoenix software applications. Additionally, the administration updates the applications to work
toward system improvements and oversees CLTC contracts and grants with other state agencies, private firms and the
federal government.

914 Home Health Services Administration:
Compiles and analyzes Home Health program budget expenditures and program utilization data; prepares forecasts for
planning and budget purposes; coordinates with internal Agency staff and MCCS, the reimbursement contractor, to
assure claims are processed correctly and provider reenrollment and reimbursement are expedited; researches, analyzes,
and compiles information on federal and state legislation, regulations, manuals and directives; develops and maintains
program related policies, procedures, manuals, provider agreements seeking input from relevant divisions within the
Agency; coordinates regional and statewide workshops as necessary to disseminate program information for staff of
home health.

916 EPSDT Screening Administration:
Provide support and assistance to physicians who participate in the Early and Periodic Screening, Diagnostic, and
Treatment service (EPSDT).
918 **Medical Professional Services Administration:**
Provide support to optometrists, opticians, podiatrists, audiologists, chiropractors, and speech therapists, physical and occupational therapists participating in the Medicaid program through claims resolution/processing, policy development, interpretation/clarification.

920 **Transportation Services Administration:**
Provide on-site to the Medicaid transportation program by monitoring broker contracts for non-emergency transportation. Assist with claims for Emergency Ambulance Transportation. Assists in coordination of out of state medically necessary services. Oversight of contracts with DSS, the Lieutenant Governor’s Office on Aging, several school districts and the SC school for the Deaf and Blind.

922 **Lab & X-Ray Services Administration:**
Provides support to laboratory and radiology providers participating in the Medicaid program through claims resolution, processing, policy development, interpretation and clarification.

924 **Family Planning Administration:**
Provides support to family planning providers, including Adolescent Pregnancy Prevention Services, participating in the Medicaid program through claims resolution & processing, policy development, interpretation & clarification.

927 **Hospice Care Administration:**
Coordinates, manages and oversees Statewide activities for Medicaid enrolled hospice providers; conducts the Prior Authorization approval process; makes recommendations to existing Medicaid hospice forms; provides the hospice claims processing resolution functions for nursing facilities. The program coordinates training for providers and provides information and technical assistance to Medicaid providers, state and federal officials, other agencies and individuals; researches and analyzes Medicaid Management Information System (MMIS) claims data to identify problem provider billing practices; researches and analyzes pre-payment and post payment MMIS claims processing to resolve suspended and rejected claims. Collaborates with staff and Provider Outreach to develop Medicaid Bulletins, presentation materials, and handouts. Develops and maintains program related policies, procedures, manuals, Medicaid bulletins, and forms which are in accordance with state and federal regulations. Maintains program manuals in accordance with Agency policy and regulation changes. Responsible for coordinating the contractual activities for hospice providers: duties include contract negotiations and renewal, budgeting, encumbrances, monitoring for compliance and budgetary restraints and payment; collaborates with other state agencies, advocacy, and provider groups to ensure efficient working relationships and effective use of resources.

929 **Optional State Supplemental Administration:**
Coordinates program implementation, daily administrative and fiscal activities of the OSS Program; conducts the long range and short term program planning activities which include monitoring the legislative proviso and federal law. Receives, reviews and responds to various inquiries and requests from CRCF operators and consumers; provides technical assistance regarding payment process, reimbursement issues and erroneous billing documents utilizing MMIS; develops and maintains program related policies, procedures, manuals, provider agreements, OSS Advisories, and handbooks, seeking input from relevant divisions within the Agency; relates information to statewide needs and slot allocation through the implementation and monitoring of the waiting list process, working closely with CLTC state office and local staff.

941 **Other Agencies Administration:**
Provides support to Other Agencies participating in the Medicaid program through claims resolution & processing, policy development, interpretation and clarification. Responsible for the oversight of State Agency Contracts.

937 **Disproportionate Share:**
The Medicaid Disproportionate Share Hospital (DSH) Program provides funding for inpatient hospitals that serve a disproportionate share of low income individuals. Federal funding is provided by Congress through the annual DSH allotment process. States are allowed flexibility when establishing state specific DSH qualification criteria which can be less restrictive than those prescribed in the law but in order to receive DSH payments a qualifying hospital must have at least a one percent Medicaid utilization rate as well as meet the federal OB requirement. The DSH program provides payment to qualifying hospitals for the unreimbursed cost of providing inpatient and outpatient hospital services to South Carolina Medicaid eligible and uninsured individuals. The state matching portion of these payments are provided
through a combination of certified public expenditures (CPE), hospital provider taxes, and state appropriations. Currently, all South Carolina general acute care hospitals, as well as all state owned governmental psychiatric hospitals, qualify for the South Carolina Medicaid DSH Program. Based upon the most recent (i.e. October 1, 2010 through September 30, 2011) DSH payment period, approximately sixty-one percent (61%) of hospitals unreimbursed costs of providing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals were reimbursed at a total cost of approximately $468 million.

Currently 67 hospitals participate in the SC Medicaid DSH Program and are broken down as follows:

- 60 - South Carolina General Acute Care Hospitals
- 1 - South Carolina Long Term Acute Care Hospitals
- 3 - SC State Owned Governmental Psych Hospitals
- 3 - Out of State Border General Acute Care Hospital

Agency oversight of this program is primarily the responsibility of the Bureau Chief of Reimbursement Methodology and Policy and staff within the Division of Acute Care Reimbursements within the Bureau of Reimbursement Methodology and Policy. Coordination of payments is made with assistance from the Bureau of Fiscal Affairs.

**939 Palmetto Senior Care**

The Program of All-inclusive Care (PACE) is care alternative under the Medicaid State Plan that is jointly funded by Medicare/Medicaid. The PACE program is a long term care alternative to the home and community-based waiver (HCB) program or nursing facility (NF) options. PACE is a program of comprehensive care that provides all primary and long-term care services to participants age 55 and older that meet the State’s nursing facility level of care criteria, and who can be safely cared for in the community through an inter-disciplinary team approach.

There are currently two PACE providers, an urban and a rural provider, and each serves a two county area; Richland and Lexington, and Orangeburg and Calhoun counties.

As a national managed care program, PACE providers are reimbursed through monthly prospective capitated payments from Medicare and Medicaid. Most PACE participants are eligible for both Medicare and Medicaid, and PACE programs receive monthly payment from both sources for each participant as eligible. As an all-inclusive program it is required to cover all services available through Medicare and Medicaid, including hospitalizations and nursing facility costs when a participant is enrolled in the program, it is a cost effective alternative to nursing facility placement. The reimbursement is based on a composite blended rate of HCB waiver and NF costs. During FY2011 PACE reimbursement was reduced 3 percent, and in FY2012 PACE enrollment limits were allocated to the respective programs. Administration of the program is provided by the Division of Community Options.

- FY 2011 Number enrolled: 412
- FY 2011 Expenditures: $11,865,663

**944 Automated Claims Processing:**

The South Carolina Department of Health and Human Services' (SCDHHS) Automated Claims Processing is completed using the State’s Medicaid Management Information System (MMIS) is used to enroll providers, adjudicate claims, pay providers, report costs and utilization, and enroll recipients into special programs. The MMIS also supports Medicaid reporting including federal MMIS reporting, coordination of the submission of Medicaid statistical information related to payments and eligibles to CMS for inclusion in the national MMIS database and coordinate the creation of data needed for federal CHIP reporting which summarize CHIP enrollment for SC. The MMIS also supports Medicaid Decision Support System (DSS) which houses statistical information related to Medicaid. The Department’s enterprise systems team oversees the development and maintenance of state policies, procedures and standards for pricing, procedures, provider enrollment, fund codes, and edit codes.

In FY2013, the MMIS system and team will be focused on the efforts of ICD-10 implementation as well as supporting the work towards MMIS replacement.

**946 Audits/Compliance:**

The Bureau of Compliance and Performance Review consists of three divisions: Program Integrity, Surveillance and Utilization Review (SUR) and Audit. The Division of Program Integrity, with a staff of nurses, pharmacy technicians, a dental hygienist, and licensed master social workers, performs investigations and reviews of providers and beneficiaries
suspected of fraud, abuse, or inappropriate utilization of Medicaid benefits. The Division also manages the Agency’s fraud hotline. The Division fulfills the federal Medicaid requirements for Program Integrity and utilization, and conducts post-payment reviews on all provider types. The Division also operates a pharmacy lock-in program for beneficiaries who show patterns of prescription drug seeking. The Division also manages the provider exclusion process and is responsible for oversight of the Recovery Audit Contractor program. The Division works closely with the SC Attorney General’s Office and makes referrals of providers and recipients suspected of Medicaid fraud. The Surveillance and Utilization Review (SUR) division is a key component of the bureau, and works closely with both Program Integrity and Audits. SUR staff conducts on-going data analysis to identify patterns in Medicaid claims data indicating waste, fraud, and abuse. Using various analytical tools, fraud algorithms, and a database with seven years worth of claims data, the division looks for aberrant billing trends among providers or for beneficiaries with a large volume of claims or prescriptions but no diagnoses of serious illness or injury.

The Bureau Chief is also the Internal Auditor for the Agency and can report the results of internal audits directly to the Agency Director. The Division of Audits follows generally accepted governmental auditing standards and performs periodic audits of managed care organizations under contract with SCDHHS to provide Medicaid benefits to members. The division also performs audits of cost reports and the Medicaid programs of other State agencies which received federal Medicaid funds through SCDHHS. The division also audits internal operations of the department for compliance with certain federal and state requirements and Agency policies and procedures, and also will be auditing recipients of Electronic Health Records incentive payments.

The Bureau does not provide services to beneficiaries but rather is responsible for key oversight, audit, and integrity functions within the Agency. Internal customers include provider program and policy divisions; beneficiary eligibility divisions; the Office of General Counsel; the Division of Appeals and Hearing; Bureau of Financial Affairs; the managed Care division; Reimbursement Methodology and Policy divisions; and the Director’s Office including legislative liaison and public information offices. External stakeholders include the SC Attorney General’s Office, other state agencies that deliver Medicaid funded services, managed care organizations, providers, beneficiaries, and tax payers.

This program generates significant income; in SFY 2011 more than $27 million was collected for overpayments due to waste, fraud and abuse

As part of the Bureau for Compliance and Performance Review, Audits, SUR, and Program Integrity (PI) activities are overseen by the Bureau Chief. The Division Director for Program Integrity reports directly to her. The Director for SURs also reports directly to the Bureau Chief. There are three program integrity departments (review teams) each with a supervisor who reports directly to the PI division director. Due to a recent reorganization of staff, the SURs director now functions as a senior consultant and no longer supervises staff; they have been moved to a program integrity team. In addition, the Division Director for Audits reports directly to the Bureau Chief and supervises six auditors, who usually work in teams of two to three auditors.

The Divisions of Program Integrity/SURs were formulated in response to federal requirements that the Medicaid Agency must have methods and criteria for identifying suspected fraud and abuse; must conduct preliminary investigations; and must refer cases to the Medicaid Fraud Control Unit in the SC State Attorney General’s Office. (42 CFR, §455 et. Seq.) The Agency must also have a state program of control for the utilization of all Medicaid services and a post payment review process that allows state personnel to develop and review recipient utilization profiles, provider service profiles, and exceptions criteria, and that identifies exceptions so that unnecessary utilization practices of beneficiaries and providers can be corrected (42 CFR, §456. 1- 23).

The SC Code of Laws, §44-6-30, mandates that SCDHHS administer the Medicaid program (Title XIX of the Social Security Act). The SCDHHS Division of Audits was formed to assist the Agency in the management, assessment, and improvement of Agency programs, services, and operations. The Division of Audits accomplishes these goals by reviewing and evaluating programs and contracts administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost effective manner.

The Bureau is responsible for ensuring compliance with multiple other federal requirements in addition to the 42 CFR §455 and §456, including:

- 4 CFR, §433.116 (e) through (h), Operation of Mechanized Claims Processing and Information Retrieval Systems
- 42 CFR, §433.304, Definitions of Abuse, Fraud and Overpayments.
• 42 CFR §433.312, Basic Requirements for Refunds:
• 42 CFR §433.316, Discovery of Overpayments
• 42 CFR §455.20, Recipient Verification Procedures
• 42 CFR §1002 et. Seq., State Initiated Exclusions from Medicaid
• 42 CFR §447.45, Timely claims payment
• 42 CFR §447.202 and 206 (c): Audit of records if payment is based on cost of services
• 42 CFR §438.608 - Program integrity requirements of managed care organizations.

The Bureau also primarily responsible for implementing other federal activities such as Medicaid Integrity Program (42 CFR, §455.200); the Recovery Audit Contractors Program (42 CFR, §455.500); the Payment Error Rate Measurement Program (PERM) (42 CFR §431.950); and the provisions of the Deficit Reduction Act of 2005 regarding Employee Education about False Claims Act.

The appropriation request for the Divisions of Program Integrity / SURs includes increases for staff expansion and other resources in order to increase recoveries and the identification/ prevention of fraud and abuse. The appropriate request for the Division of Audits anticipates replacing TGE positions with FTE positions but no expansion of staff.

B. **Budget Program Number and Name:**

II. A. 1. Medical Administration

**Agency Activity Number and Name:**
Note: If more than one activity maps to this program; provide all activity numbers, names, and approximate funding amounts.

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
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<td></td>
<td>$589,658</td>
</tr>
<tr>
<td>910</td>
<td>Dental Services Administration</td>
<td>$120,417</td>
<td>$259,719</td>
<td>$19,989</td>
<td></td>
<td>$400,125</td>
</tr>
<tr>
<td>912</td>
<td>Community Long Term Care Administration</td>
<td>$4,715,260</td>
<td>$10,170,059</td>
<td>$782,744</td>
<td></td>
<td>$15,668,063</td>
</tr>
<tr>
<td>914</td>
<td>Home Health Services Administration</td>
<td>$63,377</td>
<td>$136,694</td>
<td>$10,521</td>
<td></td>
<td>$210,592</td>
</tr>
<tr>
<td>916</td>
<td>EPSDT Screening Administration</td>
<td>$12,675</td>
<td>$27,339</td>
<td>$2,104</td>
<td></td>
<td>$42,118</td>
</tr>
<tr>
<td>918</td>
<td>Medical Professional Services Administration</td>
<td>$50,702</td>
<td>$109,355</td>
<td>$8,417</td>
<td></td>
<td>$168,474</td>
</tr>
</tbody>
</table>
C. Performance Measures:

887 Integrated Personal Care Administration:
The Department is in the process of completing a balance score card which will outline performance metrics.

889 Clinic Services Administration:

<table>
<thead>
<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2010 Actual</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td><strong>(Added &amp; Expand as Needed)</strong></td>
</tr>
<tr>
<td>ESRD</td>
</tr>
<tr>
<td>Transactions</td>
</tr>
<tr>
<td>Expenditures</td>
</tr>
<tr>
<td>Recipients</td>
</tr>
<tr>
<td>ASCs</td>
</tr>
<tr>
<td>Transactions</td>
</tr>
<tr>
<td>Expenditures</td>
</tr>
<tr>
<td>Recipients</td>
</tr>
<tr>
<td>ICs</td>
</tr>
<tr>
<td>Transactions</td>
</tr>
<tr>
<td>Expenditures</td>
</tr>
<tr>
<td>Recipients</td>
</tr>
</tbody>
</table>

891 Durable Medical Equipment Administration:

<table>
<thead>
<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2010 Actual</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td><strong>(Added &amp; Expand as Needed)</strong></td>
</tr>
<tr>
<td>DME</td>
</tr>
<tr>
<td>Transactions</td>
</tr>
<tr>
<td>Expenditures</td>
</tr>
<tr>
<td>Recipients</td>
</tr>
</tbody>
</table>
893 Coordinated Care Administration:
The Department is in the process of completing a balance score card which will outline performance metrics.

902 Hospital Services Administration:

<table>
<thead>
<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>FY 2012 Target</th>
<th>FY 2013 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transactions</td>
<td>96,659</td>
<td>92,179</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditures</td>
<td>$660,332,069</td>
<td>$702,610,806</td>
<td>$623,328,832</td>
<td>$662,087,236</td>
</tr>
<tr>
<td>Recipients</td>
<td>76,494</td>
<td>71,955</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transactions</td>
<td>822,321</td>
<td>810,365</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditures</td>
<td>$217,649,208</td>
<td>$220,782,828</td>
<td>$205,902,361</td>
<td>$214,778,132</td>
</tr>
<tr>
<td>Recipients</td>
<td>277,364</td>
<td>267,755</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Generic Dispensing Rate – This is the percentage of all claims that were dispensed with a generic product.

Generic Substitution Rate – This is the percentage of claims dispensed with a generic product when a generic product was available.

904 Nursing Facility Administration:
The department is in the process of completing a balance score card which will outline performance metrics.

906 Pharmaceutical Services Administration:

<table>
<thead>
<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>FY 2012 Target</th>
<th>FY 2013 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Dispensing Rate</td>
<td>70.9%</td>
<td>72.9%</td>
<td>Measure</td>
<td>Measure</td>
</tr>
<tr>
<td>Generic Substitution Rate</td>
<td>89.9%</td>
<td>90.5%</td>
<td>Measure</td>
<td>Measure</td>
</tr>
</tbody>
</table>

908 Physician Services Administration:

<table>
<thead>
<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Actual</th>
<th>FY 2012 Target</th>
<th>FY 2013 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Prompt Payment Rule</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Program Timely Claim Return</td>
<td>0.049%</td>
<td>0.045%</td>
<td>Measure</td>
<td>Measure</td>
</tr>
</tbody>
</table>

Federal Prompt Payment – The Prompt Payment Final Rule agencies to pay commercial obligations within certain time periods. The requirement for Medicaid claims processing is 90 percent of all claims within 30 days of receipt and 99 percent within 90 days.

Program Timely Claim Return – The time allowed by the Agency for claims to be returned from the program area to the claims processing center to help meet the federal prompt payment rule. The program area has 30 days to complete and return claims that are suspended for staff to resolve and/or make decisions on edits. This figure represents the percentage of claims exceeding the allowed 30 days processing time.
910 Dental Services Administration:
- Monitor and audit ASO contract and reports.
- Ensure access to services for beneficiaries served.

912 Community Long Term Care Administration:
The Department is in the process of completing a balance score card which will outline performance metrics.

914 Home Health Services Administration:
The Department is in the process of completing a balance score card which will outline performance metrics.

916 EPSDT Screening Administration:

<table>
<thead>
<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2010 Actual</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>(Added &amp; Expand as Needed)</td>
</tr>
<tr>
<td>Federal Prompt Payment</td>
</tr>
<tr>
<td>Program Timely Claim Return</td>
</tr>
</tbody>
</table>

**Federal Prompt Payment** – The Prompt Payment Final Rule requires agencies to pay commercial obligations within certain time periods. The requirement for Medicaid claims processing is 90 percent of all claims within 30 days of receipt and 99 percent within 90 days.

**Program Timely Claim Return** – The time allowed by the Agency for claims to be returned from the program area to the claims processing center to help meet the federal prompt payment rule. The program area has 30 days to complete and return claims that are suspended for staff to resolve and/or make decisions on edits. This figure represents the percentage of claims exceeding the allowed 30 days processing time.

918 Medical Professional Services Administration:

<table>
<thead>
<tr>
<th>Key Program Performance Indicators &amp; Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2010 Actual</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>(Added &amp; Expand as Needed)</td>
</tr>
<tr>
<td>Federal Prompt Payment</td>
</tr>
<tr>
<td>Program Timely Claim Return</td>
</tr>
</tbody>
</table>

**Federal Prompt Payment** – The Prompt Payment Final Rule agencies to pay commercial obligations within certain time periods. The requirement for Medicaid claims processing is 90 percent of all claims within 30 days of receipt and 99 percent within 90 days.

**Program Timely Claim Return** – The time allowed by the Agency for claims to be returned from the program area to the claims processing center to help meet the federal prompt payment rule. The program area has 30 days to complete and return claims that are suspended for staff to resolve and/or make decisions on edits. This figure represents the percentage of claims exceeding the allowed 30 days processing time.

920 Transportation Services Administration:
Monitor and audit Brokers and their provider network to ensure quality services are provided. Corrective actions will be required if deficiencies are cited.

922 Lab & X-Ray Services Administration:
Federal Prompt Payment – The Prompt Payment Final Rule agencies to pay commercial obligations within certain time periods. The requirement for Medicaid claims processing is 90 percent of all claims within 30 days of receipt and 99 percent within 90 days.

Program Timely Claim Return – The time allowed by the Agency for claims to be returned from the program area to the claims processing center to help meet the federal prompt payment rule. The program area has 30 days to complete and return claims that are suspended for staff to resolve and/or make decisions on edits. This figure represents the percentage of claims exceeding the allowed 30 days processing time.

924 Family Planning Administration:

Federal Prompt Payment – The Prompt Payment Final Rule agencies to pay commercial obligations within certain time periods. The requirement for Medicaid claims processing is 90 percent of all claims within 30 days of receipt and 99 percent within 90 days.

Program Timely Claim Return – The time allowed by the Agency for claims to be returned from the program area to the claims processing center to help meet the federal prompt payment rule. The program area has 30 days to complete and return claims that are suspended for staff to resolve and/or make decisions on edits. This figure represents the percentage of claims exceeding the allowed 30 days processing time.

927 Hospice Care Administration

The department is in the process of completing a balance score card which will outline performance metrics.

929 Optional State Supplemental Administration:

The Department is in the process of completing a balance score card which will outline performance metrics.

941 Other Agencies Administration:

The Department is in the process of completing a balance score card which will outline performance metrics.

937 Disproportionate Share:
### III. Budget Category Justification Sheet

| South Carolina Department of Health & Human Services (SCDHHS) |
|---|---|---|---|---|
| FY 2010 | FY 2011 | FY 2012 | FY 2013 |
| Actual | Actual | Target | Target |

**(Added & Expand as Needed)**

<table>
<thead>
<tr>
<th># of DSH Qualifying Hospitals by FFY</th>
<th>68</th>
<th>67</th>
<th>67</th>
<th>67</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total DSH Dollars Paid/Proj. by FFY</td>
<td>$481,165,732</td>
<td>$468,087,951</td>
<td>$475,156,718</td>
<td>$483,709,539</td>
</tr>
<tr>
<td>Percentage of Unreimbursed Cost Paid or Projected to be Paid by FFY</td>
<td>69%</td>
<td>61%</td>
<td>60%</td>
<td>59%</td>
</tr>
</tbody>
</table>

---

### 939 PACE

Monitor providers related to designated census limits:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Fy2009</th>
<th>Fy2010</th>
<th>Fy2011</th>
<th>Fy2012</th>
<th>Fy2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmetto SeniorCare</td>
<td>348</td>
<td>400</td>
<td>335</td>
<td>400</td>
<td>Est. 330</td>
</tr>
<tr>
<td>The Oaks PACE</td>
<td>23</td>
<td>139</td>
<td>69</td>
<td>139</td>
<td>Est. 125</td>
</tr>
<tr>
<td>Actual Census Total</td>
<td>371</td>
<td>539</td>
<td>404</td>
<td>539</td>
<td>Est. 455</td>
</tr>
<tr>
<td>Unduplicated Total</td>
<td>433</td>
<td>475</td>
<td>492</td>
<td>Est. 545</td>
<td></td>
</tr>
</tbody>
</table>

Automated Claims Processing:

<table>
<thead>
<tr>
<th>Provider</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmetto SeniorCare</td>
<td>&lt; 30 days</td>
<td>&lt; 21 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Oaks PACE</td>
<td>&lt; 30 days</td>
<td>&lt; 30 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 946 Audits/Compliance:

**Key Program Performance Indicators & Measures**

<table>
<thead>
<tr>
<th>Provider</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider fraud/ abuse cases opened</td>
<td>585</td>
<td>305</td>
<td>320</td>
<td>336</td>
</tr>
<tr>
<td>Provider fraud/ abuse cases closed</td>
<td>250</td>
<td>472</td>
<td>496</td>
<td>519</td>
</tr>
<tr>
<td>Provider fraud/ abuse cases in progress</td>
<td>530</td>
<td>181</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Recipient fraud/ abuse cases opened</td>
<td>272</td>
<td>426</td>
<td>447</td>
<td>468</td>
</tr>
<tr>
<td>Recipient fraud/ abuse cases closed</td>
<td>116</td>
<td>98</td>
<td>103</td>
<td>107</td>
</tr>
<tr>
<td>Recipient fraud/ abuse cases in progress</td>
<td>273</td>
<td>601</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>RAC Cases In Progress</td>
<td>NA</td>
<td>276</td>
<td>300</td>
<td>325</td>
</tr>
<tr>
<td>Fraud hotline calls</td>
<td>4542</td>
<td>2198</td>
<td>2200</td>
<td>3000</td>
</tr>
<tr>
<td>Complaints from all sources</td>
<td>1154</td>
<td>1297</td>
<td>1427</td>
<td>1569</td>
</tr>
<tr>
<td>Provider Recoveries</td>
<td>$3,833,584</td>
<td>$7,117,332</td>
<td>$10,675,998</td>
<td>$15,480,197</td>
</tr>
<tr>
<td>Recipient Recoveries</td>
<td>$444,214</td>
<td>$371,820</td>
<td>$500,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>RAC Recoveries</td>
<td>NA</td>
<td>$4,298,189</td>
<td>$5,000,000</td>
<td>$7,250,000</td>
</tr>
<tr>
<td>All Recoveries Including Globals</td>
<td>$41,140,383</td>
<td>$27,589,811</td>
<td>$41,384,717</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>Provider Fraud Referrals</td>
<td>12</td>
<td>15</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>
### III. Budget Category Justification Sheet

<table>
<thead>
<tr>
<th>Category</th>
<th>J02</th>
<th>South Carolina Department of Health &amp; Human Services (SCDHH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient Fraud Referrals</td>
<td>242</td>
<td>230 288 300</td>
</tr>
<tr>
<td>Beneficiary Lock-in</td>
<td>100</td>
<td>200 400 400</td>
</tr>
<tr>
<td>Return on Investment</td>
<td>NA</td>
<td>$7.49 to $1</td>
</tr>
</tbody>
</table>

**Division of Audits**

| # of Audit Reports Published   | 3  | 2  | 5  | 6  |
| # of Audit Recommendation      | 16 | 18 | NA | NA |
| $ Value of Programs Reviewed   | $3,966,638 | $120,187,213 | NA | NA |
| $ Value of Errors Identified   | $1,181,326 | $429,985 | NA | NA |
| Recoupment recommended         | $10,356 | $429,985 | NA | NA |
| EHR Audits                     | NA  | NA  | 25 | 25 |

### D. Program Interaction:

**887 Integrated Personal Care Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

**889 Clinic Services Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

**891 Durable Medical Equipment Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

**893 Coordinated Care Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

**902 Hospital Services Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

**903 Nursing Facility Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

**906 Pharmaceutical Services Administration:**
This program interacts with pharmacy providers and support staff in an effort to process pharmacy claims in the most efficient and timely manner possible. The program interacts with chain drug stores, independent drug stores, their associations, and other interested parties as it relates to policy, reimbursements and drug coverage.

**908 Physician Services Administration:**
This program interacts with providers and support staff in an effort to maintain physicians and other professional staff that delivers services directly to our recipients. The Department interacts with CMS, Sate Agencies, Associations and other entities to ensure that we are meeting the needs of all of our customers.

**910 Dental Services Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.
912 **Community Long Term Care Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

914 **Home Health Services Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

916 **EPSDT Screening Administration:**
This program interacts with providers and support staff in an effort to maintain physicians and other professional staff that delivers services directly to our recipients. The Department interacts with CMS, State Agencies, Associations and other entities to ensure that we are meeting the needs of all of our customers.

918 **Medical Professional Services Administration:**
This program interacts with providers in an effort to maintain professional staff that delivers services directly to our recipients. The Department interacts with CMS, State Agencies, Associations and other entities to ensure that we are meeting the needs of all of our customers.

920 **Transportation Services Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

922 **Lab & X-Ray Services Administration:**
This program interacts with providers and support staff in an effort to maintain physicians and other professional staff that delivers services directly to our recipients. The Department interacts with CMS, State Agencies, Associations and other entities to ensure that we are meeting the needs of all of our customers.

924 **Family Planning Administration:**
This program interacts with providers and support staff at state agencies and other contractors that deliver services directly to our recipients. The Department interacts with CMS, State Agencies, Associations and other entities to ensure that we are meeting the needs of all of our customers.

927 **Hospice Care Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

929 **Optional State Supplemental Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

941 **Other Agencies Administration:**
Recent organizational changes have the program interactions remaining under development by the senior leadership team.

937 **Disproportionate Share:**
Coordination of DSH payments are made with assistance from staff from the Bureau of Fiscal Affairs to ensure the availability of state and federal funds prior to the release of the quarterly DSH payments. Only inpatient hospitals are eligible to receive SC Medicaid DSH payments. No other Medicaid service area receives Medicaid payments for services provided to the uninsured.

939 **PACE**
The PACE program is administered by the Division of Community Options, with involvement of the respective county community Long-term Care (CLTC) regional office staff. Nurses in those offices are responsible for initial assessments to determine if applicants meet the Nursing Facilities level of care criteria, and coordinate with the PACE provider staff. The assessments are performed utilizing the CLTC Phoenix case management software system.

944 **Automated Claims Processing:**
The MMIS is used through the Department and at many other State agencies. The MMIS system is operated by Clemson University and leverages the Clemson data center and technical expertise.

**946 Audits/Compliance:**

As noted in the Program Description, the Bureau coordinates and interacts with other divisions within the Agency to:

- Enforce Medicaid policy and coverage standards,
- Identify waste, fraud, abuse, and inappropriate payments
- Collect overpayments and remit to financial department to offset Agency operations
- Develop provider and beneficiary utilization reports to aide in cost avoidance and policy decisions
- Identify aberrant providers and change provider behavior through education, sanctions, or termination from the program
- Make recommendations for improvements in Agency operating policies
- Review internal controls for effectiveness
- Ensure Agency compliance with findings and recommendations federal and state audits
- Manage the State Exclusion list to ensure that Federal Financial Participation (FFP) is not claimed for excluded providers
- Manage beneficiary Pharmacy Lock-in to help control use of prescription drugs
- Carry out federally-mandated audit and integrity activities

If the Bureau’s programs were terminated, it would be next to impossible to provide the required oversight of the Medicaid program. Identification and prevention of fraud and abuse would be severely hampered, and expenditures by abusive providers would result in increased program costs without a corresponding increase in health care outcomes. The Agency would risk the loss of billions in federal funds if the required Program Integrity/ SUR/Audit functions were not in place.

**E. Change Management:**

**887 Integrated Personal Care Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

**889 Clinic Services Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

**891 Durable Medical Equipment Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

**893 Coordinated Care Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. Coordinated Care has shifted from a penetration rate of 30 percent of the eligible population to approximately 80 percent of the eligible population in efforts to better manage the health of the beneficiaries.

**902 Hospital Services Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

**904 Nursing Facility Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.
906 **Pharmaceutical Services Administration:**
The program is managed by Magellan Health; they adjudicate claims at the point of sale, help develop cost saving initiatives, and implement IT solutions. They have provided contract services for the past five years and implemented numerous changes to control cost and provide a quality service.

908 **Physician Services Administration:**
The administrative mission of the Agency over the past year for this program has been to streamline policies and to remove waste out of the program. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed. Plans are being developed to implement a new claims processing system that will allow greater flexibility in managing policy changes in a more efficient and timely manner.

910 **Dental Services Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. The majority of dental administration has been outsourced to an Administrative Service Organization in efforts to ensure proper utilization.

912 **Community Long Term Care Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

914 **Home Health Services Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

916 **EPSDT Screening Administration:**
The administrative mission of the Agency over the past year for this program has been to increase utilization of this preventative health service. The goal of increased utilization of this service is to be proactive with healthcare and help reduce or avoid more costly expenses related to untreated medical conditions. Plans are being developed to implement a new claims processing system that will allow greater flexibility in managing policy changes in a more efficient manner.

918 **Medical Professional Services Administration:**
The administrative mission of the Agency over the past year for this program has been to streamline policies and to remove waste out of the program. We have implemented numerous policy changes as a response to the budget constraints that the Agency has addressed. Plans are being developed to implement a new claims processing system that will allow greater flexibility in managing policy changes in a more efficient manner.

920 **Transportation Services Administration:**
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. The program administration has been outsourced to a transportation broker in the past five years and recently implemented a new broker.

922 **Lab & X-Ray Services Administration:**
The administrative mission of the Agency over the past year for this program has been to streamline policies and to remove waste out of the program. The department has implemented numerous policy changes as a response to the budget constraints that the Agency has addressed. Plans are being developed to implement a new claims processing system that will allow greater flexibility in managing policy changes in a more efficient manner.

924 **Family Planning Administration:**
Staff has worked to ensure that all related billable codes are covered to maximize enhanced Federal match for family planning services. Plans are being developed to implement a new claims processing system that will allow greater flexibility in managing policy changes in a more efficient manner. The family planning program has been expanded to include services for both female and male recipients.
Hospice Care Administration:
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

Optional State Supplemental Administration:
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates. We have implemented numerous policy changes as a response to the budget constraints that the Agency has managed.

Other Agencies Administration:
The administrative mission of the Agency over the past year has been to streamline policies, eliminate waste from the programs and to determine the most appropriate reimbursement rates including contracts and arrangements with other agencies.

Disproportionate Share:
Over the past five years the mission and focus of the DSH program has not changed, as the mission has been to reimburse qualifying DSH hospitals for the unreimbursed costs of providing inpatient and outpatient hospital services to the South Carolina uninsured and Medicaid managed care enrollees (inpatient and outpatient hospital services provided to Medicaid fee for service recipients have been reimbursed at cost so there is no unreimbursed cost to claim in the calculation of the DSH payments). Starting with the federal fiscal year 2011 DSH payment program, federally required audits of all state Medicaid DSH Programs could result in the redistribution of SC Medicaid DSH funds among SC Medicaid qualifying DSH hospitals.

Beginning with SFY 2012, the Agency will begin to refocus on the FFY 2012 DSH payment program to ensure that hospitals which serve a disproportionate share of low income individuals are exempted from the five percent DSH payment reduction beginning October 1, 2011. Additionally, with the implementation of the provisions of the Affordable Care Act over time, federal DSH funding is expected to drop as more uninsured individuals become insured which will require the Agency to reassess the mission of its Disproportionate Share program.

PACE:
The mission of the PACE program has been to provide another cost effective option to HCB waiver programs and NF placement in the State’s long term care continuum. The program serves Medicaid eligible individuals who are frail and at-risk for institutional placement.

In 2006, Federal authority was modified to facilitate the expansion of PACE into rural settings. In 2008, the State was approved to establish a Rural PACE site and a new provider began operations.

Automated Claims Processing:
Automated Claims Processing has changed in the last year with the introduction of an electronic workflow through Blue Cross Blue Shield of South Carolina that handles the provider network support and claims issue resolution. In SFY2011 through SFY2014, the automated claims processing will be updated to support federally mandated efforts in support of HIPAA 5010 (January 2012) and the United States move to ICD-10 (October 2013). The Automated Claims Processing will change materially in the future as SCDHHS is in the process of replacing its MMIS system. This major update to system and business processes is expected to enable SCDHHS to undergo a significant modernization and transformation.

Audits/Compliance:
In general, the mission and focus of the Bureau have not changed, and a recurring goal is to increase identification of and recoveries from waste, non-compliance, improper payments, fraud and abuse. However, new areas of focus include: Direct program integrity auditing of providers in a managed care network.

This will require increased coordination with managed care SIU / compliance officers as well as new approaches to using managed care encounter (claims) data. This may also require changes in managed care contracts and operating procedures.
Development of a beneficiary fraud prevention unit is planned. The number of individuals eligible for Medicaid will increase (as anticipated by the Affordable Care Act), and the majority of the new beneficiaries will be enrolled in the Medicaid managed care program. The Agency faces an increased risk of paying premiums for ineligible members. A “pre-eligibility intervention” is needed to divert applicants (that meet certain risk criteria) from the eligibility approval process for investigation and review. Significant cost avoidance (millions of dollars) is assured. (Note: Not in budget request at this time).

F. Detailed Funding Information:

<table>
<thead>
<tr>
<th>FY 2012-13 Cost Estimates:</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs*</td>
<td>186.23</td>
<td>350.01</td>
<td>18.76</td>
<td>555.00</td>
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<td>Personal Service</td>
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<td>Employer Contributions</td>
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<td>Program/Case Services</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
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<td>Pass-Through Funds</td>
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<td>$0</td>
<td>$0</td>
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<td>$0</td>
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<td>Other Operating Expenses</td>
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<td>$9,393,757</td>
<td>$20,308,912</td>
<td>$1,546,163</td>
<td>$31,248,832</td>
</tr>
</tbody>
</table>

* If new FTEs are needed, please complete Section G (Detailed Justification for FTEs) below.

Is this budget category or program associated with a Capital Budget Priority? No
If yes, state Capital Budget Priority Number and Project Name:

Please List proviso numbers that relate to this budget category or programs funded by this category.

G. Changes to the Appropriation:

Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

<table>
<thead>
<tr>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012 Act</td>
<td>$9,393,757</td>
<td>$20,308,912</td>
<td>$1,546,163</td>
<td></td>
</tr>
<tr>
<td>2012-2013 Act</td>
<td>$9,393,757</td>
<td>$20,308,912</td>
<td>$1,546,163</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>% Difference</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Explanation of Changes:

H. Revenue Estimates:

Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
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<th>Restricted</th>
<th>Federal</th>
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<tr>
<td>34420000</td>
<td>Special Grants</td>
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<td>$1,546,163</td>
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</table>
III. Budget Category Justification Sheet

J02

South Carolina Department of Health & Human Services (SCDHHHS)

50000000 Federal Funds

$20,308,912

If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

Please detail the long-term sustainability of this program if cash reserves are needed to operate.

If there is federal fund or other fund spending authority requested above the revenue streams detailed above, please indicate the amount and explanation for each.

I. FTE Positions:

Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other- Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
<th>Temporary, Temporary Grant, Time -limited</th>
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<tr>
<td>2012-2013</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>2011-2012</td>
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<td>556.84</td>
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<td>2009-2010</td>
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<td>16.69</td>
<td>281.09</td>
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<tr>
<td>2009-2010</td>
<td>186.88</td>
<td>18.76</td>
<td>351.36</td>
<td>557.00</td>
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<tr>
<td>2008-2009</td>
<td>162.41</td>
<td>35.48</td>
<td>286.11</td>
<td>484.00</td>
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<tr>
<td>2008-2009</td>
<td>162.41</td>
<td>35.48</td>
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<td>2007-2008</td>
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<td>303.74</td>
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J. Detailed Justification for FTEs:

(1) Justification for New FTEs
(a) Justification:

(b) Future Impact on Operating Expenses or Facility Requirements:

(2) Position Details:

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
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<tr>
<td>Personal Service</td>
<td>$0</td>
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<td>Employer Contributions</td>
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<table>
<thead>
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<tr>
<td>Number of FTEs</td>
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<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
A. Summary description of programs and how they relate to the mission of the Agency:

**943 Medicaid Eligibility Support:**
The Medicaid Eligibility Determination System (MEDS) is used to determine and track eligibility. MEDS assists in determining eligibility and in the tracking of applications, reviews, notices and other processes related to Medicaid eligibility.

MEDS User Services provides Help Desk support for MEDS, defines system enhancements, and resolves user problems.

The MEDS Department of Interfaces is responsible for problem resolution, system enhancements, and responding to SSI and Buy-In beneficiaries regarding eligibility issues. A toll free hotline offers eligibility information and eligibility and claims problem resolution to the 800,000 plus SC Medicaid and SCHIP recipients.

The Policy and Oversight bureau develops and revises statewide policies and procedures, to ensure compliance with state and federal requirements. The area creates and maintains forms and brochures, and responds to beneficiary, legislative and non-legislative written and email correspondence. The Bureau manages all quality assurance activities for the eligibility area.

**944 Automated Claims Processing:**
The Medicaid Management Information System (MMIS) is used to enroll providers, adjudicate claims, pay providers, report costs and utilization, and enroll recipients into special programs such as Medicaid Reporting and MMIS Federal Reporting:

- Coordinate the submission of Medicaid statistical information related to payments and eligibles to CMS for inclusion in the national MMIS database and coordinate the creation of data needed for federal SCHIP reporting which summarize SCHIP enrollment for SC.
- Maintenance and Operations of the Medicaid Decision Support System which houses statistical information related to Medicaid. MMIS System Support: manages the development and maintenance of state policies, procedures and standards for pricing, provider enrollment, fund codes, and edit codes. System priorities are also established.

B. Budget Program Number and Name:

**II. A. 2. Medical Contracts**

C. Agency Activity Number and Name:

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
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<tbody>
<tr>
<td>943</td>
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<tr>
<td>944</td>
<td>Automated Claims Processing</td>
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<td>$47,044,791</td>
<td>$14,685,255</td>
<td>$87,701,964</td>
</tr>
</tbody>
</table>

D. Performance Measures:

**943 Medicaid Eligibility Support:**
The Medicaid Eligibility Determination System (MEDS) is used to determine and track eligibility. MEDS assists in determining eligibility and in the tracking of applications, reviews, notices and other processes related to Medicaid eligibility.

The Division of MEDS in the Bureau of Information Systems has application analysts that work closely with Clemson University staff where MEDS is housed and with staff from the Bureau of Program Support and eligibility staff to identify, design, test and implement needed or required enhancements to the MEDS. These enhancements are
documented and prioritized through a System Request (SR) Process. The policy and procedures manual provides guidance for the 500 plus eligibility professionals performing the eligibility function. The constituent services groups answers constituent concerns regarding coverage and claims resolution. Program Quality assurance directs and monitors program accuracy and customer service.

### 944 Automated Claims Processing:
Medicaid claims are adjudicated and payment is made to the Medicaid provider of service for the enrolled recipient for which the service was performed. The Medicaid Management Information System (MMIS) is used to adjudicate and pay Medicaid providers for services rendered and billed for Medicaid recipients.

The Division of MMIS Systems Management and the Division of MMIS System Support in the Bureau of Medicaid Systems Management has analysts and data coordinators that work closely with Clemson University staff where MMIS is housed, outside vendors and with program staff to identify, design, test and implement needed or required enhancements to the MMIS. These enhancements are documented and prioritized through a Request for Change (RFC) Process.

The Office of Reporting, Research and Special Projects create analytic studies and other specified reports for SCDHHS management using the Thomson Reuters Decision Support System (Advantage Suite).

#### E. Program Interaction:

### 943 Medicaid Eligibility Support:
Medicaid Eligibility Support assists the department, particularly the Medicaid Eligibility team with policy, training, and technology.

### 944 Automated Claims Processing:
The MMIS is used through the Department and at many other State agencies. The MMIS system is operated by Clemson University and leverages the Clemson data center and technical expertise.

#### F. Change Management:

### 943 Medicaid Eligibility Support:
Medicaid Eligibility Support has not changed in a significant manner in the past five years. However, as SCDHHS works to improve and transform its business processes the Medicaid Eligibility Support team will work to evaluate and change eligibility policy as needed. The Medicaid Eligibility Support team will work to change its policy development tools.

### 944 Automated Claims Processing:
Automated claims processing has changed in the last year with the introduction of an electronic workflow through Blue Cross Blue Shield of South Carolina that handles the provider network and claims issue resolution. In SFY2011, through SFY2014, the automated claims processing will be updated to support federally mandated efforts in support of HIPAA 5010 (January 2012) and the United States move to ICD-10 (October 2013). The automated claims processing will change materially in the future as DHHS is in the process of replacing its MMIS system. This major update to system and business processes is expected to enable DHHS to undergo a significant modernization and transformation.

#### G. Detailed Funding Information:

<table>
<thead>
<tr>
<th>FY 2012-13 Cost Estimates:</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs*</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
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<td>$0</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
Is this budget category or program associated with a Capital Budget Priority? No
If yes, state Capital Budget Priority Number and Project Name.

Please List proviso numbers that relate to this budget category or programs funded by this category.

H. Changes to the Appropriation:
Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

Funding:

<table>
<thead>
<tr>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012 Act</td>
<td>$25,905,226</td>
<td>$166,165,395</td>
<td>$39,929,442</td>
<td></td>
</tr>
<tr>
<td>2012-2013 Act</td>
<td>$30,491,918</td>
<td>$63,546,332</td>
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<tr>
<td>Difference</td>
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<td>&lt;$102,619,063&gt;</td>
<td>&lt;$20,000,000&gt;</td>
<td></td>
</tr>
<tr>
<td>% Difference</td>
<td>17.71%</td>
<td>&lt;61.76%&gt;</td>
<td>&lt;50%&gt;</td>
<td></td>
</tr>
</tbody>
</table>

Explanation of Changes:
The FY2013 Budget reflects the continuation of funding of the FY2012 Non-Recurring Appropriation Funds which were not included in the based budget ($4,411,692). This budget plan also includes new initiatives for Case Management Enterprise System. (Total funds of $350,000 and match of $175,000)

I. Revenue Estimates:
Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Federal</th>
</tr>
</thead>
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<td>Hospital Tax</td>
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<td></td>
<td></td>
<td></td>
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<td>41760000</td>
<td>Civil Monetary Penalty</td>
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<td></td>
<td></td>
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<tr>
<td>34760000</td>
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<td>50000000</td>
<td>Federal Funds</td>
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<td></td>
<td></td>
<td></td>
<td>$63,546,332</td>
</tr>
</tbody>
</table>

If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

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Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other-Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
<th>Temporary, Temporary Grant, Time -limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2013  (A)</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2011-2012  (A)</td>
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<td>N/A</td>
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</tr>
<tr>
<td>2010-2011  (F)</td>
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<td>N/A</td>
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<tr>
<td>2010-2011  (A)</td>
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<tr>
<td>2009-2010  (F)</td>
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<td>2008-2009  (F)</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2008-2009  (A)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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K. Detailed Justification for FTEs:
(1) Justification for New FTEs
   (a) Justification:
   (b) Future Impact on Operating Expenses or Facility Requirements:

(2) Position Details:

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A. Summary description of programs and how they relate to the mission of the Agency:

888 Clinic Services:
The End Stage Renal Disease (ESRD) Program provides dialysis (removal of toxic wastes from the blood) to sustain life for patients who are in renal failure. The Ambulatory Surgery Center (ASC) operates exclusively for the purpose of providing surgical services to recipients who are scheduled to arrive, receive surgery, and be discharged on the same day.

Infusion Centers (IC) were developed in an effort to allow recipients access to infusion services in settings other than physician offices and outpatient hospitals. Authority for these services is contained in 42CFR, Parts 430-498, State Law Title 44, (Sections 44-6.5 – 44-6.910).

Other clinic services are outpatient services which are limited to procedures performed by a physician, physician assistant, nurse practitioner, certified nurse midwife and provided in a RHC or FQHC. Rural Health Clinic (RHC) services are covered when administered to a patient at a RHC, skilled nursing facility or at the beneficiary’s residence. Federal Qualified Health Center (FQHC) services are covered when administered to patients at an FQHC.

FQHCs and RHCs are mandated services. A FQHC is a community health center that provides high quality health care to the underserved and uninsured population. A Rural Health Clinic (RHC) is a clinic located in a rural medically underserved area. Both provider types have a separate reimbursement structure from the standard medical office. These programs were established to address an inadequate amount of physicians serving Medicaid and uninsured individuals in rural areas and help increase the utilization of non-physician practitioners when appropriate.

890 Durable Medical Equipment:
Provide support to Durable Medical Equipment providers through claim resolution and processing, policy, development, interpretation and clarification, rate setting and assisting with budget management.

892 Coordinated Care:
Coordinated Care provides Managed Care options for enrollable Medicaid beneficiaries. The State reimburses Managed Care Organizations (MCOs) an actuarially sound capitated rate for enrolled members. MCOs provide a coordinated system of primary care with the goal of establishing them in a stable medical home. Additionally, the MCOs provide disease management, care coordination, and other enhanced services to improve health outcomes and reduce unnecessary higher cost services such as Emergency Room visits and hospitalizations. The State reimburses Care Coordination Services Organizations (CSOs) and Medical Home Networks (MHNs) a Per Member Per Month (PMPM) fee to assist Primary Care Physicians (PCPs) in the delivery of coordinated care within a stable medical home. The goals of increasing preventative care while reducing unnecessary hospitalizations and Emergency Room usage are the same as with the MCOs. The State also reimburses the Medically Complex Children's Waiver Programs an actuarially sound capitated rate for the delivery of a prepaid ambulatory health plan.

The Care Coordination program consists of a managed care organization delivery model and a medical homes network delivery model with each having different requirements which allow participation in each program. Not all beneficiaries will be eligible to participate in managed care, and of those who can participate in managed care, some may only participate by choice.

Medicaid beneficiaries in payment categories 11 (MAO extended/transitional), 16 (Pass Along Eligibles), 17 (Early Widows/Widowers), 18 (Disabled Widows/Widowers), 19 (Disabled Adult Children), 20 (Pass Along Children), 32, (Aged, Blind, Disabled), 40 (Working Poor), 59 (Low Income Families), 71(Breast and Cervical Cancer), 80 (SSI with Essential Spouse – Age 19 and Above), 87 (OCWI Pregnant Women/Infants, 88 (OCWI Partners for Healthy Children, and 91 (Ribicoff Children) are required to participate in either a managed care organization or a medical homes network to receive Medicaid services.

Medicaid beneficiaries in payment categories 12 (OCWI – Infants), 13, MAO – Foster Care/Adoption), 31 (Title IV-E Foster Care), 51 (Title IV-E Adoption Assistance, 57 (Katie Beckett/TEFRA), 60 (Regular Foster Care), 80 (SSI – Under Age 19), 81 (SSW W/Essential Spouse – Under Age 19), 85 (Optional Supplement), 86 (Optional Supplement and SSI), have a choice to participate in a managed care organization, medical homes network or fee-for-service program.
Medicaid beneficiaries in payment categories 15 (MAO – Waivers (Home and Community)) have a choice to participate in a medical homes network or fee for service program.

As of September 1, 2011 there were 592,589 Medicaid beneficiaries participating in a managed care plan with 441,757 enrolled in the managed care organization program and 150,832 enrolled in the medical homes network program.

The MCO healthcare delivery model is the SC Healthy Connections (SCHC) Managed Care Organization (MCO) program where managed care organizations are paid a per member per month (PMPM) capitated rate to provide an array of services through an established network of contracted and non-contracted providers. The MCO network of PCP providers works in partnership with the members to provide and arrange for most of the member’s health care needs, including authorizing services provided by other health care professionals. The MCO supports their provider network physicians and enrolled beneficiaries by providing care coordination, disease management and data management. The MCO reimburses providers for covered services delivered to their members. Services not covered under the MCO contract are paid fee-for-service.

The MHN healthcare delivery model is SC Healthy Connections (SCHC) Primary Care Case Management (PCCM) program linking Medicaid MHN Members with a Primary Care Provider (PCP). SCDHHS contracts with a Care Coordination Service Organization (CSO) who in turn, subcontracts with PCPs to serve as the Medicaid MHN Member’s medical home.

The PCP works in partnership with the members to provide and arrange for most of the member’s health care needs, including authorizing services provided by other health care professionals. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management and data management. All providers participating in a MHN must be enrolled as SCHC (Medicaid) providers as all services are paid on a fee-for-service (FFS) basis. The CSO is paid a per member per month (PMPM) capitated rate to provide Care Coordination services to their members.

The Medically Complex Children’s Waiver program is a component of the Medical Homes Network. The Medically Complex Children’s (MCC) Waiver serves participants under the age of 18 who meet Nursing Facility Care Level of Care (LOC) or ICF-MR Level of Care and have a chronic physical/health condition that is expected to last longer than 12 months. They must meet defined medical criteria documenting the child’s dependence upon comprehensive medical, nursing, and health supervision or intervention. If the participant is enrolled with an enhanced primary provider, the waiver will work in conjunction with the Medically Complex Children’s Program. The MCC utilizes a Medical Homes Network (MHN) to provide Enhanced Primary Care Case Management (EPCM) linkage between the families and the MHN Primary Care Providers (PCP), as well as other service providers.

901 Hospital Services:
Hospital Services provides inpatient hospital care to individuals who require specialized institutional and professional services on a continuous basis, generally a 24-hour period or longer.
- FY 2011 Total number of recipients: 71,955
- FY 2011 Total amount paid $702,610,806

Hospital Services provides outpatient hospital services that are diagnostic, therapeutic, rehabilitative or palliative items or services generally not to exceed a 24-hour period. Total number of recipients: 267,755; Total amount paid FY11 $220,782,828.00. These are mandatory services and governing authority is Federal Law 42 CFR Parts 430-498, SC Code 44-6-5-44-6-910.

903 Nursing Facility Services:
A nursing facility is a health related facility which fully meets the requirements for state nursing facility licensure and must be surveyed for compliance with the requirements of participation in the Medicaid program by the South Carolina Department of Health and Environmental Control (SCDHEC) - Bureau of Certification and be certified as meeting Federal and State requirements of participation for long term care facilities. A nursing facility provides nursing, therapy, and personal care services to individuals who do not require acute hospital care, but whose mental and physical condition requires services that are available through licensed, certified, and contracted institutional facilities.

A nursing facility may also meet the criteria to be an Institution for Mental Disease (IMD). IMD is defined as an institution of more than sixteen beds primarily engaged in providing diagnosis, treatment, or care of persons with mental
diseases, including medical attention, nursing care, and related services. Whether a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Hospitals participating in both the Medicaid and Medicare Programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as "swing bed" hospitals.

A swing bed hospital must be located in a rural area, have fewer than one hundred (100) inpatient beds exclusive of newborn and intensive care type beds, and be surveyed for compliance by SCDHEC and certified as meeting Federal and State requirements for participation for swing bed hospitals. Beneficiaries who will enter or remain in a nursing facility and have applied for Medicaid sponsorship must meet level of care criteria through pre-admission review.

Physician visits are billed and reimbursed separately from the hospital swing bed nursing services. The physician services should follow standard policies for professional reimbursement. Level of care determination is the process of identifying the extent of a person’s medical, psycho behavioral and functional disability. There are two levels of care: skilled and intermediate. Community Long Term Care (CLTC) completes initial level of care assessment.

All nursing care facilities must be able to provide skilled nursing services to all patients certified as skilled level of care patients. All nursing care facilities must be able to provide nursing and personal care services to all patients certified at the intermediate level of care. Subacute care is care provided to the totally ventilator dependant Medicaid recipient in need of less than acute hospital services and who meets level of care criteria for nursing facility services. Both a CLTC certification of subacute level of care and a provider contract amendment to provide such care are required in order to be reimbursed for this service.

SCDHHS sponsors administrative days for Medicaid-eligible patients (regardless of age) who no longer require acute hospital care but are in need of nursing home placement that is not available at that time. Medicaid sponsors administrative days in any South Carolina acute care hospital contracted within the South Carolina service area. The patient must meet either Medicaid intermediate or skilled level-of-care criteria. Coverage for administrative days may begin with the day of discharge from acute care. It is not necessary to allow for patient grace days. Medicaid coverage terminates once a nursing home bed becomes available within the South Carolina state boundaries. Should the patient or family refuse to accept the bed, the patient is then responsible for charges incurred for any remaining days.

Authority for nursing facility services is contained in 42CFR Parts 430-498, State Law Title 44 (Sections 44-6-5 - 44-6-910).

A hospice may furnish routine or continuous home care to a beneficiary who resides in a nursing facility. The facility is considered to be the beneficiary’s place of residence (the same as a house or apartment), and the Medicaid facility resident may elect the hospice benefit if he or she also meets the hospice eligibility criteria. The hospice then assumes full responsibility for professional management of the individual’s hospice care in accordance with the Hospice Conditions of Participation (42 CFR 418) and makes any arrangements necessary for inpatient care in a participating Medicare or Medicaid facility.

<table>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Skilled</td>
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<tr>
<td></td>
<td>Subacute</td>
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(Levels of Care June 2011 - SCDHHS Report/Budget fur/Office of Medicaid Reporting)
Presently, there are approximately 152 nursing facilities. The average nursing facility daily rate is $150.47 effective April 8, 2011. Rates are based on the facility’s cost report. Each facility has its own rate. Rates may change each October 1 and/or on a subsequent date upon an audit. Rates are determined by the Bureau of Long Term Care Reimbursement. Providers are notified of any rate change. The Department of Facility Services is responsible for policy and program oversight. Community Long Term Care Regional Office designated staff will oversee the preadmission process to a nursing facility.

**Medicaid Nursing Facility Permit Day**

Beginning July 1, 1988, nursing facilities which wish to continue to serve Medicaid patients must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing home may provide, and the nursing home must not exceed their allocation by more than five percent without being fined. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

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**905 Pharmaceutical Services:**

The goal of the SCDHHS Pharmacy Services program is to provide beneficiaries with access to the medications necessary to achieve an optimum level of health, while concurrently managing both the utilization and cost of the medications that SCDHHS purchases. In achieving this goal, the Pharmacy Services program performs the following three functions: ensuring access, controlling unit cost, and managing utilization.

SCDHHS contracts with Magellan Medicaid Administration (MMA) to work with the Agency in the provision of many aspects of the management of the pharmacy program. MMA, Inc. provides the POS system, operates a call center to handle all prior authorizations, computer customization and professional administrative support.

Medicaid programs are only required to provide pharmacy services for institutional care and children, with outpatient pharmacy benefits for adults being classified as an optional service. Today, medications have become a fundamental component of medical care, offering treatment, cures, and preventions that were previously impossible. An appropriately designed pharmacy benefit is also a good investment, redirecting patients from more costly modes of treatment, such as surgeries and emergency room visits, to pharmaceutical alternatives.

**907 Physicians Services:**

Physician services include a full range of primary care, preventive care, and specialty care services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis or as needed for the prevention, diagnostic, therapeutic care and treatment. Physician services are provided in the physician's offices, patient's homes, clinics, hospitals and skilled nursing facilities. Services performed in a physician’s office are considered to include both the technical and professional components unless designated as a separate service.

This program serves all benefit categories. The chart below indicates the enrollment and utilization statistics for the program ending June 30, 2011:
III. Budget Category Justification Sheet

- FY 2011 Enrollment: 386,268
- YTD Transactions: 3,971,094
- Unduplicated Recipients: 407,793

Note: Enrollment represents eligibles at a point in time, unduplicated recipients represents all recipients that received services during the fiscal year.

Program staff is responsible for developing policy, adjudicating claims, and providing training.

Physician service is the primary program that assures recipients access to medical care through the relationship that is established with the primary health care provider. During the 2013 budget year, these services will receive a much needed boost from the Affordable Care Act (ACA) by increasing the reimbursement for immunization, evaluation and management procedures to 100 percent of the 2009 Medicare fee schedule. This effort will assist with anticipated access to care issues that may result from the influx of covered lives as part of the ACA mandate.

Contracts with the three Developmental Evaluation Centers (DEC) were discontinued effective 6/30/10. These providers were enrolled individually. Services to these providers were unbundled and priced at physician pediatric subspecialists’ rates.

The three DEC sites are located at USC, MUSC and Greenville Hospital. These centers complete comprehensive evaluations and psychological testing for beneficiaries referred for developmental delays, and genetic disorders. The DEC program staff consists of a variety of practitioners including Pediatric Specialists, psychologists, and nurses and in some instances a speech therapist.

- FY2011 Patients Served: 4,006
- FY 2011 Expenditures: $2,083,036

909 Dental Services:
Children under the age of 21 are provided a range of preventive and restorative dental services, including a complete dental examination every 6 months. Education for establishing and maintaining good oral health is the preventive aspect of dental services. Adults, age 21 and over, are provided catastrophic health related dental services. Services for children are mandatory, but only medical and surgical services are mandatory for adults. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title (Sections 44, 44-6-5 - 44-6-910).

Children under the age of 21 and Adults, age 21 and over, are provided catastrophic health related dental services. Monitor 2 Agency service contracts and oversees an Administrative contract for processing all dental claims. The contracts are in place and provide coverage of required Dental Services per State Law.

911 Community Long Term Care:
The Community Long Term Care (CLTC) program provides services in homes and community settings for Medicaid recipients who need and meet the criteria to receive long term care services. Services in CLTC act as an alternative to institutional placement. The CLTC budget line includes four waivers, Community Choices (for persons with physical disabilities and the frail elderly), HIV/AIDS, Mechanical Ventilation, and Medically Complex Children. In addition, CLTC oversees the provision of state plan personal care and private duty nursing services for children.

Waiver services are overseen by case managers who work with waiver participants to implement a set of services that meet the specific needs of each individual. During the last year, CLTC has slightly reduced its service package to meet deficit reduction goals within the CLTC budget. In addition, CLTC has implemented an expanded review of service authorizations to ensure that needs are being met in the most cost effective manner. Finally, a cumulative 5 percent reduction has been applied to most waiver services.

The Community Choices waiver has proven since its inception to be a very cost effective alternative to nursing facility placement. As part of the Agency’s cost saving efforts, additional slots have been allocated to the waiver for FY 2012. These slots are currently being filled to increase the overall waiver census.
### Community Choices Waiver
The Community Choices waiver program targets persons with disabilities and the frail elderly. Individuals 18 years of age or older receive services including case management, personal care, companion services, attendant care, environmental (home) modifications, home delivered meals, adult day health care, adult care home, respite care, personal emergency response systems, incontinence supplies, nutritional supplements, limited durable medical equipment, tele-monitoring, and nursing facility transition services. Eligibility for the Community Choices waiver is twofold: participants are required to meet categorical and financial guidelines of Medicaid eligibility in addition to Medicaid medical criteria (nursing facility level of care).

### HIV/AIDS Waiver
The HIV/AIDS waiver program assists persons of all ages who have HIV disease or AIDS. The services provide in home care and are intended to reduce extended hospital stays. The HIV/AIDS waiver offers case management, personal care, environmental modifications, home delivered meals, private duty nursing, attendant care, companion care, prescription drugs, incontinence supplies, and nutritional supplements.

### Ventilator Dependent Waiver
The CLTC Ventilator Dependent waiver assists persons 21 and over who are dependent upon mechanical ventilation and wish to remain in the community. The services help a person stay at home as long as possible and avoid extended hospital and sub-acute stays. The waiver offers personal care, attendant care, environmental modifications, enhanced environmental modifications, private duty nursing, personal emergency response systems, institutional respite, in-home respite care, prescription drugs, specialized medical equipment and supplies, incontinence supplies, and nutritional supplements.

### Medically Complex Children Waiver
This waiver serves children who meet Nursing Facility or ICF-MR level of care and have a chronic physical/health condition that is expected to last longer than 12 months. Children must meet medical criteria defined by the State which makes the child dependent upon comprehensive medical, nursing, and health supervision or intervention. The services offered in this waiver include Pediatric Medical Day Care, In-Home Respite, Care Coordination, and Incontinence Supplies.

### Children’s Personal Care Service
This service is for children up to age 21 who meet medical criteria defined by the State which makes the child dependent for activities of daily living (ADL). The personal care service allows for assistance with ADLs to be provided in the child’s home on an ongoing basis.

### Children’s Private Duty Nursing
This service is for children up to age 21 who meet medical criteria defined by the State which makes the child dependent for skilled nursing services by an RN or LPN. This service has been closely aligned with the Medically Complex Children’s waiver.

913 **Home Health Services:**
Home Health services are provided to eligible recipients affected by illness or disability and is based on a physician’s orders and a specific plan of care that is reviewed every sixty (60) days. Home health services include part-time or intermittent skilled nursing, home health aide services, physical therapy, occupational therapy, speech therapy and supplies which are ordered by the physician and used during the course of a visit. Home Health services are limited to...
50 visits per fiscal year for recipients over the age of 21 and do not apply to children. Home Health services are not subject to a requirement that the individual be homebound.

There are 68 Home Health providers and one Pediatric Home Health provider currently contracted with SCDHHS. The program served:

- 6,171 - FY 2006-07
- 5,777 - FY 2007-08
- 5,172 - FY 2008-09
- 4,322 - FY 2009-10
- 4,415 - FY 2010-11

The number of Home Health recipients has decreased from FY 2006-07 to FY 2010-11 as more people are terminally ill and are being placed into Hospice. Many Home Health agencies also have a Hospice component to their companies. Nursing Home placements and Hospitalizations has increased while the Home Health line has been steadily decreasing from FY 2006-07 to FY 2010-11. This is attributed to ill patients needing a higher level of skilled nursing care for a longer duration of time in a nursing home or hospital versus receiving home health visits which are short-term intermittent with a visit limitation.

This service line includes the subprogram: Pediatric Home Health. One Pediatric Home Health Agency is permitted per county and issued a Pediatric Home Health Certificate of Need (CON) to operate in that county. This service provides specialized intermittent skilled nursing care to children ages 0 to 18. Pediatric Home Health agencies must provide skilled nursing services, home health aide services, supplies and at least one of the professional therapy services: occupational therapy, speech therapy or physical therapy. This subprogram is included in the Home Health program line.

This program initially charged a copayment of $2.00. The copayment was increased to $2.30 effective April 1, 2011 and increased again to $3.30 per visit effective for dates of service on and after July 11, 2011.

This program is monitored within the Department of Community Services by one FTE

Home Health program will provide 50 Home health visits per year for an estimated 4,500 eligible participants. The Home Health visit limit was reduced to 50 visits from 75 visits effective February 1, 2011.

The elimination of Medical Social Work services effective July 1, 2011 will save $245,427.10 based on FY 2010-11 paid claims. This service was announced in the January 10, 2008 Medicaid Bulletin and the effective date for the service being added to the Home Health program was retroactive to October 1, 2006.

Home Health providers have a 7 percent total rate reduction for all services (4 percent rate reduction effective April 2011 and 3 percent rate reduction effective July 2011) this is estimated to save $515,773.61 based on FY 2010-11 paid claims for all home health services excluding Medical Social Work services and Supplies.

915 EPSDT Screening:
The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provides well-child, comprehensive and preventive health care screenings and services to individuals under the age of 21. The basic screening package includes a comprehensive health and developmental history, assessment of physical and mental development, a comprehensive physical examination, age-appropriate immunizations, vision screening, appropriate laboratory tests and health education. It also assures that health problems are discovered, diagnosed, and treated early, resulting in better health outcomes and less costly treatment.

The EPSDT program requires any medically necessary health care services listed in Section 1905(a) of the Social Security Act be provided to an EPSDT recipient even if the services are not available under the State's Medicaid plan.

917 Medical Professional Services:
Medical Professionals are nurse practitioners, certified nurse midwives, optometrists, opticians, podiatrists, audiologist, chiropractors, speech therapists, physical and occupational therapists. Only services rendered by nurse practitioners and certified nurse midwives are mandatory, all other practitioners’ services in this category are optional, unless they are EPSDT related services.
Program staff is responsible for developing policies, adjudicating claims, and provider education. This program has sustained considerable reductions over the past few years. We have eliminated coverage for adult vision and adult podiatry service. We have reduced the utilization of chiropractic services and have instituted a check point for PT, OT and Speech services.

919 Transportation Services:
The provision of transportation services is provided to ensure that members have safe reliable access to medical services. This is a mandatory service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title (Sections 44, 44-6-5 - 44-6-910).

Medicaid eligible persons have access to services.

Transportation Services include:
• Emergency ambulance transportation
• Non-emergency transportation
• Out of state services, when medically necessary
• Contracts with DSS, the Lt. Governor’s Office on Aging, multiple independent school districts and the SC school for the Deaf and Blind for providing necessary transportation

921 Lab & X-Ray Services:
Laboratory and Radiology services are performed for the purpose of providing diagnostic and screening information to the Physician to aid in the diagnosis, prevention, treatment of impairment, disease management, and/or the assessment of health. Medically necessary laboratory and radiology services are available to all qualified beneficiaries.

Program staff is responsible for developing policy, adjudicating claims, and providing education.

Laboratory and Radiology services are mandatory and an integral part of the medical service package. These services provide diagnostic information to the Physician aiding them in the complex decision making process when making diagnostic or treatment decisions.

923 Family Planning:
Family planning services are available to all Medicaid recipients. Services include medical treatment and counseling services related to birth control alternatives and pregnancy prevention services prescribed and rendered by physicians, hospitals, clinics, pharmacies and other practitioners. Family planning services are a mandatory service. Authority for this activity is contained in 42CFR Parts 430 498, State Law Title 44, (Sections 44-6-5 - 44-6-910).

925 Medicare Premium Payments:
Medicaid beneficiaries who are “dual eligibles,” are low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. While Medicare covers basic health services, including physician and hospital care, dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as prescription drugs and long-term care. Medicare Premium expenditures for the following populations: Qualified Medicare Beneficiaries (QMB), Specified Low-income Medicare Beneficiaries (SLMB) and Qualifying Individuals (QI-1).

SCDHHS has used composite annual premium growth assumptions as follows:
• Three percent growth for QMB/SLMB eligibles whose premiums are paid with 100 percent state dollars.
• Three percent growth for QI-1 individuals whose premiums are paid with 100 percent Federal dollars.

The model currently assumes that Medicare Part A premiums will increase by 4.0 percent in January 2012 from $450 effective for CY 2011, and Medicare Part B premiums will increase by 5.0 percent in January 2012 from $115.40 effective for CY 2011.

926 Hospice Care:
Hospice is a public Agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospices, and has a valid provider
contract. Hospice coverage for South Carolina Medicaid beneficiaries is available for an unspecified number of days, subdivided into election periods as follows: two periods of 90 days each, and an unlimited number of subsequent periods of 60 days each. Benefit periods can be used consecutively or at different times during the beneficiary’s life span. At the beginning of each period, the beneficiary must be certified by a physician as terminally ill with a life expectancy of six months or less. Hospice services include discreet services such as nursing, chaplain, medical social services, physician, counseling, medical appliances including drugs and biological. For beneficiaries served by Medicaid only, hospice services must be prior approved by SCDHHS. Prior approval is given for six months. If a beneficiary continues to need services beyond six months, the hospice Agency must submit additional required documents.

There are four levels of care into which each day of care is classified:

- **Routine Home Care** - The hospice will be paid the routine home care rate for each day the patient is at home under the care of the hospice. This includes patients residing in a nursing home. This rate is paid without regard to the volume or intensity of routine home care services on any given day; however, the frequency and intensity of services delivered must be consistent with the patient’s Plan of Care (POC).

- **Continuous Home Care** - For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished in the home to the beneficiary on that day. Continuous home care is primarily nursing care — a nurse must provide the care for more than half of the period of crisis.

- **Inpatient Respite Care** - Respite care is short-term inpatient care provided to the beneficiary only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is residing in a nursing home on a permanent basis.

- **General Inpatient Care** - Payment at the inpatient rate will be made when general inpatient care is provided for services related to the terminal illness. No other fixed payment rate (i.e., routine home care) will be applicable for a day that the patient receives hospice inpatient care. Services provided in the inpatient setting must conform to the hospice’s POC. The hospice must have a contract with the inpatient facility delineating the roles of each provider in the hospice’s POC; however, the hospice is the professional manager of the patient’s care, despite the physical setting of that care or the level of care. General inpatient care is a short-term level of care and is not intended to be a permanent solution to a negligent or absent caregiver.

The federal hospice rates are issued each year, effective October 1, by Centers for Medicaid and Medicare Services (CMS) and adjusted for local wage indices. Hospice rates vary by county. There is no co-payment for beneficiaries. Presently, there are 90 Medicaid enrolled hospice providers. SCDHHS Division of Ancillary Reimbursement, in conjunction with the Department of Facility Services, notify each hospice of the approved Medicaid hospice reimbursement rates. The Department of Facility Services approves prior authorization requests for beneficiaries served by Medicaid only and provide oversight of the program and claims reimbursement. This is an optional service. 42CFR Part 418, State Law Title 44,(Sections 44-6-5 - 44-6-910).

**928 Optional State Supplementation:**

Optional State Supplementation (OSS) is designed to provide a monthly entitlement payment on behalf of an eligible aged, blind or disabled individual who lives in a licensed community residential care facility (CRCF) that is enrolled with SCDHHS to participate in the OSS program.

The OSS program serves recipients who are aged (65 or older), blind or disabled. There are approximately 349 OSS facilities and the program has served the following number of recipients:

- 4954 - FY 2006-07
- 4804 - FY 2007-08
- 4789 - FY 2008-09
- 4704 - FY 2009-10
- 4708 - FY 2010-11

The number of OSS recipients has decreased from FY 2007 to FY 2011 due to the fact that many recipients have opted to stay home with family members providing their care. This is attributed to the recession and allows their income to
remain within a family home instead of in a Community Residential Care Facility (CRCF). Some recipients are also on the CLTC waiting list to receive services through the Community Choices waiver.

This service line includes the subprogram: Integrated Personal Care (IPC). The OSS payment covers room and board and a degree of personal care. Many OSS recipients require more than a limited degree of personal care and the IPC program provides additional reimbursement to facilities to provide assistance with additional personal care services.

The OSS payment is the difference between the client’s countable income and the Net Income Limit of $1,157. Countable income is income that an OSS recipient receives each month, i.e. Social Security income.

**930 Integrated Personal Care:**

The Integrated Personal Care (IPC) program was developed by SCDHHS to maximize existing state funding for the OSS program and improve the quality of care and quality of life for residents of licensed CRCFs whose income is subsidized with OSS dollars appropriated by the General Assembly. Many of these individuals require considerably more than a limited degree of personal care assistance. The IPC program provides additional reimbursement to facilities to provide assistance with personal care for residents who meet the medical criteria required for participation. The assistance must be provided by a resident assistant that has been trained and determined competent to provide the service by a licensed nurse with weekly supervision by a licensed nurse contracted or employed by the CRCF.

The IPC Program employs three registered nurses to evaluate residents’ needs and authorize the provision of services to the facility for OSS residents who meet the IPC program medical/functional criteria. Residents are assessed by the SCDHHS RNs to establish the residents’ need for the service and the appropriateness of the care plan. Criteria for coverage are two functional dependencies or one functional dependency combined with a form of cognitive impairment. The RN employed or contracted by the facility develops the care plan, trains and determines competency of direct care staff to provide the service in an acceptable manner and provide weekly supervision and monitoring. The administrator of the facility provides daily supervision and on-site monitoring. Licensed nurses work with SCDHHS nurses to conduct periodic assessments to monitor the residents’ condition, evaluate the adequacy and quality of care, and identify residents whose needs exceed those than those that can be provided in the CRCF.

The IPC program first began authorizing personal care services in 2003. In the last eight years, over 3500 residents have received services. Currently there are 1007 IPC participating residents and 68 active IPC CRCF facilities.

The trend analysis shows a steady increase in unduplicated IPC residents:

- FY 2006-07 – 829
- FY 2007-08 – 931
- FY 2008-09 – 1,023
- FY 2009-10 – 1,206
- FY 2010-11 – 1,322

**939 PACE:**

The Program of All-inclusive Care (PACE) is a long-term care option under the Medicaid State Plan that is jointly funded by Medicare/Medicaid. The PACE program is an alternative to the home and community-based waiver (HCBS) program or nursing facility (NF) options. PACE is a program of comprehensive care that provides all primary and long-term care services to participants’ age 55 and older that meet the State’s nursing facility level of care criteria, and who can be safely cared for in the community through an inter-disciplinary team approach. There are currently two (2) PACE providers, an urban and a rural provider, and each serves a two county areas: Richland and Lexington, and Orangeburg and Calhoun counties.

As a national managed care program, PACE providers are reimbursed through monthly prospective capitated payments from Medicare and Medicaid. Most PACE participants are eligible for both Medicare and Medicaid, and PACE programs receive monthly payment from both sources for each participant as eligible. As an all-inclusive program it is required to cover all services available through Medicare and Medicaid, including hospitalizations and nursing facility costs when a participant is enrolled in the program, it is a cost effective alternative to nursing facility placement. The reimbursement is based on a composite blended rate of HCB waiver and NF costs. During FY2011 PACE reimbursement was reduced 3 percent and in FY2012 PACE enrollment limits were allocated to the respective programs. Administration of the program is provided by the Division of Community Options-SCDHHS.
III. Budget

Category Justification Sheet

J02

South Carolina Department of Health & Human Services (SCDHHS)

FY 2011 patients enrolled: 412
FY 2011 Expenditures: $11,865,663

1744 MMA Phased Down Contributions:
This represents the charges to the State of South Carolina for assuming the prescription coverage for the Medicaid/Medicare dual eligibles. South Carolina will be charged by CMS a monthly amount for the Medicare Part D program for the dual eligibles.

B. Budget Program Number and Name:
II.A.3. Medical Assistance

C. Agency Activity Number and Name:
Note: If more than one activity maps to this program; provide all activity numbers, names, and approximate funding amounts.

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>888</td>
<td>Clinic Services</td>
<td>-</td>
<td>20,294,825</td>
<td>47,942,634</td>
<td>18,000</td>
<td>68,255,459</td>
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<tr>
<td>890</td>
<td>Durable Medical Equipment</td>
<td>-</td>
<td>12,320,640</td>
<td>29,079,360</td>
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<td>41,400,000</td>
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<tr>
<td>892</td>
<td>Coordinated Care</td>
<td>-</td>
<td>440,030,348</td>
<td>1,203,781,305</td>
<td>70,000,000</td>
<td>1,713,811,653</td>
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<tr>
<td>901</td>
<td>Hospital Services</td>
<td>-</td>
<td>179,722,440</td>
<td>542,182,560</td>
<td>49,995,000</td>
<td>771,900,000</td>
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<tr>
<td>903</td>
<td>Nursing Home Services</td>
<td>-</td>
<td>149,234,551</td>
<td>361,666,494</td>
<td>4,000,000</td>
<td>514,901,045</td>
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<tr>
<td>905</td>
<td>Pharmaceutical Services</td>
<td>-</td>
<td>28,811,188</td>
<td>157,688,771</td>
<td>38,000,000</td>
<td>224,499,959</td>
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<tr>
<td>907</td>
<td>Physician Services</td>
<td>-</td>
<td>54,474,925</td>
<td>128,572,538</td>
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<td>183,047,463</td>
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<td>909</td>
<td>Dental Services</td>
<td>-</td>
<td>27,889,418</td>
<td>77,626,099</td>
<td>5,000,000</td>
<td>110,515,517</td>
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<tr>
<td>911</td>
<td>Community Long Term Care</td>
<td>-</td>
<td>51,302,819</td>
<td>121,085,688</td>
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<td>172,388,507</td>
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<tr>
<td>913</td>
<td>Home Health Services</td>
<td>-</td>
<td>1,985,148</td>
<td>4,685,376</td>
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<td>6,670,524</td>
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<tr>
<td>915</td>
<td>EPSDT Screening</td>
<td>-</td>
<td>3,233,166</td>
<td>7,630,966</td>
<td></td>
<td>10,864,132</td>
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<tr>
<td>917</td>
<td>Medical Professional Services</td>
<td>-</td>
<td>14,193,059</td>
<td>33,498,671</td>
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<td>47,691,730</td>
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<td>919</td>
<td>Transportation Services</td>
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<td>14,778,243</td>
<td>34,879,833</td>
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<td>49,658,076</td>
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<tr>
<td>921</td>
<td>Lab &amp; X-Ray Services</td>
<td>-</td>
<td>8,520,846</td>
<td>20,111,030</td>
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<td>28,631,876</td>
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<td>923</td>
<td>Family Planning</td>
<td>-</td>
<td>2,370,372</td>
<td>21,333,348</td>
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<td>23,703,720</td>
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<tr>
<td>925</td>
<td>Medicare Premium Payments</td>
<td>-</td>
<td>72,054,560</td>
<td>139,145,440</td>
<td>5,000,000</td>
<td>216,200,000</td>
</tr>
<tr>
<td>926</td>
<td>Hospice Care</td>
<td>-</td>
<td>3,717,024</td>
<td>8,772,976</td>
<td></td>
<td>12,490,000</td>
</tr>
<tr>
<td>928</td>
<td>Optional State Supplemental</td>
<td>-</td>
<td>17,632,480</td>
<td>-</td>
<td></td>
<td>17,632,480</td>
</tr>
<tr>
<td>930</td>
<td>Integrated Personal Care</td>
<td>-</td>
<td>1,568,531</td>
<td>3,702,069</td>
<td></td>
<td>5,270,600</td>
</tr>
<tr>
<td>939</td>
<td>PACE</td>
<td>-</td>
<td>4,109,656</td>
<td>9,699,671</td>
<td></td>
<td>13,809,327</td>
</tr>
<tr>
<td>1744</td>
<td>MMA Phased Down Contributions</td>
<td>-</td>
<td>80,722,176</td>
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<td>1,577,824</td>
<td>82,300,000</td>
</tr>
<tr>
<td>Total</td>
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<td>$ -</td>
<td>$1,188,966,414</td>
<td>$2,953,084,830</td>
<td></td>
<td>$4,315,642,068</td>
</tr>
</tbody>
</table>

D. Performance Measures:

888 Clinic Services:
No Specific Measures.

890 Durable Medical Equipment:
No Specific Measures

892 Coordinated Care:
Improve rates of screening, access to care, prenatal care, well child visits, follow-up treatments, and emergency department utilization.
### III. Budget Category Justification Sheet

<table>
<thead>
<tr>
<th>Category</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>901 Hospital Services:</strong></td>
<td>Improve rates of emergency department utilization and decrease average length of inpatient stays for newborns.</td>
</tr>
<tr>
<td><strong>903 Nursing Home Services:</strong></td>
<td>No Specific Measures.</td>
</tr>
<tr>
<td><strong>905 Pharmaceutical Services:</strong></td>
<td>Maintain Point of Sale (POS) downtimes to allow continued services to beneficiaries while providing the most cost efficient means of pharmaceutical purchase by leveraging the drug rebates and unit costs analysis.</td>
</tr>
<tr>
<td><strong>907 Physicians Services:</strong></td>
<td>Improve rates of screening, access to care, prenatal care, well child visits, follow-up treatments, and emergency department utilization.</td>
</tr>
<tr>
<td><strong>909 Dental Services:</strong></td>
<td>Provide appropriate utilization through the Administrative Service Organization.</td>
</tr>
<tr>
<td><strong>911 Community Long Term Care:</strong></td>
<td>Continue to provide the most cost effective alternative to institutionalized care.</td>
</tr>
<tr>
<td><strong>913 Home Health Services:</strong></td>
<td>No Specific Measures.</td>
</tr>
<tr>
<td><strong>915 EPSDT Screening:</strong></td>
<td>Continue to ensure screenings for children in both fee for service and coordinated care.</td>
</tr>
<tr>
<td><strong>917 Medical Professional Services:</strong></td>
<td>No Specific Measures</td>
</tr>
<tr>
<td><strong>919 Transportation Services:</strong></td>
<td>No Specific Measures. Contracts in place through a broker.</td>
</tr>
<tr>
<td><strong>921 Lab &amp; X-Ray Services:</strong></td>
<td>No Specific Measures. Contracts in place to ensure proper utilization.</td>
</tr>
<tr>
<td><strong>923 Family Planning:</strong></td>
<td>No Specific Measures.</td>
</tr>
<tr>
<td><strong>925 Medicare Premium Payments:</strong></td>
<td>No Specific Measures.</td>
</tr>
<tr>
<td><strong>926 Hospice Care:</strong></td>
<td>Reduction in hospital visits and nursing home admission compared to admissions prior to electing the hospice benefit.</td>
</tr>
<tr>
<td><strong>928 Optional State Supplemental:</strong></td>
<td>No Specific Measures.</td>
</tr>
<tr>
<td><strong>930 Integrated Personal Care:</strong></td>
<td>No Specific Measures.</td>
</tr>
<tr>
<td><strong>939 PACE:</strong></td>
<td>No Specific Measures.</td>
</tr>
<tr>
<td><strong>1744 MMA Phased Down Contributions:</strong></td>
<td>No Specific Measures.</td>
</tr>
</tbody>
</table>
E. Program Interaction:

**888 Clinic Services:**
There may be some overlapping of services performed in Physician offices and home settings. This program networks with internal and external customers, to include the SCOffice of Rural Health, the SCPrimary Health Care Association, and the owners of FQHCs and RHCs. The Agency assists with claims processing, policy development, and training.

**890 Durable Medical Equipment:**
Maintain relationships with DME providers in the state to continue to serve the equipment needs of beneficiaries.

**892 Coordinated Care:**
The Managed Care Department is supported in implementation and monitoring the managed care program and contract with the managed care organizations and medical homes networks by numerous other areas within the Agency such as our IT Department (receiving MC program encounters and MMIS system changes), Enrollment Broker (assignment of Medicaid beneficiaries to plans), Legal Counsel (legal interpretation of policy and contracts), Physician Services (policy interpretation), Hospital Services (policy interpretation), Durable Medical Equipment (policy interpretation), Pharmacy Department (policy interpretation), Division of Acute Care Reimbursement (FQHC/RHC rates and payments), Division of Ancillary Reimbursement (retro rate reimbursement and hospital data), Office of Reporting (reports), Division of Behavioral Health (policy interpretation), Thomson Reuters (reports), Institute for Families in Society (Reports, analysis of encounter data).

**901 Hospital Services:**
Continue monitoring the program in coordination with other program areas. Ensure no overlapping of services performed in Ambulatory Surgical Centers (ASCs).

**903 Nursing Home Services:**
Rates are determined by the Bureau of Long Term Care Reimbursement. Providers are notified of any rate change. The Department of Facility Services is responsible for policy and program oversight. Community Long Term Care Regional Office designated staff will oversee the preadmission process to a nursing facility. Nursing facilities are surveyed by the SC Department of Health and Human Services Bureau of Survey and Certification. The Department of Facility Services provides contract oversight.

**905 Pharmaceutical Services:**
The Pharmacy program interacts with all Divisions of the Agency, to include Waiver programs, Nursing Homes, and other State Agencies. Pharmacy services for institutional care and children are required, all other pharmacy services are optional. Discontinuing this optional program would greatly impact the Hospital and Physician services programs.

**907 Physicians Services:**
The Physician Services program interacts with all divisions of the Agency, to include IT, claims processing, beneficiary services, Care Management, and other state agencies.

**909 Dental Services:**
The Dental Program is mandated for children under 21. It has little connectivity to other programs except in the limited Hospital ER utilization for Adults.

**911 Community Long Term Care:**
This program interacts with Ancillary Reimbursement regarding rate setting of pilot services, Contracts Division for service providers, Divisions of CLTC, Community Options and Behavioral Health for transition into the waivers, budgets to manage grant funds, and MMIS for budget tracking.

**913 Home Health Services:**
This program interacts with Ancillary Reimbursement (Karen Maine) regarding Home Health rates and cost settlements, Contracts (Ernestine Staley) regarding Home Health contracts and change of ownership requests and Program Integrity (Candice Smith-Byrd) regarding Home Health audits and recoupment.
915 EPSDT Screening: 
The Early and Periodic Screening and Diagnostic Treatment (EPSDT) program interacts with internal and external stakeholders, to include Behavioral Health, Enhanced Care Services, State Agencies and Providers. EPSDT services are mandated.

917 Medical Professional Services: 
The Physician Services program interacts with internal and external customers to include providers, beneficiary services, Care Management, and other state agencies.

The area works with Provider Enrollment related to enrollment of the Licensed Independent Practitioners (LIPs). The area also works closely with the SCDHHS designated Quality Improvement Organization (QIO) to monitor utilization and coordination of services.

919 Transportation Services: 
Transportation impacts all aspects of Medicaid. It is dependent on the Physician’s Services Department for Prior Authorizations for specialized services including all Out of State and In-State overnight stays. The Bureau of Federal Contracts works closely with the Department to manage all aspects of the contracts with the Brokers.

921 Lab & X-Ray Services: 
The Laboratory and Radiology program interacts with a number of internal and external customers, to include the DHEC State lab, a number of specialty labs and the radiology contractor. Laboratory and Radiology services are mandated.

923 Family Planning: 
The Family Planning program interacts with internal and external customers to include Department of Health and Environmental Control (DHEC) Clinics, beneficiary services, and Care Management.

925 Medicare Premium Payments: 
Maintain the existing program interaction.

926 Hospice Care: 
Division of Ancillary Reimbursement, in conjunction with the Department of Facility Services, notifies each hospice of the approved Medicaid hospice reimbursement rates. The Department Facility Services works with the Division of Hospital and Physician Services when a hospice patient requires medical treatment not related to the terminal illness. Hospice, Home Health, nursing homes and Community Long Term Care provide very similar services. In many cases, a hospice patient is on multiple programs. Hospice are surveyed by the SC Department of Health and Human Services Bureau of Survey and Certification.

928 Optional State Supplemental (OSS): 
This program interacts with MMIS System Support regarding provider enrollment and terminations in MMIS, LTC Reimbursements regarding OSS/IPC Cost Reports and MCCS regarding the OSS monthly billing document (Turnaround document - TAD), CLTC (county offices) regarding OSS slot monitoring.

930 Integrated Personal Care (IPC): 
The IPC program is administered through Community and Facility Services. Three nurses are located regionally to conduct resident assessments and to provide program monitoring. The Central Office provides administrative support and linkage with the OSS program and MCCS billing.

939 PACE: 
The PACE program is administered by the Division of Community Options, with involvement of the respective county CLTC regional office staff. Nurses in those offices are responsible for initial assessments to determine if applicants meet the Nursing Facility (NF) level of care criteria, and coordinate with the PACE provider staff. The assessments are performed utilizing the CLTC Phoenix case management software system.

1744 Phased Down Contributions: 
Maintain the existing program interaction.
F. Change Management:

**888 Clinic Services:**
During the past few years the focus has been ensuring a strong RHC and FQHC provider network thus ensuring access to medical services in our underserved communities. Another primary focus for these groups continues to be incorporating electronic health record technology into their practices. With the ACA initiative, we anticipate that RHCs and FQHCs will continue to play an integral role in ensuring access to care for routine primary care services. ESRD reimbursements for dually eligible recipients have been bundled and should reduce Medicaid responsibilities.

**890 Durable Medical Equipment:**
The DME area has responded to the budget constraints the Agency has faced through working with the professional associations to reevaluate the rates, ensure proper prior authorizations and approvals, and work with the other program staff as needed to meet the needs of the beneficiaries.

**892 Coordinated Care:**
The managed care program has gone through many changes in growth over the last five years. With the addition of an enrollment broker in 2007, we began a program to educate eligible Medicaid beneficiaries in choosing a delivery system for their Medicaid benefits that included enrollment in a managed care organization (MCO) program, a medical homes network (MHN) program or fee-for-service. There were two MCOs and one MHN contracted with DHHS in 2007. Over the next three years five new MCOs were added. Two of the new MCOs were subsequently purchased by one of the existing MCOs and a third MCO terminated their contract.

In 2011 two new MHNs were contracted. We presently have four participating MCOs and three participating MHNs serving the Medicaid managed care population.

The managed care population has also grown since the introduction of the enrollment broker and the growth in the number of managed care plans. The program has grown from 147,617 members in January 2007 to 597,589 in September 2011. This is a growth of 449,972.

- 147,617 - January 2007
- 165,370 - January 2008
- 352,270 - January 2009
- 450,307 - January 2010
- 524,476 - January 2011
- 597,589 - September 2011

Another factor that has contributed to the growth is Medicaid Managed Care expansion which started in March 2011 when Medicaid beneficiaries eligible to participate in the managed care program were limited in the choice to a MCO or MHN program and not fee for service.

**901 Hospital Services:**
The mission of the South Carolina Department of Health and Human Services is to purchase the most health for those in need at the least cost to taxpayers. Over the last five years, the hospital area has worked with the South Carolina Hospital Association and other stakeholders to maximize the Agency’s investment in hospital care. During this time, we have been increasing our per diem rates to pay the facilities closer to their costs to reduce the number of cost settlements.

**903 Nursing Home Services:**
The mission of the South Carolina Department of Health and Human Services is to purchase the most health for those in need at the least cost to taxpayers. Over the last five years, nursing facility beds have remained stagnant. With the increase in CLTC slots and federal initiatives (i.e., Money Follows the Person Program, Rebalancing Demonstration), there is a shift to keep people in their communities.

**905 Pharmaceutical Services:**
Providing the most cost effective and clinically appropriate pharmaceutical products and services to SC Medicaid’s beneficiaries continues to be the overarching mission of the Pharmacy Services Program. Recent years have seen a great deal of focus on controlling the unit cost of prescription medications. The Preferred Drug List has matured over the last 5 years as a cornerstone in managing the pharmacy program- both through driving utilization toward less costly products and by garnering rebate revenues. Utilization control measures have also grown in number and scope and have been
customized to ensure that check-points are in place to drive providers toward evidence-based, cost effective pharmaceutical use. These efforts have created a pharmacy benefit that is managed to maximize access and outcomes while minimizing costs- a system that is far from a traditional “fee-for-service” program.

Efforts to exert downward pressure on unit costs and to ensure effective utilization will continue to be top priorities in the coming years. These will be added to a more global effort to maximize the Agency’s investment in pharmaceutical products. Rather than considering pharmacy expenditure in a silo and aiming to control those costs, drug expenditures will be examined in the context of other potential treatment modalities and care options. In those cases where medications are the least costly treatment option or act to cut costs from other parts of the healthcare system, the “good investment” that pharmaceuticals represent will be acknowledged and the pharmacy benefit will be modified and refocused to encourage appropriate and cost-effective utilization.

Another focus of the Pharmacy Services Program over the next few years will be leveraging pharmacy providers to expand beyond the role of providing medications, to instead taking a more active role in the management of beneficiaries’ medication activities. Problems of non-adherence, medication errors, and avoidable adverse effects diminish the value of medications in Medicaid, as they do in the rest of the healthcare system. Much of the Pharmacy Service Program’s focus will be directed toward investigating potential remedies for these problems, including payment for Medication Therapy Management (MTM) and similar programs.

**Physicians Services:**
The primary mission and focus of this program has not changed over the past five years. Physician Services is a core component and is a mandatory Medicaid service. The Agency has however worked very diligently over the past few years to move beneficiaries to a managed care environment. The goal for this movement has been to establish a medical home for all beneficiaries in an effort to improve health outcomes for recipients that receive health services.

The focus of the program over the next three years will continue to ensure appropriate access to needed health services. We are currently focused on improving birth outcomes and will continue this effort over the next few years. ACA initiatives will impact greatly on various aspects of this program as we prepare for delivering services to a broader population.

SCDHHS provides oversight to the DEC providers on billing policy and procedures.

**Dental Services:**
The Dental program has recently implemented an Administrative Service Organization to ensure proper utilization of dental services. In February of 2011, SCDHHS terminated the optional adult dental program.

**Community Long Term Care:**
CLTC has continued to work with stakeholders and other program areas within the Agency to provide the most cost effective alternative to institutionalized care.

**Home Health Services:**
Home Health is focused on providing the best skilled nursing care and therapy services to eligible recipients at a fiscally responsible reimbursement rate. Major new program focuses include: the Face-to-Face policy issued by CMS as part of the July 12, 2011 Medicaid Home Health proposed rule and the elimination of homebound criteria. Face-to-Face policy mandates a physician or an approved non-physician practitioner to document a face-to-face encounter with the recipient prior to ordering home health services. This will help screen out those individuals who do not have a medical justification for home health. The elimination of the homebound criteria will enable school age children to now receive home health services and attend school.

**EPSDT Screening:**
The EPSDT program follows the programmatic requirements as directed by the Centers for Medicare and Medicaid (CMS). Over the past five years the primary focus has been to increase utilization of EPSDT services over all covered age groups. During the next few years, the focus will be implementing the Bright Futures periodicity schedule which allows two additional visits to individuals in the EPSDT program. Also, with the movement from a non-managed care to a managed care environment, we anticipate an increase in the screening ratio in our annual EPSDT participation report.
917 Medical Professional Services:
Over the past five years we have instituted utilization controls and/or discontinued services in this budget line. SCDHHS has discontinued services for adults and revised its policy to include a check point for children’s physical therapy, occupational therapy, and speech therapy to ensure medical necessity. In the coming budget period, SCDHHS will continue to review and refine the check points and look for ways to expand the service delivery of these providers to address the expected provider shortage that may result for the ACA coverage mandate.

This program started as of July 1, 2010. Based on the number of licensed practitioners in SC, the department expects more practitioners to enroll over the next year.

919 Transportation Services:
The Department has been utilizing the Broker for the last five years and our mission is unchanged. The Department is the link between the neediest members and their medical care. Our mission is to provide safe, timely, and appropriate transportation to Medicaid covered services in a cost effective manner. The need is there and as long as the federal mandate is in place our mission will not change nor should it.

921 Lab &X-Ray Services:
Over the past five years, the focus in this program has been utilization control. The Department works closely with the OB/GYNs and Maternal Fetal Medicine physicians to manage the number of ultrasounds that are performed during a pregnancy. The Department also put in place a contractor that is approving all of our high tech radiology services. During the next few years, the Department will continue to monitor utilization with a focus on genetic services.

923 Family Planning:
Over the past few years the family planning program functioned under two separate policies. However, CMS gave states the option of discontinuing this practice and institute an eligibility program that covers both males and females. This policy change was implemented January 2011. The Department continues to monitor the change and will adapt our policy as needed to address the new service category. The Department is looking at ways through the Birth Outcomes Initiative to remove barriers in the future that currently prohibits recipients from receiving the most effective birth control product in the most efficient manner.

925 Medicare Premium Payments:
SCDHHS has continued to make the premium payments on behalf of the beneficiaries that are dually eligible for Medicaid and Medicare.

926 Hospice Care:
Our mission is to purchase the most health for those in need at the least cost to taxpayers. Over the last five years, the program has grown. There is not a Certificate of Need process in South Carolina. The program is serving younger people (i.e., cancer, HIV/AIDS). There has been an increase in hospices serving patients in nursing homes since 2005.

In addition, SCDHHS has recouped funds from providers who were inappropriately billing Medicaid. The Department of Facility Services assumed program management in June 2008. A prior authorization process was implemented January 2009. This was an attempt to focus on the length of stay as well as appropriateness of hospice. As we continue to see an increase in the number of beneficiaries in need of hospice care, the Department of Facility Services continues to provide educational interventions, monitor trends and seek guidance on ways to control expenditures.

928 Optional State Supplemental:
The OSS program may see an increase in both recipients and provider enrollment. If the IPC program is terminated, the 1000 clients (average) that are currently in that program will revert back to straight OSS. Every 50 clients added will add approximately $250,000 to the budget.

930 Integrated Personal Care:
The mission of the IPC program is to promote and sustain the health of residents in licensed community residential care facilities (CRCFs). The services are necessary to improve quality of care and prevent or delay premature institutionalization for those residents who meet the medical criteria.
The IPC focus is in transition. During the last year Division staff members have been in dialogue with CMS to determine if the IPC program can be successfully converted to a program that meets the current CMS community setting guidelines. This issue should be resolved within FY2011. In rebalancing, consideration should to be given to the role and potential impact of CRCFs.

939 PACE:
The mission of the PACE program has been to provide another cost effective option to HCB waiver programs and NF placement in the State’s long term care continuum. The program serves Medicaid eligible individuals who are frail and at-risk for institutional placement.

Around 2006 Federal authority was modified to facilitate the expansion of PACE into rural settings. In 2008 the State was approved to establish a Rural PACE site and a new provider began operations.

1744 MMA Phased Down Contributions:
SCDHHS received a credit due to ARRA being extended to the MMA benefit. This credit offset payments for the period of March 2010 through August 2010.

There was a partial credit available in September 2010 which offset the September 2010. The reduction in the ARRA rate ended effective June 2011, and monthly payments have increased to pre-ARRA rates.

G. Detailed Funding Information:

<table>
<thead>
<tr>
<th>FY 2012-13 Cost Estimates:</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs*</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Program/Case Services</td>
<td>$0</td>
<td>$1,188,966,414</td>
<td>$2,953,084,830</td>
<td>$173,590,824</td>
<td>$4,315,642,068</td>
</tr>
<tr>
<td>Pass-Through Funds</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Other Operating Expenses</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$ 0</td>
<td>$1,188,966,414</td>
<td>$2,953,084,830</td>
<td>$173,590,824</td>
<td>$4,315,642,068</td>
</tr>
</tbody>
</table>

*If new FTEs are needed, please complete Section G (Detailed Justification for FTEs) below.

Is this budget category or program associated with a Capital Budget Priority? No.
If yes, state Capital Budget Priority Number and Project Name:

Please List proviso numbers that relate to this budget category or programs funded by this category.

H. Changes to the Appropriation:
Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

<table>
<thead>
<tr>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
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<tr>
<td>2011-2012 Act</td>
<td>$ 846,866,472</td>
<td>$2,783,616,227</td>
<td>$225,959,944</td>
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<td>2012-2013 Act</td>
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<td>$173,590,824</td>
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</table>
III. Budget

Category Justification Sheet

South Carolina Department of Health & Human Services (SCDHHS)

<table>
<thead>
<tr>
<th>Difference</th>
<th>$342,099,942</th>
<th>169,468,603</th>
<th>$(52,369,120)</th>
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<tbody>
<tr>
<td>% Difference</td>
<td>40.40%</td>
<td>6.09%</td>
<td>&lt;23.18%</td>
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### Explanation of Changes:

The FY2013 budget plan annualizes the spending reductions implemented in FY2012, holds harmless service and eligibility levels, accounts for enrollment and inflationary cost growth rates, and invests in strategies to position the state to respond to substantial federally-driven changes. Actuarial assumptions indicate the Medicaid rolls will grow by 3.2 percent in FY2013, totaling more than 1.1 million citizens.

This enrollment growth, combined with the inflation and strategic investments required to operate within the Affordable Care Act and other federal mandates, represent a total requested budget increase of 1.8 percent.

The FY2013 Budget reflects the continuation of funding of the FY2012 Non-Recurring Appropriation Funds which were not included in the based budget ($238,317,764). The budget reflects an adjustment to our base budget to meet the growing needs of doing business with the State’s estimated 924,314 Medicaid enrollees.

This includes $5.1 million to operate within the parameters of the Affordable Care Act and $23.5 million for enrollment growth premiums for dual eligible program enrollees. A projected growth of 7.2 percent for the managed care organization and 8.8 percent for the Medical Homes Network program used to project enrollment growth of $68,709,501. This budget plan also includes new initiatives enrollment growth for children receiving TANF/SNAP benefits (total funds $29,492,975), reduction of Long Term Care Waiver List (total funds of $6,149,000 and match of $1,829,942), and the potential reinstatement of adult dental services (total $12,600,000 and match of $3,749,760).

### I. Revenue Estimates:

Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Federal</th>
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<tr>
<td>344000000</td>
<td>50 cent per Capita</td>
<td>$2,000,000</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3441</td>
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<td></td>
<td></td>
<td>$513,000</td>
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<tr>
<td>344200000</td>
<td>Special Grants</td>
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<td>347500000</td>
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<td></td>
<td>$5,500,000</td>
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<td>Hospital Tax</td>
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<td></td>
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<td>576400000</td>
<td>Federal Medicaid FMAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2,953,084,830</td>
</tr>
</tbody>
</table>

If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

Please detail the long-term sustainability of this program if cash reserves are needed to operate.

If there is federal fund or other fund spending authority requested above the revenue streams detailed above, please indicate the amount and explanation for each.

### J. FTE Positions:
III. Budget Category Justification Sheet

Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other-Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
<th>Temporary, Temporary Grant, Time-limited</th>
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<tr>
<td>2012-2013 (A)</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2011-2012 (A)</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2010-2011 (F)</td>
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<td>2010-2011 (A)</td>
<td>N/A</td>
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<tr>
<td>2009-2010 (F)</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2009-2010 (A)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2008-2009 (F)</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2008-2009 (A)</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2007-2008 (F)</td>
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<td>N/A</td>
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<tr>
<td>2007-2008 (A)</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>

K. Detailed Justification for FTEs:

(1) Justification for New FTEs
   (a) Justification:

   (b) Future Impact on Operating Expenses or Facility Requirements:

(2) Position Details:

<table>
<thead>
<tr>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position Title: Number of FTEs</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<table>
<thead>
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<tr>
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<tr>
<td>Employer Contributions</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
A. **Summary description of programs and how they relate to the mission of the Agency:**

**894 DMH Medicaid Services:**
The Department of Mental Health provides services and financial support for Community Mental Health, Rehabilitative Behavioral Health treatment services and Targeted Case Management for eligible severely emotionally disturbed children and chronically mentally ill adults. Major programs within each area of the DMH Behavioral Health includes:

- Clinic Services consist of an array of treatment services that include diagnostic assessments, therapy services and Medication Management.
- Rehabilitative Behavioral Health Services consist of an array of Community Support Services (CCS) designed to enhance and support the clinical interventions for the client. An example of CCS is Peer Support Services.
- Targeted Case Management (TCM) refers to activities that assist Medicaid beneficiaries in gaining access to needed medical, social, educational, and other services through the following four components: and consist of assessment, care planning and coordination, referral and linkage, and monitoring and following up services.

State Match dollars provided by DMH ensure funding for an array of rehabilitative behavioral health services provided by qualified, private community-based providers and Psychiatric Residential Treatment Facilities.

- FY 2011 Total Patients Served: 45,107
- FY 2011 Expenditures: $155,000,000

**895 DDSN Medicaid Services:**
The Department of Disabilities and Special Needs (DDSN) is a non-cabinet Agency that is legislatively mandated to serve several disability populations; those with intellectual disabilities and related disabilities, autism, traumatic brain injured, and spinal cord injured.

DDSN receives state funds directly from the Legislature and uses 90+ percent those funds to provide state match in a collaborative relationship with DHHS to serve those populations with Medicaid funded services. DDSN directly provides or sub-contracts with providers to offer the following four (4) major Medicaid services:

- Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
- Behavioral Health Services
- Targeted Case Management Services
- Home and Community-Based Waiver programs that serve the intellectually disabled, autistic children, and head and spinal cord injured.

**ICF/MRs:**
DDSN contracts with SC DHCP for the statewide operation of ICF/MR facilities, which include four (4) State operated Regional Centers at five (5) sites, and 83 community located smaller facilities (2, 4, and 8 bed settings), with a total number of ICF/MR beds statewide of 1,828. All are required to be licensed and surveyed by DHEC. Each facility is required to provide diagnosis, treatment, or habilitation, and ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function optimally. ICF/MR services are some of the most costly institutional services the State provides.

- FY 2011 Patients Served: 1,501
- FY 2011 Expenditures: $133,825,695

**Behavioral Health Services**
Rehabilitative Behavioral Health Services that offer an array of community-based treatment services which include diagnostic assessments, therapy services, and community support services. These services are also provided by qualified, private community-based providers and Psychiatric Residential Treatment Facilities. Also provided are outreach services that have a primary focus to develop and maintain an effective system that provides adequate access to genetic services that are family centered.

- FY 2011 Patients Served: 5,710
- FY 2011 Expenditures: $13,531,215
Targeted Case Management (TCM) Services
TCM services are available for eligible clients and are for activities that assist Medicaid beneficiaries in gaining access to needed medical, social, educational, and other services through the four basic components: assessment, care planning and coordination, referral and linkage, and monitoring and following up services.

- FY 2011 Patients Served: 18,50
- FY 2011 Expenditures: $27,430,794

Home and Community-Based Waiver Programs
By way of Memorandum of Agreement with SCDHHS, DDSN has day to day operational responsibility for four (4) home and community-based waiver programs serving several disabled populations. DDSN has established an Organized Health Care Delivery System that includes local Disability and Special Needs Boards, and some private providers, who are contracted to provide waiver services to Medicaid eligible participants meeting the waiver criteria and who are at-risk of institutional placement.

FY 2011 Combined data for the four (4) waiver programs:
- Total Patients Served: 8,786
- Total waiting list: 6,567
- Total expenditures: $359,747,558

FY 2011 Individual data for the four (4) waiver programs:
- Community Supports (CS) waiver
  - Patients Served: 1,983 Waiting list: 3,015 Expenditures: $26,818,729
- Head and Spinal Cord Injured (HASIC) waiver
  - Patients Served: 626 Waiting list: 444 Expenditures: $21,475,205
- Mental Retardation and Related Disabilities (MR/RD) waiver
  - Patients Served: 5,683 Waiting list: 2,540 Expenditures: $299,119,631
- Pervasive Developmental Disorder (PDD) waiver
  - Patients Served: 494 Waiting list: 568 Expenditures: $8,238,913

896 DHEC Medicaid Services:
DHEC services include Nursing for Children under 21 involves the provision of specialized health care services to children needing primary health care services. DHEC's Children's Rehabilitative Services (CRS Ortho) Program provides orthodontic services for Medicaid beneficiaries that have severe birth defects which result in craniofacial anomalies such as Cleft Lip and/or Cleft Palate, Prognathism, Crouzon's Syndrome, Apert's Syndrome, Mid-face and Growth Related Skeletal Deficiencies.

897 MUSC Medicaid Services:
Financial support is provided for an array of outpatient community mental health, rehabilitative behavioral health treatment services and Targeted Case Management to severely emotionally disturbed children and chronically mentally ill adults.

Targeted Case Management Services are available for eligible children and adults in the MUSC system and refers to activities that assist Medicaid beneficiaries in gaining access to needed medical, social, educational, and other services through the following four components: assessment, care planning and coordination, referral and linkage, and monitoring and following up services.

The MUSC program also provided financial support for MUSC’s Developmental Evaluation Center (DEC) to provide comprehensive diagnostic assessments to children for the purpose of identifying genetic disorders and other developmental disorders in children.
898 **University of South Carolina (USC) Medicaid Services:**

Early Intervention: Developmental Evaluation Center (DEC). Sickle Cell Case Management and Neuro Developmental Disorders are a part of community service provision at USC. DEC services are comprehensive assessments performed for the purpose of identifying genetic disorders. Sickle Cell Case Management Services include counseling and case management services to patients with Sickle Cell Disease.

899 **Of Alcohol and Other Drug Abuse (DAODAS) Medicaid Services:**

This program provides financial support for alcohol and other drug abuse rehabilitative services and targeted case management to enable DAODAS to ensure the provision of quality services to prevent or reduce the negative consequences of substance use and addictions.

DAODAS partners with public, private and social sector organizations to provide quality prevention, intervention and treatment services for the Medicaid clients. DAODAS subcontracts with 33 county alcohol and drug abuse authorities to provide the majority of direct services to citizens in all 46 counties of the state. The department itself coordinates services for adolescents who are preparing to leave alcohol and other drug inpatient treatment facilities, juvenile justice facilities or other residential settings, and to return home to their families and communities.

Targeted Case Management (TCM) is provided in accordance with section 1902(a) (10) (B) of the Social Security Act. TCM refers to activities to assist individuals in gaining access to needed medical, social, educational and other services through the following four components: assessment, care planning and coordination, referral and linkage, monitoring and follow-up.

Clients are treated so they may re-enter society and lead responsible, successful drug and alcohol free lives by using the tools of recovery they receive during treatment. Outcomes include reducing involvement with the criminal justice system, reducing client emergency room visitation. Another measure is the extent to which coordination of care exists between public and private providers.

SCDHHS is responsible for administrative guidance, policy and procedures, evaluation and monitoring of services. Staff participates in provider meetings to ensure program oversight and Medicaid related issues. Staff supports provider programs by participating on Program Committees.

DAODAS estimates that approximately 236,000 individuals in South Carolina are suffering from substance abuse problems that require immediate intervention and treatment. With a problem of this magnitude, the department must continue to ensure that individuals and families find the help they need through the vital services purchased by DAODAS and through the statewide system of county alcohol and drug abuse authorities (i.e., the local provider network).

- FY 2011 Patients Served: 12,691
- FY 2011 Expenditures: $15,054,132

900 **Continuum of Care for Emotionally Disturbed Children (COC):**

Targeted Case Management Services are available to Medicaid eligible recipients who are COC beneficiaries. These services provide coordination of care so that all COC Medicaid eligible EDC recipients have planned access to needed medical, social, educational and other services through the following four components: assessment, care planning and coordination, referral and linkage, and monitoring and follow-up. COC provides training and staff development related to Medicaid requirements and SCDHHS provides any assistance with training and staff development if needed. These services are provided in order to stabilize or strengthen the child’s current placement or prevent out-of-home care.

- FY 2011 Patients Served: 562
- FY 2011 Expenditures: $6,590,057

931 **School for the Deaf and Blind:**

Rehabilitative Behavioral Health Services (RBHS), Early Intervention Services (EI) and Targeted Case Management: The services are delivered based on medical necessity and individual treatment plans to individuals with sensory impairment- individuals who are deaf, or who are deaf and blind. RBHS are provided to individuals with a diagnosis of Seriously Emotionally Disturbed (SED). These services include diagnostic assessment, individual therapy, group therapy, behavioral health screening, treatment planning, medication management, crisis management, behavior
modification, rehabilitation psychosocial service, and family support. EI includes targeted case management services, sign language, and family training for the purpose of evaluating and treating disorders in children with the optimal goal of improving functioning.

Agency staff provides technical assistance in the following areas; policy interpretation, claims resolution, contract management, quality assurance monitoring.

School for Deaf and Blind educators and staff have specialized skills and training that make them uniquely qualified to work with this population. Staff must be or become proficient in sign language, be knowledgeable of braille, and understand the special needs of individuals with multiple handicapping conditions.

- FY 2011 Patients Served: 718
- FY 2011 Expenditures: $1,578,795

932 Department of Social Services (DSS) Medicaid Services:
The SCDSS Medicaid program allows for the provision of Rehabilitative Behavioral Health Services to Medicaid children and youth under 21, who meet medical necessity criteria, are emotionally disturbed and who are residing in the community. Rehabilitative Behavioral Health Services consist of a discrete array of community-based treatment services that include diagnostic assessments, therapy services, and Community Support Services. The program is available to children in custody of SCDSS who are in need of mental health services.

SCDSS is responsible for training and staff development related to Medicaid requirements. SCDHHS provides any assistance with training and staff development, policy interpretation and claims resolution as needed.

- FY 2011 Patients Served: 2,958
- FY 2-11 Expenditures: $12,412,716

933 DJJ Medicaid Services:
Financial support is provided for the provision of mental health and rehabilitative services to Medicaid eligible clients of DJJ who are emotionally and/or behaviorally disturbed and who are residing in the home and community. All services must be determined medically necessity and are based on an Individualized Plan of Care. Support for psychiatric residential services is also provided under some circumstances.

DJJ is responsible for ensuring that all direct care staff are properly trained and qualified to render the services as specified in the Medicaid Policy Manual that applies to the service/program.

Rehabilitative Behavioral Health Services consists of an array of community-based treatment services that include diagnostic assessments, therapy services, and Community Support Services to eligible clients.

Targeted Case Management Services are available for SED children within the DJJ system and refers to activities that assist Medicaid beneficiaries in gaining access to needed medical, social, educational, and other services through the following four components: assessment, care planning and coordination, referral and linkage, and monitoring and following up services.

State Match dollars provided by DJJ ensure funding for an array of rehabilitative behavioral health services provided by qualified, private community-based providers and Psychiatric Residential Treatment Facilities.

State Match dollars provided by DJJ ensure funds are available for incarcerated youth who are admitted to a medical institution for inpatient services. Medicaid eligibility is limited to the time the DJJ client is inpatient.

- FY 2011 Patients Served: 2,296
- FY 2011 Expenditures: $3,350,020

934 Department of Education Medicaid:
Financial support is provided for the provision of school-based rehabilitative therapies, psychological testing and evaluation, adolescent pregnancy and prevention, and an array of Rehabilitative Behavioral Health Services (RBHS) to Medicaid eligible SDE children under age 21. Services must be referred by a physician or other Licensed Practitioner of the Healing Arts as defined by the Department of Health and Human Services. All services must be determined medically necessity and are based on an Individualized Education Plan (IEP) or Individualized Plan of Care (IPOC).
These services are provided in local school districts for the purpose of evaluating and treating disorders in children with the optimal goal of improving function.

Rehabilitative therapies include services such as Auditory, Orientation and Mobility, Physical and Occupational Therapy, Speech-Language Pathology, and Nursing Services. Rehabilitative Behavioral Health Services consist of an array of school and community-based treatment services that include diagnostic assessments, therapy services, and Community Support Services to eligible clients.

- FY 2011 Patients Served: 128,168
- FY 2011 Expenditures: $47,659,000

935 Commission for the Blind:
This program provides financial support for Targeted Case Management Services to visually impaired Medicaid beneficiaries who have been determined to meet the TCH State Plan criteria. Targeted Case Management refers to activities that assist Medicaid beneficiaries in gaining access to needed medical, social, educational, and other services through the following four components: assessment, care planning and coordination, referral and linkage, and monitoring and follow-up. SCCB ensures that the allowable components are available to beneficiaries covered within the scope of the contract.

1745 Wil Lou Gray Opportunity School Medicaid:
Provide administrative support to the school to ensure that rehabilitative and related health services are available to Medicaid eligible children through budget management, rate setting, claims resolution, policy and development.

1742 Department of Corrections Medicaid:
The Department of Corrections Medicaid services provide financial support for Medicaid eligible inmates who are admitted to a medical institution (hospitals, nursing facilities, psychiatric facilities and intermediate care facilities) for inpatient services. The program serves any Medicaid eligible individual that is serving time for a criminal offense or confined involuntarily in a State or Federal prison, jail, detention facility or other penal facility. SCDHHS enrolls qualified providers that work in conjunction with SCDC to provide services to Medicaid eligible inmates.

- FY 2011 Patients Served: 99
- FY 2011 Expenditures: $2,333,948

1840 SC State Housing Authority:
The State Housing Authority gives funds annually to the (CLTC) program. These funds are used to pay for home repairs for CLTC waiver recipients. These include floor repair, door widening, and other work needed to maintain a safe and accessible home environment. The amount of funds this year is $100,000 state dollars. With federal match, this provides home repairs of approximately $333,000.
### A. Budget Program Number and Name:

#### II.A.4. Assistance Payment

### B. Agency Activity Number and Name:
Note: If more than one activity maps to this program; provide all activity numbers, names, and approximate funding amounts.

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>894</td>
<td>DMH Medicaid Services</td>
<td></td>
<td></td>
<td>$108,872,000</td>
<td>$46,128,000</td>
<td>$155,000,000</td>
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<tr>
<td>895</td>
<td>DDSN Medicaid Services</td>
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<td>$166,815,635</td>
<td>$560,536,408</td>
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<tr>
<td>896</td>
<td>DHEC Medicaid Services</td>
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<td>$4,213,499</td>
<td>$14,158,264</td>
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<tr>
<td>897</td>
<td>MUSC Medicaid Services</td>
<td>$29,401,236</td>
<td>$12,457,016</td>
<td>$41,858,252</td>
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<td></td>
</tr>
<tr>
<td>898</td>
<td>USC Medicaid Services</td>
<td>$4,033,251</td>
<td>$1,708,849</td>
<td>$5,742,100</td>
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<td></td>
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<tr>
<td>899</td>
<td>DAODAS Medicaid Services</td>
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<td>$13,249,431</td>
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<td></td>
</tr>
<tr>
<td>900</td>
<td>Continuum of Care</td>
<td>$4,628,856</td>
<td>$1,961,201</td>
<td>$6,590,057</td>
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<tr>
<td>931</td>
<td>School for the Deaf and Blind</td>
<td>$3,356,626</td>
<td>$1,422,169</td>
<td>$4,778,795</td>
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<td>932</td>
<td>DSS Medicaid Services</td>
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<td>$3,350,020</td>
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<tr>
<td>934</td>
<td>Dept of Education Medicaid</td>
<td>$35,120,000</td>
<td>$14,880,000</td>
<td>$50,000,000</td>
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<tr>
<td>935</td>
<td>Commission for the Blind</td>
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<td>$11,846</td>
<td>$39,805</td>
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<tr>
<td>1745</td>
<td>Wil Lou Gray Opportunity School Medicaid</td>
<td>$21,072</td>
<td>$8,928</td>
<td>$30,000</td>
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<td></td>
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<tr>
<td>1742</td>
<td>Department of Corrections Medicaid</td>
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<td>$694,583</td>
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<tr>
<td>1840</td>
<td>SC State Housing Authority</td>
<td>$231,792</td>
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<td>$330,000</td>
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<td></td>
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</table>
C. Performance Measures:

894 DMH Medicaid Services:
No Specific Performance Measures.

895 DDSN Medicaid Services:
ICF/MR
Continued conversion of ICFs/MR to CRCFS and CTH settings. Initiating policies to ensure the cost effectiveness and utilization of bed hold and therapeutic deinstitutionalization days. Possible reduction in the allowable bed hold days (currently 96 days each fiscal year, up to a maximum of eight days per month, and two 16 consecutive day therapeutic leave days allowed as part of the 96 aggregate days). Ensure DDSN’s new census and billing automation system is accurate via audit of utilization and claims. Monitor DHEC survey reports to determine when to invoke the automatic cancellation clause in the contract with DDSN.

Behavioral Health
• Monitoring of contract deliverables

Home and Community-Based Waiver Programs
• Ongoing monitoring of Quality Assurance functions
• Development and implementation of Administrative Services contract
• Transition of TCM services for waiver participants to waiver case management services

896 DHEC Medicaid Services:
No Specific Performance Measures.

897 MUSC Medicaid Services:
No Specific Performance Measures.

898 USC Medicaid Services:
No Specific Performance Measures.

899 DAODAS Medicaid Services:
No Specific Performance Measures.

900 Continuum of Care:
No Specific Performance Measures.

931 School for the Deaf and Blind:

Expected Results
EI: Early Intervention: Will provide assurance of timely access to community services and programs that can best meet the individual’s needs. Family Training, trains parents/caregivers in the use of developmentally appropriate activities to enhance their child's development and family supports assure that each person receives needed services in a supportive, effective, efficient, and cost effective manner. Wraparound Services are provided to children under 21 years of age who have special emotional/behavioral needs and their families. Specifically assessment, care planning, referral and linkage and monitoring and follow-up may be provided. These services are provided in order to stabilize or strengthen the child's current placement or prevent out of home care. Wraparound services are treatment oriented and goal directed. Without Wraparound Services, such as counseling, therapy, behavioral intervention, or independent living skills, the child may be in risk of placement disruption.

Expected outcomes
EI: Early detection of genetic disorders will enhance treatment modalities for increased quality of life for Medicaid recipients. Coordination of services and care with public and private providers. Outcomes are developed in conjunction with the families based on mutually identified needs

BHS: Youth will function better at home, at school and in the community. Outcomes include prevention of more costly and restrictive treatment options through adherence to a philosophy of community based, most normative and
least restrictive services delivery and the facilitation of permanency through reunification or permanent guardianship. Another measure is the extent to which coordination of care exists between public and private providers.

932 DSS Medicaid Services:
No Specific Performance Measures.

933 DJJ Medicaid Services:
No Specific Performance Measures.

934 Department of Education Medicaid:
School-Based Services: Increase access to care, provide early detection, increase beneficiary utilization of prevention services and early detection. Another measure is the extent to which coordination of care exists between public and private providers.

RBHS: Anticipated outcomes include improved functioning and performance in school, at home and in the community. Other measures evaluate whether children that received these services are residing with a consistent, stable caregiver, whether children receiving these services remain in a regular day care or school program after discharge and whether there are fewer attendance problems, suspensions and other disciplinary actions.

935 Commission for the Blind:
No Specific Performance Measures.

1742 Department of Corrections Medicaid:
Provide payment to enrolled providers of inpatient services for inmates, including hospitals, nursing facilities, juvenile psychiatric facilities and intermediate care facilities

1745 Wil Lou Gray Opportunity School Medicaid:
No Specific Performance Measures.

1840 SC State Housing Authority:
No Specific Performance Measures.

D. Program Interaction:

894 DMH Medicaid Services:
Staff attends monthly workgroup meetings to discuss past, present and future Medicaid changes that may impact DMH. Staff attends quarterly billing meetings to assist Community Mental Health Centers with any billing issues or concerns.

895 DDSN Medicaid Services:
Reimbursement rates for all programs are determined by SCDHHS.

The SCDHHS Department of Facility Services is responsible for policy and program oversight of ICF/MR facilities, The Division of Community Options for the waiver programs, and The Division of Behavioral Health for TCM and Behavioral Health services.

DDSN has responsibility for admissions to ICFs/MR, waiver operations, TCM/Behavioral Health services, and the determination of ICF/MR level of care determinations.

DHEC has licensing, survey and certification responsibility for the ICFs/MR, and residential and day waiver services. By state law, SLED must investigate all allegations regarding criminal conduct of state personnel at ICF/MR facilities.

SCDHHS’s Program Integrity and audit contractor staff provide additional oversight of programs

896 DHEC Medicaid Services:
No changes in program interactions.
897 MUSC Medicaid Services:
DFS staff participates in monthly conference calls with MUSC (BHS) to discuss Medicaid issues that may impact service delivery. MUSC participates in routinely scheduled meetings between the State agencies and SCDHHS. These meetings usually occur every other month.

898 USC Medicaid Services:
No changes in program interactions.

899 DAODAS Medicaid Services:
DAODAS works with the South Carolina Department of Mental Health (DMH), county alcohol and drug abuse authorities, local mental health providers and local hospitals to develop plans on how best to provide treatment to people with co-occurring disorders and those who visit emergency rooms (ERs) in crisis.

SCDHHS staff participates in DAODAS’s policy planning sessions and committees to reformulate how to provide best practice methods in the delivery of services.

900 Continuum of Care for Emotionally Disturbed Children:
The COC state office will provide consultation and technical assistance to Regional offices to provide appropriate management of TCM. SCDHHS maintains and revises policies and procedures and provides technical assistance.

931 School for the Deaf and Blind:
All of the RBHS and EI services are administered by the South Carolina School for the Deaf and Blind at the Spartanburg Campus. SDB staff are responsible for assessments, provision of service, and has an administrative component of the agreement which partially funds the quality assurance slot. SDB staff receives referral from the “Babynet”-First Steps staff for new clients with sensory impairment. SDB is a part of the South Carolina public School system and community provider of rehabilitative services.

932 DSS Medicaid Services:
South Carolina Department of Social Services (SCDSS) and SCDHHS interactions include the development of policies and procedures for approved RBHS, assisting in providing research for new and innovative services for possible delivery to SCDSS children and conducting Medicaid compliance reviews.

933 Department of Juvenile Justice (DJJ) Medicaid Services:
Programs are administered by DJJ State Office and more directly through 46 County Offices. Psychologists, Nurses, Licensed Independent Practitioners and other qualified clinical staff are responsible for rendering the services in compliance with the Medicaid Policy Manual. The State Office is responsible for administration, oversight, and coordination with the Medicaid Agency. SCDHHS is responsible for providing technical assistance in the form of policy interpretation and clarification, and claims resolution. SCDHHS is expected to monitor compliance and provide quality assurance.

934 Department of Education Medicaid:
State Department of Education (SDE) and SCDHHS work together in collaboration with the Local Education Districts on how best to meet the beneficiary’s individual treatment needs. SDE and SCDHHS meet quarterly to review service delivery and discuss policy and billing issues.

935 Commission for the Blind:
This program is monitored by the Division of Family Services (DFS). The DFS is responsible for providing technical assistance as needed with policy and claims resolution. With the expansion of staff at the Commission SCDHHS will continue to monitor and review this contract.

1745 Wil Lou Gray Opportunity School Medicaid:
No changes in program interactions.

1742 Department of Corrections Medicaid:
SCDHHS maintains and revises policies and procedures and provides technical assistance to Medicaid enrolled providers.
1840 SC State Housing Authority:
No changes in program interactions.

E. Change Management:

894 Department of Mental Health (DMH) Medicaid Services:
The mission has been and will continue to be to give priority to adults, children, and their families affected by serious mental illnesses and significant emotional disorders. DMH is committed to eliminating stigma and promoting the philosophy of recovery, achievement of goals in collaboration with all stakeholders, and to assure the highest quality of culturally competent services possible.

895 Department of Disabilities and Special Needs (DDSN) Medicaid Services:
ICF/MR: Over the last five years the ICF/MR program has not declined. This is due in part to small community facility conversions (decertifications) to a designated less restrictive residential settings (Community Residential Care Facilities and/or Community Training Homes) in an effort to maintain people in the least restrictive environment. As a policy DDSN has limited facility enrollments to only essential admissions.

The Money Follows the Person Grant is an effort to provide enhanced home and community-based care to Medicaid participants in Nursing Facilities or ICFs/MR. It is a Rebalancing Demonstration grant developed to assist the State in shifting its institutional costs to community-based care and will be operated through June 30, 2016.

The major goal of the Home Again project is to optimize the participant’s life choices and rights, to minimize threats to the participant’s safety and health, and to provide a mechanism for managing home and community-based alternatives to institutional care. The project allows for a range of options based on choice, role, and responsibility in the decision-making process for recipients.

It is the objective of DDSN and SCDHHS that through attrition, the Money Follows the Person grant, facility consolidation, and ongoing deinstitutionalization of individuals to home and community based waiver programs, will reduce the number of Medicaid eligible individuals in ICF/MR facilities. A Study of bed hold and therapeutic deinstitutionalization day utilization is planned to determine the effect of policy change on recipients, providers, and expenditures. An analysis of the multi-tier rate structure involving the regional and community facilities to determine cost-effectiveness.

Behavioral Health: Objective is to monitor individuals to ensure they receive appropriate health services to limit their debilitating condition, disease, or disorder in order to maximize their level of health and contain costs.

Home and Community-Based Waiver Programs: Waivers are to provide services in the community as an alternative to institutional care, in a cost-effective manner. Through case management waiver services or TCM, waiver participants are monitored to ensure they are receiving needed services to address their health care needs.

896 DHEC Medicaid Services:
The mission of this program has been and will continue to be providing most coordinated interaction with sister agencies for service delivery.

897 MUSC Medicaid Services:
The mission of this program has been and will continue to be providing outpatient Mental Health Treatment, Rehabilitative Behavioral Health Services and Targeted Case Management. MUSC will continue to make available the services set forth in the Community Mental Health and Rehabilitative Behavioral Health Services Manuals.

898 USC Medicaid Services:
The mission of this program has been and will continue to be providing most coordinated interaction with sister agencies for service delivery.

899 of Alcohol and Other Drug Abuse (DAO) Medicaid Services:
Services provided by DAODAS changed in FY 2010 to Rehabilitative Behavioral Health Services which gave them a broader range of discrete services to provide which assisted with the co-occurrence population. This aided in reducing administrative services and duplication of services provided by mental health. The Agency charged with ensuring the
provision of quality services to prevent or reduce the negative consequences of substance use and addictions. The ultimate goal of the program is recovery and long-term abstinence from drugs and alcohol.

900 Continuum of Care for Emotionally Disturbed Children:
The mission has and is to provide needed services to the Medicaid beneficiaries in the state. The restructuring of the TCM will help to identify individual problems, needs, strengths, and resources; coordinate services necessary to meet the beneficiary’s needs; and monitor the provision of necessary and appropriate services more effectively.

931 School for the Deaf and Blind:
The purpose of SDB Medicaid services continues to be providing Medicaid eligible beneficiaries access to quality medically necessary services to help the beneficiary reach his/her optimal level of functioning. These services are provided with the intent of equipping the individual with skills that will afford the individual the opportunity to live independently.

932 DSS Medicaid Services:
The mission is to provide needed services to the Medicaid beneficiaries in the custody of DSS. The restructuring of the RBHS has given the Medicaid beneficiaries the opportunity to receive more services to assist with ameliorating disabilities, improvement of the beneficiary’s ability to function independently and the possible restoration of maximum functioning through the use of diagnostic and restorative services. SCDSS is expected to continue utilization of Medicaid services to help meet the needs of children in care, promote continuity of care, provide access to community based services which reduces costly hospitalizations.

933 DJJ Medicaid Services:
DJJ is expected to continue to maximize dollars to ensure the provision of home and community-based behavioral health services to Medicaid eligible clients. Over the past several years, DJJ has reduced the number of children detained behind the fence and is expected to increase use of community-based services. Services provided are “evidence-based” and best practice for ensuring quality services that meet the individualized needs of the client in the least restrictive setting. Services will enhance community safety and well-being as re-offense rates drop and children are able to improve functioning at home, in school and in the community.

934 Department of Education Medicaid:
School Based: Identifying, coordinating and treating of medical conditions to increase level of functioning. Each school district determines which of these services will be offered to Medicaid eligible emotionally disturbed children. Services are provided to integrate therapeutic interventions with education to reduce maladaptive behaviors and foster healthy family relationships. Certain services are designed to prevent child maltreatment and increase the families’ family’s enhanced ability to meet the therapeutic needs of the child. Other services prevent more costly and restrictive treatment options and assist children in functioning successfully within their home and school environments.

935 Commission for the Blind:
The Commission for the Blind has experienced a reduction in force and therefore utilization and expenditures have declined. Recent changes in management are expected to result in increased utilization of TCM services.

1745 Wil Lou Gray Opportunity School Medicaid:
The mission of this program has been and will continue to be providing most coordinated interaction with sister agencies for service delivery.

1742 Department of Corrections Medicaid:
The program provides needed inpatient treatment services to eligible Medicaid beneficiaries in the state.

1840 SC State Housing Authority:
The mission of this program has been and will continue to be providing most coordinated interaction with sister agencies for service delivery.
### F. Detailed Funding Information:

<table>
<thead>
<tr>
<th>FY 2012-13 Cost Estimates</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs*</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Program/Case Services</td>
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<td>Pass-Through Funds</td>
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<td>$0</td>
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<td>$0</td>
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<tr>
<td>Other Operating Expenses</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$ 0</strong></td>
<td><strong>$ 0</strong></td>
<td><strong>611,375,841</strong></td>
<td><strong>259,033,955</strong></td>
<td><strong>$870,409,796</strong></td>
</tr>
</tbody>
</table>

*If new FTEs are needed, please complete Section G (Detailed Justification for FTEs) below.*

Is this budget category or program associated with a Capital Budget Priority? No

If yes, state Capital Budget Priority Number and Project Name:

Please List proviso numbers that relate to this budget category or programs funded by this category.

### G. Changes to the Appropriation:

Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

**Funding:**

<table>
<thead>
<tr>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
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</thead>
<tbody>
<tr>
<td>2011-2012 Act</td>
<td>$558,805,035</td>
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<td>$282,290,022</td>
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<tr>
<td>2012-2013 Act</td>
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<td>Difference</td>
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<td>$(23,256,067)</td>
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<td>% Difference</td>
<td>9.41%</td>
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<td>(9.08%)</td>
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</tr>
</tbody>
</table>

**Explanation of Changes:**

### H. Revenue Estimates:

Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
<th>Earmarked</th>
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<th>Federal</th>
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<td>CPE Fund</td>
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<td>344100000</td>
<td>State Agency Fund</td>
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<td>$72,115,053</td>
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<tr>
<td>500000000</td>
<td>Federal Funds</td>
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<td></td>
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<td></td>
<td>$611,375,841</td>
</tr>
</tbody>
</table>
If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

Please detail the long-term sustainability of this program if cash reserves are needed to operate.

If there is federal fund or other fund spending authority requested above the revenue streams detailed above, please indicate the amount and explanation for each.

I. FTE Positions:
Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other-Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
<th>Temporary, Temporary Grant, Time-limited</th>
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<td>2012-2013 (A)</td>
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<td>N/A</td>
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<tr>
<td>2011-2012 (A)</td>
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<td>N/A</td>
<td>N/A</td>
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<td>2010-2011 (A)</td>
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<td>N/A</td>
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<td>2009-2010 (F)</td>
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<tr>
<td>2009-2010 (A)</td>
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<td>N/A</td>
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<tr>
<td>2008-2009 (F)</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2008-2009 (A)</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2007-2008 (F)</td>
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<td>N/A</td>
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</table>

J. Detailed Justification for FTEs:
(1) Justification for New FTEs
(a) Justification:

(b) Future Impact on Operating Expenses or Facility Requirements:

(2) Position Details:

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
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</thead>
<tbody>
<tr>
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<tr>
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<td>$0</td>
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</tr>
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<td>Employer Contributions</td>
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<tr>
<td>State</td>
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<tr>
<td>Position Title:</td>
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<tr>
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<tr>
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<td>Employer Contributions</td>
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<td>$0</td>
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</tr>
<tr>
<td>State</td>
<td>Federal</td>
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<td>Total</td>
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<tr>
<td>Position Title:</td>
<td>State</td>
<td>Federal</td>
<td>Earmarked</td>
<td>Restricted</td>
<td>Total</td>
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<tr>
<td>Number of FTEs</td>
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<td>$0</td>
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</tr>
</tbody>
</table>
III. Budget

A. Summary description of programs and how they relate to the mission of the Agency:

936 Emotionally Disturbed Children:
SCDSS/Interagency System for Caring for Emotionally Disturbed Children (ISCEDC)

Financial support is provided to ensure coordinated, comprehensive access to services for ISCEDC children in the custody of the SCDSS for treatment rendered by Medicaid enrolled providers of Rehabilitative Behavioral Health Services and Psychiatric Residential Treatment Facilities. The program is available to SCDSS children under the age of 21 who are severely emotionally and/or behaviorally disturbed and meet the medical necessity criteria for the services. Services are designed to address therapeutic placements of emotionally disturbed children in South Carolina, the quality of treatment services, the avoidance of more costly and restrictive treatment options, adherence to a philosophy of community based, most normative and least restrictive services delivery and the facilitation of permanency through reunification or permanent guardianship are outcomes. Services are rendered by qualified private providers through Medicaid and the State Procurement Process. Providers are responsible for staff development related to Medicaid requirements and SCDHHS provides any assistance with training and staff development if needed.

Number served: 1,654
Expenditures: $34,919,661

B. Budget Program Number and Name:

II.A.5. Emotionally Disturbed Children

C. Agency Activity Number and Name:
Note: If more than one activity maps to this program; provide all activity numbers, names, and approximate funding amounts.

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>936</td>
<td>Emotionally Disturbed Children</td>
<td></td>
<td></td>
<td>$26,503,441</td>
<td>$11,229,249</td>
<td>$37,732,690</td>
</tr>
</tbody>
</table>

D. Performance Measures:

936 Emotionally Disturbed Children:
No specific performance measures are established at this time.

E. Program Interaction:

936 Emotionally Disturbed Children:
SCDHHS enrolls qualified providers who work in conjunction with SCDSS to provide services to Medicaid eligible children under 21. Providers must adhere to the applicable Medicaid Policy Manual.

F. Change Management:

936 Emotionally Disturbed Children:
The mission is to provide needed mental health and rehabilitative services to the Medicaid beneficiaries in the state. The restructuring of the RBHS has given the Medicaid beneficiaries the opportunity to receive more services to assist with ameliorating disabilities, improvement of the beneficiary’s ability to function independently and the possible restoration of maximum functioning through the use of diagnostic and restorative services in the least restrictive setting.
G. Detailed Funding Information:

<table>
<thead>
<tr>
<th>FY 2012-13 Cost Estimates:</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs*</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
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<td>$0</td>
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<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Program/Case Services</td>
<td>$0</td>
<td>0</td>
<td>$26,503,441</td>
<td>$11,229,249</td>
<td>$37,732,690</td>
</tr>
<tr>
<td>Pass-Through Funds</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Other Operating Expenses</td>
<td>$0</td>
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<td>$0</td>
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<tr>
<td>Total</td>
<td>$0</td>
<td>0</td>
<td>$26,503,441</td>
<td>$11,229,249</td>
<td>$37,732,690</td>
</tr>
</tbody>
</table>

* If new FTEs are needed, please complete Section G (Detailed Justification for FTEs) below.

Is this budget category or program associated with a Capital Budget Priority? No

If yes, state Capital Budget Priority Number and Project Name:.

Please List proviso numbers that relate to this budget category or programs funded by this category.

H. Changes to the Appropriation:

Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

Funding:

<table>
<thead>
<tr>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012 Act</td>
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<td>$25,186,400</td>
<td>$22,800,000</td>
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<tr>
<td>2012-2013 Act</td>
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<tr>
<td>Difference</td>
<td>0</td>
<td>$1,289,041</td>
<td>($10,770,751)</td>
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</tbody>
</table>

Explaination of Changes:
The funding mix for this program has changed over the last few years due to the discontinuation of the IV-E program. This has resulted in less state match and more federal match.

I. Revenue Estimates:

Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
<th>Earmarked</th>
<th>Restricted</th>
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<td>50000000</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>$26,503,441</td>
</tr>
</tbody>
</table>
If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

Please detail the long-term sustainability of this program if cash reserves are needed to operate.

If there is federal fund or other fund spending authority requested above the revenue streams detailed above, please indicate the amount and explanation for each.

J. FTE Positions:
Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other-Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
<th>Temporary, Temporary Grant, Time-limited</th>
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<td>2012-2013 (A)</td>
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<tr>
<td>2011-2012 (A)</td>
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<td>2010-2011 (F)</td>
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<td>2010-2011 (A)</td>
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<td>2009-2010 (F)</td>
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<td>2009-2010 (A)</td>
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<td>NA</td>
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<td>2008-2009 (F)</td>
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<td>2008-2009 (A)</td>
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<td>2007-2008 (F)</td>
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</table>

K. Detailed Justification for FTEs:
(1) Justification for New FTEs
   (a) Justification:

   (b) Future Impact on Operating Expenses or Facility Requirements:

(2) Position Details:

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
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<tbody>
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<td>Personal Service</td>
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<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
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<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
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<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
</tr>
<tr>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
A. **Summary description of programs and how they relate to the mission of the Agency:**

940 **MUSC-Maxillofacial Services:**

The contract for the Medical University of South Carolina (MUSC) Maxillofacial Prosthodontic was established to provide prosthodontics to those Medicaid beneficiaries that have lost part of their head and face anatomy to cancer, trauma or anomalies resulting from birth defects and/or genetic syndromes. The Prosthodontics are necessary to replace anatomy that has been lost and restore the ability for the beneficiary to eat, breathe, speak and maintain their health as well as reducing risks associated with their loss of normal function. It has also aided beneficiaries to seek and secure employment and become a productive member of society. The program serves beneficiaries of all ages that are enrolled in the Medicaid program.

938 **Other Entities:**

Payments made to private providers, with matching funds provided by other state agencies and public entities. Other payment adjustments that is not directly associated with a specific service line. Other Entities are programs that are managed within the existing program areas for services that are matched by entities other than HHS. These services include the teaching supplemental program and the services for Native American Tribes.

937 **Disproportionate Share:**

The Medicaid Disproportionate Share Hospital (DSH) Program provides funding for inpatient hospitals that serve a disproportionate share of low income individuals. Federal funding is provided by Congress through the annual DSH allotment process. States are allowed flexibility when establishing state specific DSH qualification criteria which can be less restrictive than those prescribed in the law. But in order to receive DSH payments a qualifying hospital must have at least a one percent Medicaid utilization rate as well as meet the federal OB requirement.

The DSH program provides payment to qualifying hospitals for the unreimbursed cost of providing inpatient and outpatient hospital services to South Carolina Medicaid eligible and uninsured individuals. The state matching portions of these payments are provided through a combination of certified public expenditures (CPE), hospital provider taxes, and state appropriations. Currently, all South Carolina general acute care hospitals, as well as all state owned governmental psychiatric hospitals, qualify for the South Carolina Medicaid DSH Program. Based upon the most recent (i.e. October 1, 2010 through September 30, 2011) DSH payment period, approximately sixty-one percent of hospitals unreimbursed costs of providing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals were reimbursed at a total cost of approximately $468 million. Currently 67 hospitals participate in the SC Medicaid DSH Program and are broken down as follows:

- 60 – South Carolina General Acute Care Hospitals
- 1- South Carolina Long Term Acute Care Hospitals
- 3 – South Carolina State Owned Governmental Psych Hospitals
- 3 - Out of State Border General Acute Care Hospitals

Agency oversight of this program is primarily the responsibility of the Bureau Chief of Reimbursement Methodology and Policy and staff within the Division of Acute Care Reimbursements within the Bureau of Reimbursement Methodology and Policy. Coordination of payments is made with assistance from the Bureau of Fiscal Affairs.

B. **Budget Program Number and Name:**

II.A.6. Other Entities
C. **Agency Activity Number and Name:**

Note: If more than one activity maps to this program; provide all activity numbers, names, and approximate funding amounts.

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
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<td>225,086</td>
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<td>Other Entities</td>
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<td>7,130,502</td>
<td>23,960,019</td>
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<tr>
<td>937</td>
<td>Disproportionate Share</td>
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<td>324,157,600</td>
<td>137,342,400</td>
<td>480,128,621</td>
<td></td>
</tr>
</tbody>
</table>

D. **Performance Measures:**

**940 MUSC-Maxillofacial Services:**
Performance Measures have not been established by senior leadership.

**938 Other Entities:**
Performance Measures have not been established by senior leadership.

**937 Disproportionate Share:**
Senior leadership is re-evaluating DSH for upcoming years.

E. **Program Interaction:**

**940 MUSC-Maxillofacial Services:**
Continue program coordination to maintain existing levels within the program.

**938 Other Entities:**
Continue program coordination to maintain existing levels within the program.

**937 Disproportionate Share:**
Coordination of DSH payments are made with assistance from staff from the Bureau of Fiscal Affairs to ensure the availability of state and federal funds prior to the release of the quarterly DSH payments. Only inpatient hospitals are eligible to receive SC Medicaid DSH payments. No other Medicaid service area receives Medicaid payments for services provided to the uninsured.

F. **Change Management:**

**940 MUSC-Maxillofacial Services:**
The mission of this program has not recently changed and no changes are planned at this time.

**938 Other Entities:**
The mission of this program has not recently changed and no changes are planned at this time.

**937 Disproportionate Share:**
Over the past five years the mission and focus of the DSH program has not changed, as the mission has been to reimburse qualifying DSH hospitals for the unreimbursed costs of providing inpatient and outpatient hospital services to the South Carolina uninsured and Medicaid managed care enrollees (inpatient and outpatient hospital services provided to Medicaid fee for service recipients have been reimbursed at cost so there is no unreimbursed
cost to claim in the calculation of the DSH payments). Starting with the federal fiscal year 2011 DSH payment program, federally required audits of all state Medicaid DSH Programs could result in the redistribution of SC Medicaid DSH funds among SC Medicaid qualifying DSH hospitals.

Beginning with SFY 2012, the Agency will begin to refocus the FFY 2012 DSH payment program to ensure that hospitals which serve a disproportionate share of low income individuals are exempted from the five percent DSH payment reduction beginning October 1, 2011. Additionally, with the implementation of the provisions of the Affordable Care Act over time, federal DSH funding is expected to drop as more uninsured individuals become insured which will require the Agency to reassess the mission of its Disproportionate Share program.

G. Detailed Funding Information:

<table>
<thead>
<tr>
<th>FY 2012-13 Cost Estimates:</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Number of FTEs*</td>
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<td>0.00</td>
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<td>0.00</td>
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<tr>
<td>Personal Service</td>
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<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
</tr>
<tr>
<td>Program/Case Services</td>
<td>$0</td>
<td>$18,853,707</td>
<td>$324,157,600</td>
<td>$137,342,400</td>
<td>$480,128,621</td>
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<tr>
<td>Pass-Through Funds</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Other Operating Expenses</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
<td>$18,853,707</td>
<td>$324,157,600</td>
<td>$137,342,400</td>
<td>$480,128,621</td>
</tr>
</tbody>
</table>

* If new FTEs are needed, please complete Section G (Detailed Justification for FTEs) below.

Is this budget category or program associated with a Capital Budget Priority?
If yes, state Capital Budget Priority Number and Project Name:

Please List proviso numbers that relate to this budget category or programs funded by this category.

H. Changes to the Appropriation:
Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

<table>
<thead>
<tr>
<th>Funding:</th>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2011-2012 Act</td>
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<td></td>
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<td>Difference</td>
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<td>% Difference</td>
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<td>(11.25%)</td>
<td>(26.4%)</td>
<td></td>
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</tr>
</tbody>
</table>

Explanation of Changes:

I. Revenue Estimates:
Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Federal</th>
</tr>
</thead>
<tbody>
<tr>
<td>44790000</td>
<td>Hospital</td>
<td></td>
<td></td>
<td>$137,342,400</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
III. Budget Category Justification Sheet  J02  South Carolina Department of Health & Human Services (SCDHHHS)

<table>
<thead>
<tr>
<th>Category</th>
<th>Funding</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34410000</td>
<td>State Agency Funding</td>
<td>$7,130,502</td>
</tr>
<tr>
<td>50000000</td>
<td>Federal Funds</td>
<td>$324,157,600</td>
</tr>
</tbody>
</table>

If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

Please detail the long-term sustainability of this program if cash reserves are needed to operate.

If there is federal fund or other fund spending authority requested above the revenue streams detailed above, please indicate the amount and explanation for each.

J. FTE Positions:
Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other-Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2013</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2011-2012</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2010-2011</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2009-2010</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2009-2010</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2008-2009</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2008-2009</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>2007-2008</td>
<td>NA</td>
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</tr>
<tr>
<td>2007-2008</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

K. Detailed Justification for FTEs:
(1) Justification for New FTEs
   (a) Justification:
       N/A
   (b) Future Impact on Operating Expenses or Facility Requirements:

(2) Position Details:

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
A. Summary description of programs and how they relate to the mission of the Agency:

**942 Medicaid Eligibility**

The Medicaid Eligibility unit determines Medicaid eligibility for the Department. Eligibility determination is handled through a combination of 46 county offices, a central eligibility processing unit, and through a sponsored worker program in hospitals and other provider’s offices.

All applicants for the SC Medicaid program must complete and submit a Medicaid application by mail or in person. The SCDHHS office staff approves or denies applications based on a combination of state and federal income and resource requirement and guidelines. Once approved, individuals are eligible to receive covered medical services, including hospital and doctor visits and prescriptions from an enrolled Medicaid provider until determined to no longer meet program requirements.

In FY2013 Medicaid Eligibility will continue its efforts to increase access to its services both through electronic/online approaches as well as by partnering with community organizations to support Medicaid eligibility and by bringing its eligibility staff closer to local communities and out of the county offices. The area will continue to improve its processes and plans to consolidate operations regionally in order to free up local eligibility staff to get more involved in the communities they serve. This area requires the Member Management project (eligibility technology replacement and improvement) to enable it to move from a primarily paper-driven workflow to a modern electronic process.

**943 Medicaid Eligibility Support**

The Medicaid Eligibility Support unit oversees Medicaid eligibility policy, training, and the management of the State’s Medicaid Eligibility Determination System (MEDS) which is used to determine and track eligibility. MEDS assists in determining eligibility and in the tracking of applications, reviews, notices and other processes related to Medicaid eligibility. The MEDS services team provides support for MEDS, defines system enhancements, and resolves user problems. The MEDS Department of Interfaces is responsible for problem resolution, system enhancements, and responding to SSI and Buy-In beneficiaries regarding eligibility issues. A toll-free hotline offers eligibility information and problem resolutions for the State’s Medicaid and CHIP recipients. The area develops and revises statewide policies and procedures and ensures compliance with state and federal requirements. The area creates and maintains forms and brochures, and responds to beneficiary correspondence.

In FY2013 the Medicaid Eligibility Support team will continue its efforts to revise policy in support of efforts to improve eligibility business processes. The Medicaid Eligibility Support team will also lead initiatives to improve eligibility processing accuracy and timeliness.

B. Budget Program Number and Name:

II. A 7. Medicaid Eligibility

C. Agency Activity Number and Name:

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>942</td>
<td>Medicaid Eligibility</td>
<td>$7,956,238</td>
<td>$13,664,615</td>
<td>$3,074,212</td>
<td>$24,695,065</td>
<td></td>
</tr>
<tr>
<td>943</td>
<td>Medicaid Eligibility Support</td>
<td>$1,627,412</td>
<td>$2,795,035</td>
<td>$628,816</td>
<td>$5,051,263</td>
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</tbody>
</table>

D. Performance Measures:

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>97% accurate</th>
<th>97% accurate</th>
</tr>
</thead>
<tbody>
<tr>
<td>942</td>
<td>Eligibility Determination Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avg Eligibility Determination Timeliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Max Eligibility Determination Timeliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avg Disability Determination Timeliness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Max Disability Determination Timeliness

*Without adequate justification.

<table>
<thead>
<tr>
<th>943 Medicaid Eligibility Support:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Policy Manuals</td>
</tr>
<tr>
<td>Train New Eligibility Staff</td>
</tr>
</tbody>
</table>

E. Program Interaction:

942 Medicaid Eligibility:
Medicaid Eligibility is the driver to determine who is in the Medicaid program. As such it interacts with all other programs that provide services to beneficiaries. Additionally, the Medicaid Eligibility team works with other state agencies for the mutual benefit of South Carolinians. In many counties, eligibility staff is collocated with Department of Social Services (DSS) staff, additionally the Medicaid Eligibility Determination System (MEDS) shares data with a variety of state agencies including the state health data warehouse housed within the Office of Research and Statistics (ORS). The MEDS system is operated by Clemson University and leverages the Clemson data center and technical expertise.

943 Medicaid Eligibility Support:
Medicaid Eligibility Support assists the department, particularly the Medicaid Eligibility team with policy, training, and technology.

F. Change Management:

942 Medicaid Eligibility:
Medicaid Eligibility has not changed in a significant manner in the past five years. However, SCDHHS is undergoing organizational and process changes that will have a material impact on the Department and the Medicaid Eligibility effort. First, SCDHHS plans to organize its eligibility efforts regionally focusing on community-based efforts to determine eligibility and enroll eligible citizens. Second, Medicaid Eligibility will be working to define its business processes and improve them in a manner that is consistent with the Medicaid Information Technology Architecture (MITA). Third, Medicaid Eligibility will support the replacement of the MEDS system and leveraging new technology to eliminate what are primarily paper-based processes today.

943 Medicaid Eligibility Support:
Medicaid Eligibility Support has not changed in a significant manner in the past five years. However, as SCDHHS works to improve and transform its business processes the Medicaid Eligibility Support team will work to evaluate and change eligibility policy as needed. The Medicaid Eligibility Support team will work to change its policy development tools.

G. Detailed Funding Information:

<table>
<thead>
<tr>
<th>FY 2012-13 Cost Estimates:</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs*</td>
<td>188.51</td>
<td>252.13</td>
<td>57.36</td>
<td>498.00</td>
<td></td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$5,999,296</td>
<td>$9,986,857</td>
<td>$2,512,198</td>
<td>$18,498,351</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$2,538,313</td>
<td>$4,255,798</td>
<td>$756,543</td>
<td>$7,550,654</td>
</tr>
<tr>
<td>Program/Case Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Pass-Through Funds</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Other Operating Expenses</td>
<td>$0</td>
<td>$1,046,041</td>
<td>$2,216,995</td>
<td>$434,287</td>
<td>$3,697,323</td>
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<tr>
<td>Total</td>
<td>$ 0</td>
<td>$9,583,650</td>
<td>$16,459,650</td>
<td>$3,703,028</td>
<td>$29,746,328</td>
</tr>
</tbody>
</table>
Is this budget category or program associated with a Capital Budget Priority? No
If yes, state Capital Budget Priority Number and Project Name:

Please List proviso numbers that relate to this budget category or programs funded by this category.

H. Changes to the Appropriation:
Please explain any changes, to include re-alignments and funding or FTE increases requested in this year’s appropriation, as detailed below:

Funding:

<table>
<thead>
<tr>
<th>Year</th>
<th>State Non-Recurring</th>
<th>State Recurring</th>
<th>Federal</th>
<th>Other (Earmarked or Restricted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012 Act</td>
<td>$9,583,650</td>
<td>$16,459,650</td>
<td>$3,703,028</td>
<td></td>
</tr>
<tr>
<td>2012-2013 Act</td>
<td>$9,583,650</td>
<td>$16,459,650</td>
<td>$3,703,028</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>% Difference</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Explanation of Changes:
N/A

I. Revenue Estimates:
Please detail Sources of revenue for this program, identified by SAP fund number if a live SCEIS Agency or the STARS number if a STARS Agency. If several sources remit to a single subfund that cannot be split by source and appropriation or program, provide an estimate of the revenue dedicated to this program.

<table>
<thead>
<tr>
<th>SAP Fund Number</th>
<th>Source Name</th>
<th>General Fund</th>
<th>Other State</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Federal</th>
</tr>
</thead>
<tbody>
<tr>
<td>35B40000</td>
<td>Sponsored Workers</td>
<td></td>
<td></td>
<td>$3,703,028</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50000000</td>
<td>Federal Funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$16,459,650</td>
</tr>
</tbody>
</table>

If expenditures for this program are greater than known or estimated revenues and the intent is to bridge part of this shortfall by drawing down balances in Agency accounts or reserves, indicate the accounts and amount of the current reserve or balance that will likely be used below.

Please detail the long-term sustainability of this program if cash reserves are needed to operate.

If there is federal fund or other fund spending authority requested above the revenue streams detailed above, please indicate the amount and explanation for each.

J. FTE Positions:
Please detail the number of FTE’s filled (F) by the program as of June 30 of each fiscal year, and the number authorized (A) by the Appropriations Act.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State</th>
<th>Other-Earmarked or Restricted</th>
<th>Federal</th>
<th>Total</th>
<th>Temporary, Temporary Grant, Time-limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2013 (A)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>2011-2012 (A)</td>
<td>188.51</td>
<td>57.36</td>
<td>252.13</td>
<td>498.00</td>
<td></td>
</tr>
<tr>
<td>2010-2011 (F)</td>
<td>183.22</td>
<td>25.43</td>
<td>234.35</td>
<td>443.00</td>
<td></td>
</tr>
<tr>
<td>2010-2011 (A)</td>
<td>188.51</td>
<td>57.36</td>
<td>252.13</td>
<td>498.00</td>
<td></td>
</tr>
<tr>
<td>2009-2010 (F)</td>
<td>186.45</td>
<td>28.71</td>
<td>241.84</td>
<td>457.00</td>
<td></td>
</tr>
<tr>
<td>2009-2010 (A)</td>
<td>188.51</td>
<td>57.36</td>
<td>252.13</td>
<td>498.00</td>
<td></td>
</tr>
<tr>
<td>2008-2009 (F)</td>
<td>184.63</td>
<td>39.56</td>
<td>251.81</td>
<td>476.00</td>
<td></td>
</tr>
</tbody>
</table>
### Detailed Justification for FTEs:

1. Justification for New FTEs
   
   a. Justification:
   
   b. Future Impact on Operating Expenses or Facility Requirements:

2. Position Details:

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>State</th>
<th>Federal</th>
<th>Earmarked</th>
<th>Restricted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Personal Service</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
IV. Capital/Non-Recurring Appropriations Request

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHS)

A. Project Name:
N/A

B. Project Approval:
N/A

C. Statement of Need:
SCDHHS has submitted to and received approval from the Centers for Medicare and Medicaid Services (CMS) for enhanced federal matching funds for a number of mandated technology projects to modernize and improve its Medicaid information technology systems. This amount is $7,157,264 in match and $30,353,993 in federal funds for a total of $37,511,257.

D. Agency Activity Number and Name:
Note: If more than one activity maps to this project provide all activity numbers, names, and approximate funding amounts.

<table>
<thead>
<tr>
<th>Activity Number</th>
<th>Activity Name</th>
<th>State Non-Recurring Funds</th>
<th>State Recurring Funds</th>
<th>Federal Funds</th>
<th>Other Funds</th>
<th>Total Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>944</td>
<td>Automated Claims Processing</td>
<td>$30,353,993</td>
<td>$7,157,264</td>
<td></td>
<td></td>
<td>$37,511,257</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

E. Project Description:
Note: In addition to a basic description, include whether or not this is a capital or non-capital project. If non-capital, explain how this non-recurring appropriation will be spent on non-recurring activities.

*Replacement of Medicaid Management Information System (MMIS)* – SCDHHS will continue its efforts to replace its aging mainframe claims adjudication and payment system with a more flexible and powerful modern system that is aligned with CMS’ Medicaid Information Technology Architecture (MITA) and addresses CMS’ Seven Standards and Conditions for modern Medicaid systems. Non-compliance with MITA and the Seven Standards could result in loss of federal matching funds. This project will replace the MMIS system, consolidate SCDHHS vendor contracts and ultimately reduce the Department’s total operating costs.

*Replacement of Medicaid Eligibility Determination System (MEDS)* – SCDHHS will continue its efforts to replace its aging mainframe eligibility and enrollment systems with a more flexible and powerful modern system that is aligned with CMS’ Medicaid Information Technology Architecture (MITA) and addresses CMS’ Seven Standards and Conditions for modern Medicaid systems. This project prepares the Department for Medicaid eligibility requirements related to broader changes in Medicaid eligibility and will support the Department in its efforts to improve its eligibility and enrollment processes.

*International Statistical Classification of Diseases (ICD-10)* – SCDHHS will continue its efforts to update its systems to comply with the United States move to Version 10 of the International Statistical Classification of Diseases (to ICD-10 from ICD-9) through changes to its policies, systems, and operations. Failure to implement these updates will eventually result in the inability to receive claims from providers. The existing coding does not support initiatives such as pay for performance, managing quality of care, and benchmarking. The goals of this code change is to modernize terminology, increase information for public health, bio-surveillance, and quality measurement.

*Health Information Technology and Health Information Exchange (HIT/HIE)* – SCDHHS is the recipient of federal funding in the support of the development of a statewide health information exchange (SCHIEx) and supports the administration of the funding for HIE development and operations.

*Electronic Health Records Incentive Payment Program (EHR Incentives)* – Included in the American Recovery and Reinvestment Act of 2009. Provides for 100% federally funded incentive payments to eligible and qualifying providers who adopt, implement, or upgrade to certified Electronic Health Record (EHR) technology or use it in a meaningful way. DHHS receives 90/10 funding for the administration of the program.
IV. Capital/Non-Recurring Appropriations Request

| Agency Code | Agency Name: SC Department of Health and Human Services (SCDHHS) |

**F. Funding**

Total New Request: ____N/A______ Previously Approved Funds: ____N/A_____ Expenditures to Date: _____ N/A___

Identify the source(s) of funds for this appropriation (general fund, surplus, federal funding, local match, etc.):

**G. Justification for additional future operating costs:**

Will additional annual operating costs be absorbed into your existing budget? If so, what resources will lose funding to facilitate this?

If not, will additional funds be needed in the future?

Identify the source of additional funds:

Detail the lifecycle cost of the funded project below

<table>
<thead>
<tr>
<th>Year</th>
<th>Capital</th>
<th>Operating</th>
<th>Total</th>
<th>State; Non-Recurring</th>
<th>General; Recurring</th>
<th>Federal</th>
<th>Other (Earmarked/Restricted)</th>
<th>Use of Current FTE</th>
<th>Additional FTEs needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tbody>
</table>
V. Proviso Justification Form

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
17.2

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
II.A4D-MUSC

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Another agency’s proviso that has consequences at DHHS.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Amend.

E. Title
Descriptive Proviso Title:
MUSC: Rural Dentist Program

F. Summary
Summary of Existing or New Proviso:
Proviso creates a rural dentist program at MUSC, administered by SC AHEC.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Amend to strike DHHS from board referenced in proviso.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Delete as DHHS has not participated on this board.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline

17.2. MUSC: Rural Dentist Program
The Rural Dentist Program, in coordination with the Department of Health and Environmental Control’s Public Health Dentistry Program, is established at the Medical University of South Carolina. The funds appropriated to the Medical University of South Carolina for the Rural Dentist Program shall be administered by the South Carolina Area Health Education Consortium physician recruitment office. The costs associated with administering this program are to be paid from the funds appropriated to the Rural Dentist Program and shall not exceed four percent of the appropriation. The Medical University of South Carolina is responsible for the fiscal management of funds to ensure that state policies and guidelines are adhered to. MUSC shall be permitted to carry forward unspent general funds appropriated to the Rural Dentist program provided that these funds be expended for the program for which they were originally designated. A board is created to manage and allocate these funds to insure the location of licensed dentists in rural areas of South Carolina and on the faculty of the College of Dental Medicine at MUSC. The board will be composed of the following: the Dean, or his designee, of the MUSC College of Dental Medicine; three members from the South Carolina Dental Education Foundation Board who represent rural areas; and the President of the South Carolina Dental Association. The Director of DHEC’s Office of Primary Care; the Director or his designee of the Department of Health and Human Services; and the Executive Director of the South Carolina Dental Association shall serve as ex officio members without vote. This board shall serve without compensation.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate “New #1”, “New #2”, etc.):*
   21.1

B. **Appropriation**
   Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority:*)
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Agency specific.

D. **Action**
   (Indicate Keep, Amend, Delete, or Add):
   Keep.

E. **Title**
   Descriptive Proviso Title:
   DHHS: Recoupment/Restricted Fund

F. **Summary**
   Summary of Existing or New Proviso:
   This proviso provides a mechanism for DHHS to collect refunds and overpayments, and establishes an account in the Treasurer’s Office to manage related funds. The proviso directs the maximum amount to be deposited into the account, with excess funds remitted to the General Fund.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   (If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso allows DHHS to collect and utilize recoupment funds and supports refund and overpayment collections.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   21.1. (DHHS: Recoupment/Restricted Fund) The Department of Health and Human Services shall recoup all refunds and identified program overpayments and all such overpayments shall be recouped in accordance with established collection policy. Further, the Department of Health and Human Services is authorized to maintain a restricted fund, on deposit with the State Treasurer, to be used to pay for liabilities and improvements related to enhancing accountability for future audits. The restricted fund will derive from prior year program refunds. The restricted fund shall not exceed one percent of the total appropriation authorization for the current year. Amounts in excess of one percent will be remitted to the general fund.
<table>
<thead>
<tr>
<th>V. Proviso Justification Form</th>
<th>Agency Code</th>
<th>Agency Name  SC Department of Health and Human Services (SCDHH)</th>
</tr>
</thead>
</table>

A. **Proviso Number**  
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate “New #1”, “New #2”, etc.*):  
21.2

B. **Appropriation**  
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority*):  
NA

C. **Agency Interest**  
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?  
Agency-specific.

D. **Action**  
(Indicate Keep, Amend, Delete, or Add):  
Delete.

E. **Title**  
Descriptive Proviso Title:  
DHHS: Long Term Care Facility Reimbursement Rate

F. **Summary**  
Summary of Existing or New Proviso:  
Proviso describes the process the agency shall follow in consideration of reimbursement rate setting for long term care facilities, giving the agency the option of applying an inflation factor to increase rates annually.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**  
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):  
Delete unnecessary proviso.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**  
Permissive proviso does not direct expenditures.

I. **Justification**  
Refer to the instructions for the correct question to answer in this space, based on the action you selected  
Proviso is no longer necessary as state  
Permissive proviso not necessary as DHHS already has this authority in its State Plan.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**  
There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**  
21.2. (DHHS: Long Term Care Facility Reimbursement Rate) The Department, in calculating a reimbursement rate for long term care facility providers, shall obtain for each contract period an inflation factor, developed by the Budget and Control Board, Division of Budget and Analyses. Data obtained from Medicaid cost reporting records applicable to long term care providers will be supplied to the Budget and Control Board, Division of Budget and Analyses. A composite index, developed by the Budget and Control Board, Division of Budget and Analyses will be used to reflect the respective costs of the components of the Medicaid program expenditures in computing the maximum inflation factor to be used in long term care contractual arrangements involving reimbursement of providers. The Division of Budget and Analyses of the Budget and Control Board shall update the composite index so as to have the index available for each contract renewal. The department may apply the inflation factor in calculating the reimbursement rate for the new contract period from zero percent (0%) up to the inflation factor developed by the Division of Budget and Analyses.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate "New #1", "New #2", etc.):
   
   21.3

B. **Appropriation**
   Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   
   Agency-specific.

D. **Action**
   (Indicate Keep, Amend, Delete, or Add):
   
   Keep.

E. **Title**
   Descriptive Proviso Title:
   
   DHHS: Medical Assistance Audit Program Remittance

F. **Summary**
   Summary of Existing or New Proviso:
   
   Proviso directs DHHS to provide Medicaid state match funds in support of State Auditor’s nursing home cost report auditing function. The nursing home cost report audits are needed as part of Medicaid’s reimbursement methodology for these long term care providers. State Auditor performance of these cost reports is cost effective for the State, as DHHS would otherwise have to perform or contract for these services.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   (If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso directs that DHHS provide funding support of necessary Auditor’s Office function.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   
   Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   
   21.3. (DHHS: Medical Assistance Audit Program Remittance) The Department of Health and Human Services shall remit to the State Auditor’s Office an amount representing fifty percent (allowable Federal Financial Participation) of the cost of the Medical Assistance Audit Program as established in the State Auditor’s Office of the Budget and Control Board Section 80B. Such amount shall also include appropriated salary adjustments and employer contributions allocable to the Medical Assistance Audit Program. Such remittance to the State Auditor’s Office shall be made monthly and based on invoices as provided by the State Auditor’s Office of the Budget and Control Board.
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
21.4

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Keep.

E. Title
Descriptive Proviso Title:
DHHS: Third Party Liability Collection

F. Summary
Summary of Existing or New Proviso:
Proviso allows DHHS to fund third party collection efforts from funds collected by such efforts.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Permissive proviso allows DHHS to use collected TPL and drug rebate funds to support those programs.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso could be considered for codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.4. (DHHS: Third Party Liability Collection) The Department of Health and Human Services is allowed to fund the net costs of any Third Party Liability and Drug Rebate collection efforts from the monies collected in that effort.
V. Proviso Justification Form

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):

21.5

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Amend.

E. Title
Descriptive Proviso Title:
DHHS: Medicaid State Plan

F. Summary
Summary of Existing or New Proviso:
Proviso allows DHHS to bill other agencies so they provide the state match for Medicaid services that were either formerly paid solely with state funds, or have been added to the Medicaid State Plan at the request of the other state agencies.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Amend to ensure process for appropriate state match funds for Medicaid services.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso as amended provides appropriate state match source for Medicaid services.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso as amended provides mechanism to ensure state agencies utilizing Medicaid matching funds provide the corresponding state match funds.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
Medicaid pays for services when match comes from other state agencies. In SFY 2012, $841 million was allocated as federal Medicaid match to state agencies which provide corresponding state match.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline

21.5. (DHHS: Medicaid State Plan) Where the Medicaid State Plan has been altered to cover services that previously were provided by one hundred percent state funds, or that have been requested to be added by other state agencies, the department can bill other agencies for the state share of services provided through Medicaid, or the required State General Funds can be diverted from the General Assembly to DHHS. In order to comply with Federal regulations regarding allowable sources of matching funds, state agencies are authorized to make appropriation transfers to the Department of Health and Human Services to be used as the state share when certified public expenditures are not allowed for those state agency Medicaid services. The department will keep a record of all services affected and submit periodic reports to the Senate Finance and House Ways and Means Committees.
A. **Proviso Number**  
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate "New #1", "New #2", etc.):**  
21.6

B. **Appropriation**  
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority):  
II.A3E-Physician

C. **Agency Interest**  
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?  
Agency-specific.

D. **Action**  
*(Indicate Keep, Amend, Delete, or Add):**  
Keep.

E. **Title**  
Descriptive Proviso Title:  
DHHS: Medically Indigent Assistance Fund

F. **Summary**  
Summary of Existing or New Proviso:  
Proviso authorizes DHHS to provide Medicaid disproportionate share funds to hospitals eligible for the funds, on the condition that payments due to audit findings are the responsibility of the hospitals.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**  
*(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):**

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**  
Proviso authorizes agency to expend DSH funds to eligible hospitals. Such funds are a source of hospitals’ revenue.

I. **Justification**  
Refer to the instructions for the correct question to answer in this space, based on the action you selected  
Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**  
The DSH funding mechanism represents a significant source of funding to the Medicaid program. In SFY 2012, $547 million total funds (state and federal) was allocated for DSH reimbursement.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**  
21.6. (DHHS: Medically Indigent Assistance Fund) The department is authorized to expend disproportionate share funds to all eligible hospitals with the condition that all audit exceptions through the receipt and expenditures of these funds are the liability of the hospital receiving the funds.
V. Proviso Justification Form

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
21.7

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Delete.

E. Title
Descriptive Proviso Title:
DHHS: Admin. Days/Swing Beds Reduction Prohibition

F. Summary
Summary of Existing or New Proviso:
Proviso prohibits DHHS from reducing funds for Admin Days/Swing Beds when making Medicaid reduction decisions.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Deleting proviso allows DHHS administrative authority and flexibility to manage the Medicaid program.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso affects expenditures by restricting agency’s ability to manage Medicaid funding changes.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
DHHS should have fiscal and programmatic management authority for the Medicaid program. The agency would carefully consider the value of Admin Days/Swing Beds when weighing reduction decisions.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
Though Admin. Days/Swing Beds represent only a portion of hospitals’ revenue, the flexibility to manage all reimbursement options should be preserved.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.7. (DHHS: Admin. Days/Swing Beds Reduction Prohibition) Funds appropriated herein for hospital administrative days and swing beds shall not be reduced in the event the agency cuts programs and the services they provide.
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
21.8

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Delete.

E. Title
Descriptive Proviso Title:
DHHS: Nursing Home Sanctions

F. Summary
Summary of Existing or New Proviso:
Proviso authorizes DHHS to establish a fund within the Treasurer’s Office, and deposit and utilize funds from nursing home fines for the protection of the health and safety of nursing home residents, in accordance with state law.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Delete unnecessary proviso which is already codified.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Directs agency to deposit and expend funds as already prescribed in Code.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Fund is already established in Code.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.8 (DHHS: Nursing Home Sanctions) The Department of Health and Human Services is authorized to establish an interest-bearing restricted fund with the State Treasurer, to deposit fines collected as a result of nursing home sanctions. The department may use these funds consistent with the provision of Section 44-6-470.
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.): 21.9

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority): NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences? Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add): Keep.

E. Title
Descriptive Proviso Title:
DHHS: Registration Fees

F. Summary
Summary of Existing or New Proviso:
Proviso allows DHHS to receive and spend registration fees for educational, training and certification programs.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso could be considered for codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.9. (DHHS: Registration Fees) The department is authorized to receive and expend registration fees for educational, training, and certification programs.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.)*:
   
   21.10

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority)*:
   
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add)*:
   
   Keep.

E. **Title**
   Descriptive Proviso Title:
   
   **DHHS: Fraud and Abuse Collections**

F. **Summary**
   Summary of Existing or New Proviso:
   
   **Proviso allows DHHS to keep state portion of collections from fraud and abuse efforts, instead of potentially remitting them to the General Fund or another destination.**

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified)*:

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   **Proviso allows DHHS to retain funds collected from program integrity efforts to continue supporting this vital Medicaid function.**

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   
   **Proviso could be considered for codification.**

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   
   **The return on investment for program integrity efforts is significant, and the program’s success acts as a deterrent to other potential fraud and abuse activity.**

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   
   **21.10. (DHHS: Fraud and Abuse Collections) The Department of Health and Human Services may offset the administrative costs associated with controlling fraud and abuse.**
A. **Proviso Number**
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*

21.11

B. **Appropriation**
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*

NA

C. **Agency Interest**
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?

Agency-specific.

D. **Action**
*(Indicate Keep, Amend, Delete, or Add):*

Keep.

E. **Title**
Descriptive Proviso Title:

DHHS: Provider Reimbursement Rate Report

F. **Summary**
Summary of Existing or New Proviso:

Proviso directs DHHS to prepare a report comparing Medicaid provider reimbursement rates to Medicare and State Health Plan rates.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
*(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**

Proviso does not direct expenditure of funds.

I. **Justification**
Refer to the instructions for the correct question to answer in this space, based on the action you selected

Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
There is minimal fiscal impact directly attributable to this proviso – the agency contracts for this report.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**

21.11. (DHHS: Provider Reimbursement Rate Report) The Department of Health and Human, in conjunction with the Office of Research and Statistics of the Budget and Control Board, shall prepare a report that compares the reimbursement rate of Medicaid providers to the reimbursement rate of the Medicare Program and the State Health Plan. This report shall be completed by January thirty-first, each year, and submitted to the Governor and the members of the General Assembly.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   
   21.12

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   
   II.A7-Medicaid Eligibility
   II.A2D- Eligibility

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   
   Keep.

E. **Title**
   Descriptive Proviso Title:
   
   DHHS: Medicaid Eligibility Transfer

F. **Summary**
   Summary of Existing or New Proviso:
   
   **Proviso transfers Medicaid eligibility function from DSS to DHHS, and requires counties to continue providing office space for eligibility workers.**

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso’s requirement for counties to furnish office space protects other DHHS funding.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   
   Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   The elimination of this proviso could cost the agency approximately $1 million in State funds yearly.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   
   21.12. *(DHHS: Medicaid Eligibility Transfer)* The South Carolina Department of Health and Human Services (DHHS) is hereby authorized to determine the eligibility of applicants for the South Carolina Medicaid Program. Personnel of the Department of Social Services (DSS) engaged in this function full-time, and other DSS personnel engaged in this function who are identified by agreement of DSS and DHHS, are transferred to DHHS. The governing authority of each county shall continue to provide office space and facility service for this function as they do for DSS functions under Section 43-3-65.
A. **Proviso Number**  
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate “New #1”, “New #2”, etc.*):  
21.13  

B. **Appropriation**  
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority*):  
NA  

C. **Agency Interest**  
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?  
Agency-specific.  

D. **Action**  
(Indicate Keep, Amend, Delete, or Add):  
Keep.  

E. **Title**  
Descriptive Proviso Title:  
DHHS: Franchise Fees Suspension  

F. **Summary**  
Summary of Existing or New Proviso:  
Proviso suspends 2002 joint resolution that imposed nursing home franchise fee to provide funding for Medicaid.  

G. **Explanation of Amendment to/or Deletion of Existing Proviso**  
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):  

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**  
Proviso does not direct expenditure of funds.  

I. **Justification**  
Refer to the instructions for the correct question to answer in this space, based on the action you selected  
Proviso could be considered for codification.  

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**  
The amount of funds derived from implementation of a nursing home bed fee are proportional to the amount of the fee implemented.  

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**  
21.13. (DHHS: Franchise Fees Suspension) Franchise fees imposed on nursing home beds and enacted by the General Assembly during the 2002 session are suspended.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   
   21.14

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   
   Delete.

E. **Title**
   Descriptive Proviso Title:
   
   DHHS: Cost Savings Suggestion Award Program

F. **Summary**
   Summary of Existing or New Proviso:
   
   Proviso authorizes DHHS to establish cost savings award program for employees of Medicaid providers who provide money saving ideas, with potential cash or honorary awards up to $20,000.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*
   
   Delete unused program.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso authorizes to provide funds to those who generate cost savings ideas.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   
   Proviso has not yielded any cost savings ideas.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   
   21.14. **(DHHS: Medicaid Cost Savings Suggestion Award Program)** The department is authorized to provide cash or honorary awards to employees of Medicaid providers whose suggestion is adopted by the committee administering the Medicaid Cost Savings Suggestion Award Program that will result in savings of state or federal dollars. Employees of the department are not eligible for cash awards. The department is authorized to fund this program from revenue from third party liability collections. The maximum amount of funds that may be used annually for the program is $20,000.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   
   21.15

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   
   Keep.

E. **Title**
   Descriptive Proviso Title:
   
   DHHS: Program Integrity Efforts

F. **Summary**
   Summary of Existing or New Proviso:
   
   Proviso instructs DHHS to expand program integrity efforts, utilizing internal and external resources or contracts to do so.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   
   Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   
   21.15. *(DHHS: Program Integrity Efforts)* The Department of Health and Human Services is instructed 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 department's ability to detect and eliminate provider fraud.
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*

21.16

B. Appropriation
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*

NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?

Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):

Keep.

E. Title
Descriptive Proviso Title:

DHHS: Post Payment Review

F. Summary
Summary of Existing or New Proviso:

Proviso requires DHHS to perform reviews on medical services related to the Hyde Amendment, and provide the result of such reviews when requested by the General Assembly.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary

Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected

Proviso should be discussed prior to codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline

21.16. (DHHS: Post Payment Review) The department is directed to perform post payment reviews as permitted under Medicaid regulations to ensure compliance with the Hyde Amendment provisions as it relates to the performance of medically necessary services under the Medicaid program. The results of such reviews shall be available to the General Assembly upon request in a format that meets the requirements of the Health Insurance Accountability and Portability Act (HIPAA) and Medicaid confidentiality regulations.
A. **Proviso Number**
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*

21.17

B. **Appropriation**
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*

NA

C. **Agency Interest**
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences? *Agency-specific.*

D. **Action**
*(Indicate Keep, Amend, Delete, or Add):*

Delete.

E. **Title**
Descriptive Proviso Title:

**DHHS: Long Term Care Facility Reimbursement Rates**

F. **Summary**
Summary of Existing or New Proviso:

Proviso requires DHHS to submit the State Plan amendment for long term care facility rates to the federal government before August first, during years when funds are allocated to DHHS for such rate increases.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
*(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

Delete to allow DHHS administrative flexibility.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
Proviso does not direct expenditure of funds.

I. **Justification**
Refer to the instructions for the correct question to answer in this space, based on the action you selected

Proviso is not necessary as the agency would submit a State Plan Amendment for any rate change and would only increase rates when justified and as part of a balanced, sustainable reimbursement strategy.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**

21.17. *(DHHS: Long Term Care Facility Reimbursement Rates)* The department shall submit its Medicaid State Plan amendment for long term care facility reimbursement rates to the Federal government prior to August first of each year provided the State Appropriations Act has been enacted prior to that date. This provision shall apply only in those years when funds are allocated for rate increases.
V. Proviso Justification Form

<table>
<thead>
<tr>
<th>Agency Code</th>
<th>Agency Name</th>
<th>SC Department of Health and Human Services (SCDHHHS)</th>
</tr>
</thead>
</table>

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*

21.18

B. Appropriation
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*

NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
*(Indicate Keep, Amend, Delete, or Add):*
Amend.

E. Title
Descriptive Proviso Title:
DHHS: Upper Payment Limit for Non-state Owned Public Nursing Facilities

F. Summary
Summary of Existing or New Proviso:
Requires DHHS to submit a plan to the federal government for supplemental payments to certain safety net nursing facilities and report to the General Assembly on the plan.

G. Explanation of Amendment to/or Deletion of Existing Proviso
*(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*
Technical amendment to correct date.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso directs DHHS to make supplemental payments to qualifying facilities.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Amend to correct date.

J. Fiscal Impact *(Include impact on each source of funds – state, federal, and other)*
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.18. *(DHHS: Upper Payment Limit for Non-state Owned Public Nursing Facilities)* The department shall prepare and submit to the Center for Medicare and Medicaid Services no later than August first of each year *12**, 2010, a state plan amendment to provide Medicaid supplemental payments to non-state owned public nursing facilities who qualify as Essential Public Safety Net providers. The department shall provide a report on the plan amendment to the House of Representatives Ways and Means Committee and the Senate Finance Committee by the aforementioned date.
### A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.)*:

21.19

### B. Appropriation
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority)*:
NA

### C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

### D. Action
(Indicate Keep, Amend, Delete, or Add):
Delete.

### E. Title
Descriptive Proviso Title:
DHHS: Nursing Services to High Risk/High Tech Children

### F. Summary
Summary of Existing or New Proviso:
Proviso directs DHHS to establish separate, higher pay scales for certain services to medically fragile children.

### G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Delete to allow the agency to apply market-based reimbursement methodology reflecting the priorities of the state and the value of the services provided.

### H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso inappropriately directs DHHS to expend funds for purposes already being reimbursed in set rates.

### I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso is not necessary because the rates for these services include calculations reflecting the skill required for their provision, just as the composition of all rates considers such factors. Diverting scarce resources to “double pay” one set of providers undermines the state’s effort to manage a balanced Medicaid program.

### J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
This proviso required the agency to increase the rate of pay by $3 per hour for RNs and LPNs for these services.

### K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.19. (DHHS: Nursing Services to High Risk/High Tech Children)– The Department of Health and Human Services shall continue a separate classification and compensation plan for Registered Nurses (RN) and Licensed Practical Nurses (LPN) who provide services to Medically Fragile Children, who are Ventilator dependent, Respirator dependent, Intubated, and Parenteral feeding or any combination of the above. The classification plan shall recognize the skill level that these nurses caring for these Medically Fragile Children must have over and above normal home-care or school-based nurses.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*  
   21.20

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*  
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?  
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*  
   Delete.

E. **Title**
   Descriptive Proviso Title:  
   DHHS: Pediatric Literacy Program

F. **Summary**
   Summary of Existing or New Proviso:  
   Requires DHHS to assist any non-profit pediatric literacy program to expand its operations.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*  
   Delete as unnecessary.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected  
   Proviso is not needed, as the agency has already complied with its provisions several years ago, and has not been approached by any such non-profits since.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   21.20. *(DHHS: Pediatric Literacy Program) The department shall coordinate with any pediatric, non-profit early literacy program, upon request of such program, to identify program participants who are also enrolled as Medicaid providers and, to the extent possible based on data available to the department, work with the program to determine potential geographic areas for program expansion.*
V. Proviso Justification Form

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
21.21

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Delete.

E. Title
Descriptive Proviso Title:
DHHS: Prior Authorization-Formulary Changes

F. Summary
Summary of Existing or New Proviso:
Requires DHHS to coordinate with managed care plans to ensure a common prior authorization form for certain mental health pharmacy products and to ensure a process and protections are in place for patients affected by potential changes to managed care plans’ pharmacy formularies. Allows patients adversely affected by such formulary changes to enroll in another managed care plan or fee-for-service Medicaid.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Delete unnecessary proviso because agency has this in policy.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso just reflects current policy, so is unnecessary.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.21. (DHHS: Prior Authorization-Formulary Changes) The Department of Health and Human Services shall coordinate and approve formulary changes for medications prescribed to treat major depression, schizophrenia, or bipolar disorder as defined by the most recent edition of the Diagnostics and Statistical Manual of the American Psychiatric Association or following prescribing practice guidelines established by the American Psychiatric Association. The department shall require, in its managed care policy and procedures guide, managed care organizations to utilize a common prior authorization form for drugs used to treat major depression, schizophrenia, or bipolar disorder. Adverse changes to a plan formulary must be coordinated with the agency. If a formulary change regarding a medication prescribed to treat one of the conditions listed above will adversely affect the patient’s condition, the grievance process must be exhausted prior to the beneficiary initiating disenrollment from the plan. At no time will a patient who is actively on medication for treatment of one of the above conditions at the time of enrollment in a managed care plan be denied coverage for such medication until resolution of the grievance process. If the department determines the grievance process does not provide favorable relief for the beneficiary, the beneficiary shall be allowed to enroll in fee-for-service or another managed care plan providing formulary coverage.
A. **Proviso Number**
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.)*:

21.22

B. **Appropriation**
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority)*:

NA

C. **Agency Interest**
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?

Agency-specific.

D. **Action**
(Indicate Keep, Amend, Delete, or Add):

Delete.

E. **Title**
Descriptive Proviso Title:

DHHS: Modular Ramps

F. **Summary**
Summary of Existing or New Proviso:

Proviso allows DHHS to lease modular ramps if cost effective.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

Delete to allow agency administrative flexibility.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
Proviso does not direct expenditure of funds.

I. **Justification**
Refer to the instructions for the correct question to answer in this space, based on the action you selected

Permissive proviso is not necessary; and agency can pursue any cost-effective strategies such as ramp leases without the proviso.

J. **Fiscal Impact** *(Include impact on each source of funds – state, federal, and other)*
There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**

21.22 *(DHHS: Modular Ramps)* The Department of Health and Human Services is authorized to lease modular ramps in the event the department can foresee demonstrated cost savings to the department.
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.)*:
21.23

B. Appropriation
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority)*:
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Amend.

E. Title
Descriptive Proviso Title:
DHHS: Medicaid Cost and Quality Effectiveness

F. Summary
Summary of Existing or New Proviso:
Proviso requires DHHS to compare coordinated care models and fee-for-service for quality and cost-effectiveness, prescribing the process for such comparison. Proviso calls for the report and plan report cards to be made public.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Amend to extend report deadline.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Amending would allow time to collect data to present a report on the entire prior fiscal year. As written, proviso does not give agency enough time to collect necessary medical claims data to present a report on the previous fiscal year.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.23. (DHHS: Medicaid Cost and Quality Effectiveness) The Department of Health and Human Services shall establish a procedure to assess the various forms of managed care (Health Maintenance Organizations and Medical Home Networks, and any other forms authorized by the department) to measure cost effectiveness and quality. These measures must be compiled on an annual basis. The Healthcare Effectiveness Data and Information Set (HEDIS) shall be utilized for quality measurement and must be performed by an independent third party according to HEDIS guidelines. Cost effectiveness shall be determined in an actuarially sound manner and data must be aggregated in a manner to be determined by a third party in order to adequately compare cost effectiveness of the different managed care programs versus Medicaid fee-for-service. The methodology must use appropriate case-mix and actuarial adjustments that allow cost comparison of managed care organizations, medical home networks, and fee-for-service. The department shall issue annual healthcare report cards for each participating Medicaid managed care plan and Medical Home Network operating in South Carolina and the Medicaid fee-for-service program. The report card measures shall be developed by the department and the report card shall be formatted in a clear, concise manner in order to be easily understood by Medicaid beneficiaries. The results of the cost effectiveness calculations, quality
measures and the report cards shall be made public on the department’s website by Dec. 31 for the prior state fiscal year. No later than ninety days after the end of each fiscal year.
A. **Proviso Number**  
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1", "New #2", etc.):*  
21.24

B. ** Appropriation**  
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*  
NA

C. **Agency Interest**  
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?  
Agency-specific.

D. **Action**  
(Indicate Keep, Amend, Delete, or Add):  
Keep.

E. **Title**  
Descriptive Proviso Title:  
DHHS: SCHIP Enrollment and Recertification

F. **Summary**  
Summary of Existing or New Proviso:  
Proviso requires DHHS to utilize data from other state agencies to identify children potentially eligible for Medicaid or CHIP.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**  
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):  

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**  
Proviso does not direct expenditure of funds.

I. **Justification**  
Refer to the instructions for the correct question to answer in this space, based on the action you selected  
Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**  
Though enrollment of more CHIP children affects expenditures, ensuring an efficient enrollment and recertification process reduces unnecessary administrative expenses and positions the state to handle future enrollment growth.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**  
21.24. (DHHS: SCHIP Enrollment and Recertification) The Department of Health and Human Services shall enroll and recertify eligible children to the State Children’s Health Insurance Program (SCHIP) and must use available state agency program data housed in the Budget and Control Board’s Office of Research and Statistics, to include the Department of Social Services’ Food Stamp program and the Department of Education’s Free and Reduced Meal eligibility data. Use of this data and cooperative efforts between state agencies reduces the cost of outreach and maintenance of eligibility for SCHIP.
V. Proviso Justification Form

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHHS)

A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.)*:
   21.25

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority)*:
   NA

C. **Agency terest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Keep.

E. **Title**
   Descriptive Proviso Title:
   DHHS: Carry Forward

F. **Summary**
   Summary of Existing or New Proviso:
   **Proviso allows DHHS to carry forward unexpended cash balances from certain agency funds and accounts, and provide a legislative report about these funds and balances, including the authority of use.**

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   **Proviso could be considered for codification.**

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   21.25. *(DHHS: Carry Forward)* The Department of Health and Human Services is authorized to carry forward cash balances from the prior fiscal year into the current fiscal year for any earmarked or restricted trust and agency, or special revenue account or subfund. The department shall submit a comprehensive reporting of all cash balances brought forward from the prior fiscal year. The report shall, at a minimum, for each account or subfund include the following: the statutory authority that allows the funds to be carried forward, the maximum authorized amount that can be carried forward, the general purpose or need for the carry forward, the specific source(s) of funding or revenue that generated the carry forward, and a detailed description of any pending obligations against the carry forward. The report must be submitted to the President Pro Tempore of the Senate, Chairman of the Senate Finance Committee, Speaker of the House of Representatives, and Chairman of the House Ways and Means Committee, within fifteen days after the Comptroller General closes the fiscal year.
A. **Proviso Number**
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate “New #1”, “New #2”, etc.*):

21.26

B. **Appropriation**
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority*):
NA

C. **Agency Interest**
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. **Action**
(Indicate Keep, Amend, Delete, or Add):
Keep.

E. **Title**
Descriptive Proviso Title:
DHHS: Medicaid Provider Fraud

F. **Summary**
Summary of Existing or New Proviso:
Proviso directs DHHS to increase provider fraud efforts and report to the General Assembly on the result of those efforts.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
Proviso does not direct expenditure of funds.

I. **Justification**
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso could be considered for codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**

21.26. (DHHS: Medicaid Provider Fraud) The department shall expand and increase its effort to identify, report, and combat Medicaid provider fraud. The department shall report to the General Assembly before April 1, 2012 on the results of these efforts, funds recuperated or saved, and information pertaining to prosecutions of such actions, including pleas agreements entered into.
V. Proviso Justification Form

Agency Code J02
Agency Name SC Department of Health and Human Services (SCDHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
21.27

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Keep.

E. Title
Descriptive Proviso Title:
DHHS: Community Health Plans

F. Summary
Summary of Existing or New Proviso:
Requires DHHS oversight of financial and operational aspects of non-insurance community health plans.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso could be considered for codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.27. (DHHS: Community Health Plans) The Department of Health and Human Services shall oversee all community health plans approved to operate as a pilot program for the purpose of providing health care. Such oversight shall include the review and approval of the financial and business plan of the community health plan. Only those plans receiving approval from the department, the Chairman of the Senate Finance Committee, and the Chairman of the House Ways and Means Committee prior to January 1, 2009 shall be authorized to operate as an approved community health plan pursuant to this provision. The department shall approve participation requirements of community health plans. An approved community health plan acting in accordance with these provisions shall not be considered as providing insurance or an unauthorized insurer.
V. Proviso Justification Form

Agency
Code
J02
Agency Name SC Department of Health and Human Services (SCDHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
21.28

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Delete.

E. Title
Descriptive Proviso Title:
DHHS: Personal Emergency Response System

F. Summary
Summary of Existing or New Proviso:
Proviso allows DHHS to consider the use of two-button PERS units.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Delete because such response systems are available to Medicaid recipients.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso is unnecessary as it is permissive, allowing DHHS to do something it is already doing.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.28. (DHHS: Personal Emergency Response System) The Department of Health and Human Services may consider the use of Personal Emergency Response Systems (PERS) units with additional functionality to include the use of a two-button system that is UL or ETL certified.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate “New #1”, “New #2”, etc.*): 21.29

B. **Appropriation**
   Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority*):
   II.A6D-Gaps Asst.

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Amend.

E. **Title**
   Descriptive Proviso Title:
   DHHS: GAPS

F. **Summary**
   Summary of Existing or New Proviso:
   Proviso requires DHHS to suspend the GAPS law for current fiscal year.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*
   Technical amendment to remove date and cover the current fiscal year.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso’s suspension of DHHS prevents DHHS from spending state only, non Medicaid-machable funds for this program.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso would require discussion prior to codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   21.29. (DHHS: GAPS) The requirements of Title 44, Chapter 6-610 through Chapter 6-660 shall be suspended for Fiscal Year 2011-12 the current state fiscal year.
V. Proviso Justification Form

Agency Code J02
Agency Name SC Department of Health and Human Services (SCDHHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate "New #1", "New #2", etc.):

21.30

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
II.A6F- Disproportionate Share

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Agency-specific.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Keep.

E. Title
Descriptive Proviso Title:
DHHS: Disproportionate Share - DMH

F. Summary
Summary of Existing or New Proviso:
Proviso directs DHHS to transfer funds to DMH to offset federal changes to DSH program, and to minimize future impact of the DSH changes on DMH.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso directs DHHS to transfer funds from the Medicaid budget to the DMH budget. This function is now addressed by a change in the Medicaid State Plan.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Keep during current budget uncertainty.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
Proviso’s impact on DHHS budget is factored into agency’s budget considerations.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
21.30. (DHHS: Disproportionate Share - DMH) For the current fiscal year, the department is directed to transfer funds to the Department of Mental Health to make up any shortfall in disproportionate share funding due to rule changes from the Center for Medicare and Medicaid Services from the latest federal fiscal year amount. The department must also take any necessary action, including the submission of an amendment to the State Medicaid Plan, to minimize the impact of disproportionate share funding redistribution to the Department of Mental Health in future years.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
   21.31

B. **Appropriation**
   Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Agency-specific.

D. **Action**
   (Indicate Keep, Amend, Delete, or Add):
   Delete.

E. **Title**
   Descriptive Proviso Title:
   DHHS: In-Home Health Care Systems for Medicaid Recipients

F. **Summary**
   Summary of Existing or New Proviso:
   Proviso allows DHHS to manage a pilot program utilizing an in home health care system, with the goal of reducing unnecessary costs associated with inappropriate use of the emergency room. Proviso describes the specifics of the in home health care system to be used.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   (If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
   Delete to allow agency to assess pilot and its potential for future use.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso may require expenditure of funds necessary to implement pilot program.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso can be deleted as pilot is implemented until agency can assess application for future use.

J. **Fiscal Impact** (Include impact on each source of funds – state, federal, and other)
   Agency will monitor to see if proviso implementation results in savings.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   21.31. (DHHS: In-Home Health Care Systems for Medicaid Recipients) The Department of Health and Human Services, during Fiscal Year 2011-12, within the funds appropriated, upon application by the department, may pilot test an in-home health care system. The pilot test must include a statistically valid sample of Medicaid patients within the counties as determined by the Director of the Department of Health and Human Services. This program shall provide a state of the art in-home health care system which provides around the clock access to medical assessment care and additionally provides an emergency response function that gives a Medicaid recipient the ability to contact a local emergency response center.
   The purpose of the program is to reduce the amount of emergency room visits in non-emergency cases and to reduce the amount of visits to other medical care facilities in order to save on the cost of providing this care and in order to provide better health care.
   The in-home health care system option must consist of three main components:
   (1) the medical console and wireless transmitter;
   (2) the medical triage center; and
   (3) the emergency response call center.
The medical console and wireless transmitter must have the following capabilities:

1. The medical console must be capable of communication between two separate call centers, one of which is a monitoring facility to provide certified medical triage care twenty-four hours a day and the other of which is a monitoring facility to provide emergency response services twenty-four hours a day.

2. The wireless transmitter for the medical console must have two buttons, one for transmitting a signal to the console to contact the emergency response monitoring facility, and the second button also must send a wireless signal to the console to trigger contact with the medical triage center.

3. The medical console must be able to send a report/event code to the emergency response call center after a medical triage center call has been placed.

4. An emergency button on the medical console must include Braille for the sight-impaired.

The medical triage center must have or be:

1. Open twenty-four hours a day, three hundred sixty-five days a year;

2. A call center must be located in the United States;

3. Utilization Review Accreditation Commission (URAC) accredited;

4. On-call availability of a South Carolina licensed physician, twenty-four hours, seven days a week for guidance or review of clinical calls as needed;

5. Registered nurses with a minimum of ten years experience available to answer all calls;

6. All calls digitally recorded and archived, and a triage report prepared and sent;

7. Daily monitoring of communications with the call center;

8. Fully HIPAA compliant;

9. Bilingual staff in English and Spanish;

10. A mechanism that ensures that a caller will never receive a busy signal or voice mail when accessing the nurse advice line;

11. Clinical staff able to serve pediatric, adolescent, adult, and senior populations, as well as health care expertise in a variety of clinical areas such as emergency room, pediatrics, critical care, oncology, cardiology, pulmonary, geriatrics, obstetrics/gynecology, and general medicine; and

12. The infrastructure in place to allow the telephone network to digitally communicate with the medical console for incoming call connection, call disconnect, and client file access.

The emergency response call center must:

1. Be open twenty-four hours a day, three hundred sixty-five days a year;

2. Be located in South Carolina;

3. Maintain a digital receiver capable of processing two-way voice audio using multiple formats.

Facilities, emergency response, and the medical triage center, shall offer all recipients selected by the department unlimited use of services provided by the emergency monitoring and medical triage facilities at no additional cost burden to the state.

The pilot-testing program must be conducted for the current fiscal year. The department in developing and administering this program is authorized to take such actions as may be required, including making requests for Medicaid waivers when necessary.

The department, in implementing this program on a pilot-testing basis, also is authorized to contract with a third-party provider or vendor to furnish and operate the program or a physician's office that provides a similar patient service.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1", "New #2", etc.):*
   21.32

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Agency-specific.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Delete.

E. **Title**
   Descriptive Proviso Title:
   DHHS: Medicaid Reporting

F. **Summary**
   Summary of Existing or New Proviso:
   Proviso directs DHHS to report quarterly all cost-saving changes, and potential impact on providers, beneficiaries, and utilization.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*
   Delete as agency generally monitors such impact resulting from program changes. Federal approval process for such changes requires agency diligence.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Deletion of proviso does not affect impact of Medicaid changes, or DHHS’ effort to monitor the impact of Medicaid changes.

J. **Fiscal Impact** *(Include impact on each source of funds – state, federal, and other)*
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   21.32. *(DHHS: Medicaid Reporting)*—Within ninety days of the end of each quarter in Fiscal Year 2011-12, the department shall report each cost-saving measure implemented. By county, the department shall report the number of enrolled and active providers by provider type, provider specialty and sub-specialty, the number of recipients, the number of recipients by provider type, the expenditures by provider type and specialty, and service level utilization trends. The department shall continue to annually report HEDIS measures, noting where measures improve or decline. Each report shall be submitted to the Chairman of the Senate Finance Committee, the Chairman of the Ways and Means Committee, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives, and be prominently displayed on the department’s website.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   22.15

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Proviso from another agency affecting DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Keep.

E. **Title**
   Descriptive Proviso Title:
   DHEC: Medicaid Nursing Home Bed Days

F. **Summary**
   Summary of Existing or New Proviso:
   Proviso identifies the maximum number of Medicaid patient days that DHEC can issue to nursing facilities.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso should be discussed prior to codification.

J. **Fiscal Impact** *(Include impact on each source of funds – state, federal, and other)*
   Medicaid funding is considered as DHEC determines yearly number of nursing home patient days. DHHS is assessing Medicaid bed day permit processes and procedures.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   22.15. *(DHEC: Medicaid Nursing Home Bed Days)* Pursuant to Section 44-7-84(A) of the 1976 Code, the maximum number of Medicaid patient days for which the Department of Health and Environmental Control is authorized to issue Medicaid nursing home permits is 4,452,015.
A. **Proviso Number**
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1", "New #2", etc.):*

22.18

B. **Appropriation**
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*

NA

C. **Agency Interest**
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?

*Proviso from another agency affecting DHHS.*

D. **Action**
*(Indicate Keep, Amend, Delete, or Add):*

Keep.

E. **Title**
Descriptive Proviso Title:

*DHEC: Nursing Home Medicaid Bed Day Permit*

F. **Summary**
Summary of Existing or New Proviso:

*Proviso requires Medicaid patient day permits to transfer with a patient who moves from one nursing home to another as a result of violations of state or federal law or Medicaid certification requirements.*

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
*(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**

*Proviso does not direct expenditure of funds.*

I. **Justification**
Refer to the instructions for the correct question to answer in this space, based on the action you selected

*Proviso should be discussed prior to codification.*

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**

*DHHS is assessing Medicaid bed day permit processes and procedures.*

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**

22.18. *(DHEC: Nursing Home Medicaid Bed Day Permit)* When transfer of a Medicaid patient from a nursing home is necessary due to violations of state or federal law or Medicaid certification requirements, the Medicaid patient day permit shall be transferred with the patient to the receiving nursing home. The receiving facility shall apply to permanently retain the Medicaid patient day permit within sixty days of receipt of the patient.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.)*:
   22.22

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority)*:
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Proviso from another agency affecting DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Keep.

E. **Title**
   Descriptive Proviso Title:
   DHEC: Allocation Patient Days

F. **Summary**
   Summary of Existing or New Proviso:
   Proviso directs DHEC to allocate additional Medicaid patient days authorized above previous year’s level, and prescribes the allocation process. Proviso also prevents certain facilities from reductions in their Medicaid permits or licensed bed capacities, except as prescribed by law.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso should be discussed prior to codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   DHHS is assessing Medicaid patient days processes and procedures.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   22.22. *(DHEC: Allocation Patient Days)* The department will allocate additional Medicaid patient days authorized above the previous fiscal year’s level based on the percentage of the additional requested Medicaid patient days and a percentage of the need indicated by the Community Long Term Care waiting list in priority order: (1) to those nursing homes currently holding a Medicaid nursing home permit; (2) to those nursing homes that are currently licensed, but do not participate in the Medicaid program; (3) to those nursing homes that have been approved under the Certificate of Need program. Facilities licensed as of July 1, 2006 shall not have their Medicaid permits or licensed bed capacity reduced by the department except as provided in Section 44-7-84(B) or 44-7-290 of the 1976 Code.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.)*:
   23.14

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority)*:
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Proviso from another agency affecting DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add)*:
   Keep.

E. **Title**
   Descriptive Proviso Title:
   DMH: Medicaid Beneficiary Choice

F. **Summary**
   Summary of Existing or New Proviso:
   Proviso allows Medicaid beneficiaries receiving certain behavioral health services funded in part by DMH to receive such care from any qualified Medicaid provider enrolled by DHHS.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified)*:

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso should be discussed prior to codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   Medicaid pays for services even when other state agencies provide the state match.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   23.14. *(DMH: Medicaid Beneficiary Choice)* For Medicaid covered community based paraprofessional rehabilitative behavioral health services for which the Department of Mental Health provides state identified matching funds, the department must allow a Medicaid beneficiary to receive medically necessary community based paraprofessional rehabilitative behavioral health services from any qualified Medicaid provider enrolled by the Department of Health and Human Services as of July 1, 2.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   24.4

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   **Proviso from another agency affecting DHHS.**

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   **Keep.**

E. **Title**
   Descriptive Proviso Title:
   DDSN: Medicaid Funded Contract Settlements

F. **Summary**
   Summary of Existing or New Proviso:
   **Proviso authorizes DDSN to carry forward and keep settlements under Medicaid-funded contracts.**

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   **Proviso does not direct expenditure of funds.**

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   **Proviso should be discussed prior to codification.**

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   Medicaid pays for services even when other state agencies provide the state match.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   24.4. *(DDSN: Medicaid Funded Contract Settlements) The department is authorized to carry forward and retain settlements under Medicaid-funded contracts.*
V. Proviso Justification Form

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
24.9

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Proviso from another agency affecting DHHS.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Keep.

E. Title
Descriptive Proviso Title:
DDSN: Pervasive Developmental Disorder

F. Summary
Summary of Existing or New Proviso:
Proviso requires DDSN and DHHS to manage a Medicaid pilot program to treat children with Pervasive Developmental Disorders, and prescribes program parameters and requirements.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
DDSN provides state match and DHHS draws federal matching funds for this project.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso should be discussed prior to codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
Medicaid pays for services even when other state agencies provide the state match.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
24.9. (DDSN: Pervasive Developmental Disorder) The Department of Disabilities and Special Needs, as the agency authorized to treat autistic disorder, is designated for a Medicaid project to treat children who have been diagnosed by eight years of age with a pervasive developmental disorder. The project must target the youngest ages feasible for treatment effectiveness, treatment for each individual child shall not exceed three years without a special exception as defined in the waiver, and reimbursement for each individual participant may not exceed $50,000 per year. The Department of Disabilities and Special Needs and the Department of Health and Human Services will determine the areas of the State with the greatest need and availability of providers. Children participating in the project will be selected based upon an application system developed in compliance with the Medicaid waiver. Treatment will be provided as authorized and prescribed by the department according to the degree of the developmental disability. In authorizing and prescribing treatment the department may award grants or negotiate and contract with public or private entities to implement intervention programs, which must comply with Medicaid reimbursement methodologies, for children who have been diagnosed with a pervasive developmental disorder. “Pervasive developmental disorder” means a neurological condition, including autistic disorder and Asperger’s syndrome, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. The department shall report semi-annually to the General Assembly and the Governor on the developmental progress of the children participating in the project and the fiscal status of the project, to include
expenditure data and appropriation balances. This provision does not establish or authorize creation of an entitlement program or benefit.
V. Proviso Justification Form

Agency Code J02
Agency Name SC Department of Health and Human Services (SCDHHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate "New #1", "New #2", etc.):
24.15

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Proviso from another agency affecting DHHS.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Keep.

E. Title
Descriptive Proviso Title:
DDSN: FMAP Extension Carry Forward

F. Summary
Summary of Existing or New Proviso:
Proviso authorizes DDSN to carry forward unused funds related to increased FMAP to be used for specified purposes.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Temporary, one-time money from federal increased FMAP supplemented state funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso should be discussed prior to codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
Medicaid pays for services even when other state agencies provide the state match.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
24.15. (DDSN: FMAP Extension Carry Forward) The department is authorized to carry forward the funds received as a result of the January through June 2011 federal extension of the increased FMAP. The department is authorized to use the funds to maintain current service levels, to support Traumatic Brain or Spinal Cord Injury Post-Acute Rehabilitation, system enhancements of the assessment process and the monitoring and documentation process for home and community based services in order to increase efficiency and reduce fraud and abuse.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   89.10

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   General proviso that affects DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Keep.

E. **Title**
   Descriptive Proviso Title:
   **GP: Federal Funds - DHEC, DSS, DHHS - Disallowances**

F. **Summary**
   Summary of Existing or New Proviso:
   Allows agencies to expend appropriations to cover program operations of prior fiscal years where adjustments are necessary under federal regulations or audit exceptions.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Provides agencies’ authority to manage funds for audit exceptions.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   **Proviso should be discussed prior to codification.**

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   Funds related to disallowances can vary and are considered in DHHS’ budgetary considerations.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   89.10. *(GP: Federal Funds - DHEC, DSS, DHHS - Disallowances)* Amounts appropriated to the Department of Health and Environmental Control, Department of Social Services and Department of Health and Human Services may be expended to cover program operations of prior fiscal years where adjustment of such prior years are necessary under federal regulations or audit exceptions. All disallowances or notices of disallowances by any federal agency of any costs claimed by these agencies shall be submitted to the State Auditor, the Senate Finance Committee and the House Ways and Means Committee, within five days of receipt of such actions.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   89.13

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   General proviso that affects DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Keep.

E. **Title**
   Descriptive Proviso Title:
   GP: SC Health & Human Services Data Warehouse

F. **Summary**
   Summary of Existing or New Proviso:
   Creates and outlines provisions related to SC Health & Human Services Data Warehouse.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso should be discussed prior to codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   There is minimal or no fiscal impact directly attributable to this proviso.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   89.13. (GP: SC Health & Human Services Data Warehouse) There is hereby established within the Office of Research and Statistics, South Carolina Budget and Control Board, the South Carolina Health and Human Services Data Warehouse. The purpose of the Warehouse is to ensure that the operation of health and human services agencies may be enhanced by coordination and integration of client information. Client data is defined as person-level data that is created, received, and/or maintained by state agencies and other entities required to report client information to the Office of Research and Statistics under this provision. To integrate client information, client data from health and human services state agencies will be linked to improve client outcome measures, enabling state agencies to analyze coordination and continuity of care issues. The addition of these data will enhance existing agency systems by providing client data from other state agency programs to assist in the provision of client services. Certain client information shall be delivered to the Office of Research and Statistics in order to assist in the development and maintenance of this Warehouse. The following agencies shall report client information:
   - Departments of:
     1. Health and Human Services;
     2. Health and Environmental Control;
     3. Mental Health;
     4. Alcohol and Other Drug Abuse Services;
     5. Disabilities and Special Needs;
6. Social Services;
7. Vocational Rehabilitation;
8. Education;
9. Juvenile Justice;
10. Corrections;
11. Probation, Parole and Pardon Services;
   • Office of the Governor
1. Children's Foster Care Review Board;
2. Continuum of Care;
   • Office of the Lieutenant Governor, Division on Aging;
   • South Carolina School for the Deaf and the Blind;
   • Commission for the Blind, and
   • Other entities as deemed necessary by the Office of Research and Statistics.

These agencies and departments shall collect and provide client data in formats and schedules to be specified by the Office of Research and Statistics (Office). The Office shall establish a Memorandum of Agreement with each agency, department or division. These Memorandums of Agreement shall specify, but are not limited to, the confidentiality of client information, the conditions for the release of data that may identify agencies, departments, divisions, programs and services, or clients, any restrictions on the release of data so as to be compliant with state and federal statutes and regulations on confidentiality of data, conditions under which the data may be used for research purposes, and any security measures to be taken to insure the confidentiality of client information.

To ensure accountability and the coordinated, efficient delivery of health and human services, the Office shall implement, in consultation with state health and human services agencies and other entities as deemed necessary by the Office, an integrated data system that includes client data from all participating agencies.

In order to provide for inclusion of other entities into the South Carolina Health and Human Services Data Warehouse and other research and analytic-oriented applications that will assist the state in the efficient and effective provision of services, the Office shall have the authority to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity to provide statistical, research and information dissemination services including, but not limited to, program and outcomes evaluation, program monitoring/surveillance, projects to determine the feasibility of data collection and/or analyses, information dissemination and research. The confidentiality of data collected under these initiatives shall comply with applicable state and federal laws governing the privacy of data.

The Office shall have the power to promulgate regulations, policies and procedures, in consultation with the participating agencies, for the development, protection and operation of the Data Warehouse, other research and analytic-oriented applications, and their underlying processes.

The Office shall develop internet-accessible secure analytic query tools (such as analytic cubes) using integrated client data from the Warehouse. All agencies shall cooperate with the Office in the development of these analytic tools. It is the intent of this provision that the analytic tools developed under this provision shall be made available to members of the South Carolina General Assembly and their research staff members, state agencies, and researchers. To that end, the Office shall, in consultation with the participating agencies, promulgate regulations addressing access to and use and release of information generated through use of the query tools.

All state agencies participating in the Warehouse shall utilize it and its associated software applications in the day-to-day operation of their programs and for coordination, collaboration, program evaluation and outcomes analysis. The Department of Health and Environmental Control shall be exempt from usage of the integrated client management system and the analytic query tools in the day-to-day operation of their Client Automated Record and Encounter System and their South Carolina Community Assessment Network, but shall provide the Warehouse with client data from the system and network.

No state agency shall duplicate any of the responsibilities of this provision.
For purposes of this subsection, all state laws, regulations, or any rule of any state agency, department, board, or commission having the effect or force of law that prohibits or is inconsistent with any provision of this subsection is hereby declared inapplicable to this subsection.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   89.27

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   NA

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   General proviso that affects DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Keep.

E. **Title**
   Descriptive Proviso Title:
   GP: TEFRA – Tax Equity and Fiscal Responsibility Act

F. **Summary**
   Summary of Existing or New Proviso:
   Proviso creates the state Medicaid TEFRA program for children with special needs.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso’s directive directs DHHS to expend funds to cover a Medicaid eligibility category.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso should be discussed prior to codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   This Medicaid eligibility category comprises children with high cost medical needs.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   89.27. (GP: TEFRA-Tax Equity and Fiscal Responsibility Act) It is the intent of the General Assembly that the State Medicaid Plan be amended to provide benefits for disabled children as allowed by the Tax Equity and Fiscal Responsibility Act (TEFRA) option. State agencies, including but not limited to, the Department of Social Services - the Continuum of Care, the Department of Health and Environmental Control, the Department of Mental Health, the Department of Disabilities and Special Needs, and the Department of Health and Human Services shall collectively review and identify existing state appropriations within their respective budgets that can be used as state match to serve these children. Such funds shall be used effective January 1, 1995 to implement TEFRA option benefits. Agencies providing services under the provisions of this paragraph must not spend less in the current fiscal year than expended in the previous fiscal year.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   
   89.42

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   
   General proviso that affects DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   
   Keep.

E. **Title**
   Descriptive Proviso Title:
   
   GP: Tobacco Settlement Funds Carry Forward

F. **Summary**
   Summary of Existing or New Proviso:
   
   Allows agencies to retain and carry forward unexpended Tobacco Settlement Agreement funds from the prior year to the current year, to expend for the same purposes.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso authorizes DHHS to expended Tobacco Settlement funds carried forward for like purpose from year to year.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   
   Proviso should be discussed prior to codification.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   DHHS receives $10 million each year from the Settlement funds.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   89.42. (GP: Tobacco Settlement Funds Carry Forward) State agencies are hereby authorized to retain and carry forward any unexpended Tobacco Settlement Agreement funds from the prior fiscal year into the current fiscal year and to expend such funds for the same purpose.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate “New #1”, “New #2”, etc.*):
   89.53

B. **Appropriation**
   Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority*):

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   General proviso that affects DHHS.

D. **Action**
   (Indicate Keep, Amend, Delete, or Add):
   Keep.

E. **Title**
   Descriptive Proviso Title:
   GP: Tobacco Funds

F. **Summary**
   Summary of Existing or New Proviso:
   Requires that excess Tobacco Settlement Funds above prescribed amounts required for stated purposes be deposited with DHHS for health care expenditures match.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   (If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso does not direct expenditure of funds.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso should be discussed prior to codification.

J. **Fiscal Impact** (Include impact on each source of funds – state, federal, and other)
   DHHS receives $10 million each year from Tobacco Settlement funds.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   89.53. (GP: Tobacco Funds) The Tobacco Settlement Revenue Management Authority may determine by resolution that some or all of the amounts on deposit in the Healthcare Tobacco Settlement Trust Fund established pursuant to Section 11-11-170, whether in the form of principal or interest, may be used to refund bonds issued pursuant to Chapter 49, Title 11, to purchase such bonds, directly or indirectly, and/or to secure bonds issued to refund such bonds. Any amounts received by the Authority pursuant to the preceding clause in excess of the amount required to refund or purchase such bonds and all tobacco settlement receipts received by the State pursuant to Section 11-49-130 must be deposited directly with the Department of Health and Human Services for health care expenditures to achieve the maximum Medicaid match.
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate "New #1", "New #2", etc.):
89.92

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
NA

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
General proviso that affects DHHS.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Amend.

E. Title
Descriptive Proviso Title:
GP: Information Technology for Health Care

F. Summary
Summary of Existing or New Proviso:
Proviso requires promotion of the use of health information technology through SCHIEx.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):
Amend to reflect updated status of this initiative.

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso does not direct expenditure of funds.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Agency recommends proviso be codified.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
There is minimal or no fiscal impact directly attributable to this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
89.92. (GP: Information Technology for Health Care) From the funds appropriated and awarded to the South Carolina Department of Health and Human Services for the Health Information Technology for Economic and Clinical Health Act of 2009, the department shall advance the use of health information technology and health information exchange to improve quality and efficiency of health care and to decrease the costs of health care. In order to facilitate the qualification of Medicare and/or Medicaid eligible providers and hospitals for incentive payments for meaningful health information technology (HIT) use, a health care organization participating in a the South Carolina Health Information Exchange (SCHIEx) or a Regional Health Information Organization (RHIO) or a hospital system health information exchange (HIE) that participates in SCHIEx may release patient records and medical information, including the results of any laboratory or other tests ordered or requested by an authorized health care provider within the scope of his or her license or practice act, to another health care organization that requests the information via a HIE for treatment purposes with or without express written consent or authorization from the patient. A health care organization that receives or views this information from a patient’s electronic health record or incorporates this information into the health care organization’s electronic medical record for the patient in providing treatment is considered an authorized person for purposes of 42 C.F.R. 493.2 and the Clinical Laboratory Improvement Amendments.
V. Proviso Justification Form

Agency Code: J02
Agency Name: SC Department of Health and Human Services (SCDHHHS)

A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):
89.107

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):
None

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
General proviso which affects DHHS.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Keep.

E. Title
Descriptive Proviso Title:
GP: Opt Out of Federal Patient Protection and Affordable Care Act

F. Summary
Summary of Existing or New Proviso:
Proviso requires state to opt out of certain provisions of the health care reform bill.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso should be discussed prior to codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
Agency is assessing the impact of the Affordable Care Act provisions cited in this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
89.107. (GP: Opt Out of Federal Patient Protection and Affordable Care Act) If federal law permits, the State of South Carolina opts out of the following provisions in the federal Patient Protection and Affordable Care Act (Public Law 111-148):
(1) Subtitles A through C of Title I (and the amendments made by such subtitles), except for Sections 1253 and 1254;
(2) Parts I, II, III, and V of subtitle D of Title I (and the amendments made by such parts);
(3) Part I of subtitle E of Title I (and the amendments made by such part);
(4) Subtitle F of Title I (and the amendments made by such subtitle);
(5) Sections 2001 through 2006 (and the amendments made by such sections); and
(6) Sections 10101 through 10107 (and the amendments made by such sections).
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
90.3

B. Appropriation
Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
None.

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Statewide Revenue proviso that affects DHHS.

D. Action
*(Indicate Keep, Amend, Delete, or Add):*
Keep.

E. Title
Descriptive Proviso Title:
SR: Tobacco Settlement

F. Summary
Summary of Existing or New Proviso:
Proviso allocates $10 million from the Tobacco Settlement Trust Fund to DHHS.

G. Explanation of Amendment to/or Deletion of Existing Proviso
*(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
DHHS budget considerations include the funds provided by this proviso.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso should be discussed prior to codification.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
DHHS receives $10 million matchable funds from this proviso.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
90.3. *(SR: Tobacco Settlement) Contingent upon the approval of the Tobacco Settlement Revenue Management Authority and parties to the trust agreement, the State Treasurer shall transfer an amount equal to $10,000,000 from the unrestricted taxable proceeds portion of the principal of the Healthcare Tobacco Settlement Trust Fund established pursuant to Section 11-11-170(B)(1) of the 1976 Code to the Department of Health and Human Services to be expended as follows: $10,000,000 for Medicaid. The State Treasurer is authorized and directed to transfer to the Office of the Attorney General from funds available to the Tobacco Settlement Management Authority such amounts as shall be necessary for the enforcement of Chapter 47 of Title 11, The Tobacco Escrow Fund Act, which will protect the payments to the State under the Master Settlement Agreement.*
A. **Proviso Number**
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (*If new indicate “New #1”, “New #2”, etc.):*

90.9

B. **Appropriation**
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding priority):*

None.

C. **Agency Interest**
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?

Statewide Revenue proviso that affects DHHS.

D. **Action**
(Indicate Keep, Amend, Delete, or Add):

Amend.

E. **Title**
Descriptive Proviso Title:

SR: Health Care Maintenance of Effort Funding

F. **Summary**
Summary of Existing or New Proviso:

Proviso directs funds from increased cigarette tax to DHHS, and describes the use of the funds, including restrictions on using any residual funds.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

Amend language prescribing DHHS methods and criteria for determining any potential use of residual funds.

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**

DHHS SFY budget will be built with consideration of these funds.

I. **Justification**
Refer to the instructions for the correct question to answer in this space, based on the action you selected

Amended proviso authorizes potential use of residual funds if needed to manage unanticipated Medicaid enrollment growth.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**

DHHS requests these funds as recurring funds in SFY2013 budget.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**

90.9. (SR: Health Care Maintenance of Effort Funding) The source of funds appropriated in this provision is $157,299,845 from the revenue collected during Fiscal Year 2010-11 and Fiscal Year 2011-12 from the 50 cent cigarette surcharge and deposited into the South Carolina Medicaid Reserve Fund and shall be utilized by the Department of Health and Human Services for the Medicaid Program’s maintenance of effort. By this provision these funds are deemed to have been received and are available for appropriation. The residual funds from the cigarette surcharge shall remain in the South Carolina Medicaid Reserve Fund and may be used by the director of the Department of Health and Human Services to ensure access to care in rural and underserved areas of the state, or address unanticipated growth in enrollment. Within ninety days of the start of the fiscal year, the department shall develop methods and criteria for determining how access or unanticipated enrollment growth issues will be identified, assessed and addressed. Any use of these funds shall require thirty days prior notice to the Chairmen of the Senate Finance and House Ways and Means Committees. The department shall provide an assessment of access to care as part of the reporting requirements stipulated in Proviso 21.32, (DHHS: Medicaid Reporting). The director is not
authorized to access any of the residual funds prior to January 31, 2012. The director must submit a proposal for any use of the funds to the General Assembly by January 1, 2012. If no action is taken on the proposal by the General Assembly by January 31, 2012, the director may access the residual funds as presented in the proposal. Unexpended funds appropriated pursuant to this provision may be carried forward to succeeding fiscal years and expended for the same purposes.
A. **Proviso Number**
   Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number *(If new indicate “New #1”, “New #2”, etc.):*
   90.11

B. **Appropriation**
   Related budget category, program, or non-recurring request *(Leave blank if not associated with funding priority):*
   None.

C. **Agency Interest**
   Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
   Statewide Revenue proviso affecting DHHS.

D. **Action**
   *(Indicate Keep, Amend, Delete, or Add):*
   Allocate funds as recurring for DHHS budget.

E. **Title**
   Descriptive Proviso Title:
   SR: Non-recurring Revenue

F. **Summary**
   Summary of Existing or New Proviso:
   Allocates to DHHS $45.5 million non-recurring funds from various sources.

G. **Explanation of Amendment to/or Deletion of Existing Proviso**
   *(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):*

H. **Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary**
   Proviso allocates non-recurring funds as part of SFY 2012 budget.

I. **Justification**
   Refer to the instructions for the correct question to answer in this space, based on the action you selected
   Proviso's provisions require discussion as these one-time funds are necessary to Medicaid's maintenance of effort budget.

J. **Fiscal Impact (Include impact on each source of funds – state, federal, and other)**
   DHHS requests these funds as recurring funds in SFY 2013 budget.

K. **Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline**
   90.11. *(SR: Non-recurring Revenue) (A) The source of revenue appropriated in this provision is $255,804,144 of non-recurring revenue generated from the following sources, transferred to the State Treasurer. This revenue is deemed to have occurred and is available for use in Fiscal Year 2011-12 after September 1, 2011, following the Comptroller General's close of the state's books on Fiscal Year 2010-11.
   (1) $71,000,600 from Fiscal Year 2009-10 Contingency Reserve Fund;
   (2) $173,803,544 from Fiscal Year 2010-11 unobligated general fund revenue as certified by the Board of Economic Advisors;
   (3) $1,000,000 from F03, Budget and Control Board, Subfund 4154, Ordinary Sinking Fund;
   (4) $3,000,000 from F03, Budget and Control Board, Subfund 3197, Motor Pool; and
   (5) $7,000,000 from R40, Department of Motor Vehicles from any earmarked or restricted account designated as “special revenue funds” as defined by the Comptroller General’s records if the funds transferred from the Department of Motor Vehicles by Proviso 90.10 of Act 291 of 2010 have been repaid pursuant to Proviso 90.9 of Act 291 of 2010.
V. Proviso Justification Form

Any restrictions concerning specific utilization of these funds are lifted for the specified fiscal year. The above agency transfers shall occur no later than thirty days after the close of the books on Fiscal Year 2010-11 and shall be available for use in Fiscal year 2011-12.

(B) The State Treasurer shall disburse the following appropriations by September 30, 2011, for the purposes stated:

1. H63-Department of Education
   - Student Cost ........................................................................................................................................ $...... 56,174,107;
   - Transportation ........................................................................................................................................... $...... 3,000,000;

2. H03-Commission on Higher Education
   - SREB Dues ............................................................................................................................................ $........ 591,019;

3. H59-State Board for Technical and Comprehensive Education
   - CATT Program ........................................................................................................................................ $...... 1,000,000;

4. J02-Department of Health and Human Services
   - Medicaid Maintenance of Effort .................................................................................................................... $..... 45,577,252;

5. R60-Department of Employment and Workforce
   - Unemployment Insurance Trust Fund ........................................................................................................ $....146,000,000;

6. P20-Clemson University-PSA
   - Agency Operations ........................................................................................................................................ $........ 250,000;

7. K05-Department of Public Safety
   - Illegal Immigration ........................................................................................................................................ $........ 611,766;

8. E23-Commission on Indigent Defense
   - Civil Appointment Fund ................................................................................................................................. $...... 1,500,000;

9. J04-Department of Health and Environmental Control
   - Donate Life ................................................................................................................................................. $........ 100,000; and

10. D10-State Law Enforcement Division
    - Methamphetamine Lab Clean-Up ............................................................................................................... $...... 1,000,000;

The funds appropriated above to the Department of Employment and Workforce may only be used by the department to make payments on outstanding loans from the Unemployment Insurance Trust Fund. As soon as practicable after the effective date of this act, the Department of Employment and Workforce is directed to recalculate premium rates. The recalculated premium rates shall be retroactive to January 1, 2011. Any cost savings to employers in rate class 2-20 due to general fund appropriations in any particular year must be allocated proportionately to each employer with respect to each respective employer's responsibility in paying back the federal unemployment loan that particular year and must be administered by the department. Employers must be notified of changes in the premiums due and employer accounts must be credited and adjusted as appropriate. The Department of Employment and Workforce is directed to contact the Federal Government by August 1, 2011, to maximize efforts to buy the loan down to the greatest extent possible.

In the event that the Fiscal Year 2010-11 unobligated general fund revenue as certified by the Board of Economic Advisors does not total at least $173,803,544, then the appropriations in subsection (B)(4) of this provision for Medicaid Maintenance of Effort shall be reduced to cover the amounts not realized. If the reduction in the Medicaid Maintenance of Effort appropriation is not sufficient to cover the amounts not realized, then the remaining appropriations in this provision shall be reduced on a pro rata basis by an amount sufficient to cover the amounts not realized. In the event that $7,000,000 is not transferred from the Department of Motor Vehicles, then the remaining appropriations in this provision shall be reduced on a pro rata basis.

Unexpended funds appropriated pursuant to this provision may be carried forward to succeeding fiscal years and expended for the same purposes.

(C) For Fiscal Year 2011-12, the license plate replacement interval is suspended until the funds transferred from the department within this provision are repaid to the department or until such time as the Plate Replacement Fee Fund has a sufficient balance to reinstitute license plate replacement.

(D) From the escrow account established pursuant to Proviso 90.13 of Act 310 of 2008, the remaining funds shall be used to offset any operating shortfalls resulting from the Barnwell Low Level Waste Facility operations in order to preserve the economic viability of the facility. The amount distributed to offset any operating shortfalls shall be determined by calculating the difference between the allowable operating costs plus adjustments as approved by the Public Service Commission, and the access fees paid by the Atlantic Compact generators. Funds remaining in the account to offset operating shortfalls shall also be used to maintain access fees to the facility for Fiscal Year 2011-12 at the Fiscal Year 2009-10 level. There shall also be paid from the escrow account the annual dues of the Southern States Energy Board.
A. Proviso Number
Using the renumbered 2012-13 proviso base provided on the OSB website, indicate the proviso number (If new indicate “New #1”, “New #2”, etc.):

90.14

B. Appropriation
Related budget category, program, or non-recurring request (Leave blank if not associated with funding priority):

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency’s section that has had consequences?
Statewide Revenue proviso affecting DHHS.

D. Action
(Indicate Keep, Amend, Delete, or Add):
Allocate funds as recurring for DHHS budget.

E. Title:
Descriptive Proviso Title:
SR: Non-recurring Revenue – Increased Enforcement Collections

F. Summary
Summary of Existing or New Proviso:
Proviso allocates $28 million non-recurring funds to DHHS from increased tax collection enforcement.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to codification, note the section of the Code of Laws where the language has been codified):

H. Explanation of how this proviso directs the expenditure or appropriation of funds, and why this direction is necessary
Proviso allocates non-recurring funds as part of SFY 2012 budget.

I. Justification
Refer to the instructions for the correct question to answer in this space, based on the action you selected
Proviso’s provisions require discussion as these one-time funds are necessary to Medicaid’s maintenance of effort budget.

J. Fiscal Impact (Include impact on each source of funds – state, federal, and other)
DHHS requests these funds as recurring funds in SFY 2013 budget.

K. Text of New Proviso with Underline or Entire Existing Proviso Text with Strikeover and Underline
90.14. (SR: Non-recurring Revenue – Increased Enforcement Collections) For Fiscal Year 2011-12, the Department of Revenue shall continue its efforts pertaining to increased enforcement collections as established in Fiscal Year 2009-10. The department may collect revenues from foreign collections within its jurisdiction, which may include but is not limited to corporate, individual or sales tax collections but especially shall focus on enforced collections and outstanding liabilities. Funding previously received by the department for enforced collections shall be used to fund foreign auditors to conduct foreign audits of multi-national and international corporations. Personnel may include revenue officers and criminal investigators. These employees will focus on collecting outstanding liabilities owed to this state. During the current fiscal year, in applying the revenue statutes of this State, the department's interpretation of those statutes must be based solely on the plain meaning of the statute's text and the legislative intent giving rise to the enactment of the statutes. Terms contained in the tax statutes of this State may not be given broader meaning beyond the meaning of the statute. At least twice during the fiscal year, the department shall submit a report to the Chairman of the Senate Finance Committee and the Chairman of the House Ways and Means Committee regarding any discovered ambiguity in the meaning of a revenue statute. The first report must be submitted no later
than November first and the second report must be submitted no later than May first of the fiscal year. The funds collected under this provision shall be deposited in a fund separate and distinct from the general fund as established within the Office of the State Treasurer, except that any motor fuel funds collected as a result of the enforced collection efforts shall be distributed in the same manner as other motor fuel tax revenues are currently distributed. When the department determines that quarterly enforced collections have exceeded the schedule provided in this provision, the department shall deposit the excess funds into the separate and distinct fund not to exceed the totals as provided in this provision.

For the fiscal year beginning July 1, 2011 and ending June 30, 2012, of the first $48,080,667 in enforced collections resulting from increased enforcement, the State Treasurer shall disburse 58.4% to the Department of Health and Human Services for Medicaid Maintenance of Effort and 41.6% to the Department of Education for the Education Foundation Supplement so that the resulting amount of remittances are:

J02-Department of Health and Human Services-Medicaid Maintenance of Effort ............................................................... $28,080,667; and
H63-Department of Education-Education Foundation Supplement ............................................................. $20,000,000.

For the fiscal year beginning July 1, 2011 and ending June 30, 2012, the State Treasurer shall disburse quarterly the following funds on a pro rata basis:

(1) E28-Election Commission
    2012 Primary Election ................................................................. $253,000;
(2) K05-Department of Public Safety
    Highway Patrol Overtime.............................................................. $5,000,000; and
(3) P16-Department of Agriculture
    Agri-Business Economic Development ........................................... $500,000.

Prior to the close of the books on Fiscal Year 2011-12, the funds accumulated in the aforementioned separate and distinct fund shall be transferred to the General Reserve Fund, up to the amount necessary to meet the constitutional five percent requirement.

To insure that customary and usual enforced collections are unaffected by this provision, the Office of the State Treasurer may not disburse funds from this account until the following schedule of General Fund enforced collections are deposited by the Department of Revenue by the end of each quarter in the fiscal year. If quarterly General Fund enforced collections do not reach the required levels, distributions from this account are suspended for that quarter.

The required deposits of quarterly General Fund enforced collections by the end of each quarter are:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>July to September</td>
<td>$11,250,000</td>
</tr>
<tr>
<td>October to December</td>
<td>$22,500,000</td>
</tr>
<tr>
<td>January to March</td>
<td>$33,750,000</td>
</tr>
<tr>
<td>April to June</td>
<td>$45,000,000</td>
</tr>
</tbody>
</table>

The Department of Revenue shall report on a quarterly basis to the finance committees of the General Assembly and to the Board of Economic Advisors on the amount of customary and usual enforced collections and the excess collections from the enhanced collection activities. The Department of Revenue shall provide assistance to the Board of Economic Advisors to assist in monitoring revenue collection seasonal flows that impact the funding of state government programs.

By this provision these funds are deemed to have been received and are available for appropriation. Unexpended funds appropriated pursuant to this provision may be carried forward to succeeding fiscal years and expended for the same purpose.
<table>
<thead>
<tr>
<th><strong>Summary</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Award Title</strong></td>
<td>Medical Assistance Program</td>
</tr>
<tr>
<td><strong>CFDA Number/Title</strong></td>
<td>(XX.XXX) Other CFDA, if &quot;Other&quot;, identify: 093.778/Medical Assistance Program</td>
</tr>
<tr>
<td><strong>Award Number (Federal)</strong></td>
<td>05-1105SC5MAP; 05-1105SC5ADM, 05-1105SCINCT; 05-1105SCHIMP (Current Year)</td>
</tr>
<tr>
<td><strong>Start Date</strong></td>
<td>10/01/10</td>
</tr>
<tr>
<td><strong>End Date</strong></td>
<td>09/30/13</td>
</tr>
<tr>
<td><strong>Federal Agency</strong></td>
<td>Department of Health and Human Services (75)</td>
</tr>
<tr>
<td><strong>Federal Subagency</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Award Period</strong></td>
<td>Continuing</td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total Award Amount</strong></td>
<td>$11,093,563,046.61</td>
</tr>
<tr>
<td><strong>Amount Available in FY 2012-13</strong></td>
<td>$4,164,492,000.00</td>
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<tr>
<td><strong>State Match Required?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Local Match Required?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Assistance Type</strong></td>
<td>Formula Grant</td>
</tr>
<tr>
<td><strong>State Match Required?</strong></td>
<td>If &quot;Yes&quot;, describe, and provide SAP Fund Number(s) of funding sources</td>
</tr>
<tr>
<td><strong>Local Match Required?</strong></td>
<td>If &quot;Yes&quot;, describe</td>
</tr>
<tr>
<td><strong>Assistance Type</strong></td>
<td>If &quot;Other&quot;, explain</td>
</tr>
</tbody>
</table>

10010000 General Fund, 30417000 Revenue Clearing, 31000000 Hlth Opportunity Acct, 31870000 Medicaid Reserve FD, 34400000 Med Care Prog-50 CAP, 34410000 St Agy-Maid Alloc, 34420000 Special Grants, 34750000 County Medicaid, 34760000 Medicaid CPE, 35047000 Med Asst Prog Ref-St, 36H60000 Hlth Care Annual MOE, 38610000 Serv Emot Dist Chld, 41760000 Nursing Home Sanc, 42750000 HHS-Health Trst Earn, 44790000 Medicaid Exp MIAA, 60060000 CPE Activity, 28230000 Indirect Cost Rec, 30037000 Dual Employment, 35B40000 Medicaid Spons Work, 38907000 Parking Fund, 39580000 Sale of Assets
Federal Aid Justification

05-1105SC5MAP; 05-1105SC5ADM, 05-1105SCINCT; 05-1105SCHIMP (Current Year)

Is administrative and/or indirect cost recovery permitted? If so, explain:

Yes, the State-wide indirect costs are billed for the central accounting function by the Comptroller General’s Office for recovery.

Will funds be passed-through to other entities? If so, what types of entities, and how will funds be distributed?

No funds will be passed through to other entities.

Questions

How is the use of these funds essential to your agency’s mission?

SCDHHS is the single State agency designated to administer or oversee the administration of the Medicaid program under Title XIX of the Social Security Act. The purpose of SCDHHS is to develop a unified system of planning, financing and administering inter-agency health and human services programs and to assure that essential services provided by such programs are delivered in the most effective and efficient manner.

The S.C. Medicaid EHR Incentive Program provides federal incentives to eligible providers as they adopt, implement, upgrade to, or meaningfully use certified Electronic Health Records (EHR) technology. The SCDHHS Health Information Technology (HIT) Division operates to administer the program and provides the means by which providers may initially attest to meeting objectives of the Program, and ultimately exchange patient information in-line with national goals for improvement of health, reduction of health care disparities, and greater efficiencies in health care. This supports our agency’s mission to purchase the most health for those in need at the least cost to taxpayers.

What budgetary, compliance, and programmatic obligations will the state incur (now or in the future) through the receipt of these funds?

The State must provide for the categorically needy inpatient and outpatient hospital services; rural health clinic services; federally-qualified health center services; other laboratory and x-ray services; nursing facility services; home health services for persons over age 21; family planning services; physicians’ services; early and periodic screening, diagnosis, and treatment for individuals under age 21; pediatric or family nurse practitioner services; and services furnished by a nurse-midwife as licensed by the State. The State is required to provide for the medically needy a minimum mix of services for which Federal financial participation is available.

To obtain/maintain enhanced funding for EHR, the state must comply with regulation related to: (1) Administration; (2) Oversight; and (3) Pursuit of Initiative.

What outcome and/or performance measures will you track and/or report on in association with this award?

The Medicaid and CHIP Programs ensure the quality of eligibility determination through an assurance process established by federal mandates that collects data on eligibility, beneficiary liability, and claim payments. The purpose of this assurance is to measure, identify, and reduce dollar loss due to erroneous eligibility determination or to ensure clients receive all benefits to which they are entitled. Reports are provided to policy makers and processing staff to improve the eligibility process.

The HIT Division and the Centers for Medicare and Medicaid Services (CMS) currently track providers who have met the Program requirements for Year One participation and received the incentives. Successive years of the program will require that the provider meaningfully use the technology as measured against federal mandates for meaningful use objectives and clinical quality measures. This information will be ultimately be exchanged and reported at the national level.

What is the name and title of the individual in your agency who is responsible for the success of this program?

The Medicaid and CHIP Programs ensure the quality of eligibility determination through an assurance process established by federal mandates that collects data on eligibility, beneficiary liability, and claim payments. The purpose of this assurance is to measure, identify, and reduce dollar loss due to erroneous eligibility determination or to ensure clients receive all benefits to which they are entitled. Reports are provided to policy makers and processing staff to improve the eligibility process.

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<table>
<thead>
<tr>
<th>FY 2012-13 Agency Budget Request</th>
<th>Agency Code: J02</th>
<th>Agency Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC Department of Health and Human Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Federal Aid Justification  
05-1105SC5MAP; 05-1105SC5ADM, 05-1105SCINCT; 05-1105SCHIMP  (Current Year)

Melanie Giese, Deputy Director of Program  
Susan W. Hartnett, Director of the Division of HIT
**Summary**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Title</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>CFDA Number/Title</td>
<td>(XX.XXX) Other CFDA</td>
</tr>
<tr>
<td>Award Number (Federal)</td>
<td>05-1005SC5021, 05-1105SC5021 (Current Year); 1Z0CMS030540-01-02</td>
</tr>
<tr>
<td>Start Date</td>
<td>10/01/09</td>
</tr>
<tr>
<td>Federal Agency</td>
<td>Department of Health and Human Services (75)</td>
</tr>
<tr>
<td>End Date</td>
<td>09/30/15</td>
</tr>
<tr>
<td>Federal Subagency</td>
<td></td>
</tr>
<tr>
<td>Award Period</td>
<td>Periodic Renewal</td>
</tr>
</tbody>
</table>

**Financial**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>Total Award Amount</td>
<td>$322,657,613.00</td>
</tr>
<tr>
<td>Amount Available in FY 2012-13</td>
<td>$98,590,732.00</td>
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<tr>
<td>State Match Required?</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Match Required?</td>
<td>No</td>
</tr>
<tr>
<td>Assistance Type</td>
<td>Formula Grant</td>
</tr>
<tr>
<td>Is administrative and/or indirect cost recovery permitted?</td>
<td>No administrative and/or indirect cost recovery if permitted.</td>
</tr>
</tbody>
</table>

**State Match Required?**

- Yes

**Is administrative and/or indirect cost recovery permitted?**

- No administrative and/or indirect cost recovery if permitted.

**Will funds be passed-through to other entities?**

- No funds will be passed through to other entities.

---

**Agency Code: J02**

SC Department of Health and Human Services
Questions

How is the use of these funds essential to your agency's mission?

SCHIP is to provide expanded benefits under the South Carolina Medicaid State plan. South Carolina expanded Medicaid coverage to children who are under age 19 with family incomes at or below 150 percent of the Federal poverty level (FPL).

The CHIPRA grant is aimed at establishing and improving the quality of children's health care through measures of quality, promotion of health information technology and the implementation of a provider based (medical home and integration of behavioral health) model.

What budgetary, compliance, and programmatic obligations will the state incur (now or in the future) through the receipt of these funds?

For SCHIP, the State may spend up to 10 percent of their total CHIP expenditures (Federal and State) on non-benefit activities, including: outreach conducted to identify and enroll eligible children in CHIP; administration costs; health services initiatives; and other child health assistance. Also, in accordance with the provisions of OMB Circular No. A-133 (Revised, June 27, 2003), “Audits of States, Local Governments and Non-Profit Organizations,” non-federal entities that expend financial assistance of $500,000 or more in Federal awards will have a single or a program-specific audit conducted for that year. A State child health plan under Title XXI must include an assurance the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

What outcome and/or performance measures will you track and/or report on in association with this award?

The Medicaid and CHIP Programs ensure the quality of eligibility determination through an assurance process established by federal mandates that collects data on eligibility, beneficiary liability, and claim payments. The purpose of this assurance is to measure, identify, and reduce dollar loss due to erroneous eligibility determination or to ensure clients receive all benefits to which they are entitled. Reports are provided to policy makers and processing staff to improve the eligibility process.

For CHIPRA:  
A.) To experiment with, and evaluate the use of, newly developed and evidence-based measures of the quality of children's health care. (i.e. our 18 provider practices work on 24 quality measures.) 
B.) Promote the use of C. Evaluate provider-based models which improve the delivery of children's health care. (i.e. to improve children's quality of care by promoting the pediatric medical home's use of HIT and integration/coordination of mental health treatment into the medical home.)

What is the name and title of the individual in your agency who is responsible for the success of this program?

Melanie Giese, Deputy Director of Program

For CHIPRA – Lynn Martin, Program Manager in the Program Management Office.
### Summary

<table>
<thead>
<tr>
<th>Award Title</th>
<th>State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFDA Number&gt;Title</td>
<td>(XX.XXX) Other CFDA</td>
</tr>
<tr>
<td>Award Number (Federal)</td>
<td>05-1105-SC-5001 (Current Year)</td>
</tr>
<tr>
<td>Award Number (State)</td>
<td></td>
</tr>
<tr>
<td>Award Period</td>
<td>Continuing</td>
</tr>
</tbody>
</table>

### Financial

| Total Award Amount | $ 5,044,005.00 | Amount Available in FY 2012-13 | $ 1,820,724.00 |
| State Match Required? | Yes | If "Yes", describe, and provide SAP Fund Number(s) of funding sources | 10010000 General Fund |
| Local Match Required? | No | If "Yes", describe | |
| Assistance Type | Formula Grant | If "Other", explain | |

Is administrative and/or indirect cost recovery permitted? If so, explain: No administrative and/or indirect cost recovery if permitted.

Will funds be passed-through to other entities? If so, what types of entities, and how will funds be distributed? No funds will be passed through to other entities.
**Questions**

How is the use of these funds essential to your agency's mission?

These funds provide financial assistance to determine whether or not providers and suppliers of health care services are in compliance with Federal regulatory health and safety standards and conditions of participation. Also funds are available to the State for the purpose of inspecting providers and suppliers of health care services, to ensure mandatory adherence to Medicare/Medicaid health and safety standards and conditions.

What budgetary, compliance, and programmatic obligations will the state incur (now or in the future) through the receipt of these funds?

In accordance with the provisions of OMB Circular No. A-133 (Revised, June 27, 2003), "Audits of States, Local Governments and Non-Profit Organizations," non-federal entities that expend Federal awards of $500,000 or more in Federal awards will have a single or a program-specific audit conducted for that year. Also, the State must maintain survey or time records, and line item and expenditure documentation, which substantiate the costs relating to survey activities.

What outcome and/or performance measures will you track and/or report on in association with this award?

SCDHHS will track the number of surveys completed within a year, facility deficiencies and compliance. Survey and certification is the only system that provides on-site, objective and outcome-based verification by knowledgeable and trained individuals to assure that basic standards of quality are being met by healthcare providers across the nation or, if not met, that appropriate remedies are promptly applied and implemented effectively. No more than 15.9 months elapses between surveys for any particular nursing home. All nursing homes in the State are surveyed, on average, once per year. The State-wide average interval between consecutive standard surveys must be 12.9 months or less. Nursing Home Oversight & Improvement Program (NHOIP): All aspects of the nursing home improvement program are sustained (e.g., off-hour surveys, Special Focus Facilities, etc.).

What is the name and title of the individual in your agency who is responsible for the success of this program?

Nicole Mitchell Threatt, Department Head for the Department of Facility Services - Program Coordinator II
| Summary |
|-----------------|----------------|
| Award Title      | ARRA - State Grants to Promote Health Information Technology |
| CFDA Number/Title| (93.719) ARRA - State Grants to Promote Health Information Technology |
| Award Number (Federal) | 90HT0053/01 |
| Start Date       | 03/15/10 |
| Federal Agency   | Department of Health and Human Services (75) |
| Award Number (State) | 90HT0053/01 |
| End Date         | 03/14/14 |
| Federal Subagency| |
| Award Period     | Periodic Renewal |
| if "Other", explain: | |

| Financial |
|-----------------|-----------------|
| Total Award Amount | $ 9,576,408.00 |
| Amount Available in FY 2012-13 | $2,356,913.47 |
| State Match Required? | Yes |
| If "Yes", describe, and provide SAP Fund Number(s) of funding sources | 10010000 General Fund, 34410000 St Agy-Maid Alloc, 34420000 Special Grants, 35B40000 Medicaid Spons Work |
| Local Match Required? | No |
| If "Yes", describe | |
| Assistance Type | Project Grant |
| Is administrative and/or indirect cost recovery permitted? If so, explain: | No administrative and/or indirect cost recovery if permitted. |
| Will funds be passed-through to other entities? If so, what types of entities, and how will funds be distributed? | No funds will be passed through to other entities. |

No funds will be passed through to other entities.
How is the use of these funds essential to your agency's mission?

The Governor designated SCDHHS as the grant applicant for the State Health Information Exchange (HIE) Cooperative Agreement for the State of South Carolina. The purpose of the Cooperative Agreement is to establish a statewide HIE that will facilitate exchange of clinical information. Given the significant number of South Carolinians enrolled in Medicaid, SCDHHS has a vested interest in the future of health information exchange for the State.

What budgetary, compliance, and programmatic obligations will the state incur (now or in the future) through the receipt of these funds?

In FY 2010, there was no match required. Beginning with fiscal year 2011, the HITECH Act, Section 3013, requires awardees to make available non-Federal contributions (which may include in-kind contributions) toward the costs of a grant awarded in an amount equal to not less than $1 for each $10 of federal funds provided under this grant in fiscal year 2011, not less than $1 for each $7 of federal funds provided under this grant in fiscal year 2012 and not less than $1 for each $3 of federal funds provided under this grant for all subsequent fiscal years.

Recipients of Federal awards from funds authorized under Division A of the ARRA must comply with all requirements specified in Division A of the ARRA (Public Law 111-5), including reporting requirements outline in Section 1512 of the Act. For purposes of reporting, ARRA recipients must also report on ARRA sub-recipient (sub-grantee and sub-contractor) activities. Reports required by ARRA will be required quarterly.

Also, in accordance with the provisions of OMB Circular No. A-133 (Revised, June 27, 2003), "Audits of States, Local Governments and Non-Profit Organizations," non-federal entities that expend financial assistance of $500,000 or more in Federal awards will have a single or a program-specific audit conducted for that year.

What outcome and/or performance measures will you track and/or report on in association with this award?

The outcome of this Cooperative Agreement is a sustainable statewide HIE.

What is the name and title of the individual in your agency who is responsible for the success of this program?

John Supra, Chief Information Officer, Deputy Director of Eligibility
<table>
<thead>
<tr>
<th>Summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Title</td>
<td>Alternatives to Psychiatric Residential Treatment Facilities for Children</td>
</tr>
<tr>
<td>CFDA Number/Title</td>
<td>(XX.XXX) Other CFDA</td>
</tr>
<tr>
<td>Award Number (Federal)</td>
<td>1S0CMS300131-01-03</td>
</tr>
<tr>
<td>Start Date</td>
<td>12/20/06</td>
</tr>
<tr>
<td>Federal Agency</td>
<td>Department of Health and Human Services (75)</td>
</tr>
<tr>
<td>Award Number (State)</td>
<td></td>
</tr>
<tr>
<td>End Date</td>
<td>09/30/14</td>
</tr>
<tr>
<td>Federal Subagency</td>
<td></td>
</tr>
<tr>
<td>Award Period</td>
<td>Periodic Renewal</td>
</tr>
<tr>
<td>If &quot;Other&quot;, explain:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Financial</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total Award Amount</td>
<td>$ 11,506,436.00</td>
</tr>
<tr>
<td>Amount Available in FY 2012-13</td>
<td>$ 3,176,491.00</td>
</tr>
<tr>
<td>State Match Required?</td>
<td>Yes</td>
</tr>
<tr>
<td>If &quot;Yes&quot;, describe, and provide SAP Fund Number(s) of funding sources</td>
<td>10010000 General Fund</td>
</tr>
<tr>
<td>Local Match Required?</td>
<td>No</td>
</tr>
<tr>
<td>If &quot;Yes&quot;, describe</td>
<td></td>
</tr>
<tr>
<td>Assistance Type</td>
<td>Project Grant</td>
</tr>
<tr>
<td>If &quot;Other&quot;, explain</td>
<td></td>
</tr>
<tr>
<td>Is administrative and/or indirect cost recovery permitted?</td>
<td>No administrative and/or indirect cost recovery if permitted.</td>
</tr>
<tr>
<td>Will funds be passed-through to other entities?</td>
<td>No funds will be passed through to other entities.</td>
</tr>
<tr>
<td>If so, what types of entities, and how will funds be distributed?</td>
<td></td>
</tr>
</tbody>
</table>
### FY 2012-13 Agency Budget Request

<table>
<thead>
<tr>
<th>Agency Code: J02</th>
<th>Agency Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC Department of Health and Human Services</td>
<td>150CMS300131-01-03</td>
</tr>
</tbody>
</table>

### Federal Aid Justification

#### Questions

**How is the use of these funds essential to your agency's mission?**

The funds are essential to our mission to maintain the operations of Community Alternatives to Psychiatric Residential Treatment Facility (PRTF) Demonstration/Waiver. Waiver services are designed to prevent institutional placements of emotionally disturbed children in SC, the quality of treatment services, the avoidance of more costly and restrictive treatment options, adherence to a community-based philosophy, and most normative and least restrictive services delivery. The occurrence and severity of disabilities will be reduced where possible. Clients will function at an optimal level in the least restrictive level of care. Functioning will improve at school, at home and in the community. Another measure is the extent to which coordination of care exists between public and private providers.

**What budgetary, compliance, and programmatic obligations will the state incur (now or in the future) through the receipt of these funds?**

In accordance with the provisions of OMB Circular No. A-133 (Revised, June 27, 2003), "Audits of States, Local Governments and Non-Profit Organizations," non-federal entities that expend financial assistance of $500,000 or more in Federal awards will have a single or a program-specific audit conducted for that year. The State program design under this demonstration shall comply with existing Medicaid statutory and regulatory requirements governing the administration and operation of a section 1915 (c) waiver program, especially the six statutory assurances relating to 1) health welfare; 2) financial accountability; 3) evaluation of need; 4) alternative; 5) average per capita expenditure; and 6) actual total expenditure.

**What outcome and/or performance measures will you track and/or report on in association with this award?**


**What is the name and title of the individual in your agency who is responsible for the success of this program?**

Erin Donovan, Project Director
<table>
<thead>
<tr>
<th>Summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Title</td>
<td>South Carolina Money Follows The Person Demonstration Grant (Home Again)</td>
</tr>
<tr>
<td>CFDA Number/Title</td>
<td>(XX.XXX) Other CFDA</td>
</tr>
<tr>
<td>Award Number (Federal)</td>
<td>1LICMS300152-01-03</td>
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<tr>
<td>Start Date</td>
<td>01/01/07</td>
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<td>Federal Agency</td>
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<td>Award Number (State)</td>
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<td>End Date</td>
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<td>Federal Subagency</td>
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<td>Award Period</td>
<td>Periodic Renewal</td>
</tr>
<tr>
<td>if &quot;Other&quot;, explain:</td>
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</tbody>
</table>

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<td>Amount Available in FY 2012-13</td>
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<td>State Match Required?</td>
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<tr>
<td>If &quot;Yes&quot;, describe, and provide SAP Fund Number(s) of funding sources</td>
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<tr>
<td>Is administrative and/or indirect cost recovery permitted? If so, explain:</td>
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<tr>
<td>Will funds be passed-through to other entities? If so, what types of entities, and how will funds be distributed?</td>
<td>No funds will be passed through to other entities.</td>
</tr>
</tbody>
</table>
Questions

How is the use of these funds essential to your agency's mission?

Agency Mission: The mission of the South Carolina Department of Health and Human Services is to purchase the most health for those in need at the least cost to taxpayers.

Currently, forty-three States have implemented Money Follows the Person (MFP) Demonstration Programs. After a pre-implementation period, States began actively transitioning individuals into community settings in the spring of 2008. Since the beginning of calendar year 2009, the number of participants transitioning has increased as solutions to barriers were identified and significant technical assistance is continuing to be provided to help States meet transition benchmarks they set.

South Carolina benchmarked 426 individuals through FY 2012-2016 and services are funded at an enhanced 85% Federal match for the first 365 days the individual receives services in their home and community. This provides an opportunity for South Carolina to utilize the state savings created by the enhanced Federal match to build capacity in local communities and will benefit South Carolina through the addition of approximately $23 million additional Federal dollars over the life of the grant. Throughout the additional Federal dollars, South Carolina Department of Health and Human Services will be able to serve those in need at the least cost to taxpayers because the MFP Demonstration grant contributes to reduce spending on institutional services, which are approximately four times more expensive than home and community based services.

What budgetary, compliance, and programmatic obligations will the state incur (now or in the future) through the receipt of these funds?

This program has MOE requirements, see funding agency for further details. Total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for fiscal year 2005 or any succeeding fiscal year before the first of the year of the MFP demonstration project. At the end of each demonstration grant year, the State will be required to produce documentation that SCDHHS has not exceeded the determined budget ceiling and meet all CMS financial requirements. The format of this financial report will be determined during the IP phase of the Demonstration Semi-Annual Progress Reports: Web-based reports in a pre-determined format will be required to be submitted semi-annually. The submission of the finalized IP will be due no later than 9 months after receipt of the Notice of Financial Assistance Award. The IP will be considered the First report due under this demonstration. No performance monitoring is required.

To promote effective outcomes from the demonstration, the statute provides waiver authority for four provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of the demonstration. These provisions are: (1) Statewideness (Section 1902(a)(1) of the Social Security Act) - in order to permit implementation of a State initiative in a selected area or areas of the State. (2) Comparability (Section 1902(a)(10)(B) - in order to permit a State initiative to assist a selected category or categories of individuals enrolled in the demonstration. (3) Income and Resource Eligibility (Section 1902(a)(10)(C)(i)(III) - in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care. (4) Provider agreement (Section 1902(a)(27)) - in order to permit a State to implement self-direction services in a cost-effective manner for purposes of this demonstration program.

What outcome and/or performance measures will you track and/or report on in association with this award?

The MFP grant will track and/or report on the number of people who transitioned out based on each year’s benchmarks. The benchmarks will be used to measure the program’s level of success.

What is the name and title of the individual in your agency who is responsible for the success of this program?

Adam Hiers, Program Coordinator II
Selim Son, Program Coordinator II