SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Update on Healthy Connections Medicaid

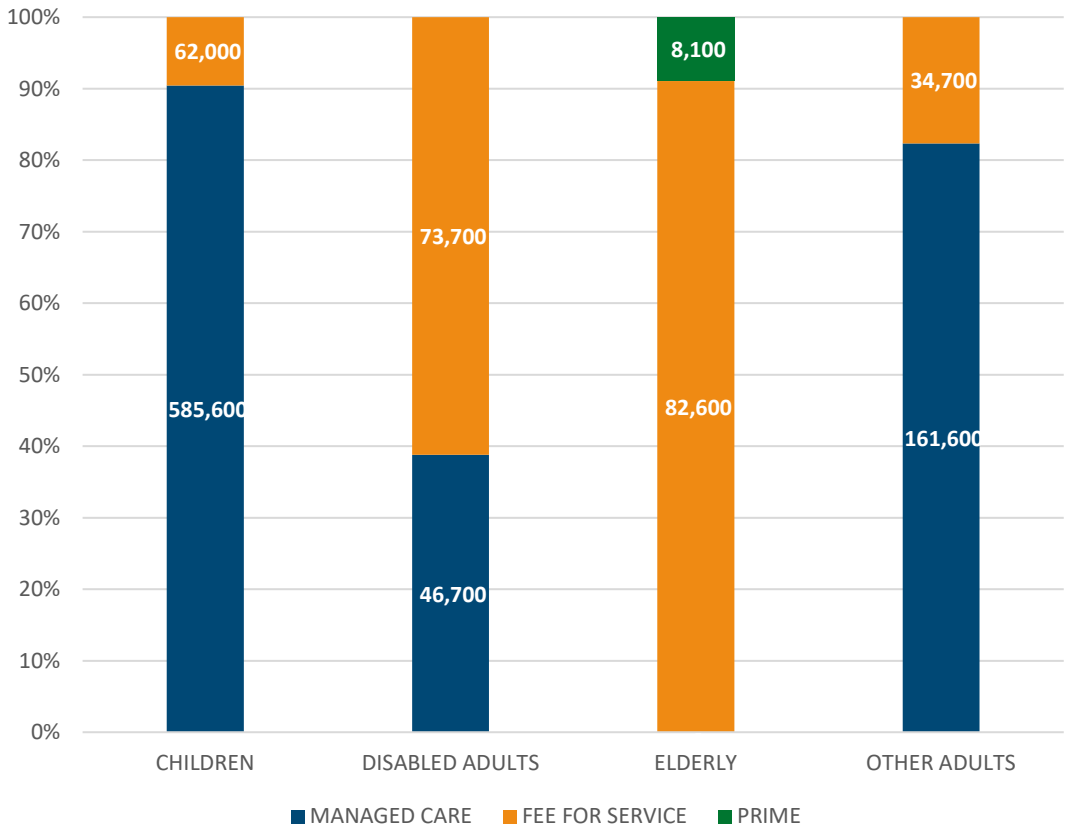
SCAAP Annual Meeting

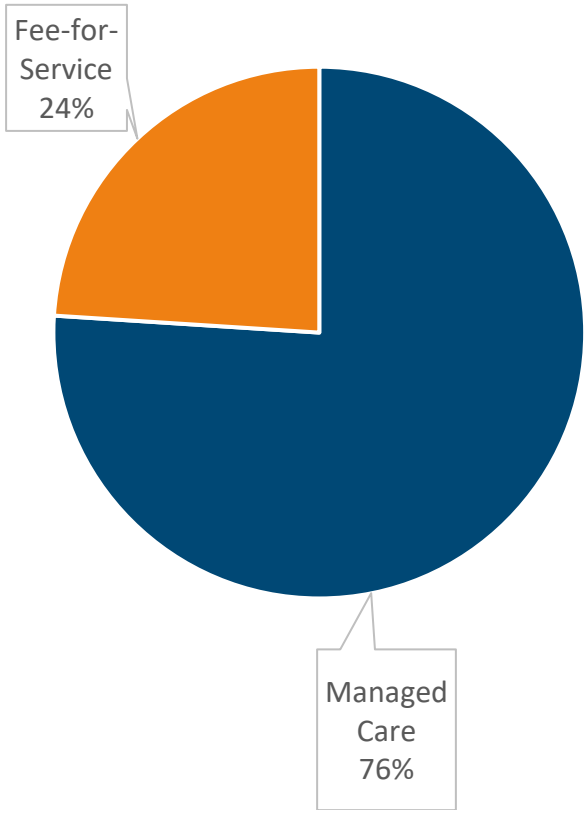
Eunice Medina
Director, SCDHHS

August 2025

Full-benefit Membership by Population

(as of May 31, 2025)





Total Full-benefit Enrollment: Approx. 1.06 million

Physician Workforce

SCDHHS partnered with Health Management Associates, Inc. to conduct a comprehensive, **ten-year workforce assessment** examining the supply, demand, and geographic distribution of physicians across South Carolina. The analysis covered 27 medical specialties and found that not all are expected to experience a shortage. The table below highlights the five specialties projected to face the **most significant physician shortages** over the next decade.

Rank	Provider Specialty
1	OB/GYN
2	Family Medicine
3	Pediatrics
4	Radiology
5	Ophthalmology

Physician Workforce - GME

Guided by research and recommendations from Milliman and HMA, SCDHHS will transition to a **pay-per-resident model** that incentivizes residency programs in specialties identified as high-need areas within the state.

After Oct. 1, 2025

- Shift to standard per-resident model, based on Medicare-reported Full-Time Equivalent (FTE)
- Removes GME from outpatient/inpatient add-ons
- Quarterly payments of at least **$80,000/year per resident + incentives**

Benefits

Transparent: Clear allocation methodology
Education-Centered: Prioritizes quality, not volume
Inclusive: Supports large, small, rural, and urban hospitals
Simplified: Reduces administrative complexity

Physician Workforce - GME

Incentives aligned with most pressing needs from **workforce studies**

Eligibility based on **new position** creation not yet reflected in Medicare cost report.

Specialty	Incentive/FTE
OB/GYN	$150,000
Family Medicine	$125,000
Pediatrics	$125,000
Psychiatry	$100,000
Internal Medicine	$90,000

Key Guardrails

Incentives apply only to the **first two years** of training

No double funding for same FTE

Attrition must be reported – funding adjusted accordingly

Year 3 transition to Medicare-based reporting expected

Program Updates – TMaH

South Carolina is **one of fifteen states** awarded a **ten-year Cooperative Agreement** through CMS to implement the Transforming Maternal Health (TMaH) Model.

CMS will award up to $17 million

TMaH Model

- A Medicaid and CHIP innovation model developed by CMS to **improve maternal health outcomes**.
- Focuses on **whole-person care** before, during, and after pregnancy.
- Emphasizes **access and quality** through enhanced care delivery and payment reforms.

		
Access to Care, infrastructure, and workforce capacity: Enhance access to culturally sensitive, person-centered maternal care by expanding the perinatal workforce and removing barriers to services.	**Quality improvement and safety**: Promote the consistent use of evidence-based safety protocols to improve maternal and infant health outcomes and support hospitals in achieving the federal "Birthing-Friendly" designation.	**Whole-person care delivery**: Ensure individualized, comprehensive maternal care by developing personalized care plans that address each mother's physical, mental, and social health needs.

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Program Updates – IBH

South Carolina is **one of four states** awarded an **eight-year grant** through CMS to implement the Innovation in Behavioral Health (IBH) model.

Awarded $7.2 million

IBH Model

- A **value-based care model** from CMS focused on improving **behavioral health integration** in Medicaid and CHIP.
- Targets **mental health and substance use disorders (SUDs),** particularly for adults with **moderate to severe** needs.
- Aims to **coordinate physical and behavioral health services** through community-based care teams.

	**Improves Behavioral Health Access:** Expands care options in underserved and rural areas through community care hubs.
	**Promotes Cost Savings:** Reduces ER use and inpatient admissions by focusing on prevention and coordination.
	**Supports Whole-Person Care:** Integrates mental health, SUD, and physical health services in a seamless system.
	**Reduces Disparities:** Designed to address gaps in behavioral health services for vulnerable populations.
	**Strengthens Local Infrastructure:** Invests in workforce development and provider partnerships across systems.

Program Highlights

Intensive Case Management *(1/1/2025)*

- Effective Jan. 1, MCOs must enroll eligible individuals in intensive case management programs that incorporate a combination of in-person and virtual interactions

Interaction Between Medicaid HCBS Waiver Programs and the Hospice Benefit *(1/1/2025)*

- Update to the hospice and HCBS waiver policies to remove limitations on simultaneously receiving both HCBS and hospice services. This change only applies to HCBS waiver participants who are enrolled in the Community Choices, HIV/AIDS and Mechanical Ventilator Dependent waiver programs.

Program Highlights *cont.*

Autism Spectrum Disorder *(9/1/2025)*

- Updates will allow additional diagnostic tools to support an ASD diagnosis, allow primary care physicians to diagnose ASD in the medical care home, streamline eligibility evaluations completed by SC OIDD and SC DOE, and ensure children at high-risk for ASD can access ABA therapy while waiting for an evaluation

OTP Rate Increase *(10/1/2025)*

- Increase in the weekly rate of two of the most highly utilized OTP procedure codes, medication assisted treatment with Methadone and Buprenorphine.

Program Highlights – HCBS

Palmetto Coordinated System of Care Waiver Sunset *(7/31/2025)*

- Based on an assessment of the waiver, **SCDHHS will sunset the PCSC 1915(c) and concurrent 1915(b)(4) no later than its expiration date of Jul. 31, 2025.**
- MCO Members will transition to intensive case management, and Fee-For-Service members will receive targeted case management from the Continuum of Care

Medically Complex Children's Waiver *(7/1/2025)*

- Children's attendant care (self-directed) has been added to the Medically Complex Children (MCC) waiver effective **Jul. 1, 2025**.

Intellectual Disability and Related Disabilities Waiver *(7/1/2025)*

- Caregiver coaching has been added to the Intellectual Disability and Related Disabilities waiver effective **Jul. 1, 2025.**

Children's Personal Care *(state plan service)*

- On Jul. 1, 2025, SCDHHS issued a separate scope of service for children's personal care with updated definitions, including service locations, supervision requirements, and transportation to Medicaid-covered services. Based on provider feedback, revisions are being considered to allow services outside the home (approval must be obtained), with further stakeholder input planned over the next six months.

Program Updates – Procurements

Non-emergency Medical Transportation	Awarded
Dental Services Prepaid Ambulatory Health Plan (PAHP)	RFP in progress
Clinical Data Exchange	RFP in progress
Pharmacy Benefit Administrator	RFP in progress

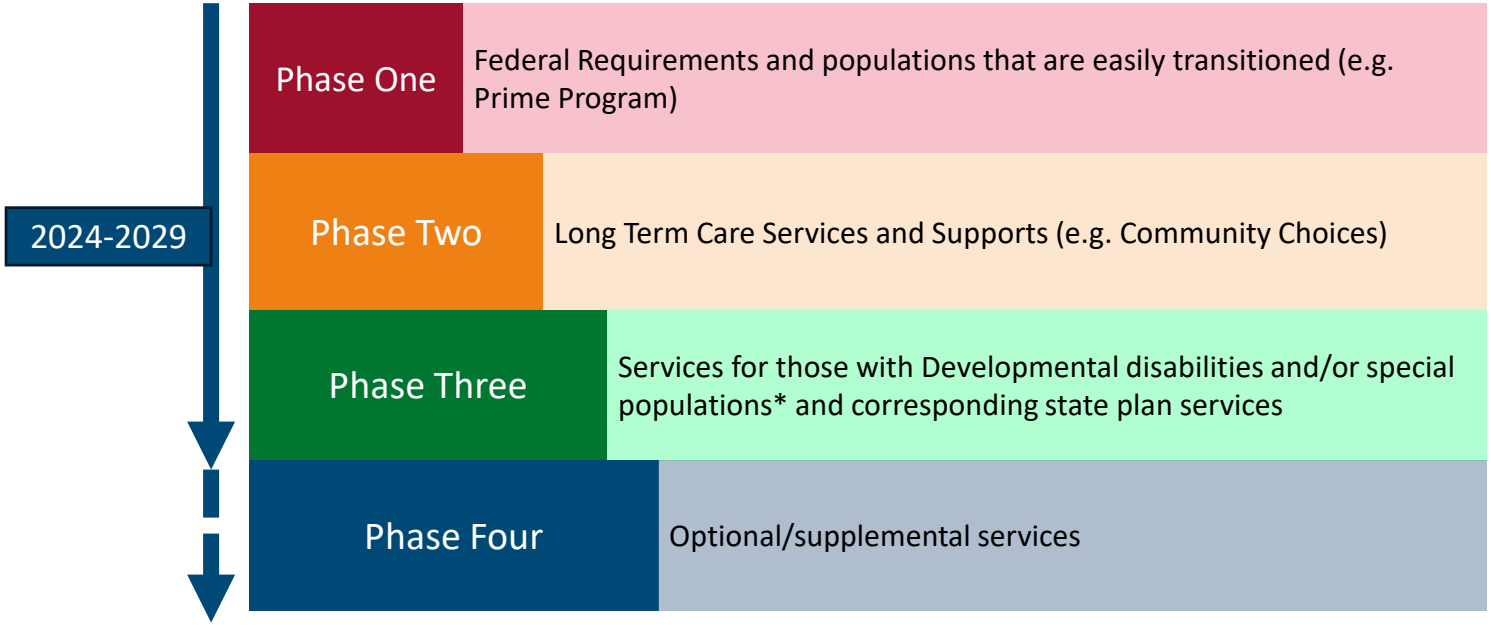
Managed Care Update – MCO Certification

- In late 2024, South Carolina received approval from (CMS) to limit the number of Managed Care Organizations (MCOs) operating in the state to **no fewer than two and no more than four**.
- This decision was made to **enhance the quality of care** for Medicaid members by ensuring that only the **highest-performing MCOs** continue to serve the population.
- Currently, five MCOs operate in South Carolina, prompting the need for a rigorous evaluation and selection process to align with our new limits.
- In response, we have developed a comprehensive **MCO Certification process** designed to assess each organization's ability to deliver high-quality, value-driven care.
- The certification plan was announced to the MCOs in February 2025, and the state has since been providing ongoing support and detailed materials to help them understand and prepare for the certification process.
- The formal MCO Certification process will launch on **July 1, 2025**, and is expected to **conclude in 2027**, allowing sufficient time for evaluation, transition, and implementation.

Managed Care Update – MCO Carve-in

Agency Strategic Plan

"Optimize best practice in Medicaid managed care
by completing a transition to near **100% managed care by SFY 2029"**



**Potential for one plan obtained via the procurement process through a request for proposals*

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Pharmacy Updates & Cellular and Gene Therapy

SCAAP Annual Meeting

Dr. Kevin Wessinger
Chief Medical Officer, SCDHHS

August 2025

Program Updates – Pharmacy

SCDHHS Initiative	Tentative Effective Date	Status
Prohibit spread pricing and create uniform contract definitions.	7/1/25	✓
Require annual reporting on any fees (e.g., transaction fees, etc.) charged by PBMs to contract network pharmacies to monitor trends.	7/1/25	
For independents*: Require MCOs/PBMs to pay in accordance with current FFS reimbursement methodology. This would include a $10.50 dispensing fee.	1/1/26	In progress
Contract with external vendor to monitor MCO compliance for adjudication and payment.	1/1/26	In progress
Prohibit MCOs from requiring the use of mail order prescriptions and accommodate member choice.	7/1/25	

*Additional types of pharmacy providers are under consideration

Program Updates – Pharmacy *cont.*

SCDHHS Initiative	Tentative Effective Date	Status
340B Program Review: Established in 1992, the federal 340B program provides reduced price outpatient prescription drugs to eligible providers. This low price is in lieu of the otherwise required federal rebate.	**Phase 1: MCO Contract Efficiency- 10/1/25**	**In Progress**
Pharmacy Network Requirements: Develop time and distance requirements to ensure access in rural areas.	**7/1/25**	
Streamlining Processes: Continuous review through biannual audits focusing on enhancing member experience.	**Next Audit in 2026**	**First Audit Complete**
Cost of Dispensing Survey: Conduct a survey of pharmacies to determine the actual cost of dispensing drugs.	**Begin one year post payment changes**	**In progress**

*Additional types of pharmacy providers are under consideration

CMS CGT Model

- Gene therapy is an exciting and rapidly developing field in the pharmaceutical field, but creates challenges for the entire medical community, especially regarding the potential for extremely high costs for these therapies, which may limit access to care for possible recipients.
- State Medicaid agencies are at increased risk for exponential costs, due to federal requirements that Medicaid must provide a pathway to coverage for all drugs that are FDA approved whose manufacturer participates in the Medicaid Drug Rebate Program (MDRP).
- In response to this issue, CMS has developed a Cellular and Gene Therapy Model (CGT model) to assist states in providing access to these life changing and potentially life saving therapies..

CMS CGT Model *cont.*

- The CGT model allows for states to participate in Value Based Purchasing with CMS negotiated terms for Supplemental Rebate Agreements (SRA) and Outcome Based Agreements (OBA), which will help costs.
- Model participation is optional for states.
- SC was one of the earliest states to participate, effective 6/1/2025.
- An SRA allows for the state to directly receive a supplemental rebate from the manufacturer. This rebate is in addition to the required federal rebate. This rebate can be negotiated by the state, or the state can choose the CMS negotiated supplemental rebate. SC had already submitted the required state plan amendment (SPA) in 2024 to negotiate a SRA.
- An OBA allows for the state to receive a partial refund if the gene therapy fails. The required SPA also allows for the state to participate in the OBA which has been negotiated by CMS.

CGT Model/Sickle Cell Gene Therapy

- The first gene therapy included in this model for 2025 is for sickle cell disease. The current expectation is that other gene therapies will be added to the model beginning in 2026.
- For sickle cell gene therapy, the CGT model requires coverage for transportation and related expenses, as well as requiring for the manufacturer to pay for fertility preservation for fifteen years, if so desired by the recipient. The CGT Model also ensures uniform payment to authorized treatment centers to help assure access.
- SC Healthy Connections Medicaid already covers the two gene therapy products currently FDA approved for sickle cell disease, and several members are already well into their "treatment journey" at MUSC. One member has been infused and completed the process

Sickle Cell Gene Therapy

- Both sickle cell gene therapy products are approved for 12 years of age and up. Both manufacturers are participating in the CMS CGT.
- The primary indication for both products is recurrent vaso-occlusive crises. This treatment involves a 7-9 month “treatment journey” that includes multiple hospitalizations including bone marrow ablation.
- In addition to an estimated expense of several hundred thousand dollars for these hospitalizations and other related services, CMS requires for Medicaid to “carve out” payment for the gene therapy to pay the hospital for the drugs, which cost up to 3.1 million dollars.

Sickle Cell Gene Therapy in SC

- SC has the fourth highest prevalence of sickle cell disease of any state in the US.
- MUSC is currently the only authorized treatment center in SC for sickle cell gene therapy.
- MUSC estimates a maximum capacity of 6-10 treatments can be done per year for the next several years. It is estimated that somewhere around 400 of the members with sickle cell gene disease that are currently enrolled in SC Medicaid might qualify for this treatment. The potential fiscal impact for the state to cover this and other forms of gene therapy is quite significant.

Sickle Cell Gene Therapy

- Lovotibeglogene autotemcel: “lovo-cel”
- Modifies patients own hematopoietic stem cells, using a lentiviral vector to transfer a healthy beta-globin gene responsible for producing normal hemoglobin A.
- 97% of study participants achieved the primary outcome of being free of severe VOEs between 6 -18 months post-infusion. The median annual number of severe VOEs decreased from 3 at baseline to 0 at follow-up. Moreover, lovo-cel was found to reduce the average number of annualized hospital days and hospital admissions at 24 months
- Does have an FDA required “black box warning” re possible increased risk of hematologic malignancy after infusion.
- Currently, the only two SC Healthy Connections Medicaid members to complete the treatment journey at MUSC (outside of clinical trials) received this version.

Sickle Cell Gene Therapy *cont.*

- Exagamglogene-autotemcel: “exa-cel”
- Uses CRISPR gene editing technology of the patients own hematopoietic stem cells to reactivate the BC11A gene that produces fetal hemoglobin.
- CLIMB SCD-121 study: treatment with exa-cel eliminated vaso-occlusive crises in 97% of patients with sickle cell disease for a period of 12 months or more. The mean duration of freedom from vaso-occlusive crises was 22.4 months and 28 of 29 patients have remained free from vaso-occlusive crises as of the data-cutoff date. The mean percentage of fetal hemoglobin was 36.9±9.0% at month 3, increased to 43.9±8.6% at month 6, and was at least 40% during follow-up.
- Does not have a “black box warning” per the FDA.

Sickle Cell Disease/AAP

- The AAP does not yet have a policy specifically regarding sickle cell gene therapy, but instead emphasizes comprehensive care for sickle cell disease, and acknowledges gene therapy may play a role.
- Ideally, all newborns with sickle cell disease should be referred to a pediatric sickle cell center or hematologist by 3 months of age.
- All infants and children with sickle cell anemia (HbSS) and Sβ0-thalassemia should receive prophylaxis with penicillin V potassium until they are 5 years old and have completed the pneumococcal vaccine series.
- Transcranial doppler ultrasonography screening is recommended annually from ages 2-16 years in children with HbSS and Sβ0-thalassemia due to risk of developing a stroke. Most clinics also obtain a one-time non-sedated brain MRI in school-age children to screen for silent infarcts.

Sickle Cell Disease/AAP *cont.*

- School performance should be monitored, and educational accommodations such as an individualized education program/504 plan should be provided if needed.
- Ophthalmology evaluations should be performed annually starting at age 10 years to screen for retinopathy.
- Treatment with hydroxyurea should be offered to all children with HbSS and Sβ0-thalassemia at age 9 months, even those without clinical symptoms.
- Genetic transmission of sickle cell disease should be discussed with parents of newly diagnosed infants as well as teenagers with sickle cell disease.
- Progesterone-only contraceptives are recommended for teenagers with sickle cell disease due to concerns for increased risk for thrombosis. Pregnancy is comanaged by a hematologist and high-risk obstetrician.


SOUTH CAROLINA
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