SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Healthy Connections Medicaid Update For SCAAP CATCH MEETING

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Disclosures

- The presenter has no relevant financial relationships to disclose.

Learning Objectives

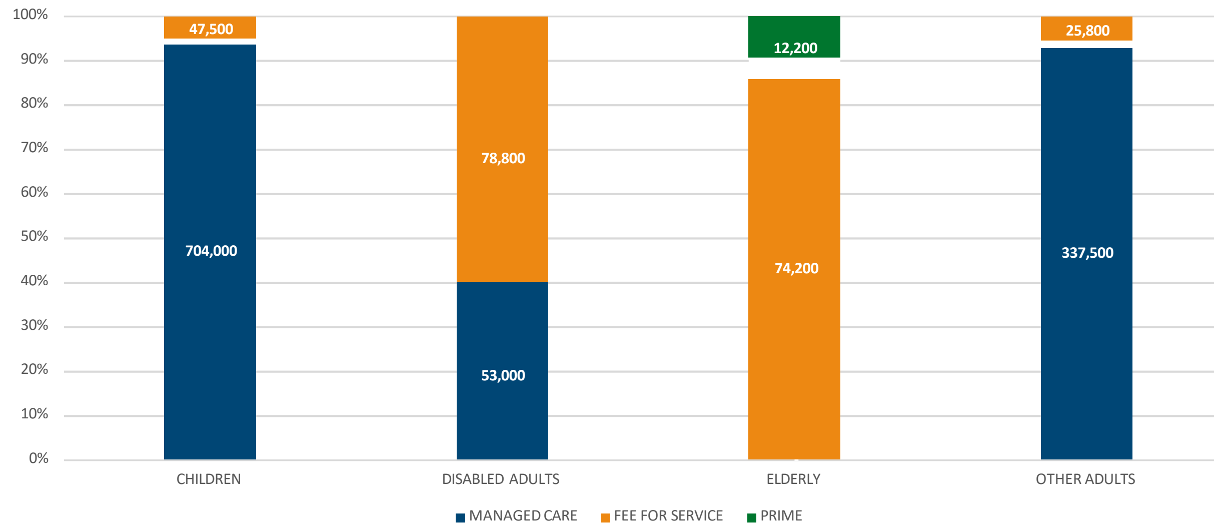
At the conclusion of this presentation, learners will be able to:

- Be aware of changes in enrollment and the recertification procedures for SC DHHS as part of unwinding from the PHE.
- Be aware of new programs and policies instituted by SC DHHS in 2024, especially in how they impact care for children in SC

Healthy Connections Medicaid Enrollments and Redeterminations Update

Full-benefit membership by Population

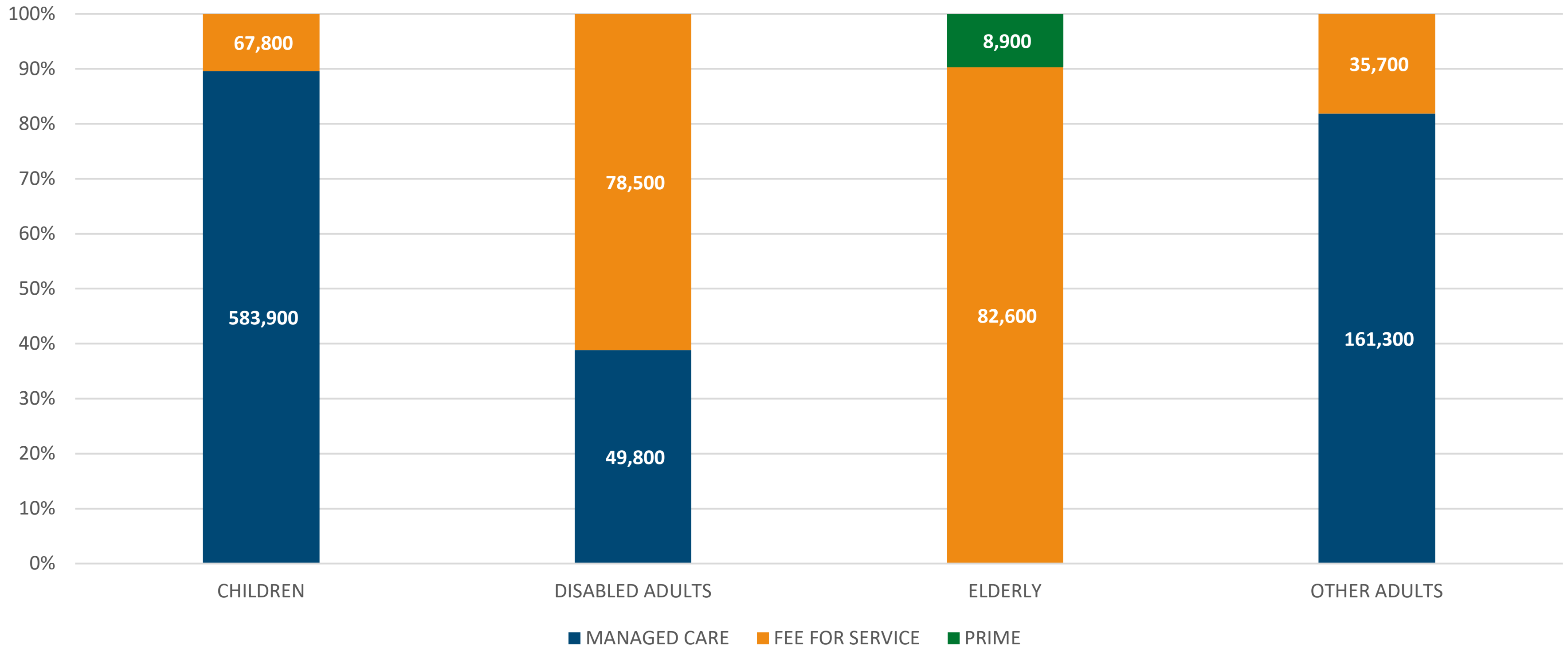
(as of March 31st, 2023)



Total Enrollment: ~1,333,000: 751,500 children

Full-benefit membership by Population

(as of November 30th, 2024)



Approximate Total Enrollment: 1.08 million   Approximate Children Enrolled: 652,000

Full-benefit Enrollment Point-in-time Data Trends

- Pre PHE (Feb 2020) there were 1.06 million full benefit members enrolled in Healthy Connections Medicaid.
- At peak enrollment due to the Families First Coronavirus Response Act there were 1.34 million full benefit members enrolled in May 2023, as no disenrollments were allowed.
- As of November 2024, total full member enrollment was ~ 1.08 million, thus enrollment has decreased by ~245,000 members, but is increased slightly (~20,000 members) from the pre-PHE enrollment number.
- In Feb 2020 there were 650,713 children enrolled vs 652,000 in October 2024. Therefore, there are currently ~1300 more children enrolled now than pre-PHE, but there are ~99,500 fewer than were enrolled prior to unwinding. However, any member under 19 years of age that was enrolled prior to the PHE was still classified as a child in May of 2023, therefore the 2023 numbers included 20–22-year-olds that were no longer eligible for Medicaid in SC d/t their age.

Policy Updates

Behavioral Health Coverage Updates

- Crisis Stabilization Units
- ASD Services Update
- Collaborative Care Model (CoCM)
- School Based Counseling
- Intensive Outpatient Hospitalization and Partial Hospitalization Programs (IOP/PHP)

Hospital-based Crisis Stabilization

- Managing behavioral health crises in hospital emergency departments (EDs) is a serious issue across our state.

- Placing these patients in the chaotic environment of the ED often exacerbates psychiatric and/or substance use issues and long waits for inpatient bedspaces result in extended ED stays, thus increasing instability in the patient and placing additional burdens on ED staff.

- In 2023, SCDHHS offered and awarded 13 South Carolina hospitals across the state a total of $45.5 million to build specialized hospital-based ED units dedicated to behavioral health crises. Three units are already open (AnMed, Trident, Lexington Medical Center) All 13 are scheduled to open by 2026

ASD Services

The following ASD services were added effective 7/1/24:

- 97152 Behavior Identification Supporting Assessment, by technician
- 97157 Multi-family Group Adaptive Behavior Treatment Guidance
- 0362T Behavior Identification Supporting Assessment
  - Qualified provider with two or more technicians
- 0373T Adaptive Behavior Treatment
  - Qualified provider with two or more technicians

- SCDHHS welcomed Developmental Pediatrician Shawna McCafferty MD, FAAP to help develop and refine autism services in July 2024.

Collaborative Care Model (CoCM)

- Coverage for the CoCM was added effective 10/1/24
- The CoCM is a patient-centered, evidence-based approach to integrate physical and behavioral health services in primary care settings.
- The CoCM leverages a team-based, interdisciplinary and systematic approach to screen, diagnose, treat and provide behavioral health care.
- Primary care provider (PCP)-led teams of qualified professionals are eligible to receive reimbursement for CoCM services.
    - These teams must include a PCP, a behavioral health care manager, and a psychiatric consultant.
  - The CoCM includes:
    - Care coordination and management between your PCP and your behavioral health provider;
    - Regular, systematic monitoring and treatment using a validated clinical rating scale; and
    - Regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement.

School-based Behavioral Health Services

- Effective date for SCDHHS' initiative was July 1, 2022

- Goal was a counselor in every school
  - Partnership with USC's Department of Psychology created the SC School Behavioral Health Academy
  - Identified three pathways for school district flexibility in increasing available provider options with Medicaid reimbursement—direct hire, contract with DMH, contract with private providers
  - Created a specialized rate structure to incentivize school-based services

School Mental Health Services Data

- The number of school-based mental health counselors rose from approximately 600 in the 2021-2022 school year to 1,209 at the start of the 2023-2024 school year. The number of school-based mental health counselors rose from approximately 600 in the 2021-2022 school year to 1209 at the start of th e2023-2024 school year, and was up to 1,343 at the start of the 2024-2025 school year.

- As of September 2024, the mental health counselor-to-student ratio is approximately 1:593.
  - 2022 data showed a ratio of 1:1,300.
  - January 2023 data showed a ratio of 1:829.
  - September 2023 data showed a ratio of 1:653.

- The number of school-based mental health counselors by all three employment types (DMH-employed, school district-employed and private mental health counselors) increased.

- The majority of school-based mental health counselors are now employed by local school districts. In January 2022, 60% of school-based counselors were employed by DMH.

- All school districts now have access to mental health counseling services. In January 2022, nine districts did not have any access to school-based mental health counseling services.

PHP/IOP Background

- Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) provide clinical diagnostic and treatment services at a level of intensity similar to an inpatient or residential program, but on a less than 24-hour basis.
- These services include therapeutic milieu, nursing, psychiatric evaluation, medication management, and group, individual, and family therapy.
- PHP and IOP may be appropriate when a patient does not require a restrictive 24-hour inpatient setting but does need a higher intensity of treatment services than standard outpatient treatment can provide.

PHP/IOP Background

- PHP and IOP provide a time-limited service to stabilize acute symptoms and can be used as either a step-down from inpatient care, or a "step up" from standard outpatient treatment, operating as a stand-alone level of care.
- As SCDHHS continues to complete the array of treatment services necessary for a robust and sustainable continuum of behavioral health services in South Carolina, PHP and IOP accomplish two primary goals:
  - Effecting transition from more intensive levels of care to that of outpatient settings to create a comprehensive community reintegration process, and
  - Providing diversion from hospital/residential level of care when clinically appropriate.

Medically Complex Waiver Update

- SCDHHS intends to file a waiver amendment with CMS for the MCC SC.0675 1915(c) waiver. Effective date: On or after October 1, 2024.
- The purpose of the amendment is to add self- directed attendant care as a service to the waiver. Attendant care for children enrolled in the MCC waiver is defined as extensive hands-on assistance for at least two of the seven key activities of daily living (ADL) (i.e., bathing, dressing, eating, toileting, hygiene, mobility and transferring).
- MCC attendant care is intended to provide **extraordinary** direct care services to children aged birth through 20 who need hands-on assistance with ADLs that cannot be completed in an age-appropriate manner.
  - **Extraordinary** care exceeds the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.
- Attendants must meet all South Carolina Medicaid provider qualifications and demonstrate competency in caring for the participant. The service must be medically necessary and is furnished in the participant's home

Rate and Policy Updates for COVID-19 Testing, Vaccine Administration and Treatment Services

- SCDHHS announced rate and policy updates for dates of services on or after Oct. 1, 2024, in Medicaid bulletin #24-051
- During the federal COVID-19 PHE, SCDHHS created temporary reimbursement methodologies and coverage policies for COVID-19 testing, vaccine administration and treatment services.
- Changes to what were previously temporary reimbursement
  - During the federal COVID-19 PHE, SCDHHS' reimbursement guidance for COVID-19 testing and vaccine administration followed the Medicare fee schedule under the American Rescue Plan Act authority. SCDHHS updated the reimbursement rates for these services to align with the South Carolina State Plan reimbursement methodology.
  - Updated rates are reflected on the following fee schedules: physicians, independent lab and radiology and outpatient hospital

Rate and Policy Updates for COVID-19 Testing, Vaccine Administration and Treatment Services

- Coverage of services under the State Plan benefit
  - COVID-19 testing performed by qualified providers will become a covered State Plan service for full-benefit Healthy Connections Medicaid members.
  - COVID-19 vaccines and vaccine administration will become a covered State Plan service for full-benefit Healthy Connections Medicaid members, in accordance with the U.S. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices recommendations and guidance issued via Medicaid bulletin MB# 23-044.
  - COVID-19 testing will continue to be paid as "bill-above" when performed by RHC providers.
  - COVID-19 vaccine administration will continue to be paid as a "bill-above" service when delivered by a FQHC or RHC provider.

Nutritional Counseling Expansion

- **Updated Service Limits were effective 1/1/24**
- A total of 12 hours of combined initial, re-assessment and group medical nutrition therapy may be reimbursed per state fiscal year, per Medicaid member. State fiscal years begin on July 1 and end on June 30 of the following calendar year.
- **Telehealth**
- Nutritional counseling services may be provided in person or via telehealth.
- Telehealth encounters must be billed with a GT modifier and count toward the 12 hours of combined medical nutrition therapy services provided to a Medicaid member per state fiscal year. Services delivered in-person or via telehealth by the same provider type will be reimbursed at the same rate.

Single (Universal) PDL

- SCDHHS implemented a single PDL for all beneficiaries effective July 1st, 2024, regardless of which MCO or FFS Medicaid is the payer.
- This change was intended to minimize disruption and promote continuity in medications for beneficiaries when they change plans.
- This change was also intended to minimize medical provider and pharmacy administrative burden, especially as the intent is to also have universal and transparent prior authorization criteria.
- Creates uniformity in cost of ingredients and dispensing fees
- Leverages federal drug rebates to improve stewardship of state funds

Single Preferred Drug List FAQs

- ***What is the single PDL?*** A PDL is a list of outpatient drugs covered under the pharmacy benefit that health care payors use to encourage providers to prescribe certain drugs over others. The single, state-directed pharmacy benefit PDL is a list of ***outpatient pharmacy*** preferred products for both the South Carolina Department of Health and Human Services' (SCDHHS) fee-for-service (FFS) Medicaid program (Medicaid) and its five Medicaid managed care organizations (MCOs). ***The single PDL is not a comprehensive list of all medications covered by Medicaid.***

- ***How does this affect continuity of care*** if a member has a prior authorization (PA) for a prescription? ***Medicaid members who are enrolled in an MCO and have a prescription dated on or before June 30, 2024, can continue to access their prescribed drugs for up to six months or through Dec. 31, 2024, regardless of whether it is included on the single PDL. The transition to a single PDL will not affect PA for drugs for those enrolled in the FFS Medicaid program.***

Single Preferred Drug List FAQs

- ***How are drugs chosen for the PDL?*** The SCDHHS Pharmacy and Therapeutics (P&T) Committee reviews, discusses and votes on changes to the PDL recommended by SCDHHS. Information about the quarterly P&T Committee meetings is available online here.
- ***How does this change affect drug classes that are not included in the PDL? Drug classes not included in the PDL are classified as non-managed***. Covered outpatient drugs, per United States Code 42 USC 1396r-8, that are not included on the PDL will remain covered for South Carolina Healthy Connections Medicaid members. ***These agents may be subject to clinical criteria requirements as specified by the MCO in which the member is enrolled.*** Clinical criteria requirements for those enrolled in the FFS Medicaid program are not changing at this time. ***Non-managed products cannot be listed as preferred or non-preferred.***

Single Preferred Drug List FAQs

- ***How does the PDL change affect physician-administered drugs under the medical benefit?*** At this time, the PDL only affects outpatient pharmacy products covered under the pharmacy benefit. The medications and devices listed on the PDL are billed and dispensed by pharmacy providers and processed through the pharmacy benefit.

- ***Will the process to obtain a PA change?*** No, the process to obtain a PA will not change***. Each MCO and the FFS Medicaid program will continue to process claims for their members. Prescribing providers should continue to submit PA requests to the member's MCO or through Magellan Rx Management if the member is covered through the FFS Medicaid program's pharmacy benefit.***

- ***Will MCOs use different PA and utilization criteria for non-preferred drugs on the PDL? MCOs will not be directed to follow SCDHHS' FFS pharmacy PA or utilization criteria***. However, MCOs must develop and utilize criteria in compliance with sections 1902,1903 and 1927 of the Social Security Act and 42 CFR § 438.3, prescription drug coverage under Medicaid***. MCOs should demonstrate coverage consistent with the amount, duration and scope as described by Medicaid FFS***. The transition to a single PDL will not affect PA or utilization criteria for pharmacy products for those enrolled in the FFS Medicaid program.

Single Preferred Drug List FAQs

- ***How will new drugs to market be handled?*** The PDL will update on a continuous basis. Drugs that are new-to-market and meet Centers for Medicare & Medicaid Services outpatient drug requirements will be covered as non-preferred until reviewed by SCDHHS and the P&T Committee. Once a determination is made, drug classes may be added to, edited or removed from the PDL.

- ***Can generic equivalents or biosimilars be approved based on continuity of* care when branded products are preferred, on or after July 1, 2024? Generic equivalents and biosimilars will be allowed to be filled during the continuity of care period until Dec. 31, 2024. During this period, prescribers and pharmacies are encouraged to continue the medication with the branded product**.

- ***For Medicaid members who become Medicaid-eligible after July 1, 2024, is a one-time transition fill allowed for medications on which the member has demonstrated they are stable but that are not on the single PDL?*** Yes, up to a 90-day supply of therapy may be dispensed for continuity of care.

SPDL Brand Vs Generic Preferences

- Many state Medicaid plans differ from commercial plans in that certain branded versions of drugs are preferred over generic. Due to manufacturer agreements with CMS or the state, the branded versions may be more cost-effective for the state for certain drugs. SC DHHS maintains a brand vs generic list that can be found at https://southcarolina.fhsc.com/providers/pdl.asp
- The MCO plans historically have not had the same preferences. This will necessitate a transition for certain drugs from generic to branded versions for these drugs by January 1st, 2025. Prescribers are strongly encouraged to make this transition when renewing existing prescriptions and initiating new prescriptions as soon as possible.
- SC DHHS and the MCOs will have processes to allow for drug shortage overrides. Participating pharmacies are aware of this transition and have been encouraged to account for this change in their ordering of medications.
- A major change effective 1/1/25 is that generic ADHD drugs are now preferred over branded versions.

SPDL Brand Vs Generic Preferences

SC Healthy Connections Medicaid

Brand Name Preferred over Generic List UPDATED 01/01/25							
Adcirca®	Butrans®	Elidel®	Flovent HFA®*	Narcan® Nasal	Pradaxa®	Sandimmune® Capsule**	Trileptal® Suspension
Advair Diskus®	Carbatrol®	Emend® Cap	Humalog Jr® Kwikpen®**	Natroba®	Protonix® Suspension	Saphris®	Ventolin® HFA
Advair HFA®	Celontin®	Emend® Pack	Humalog® Mix Kwikpen®**	Nexium® Suspension	Rapamune® Solution*	Spiriva® Handihaler®	Victoza®
Alphagan P® 0.1%, 0.15%	Chantix®*	Entresto® Tablet	Humalog® Kwikpen®**	Novolog® Cartridge**	Rapamune® Tablet*	Suboxone® Film	Vigamox®
Amitiza®	Chantix® Pack*	Epipen®**	Humalog® Vial**	Novolog® Mix Flexpen®**	Relpax®	Symbicort®	Vimpat® Solution
Apriso®	Ciprodex®*	Epipen Jr®**	Imitrex® Nasal	Novolog® Mix Vial	Restasis®	Tegretol® XR	Vimpat® Tablet
Azopt®	Combigan®	Exelon® Patch	Lantus® Solostar®	Novolog® Flexpen®**	Retin-A® Cream	Tekturna®	Vyvanse® Capsule
Banzel® Susp	Copaxone® 20mg/ml dose	Farxiga®	Lantus® Vial	Novolog® Vial**	Retin-A® Gel	Testim® Gel 1% Packet	Vyvanse® Chewable
Banzel® Tab	Daytrana®	Finacea®	Lumigan®	Oxycontin®	Sabril® Powder Pack	Transderm-Scop®	Xigduo® XR
Benicar HCT®	Dexilant®	Firvanq®	Myrbetriq®	Pentasa®	Sabril® Tablet	Travatan-Z®	

* = Brand Name AND Generic are BOTH Preferred (various reasons including drugs being discontinued, shortages, etc.)

** = Brand and AUTHORIZED GENERIC (only) are BOTH Preferred

This list is current as of 01/01/2025, is subject to change at any time, should not be considered all-inclusive, and cannot be used for claims payment. **FOR INFORMATIONAL PURPOSES ONLY**.

SPDL Continuity of Care Expiration

- Medicaid members who are enrolled in an MCO and have a prescription dated on or before June 30, 2024, could continue to access their prescribed drugs for up to six months or through Dec. 31, 2024, regardless of whether it is included on the single PDL

- This continuity of care exception expired 1/1/2025, which likely has led to some disruption for prescribers and members. There have been instances that some medications on the brand vs. generic list were not available via the pharmacy in the branded version. If lack of availability is due to a true drug shortage, there is an override process.

SC SPDL: Other Notes for Prescribers

- ***Non-Managed classes are not listed on the Single PDL at this time. Some commonly prescribed drugs such as penicillin and sulfa antibiotics and oral contraceptives are currently non-managed classes.*** For FFS Medicaid members these medications are treated as open classes and generally are covered for all FDA approved ages and indications. As MCOs may have additional clinical criteria for some of these drugs, please consult the MCO comprehensive drug list for clarification if needed. MCOs will each publish a comprehensive drug list on their website. These lists are also linked on the SC DHHS website.

Compounded Drug Policy

- The South Carolina Department of Health and Human Services (SCDHHS) will update its multi-ingredient compound coverage effective Jan. 1, 2025.
- ***Multi-ingredient compounds are covered by SCDHHS if the individual ingredients of the compound are eligible for a federal rebate***. Multi-ingredient compounds provide drug therapies that are not commercially available as a U.S. Food and Drug Administration (FDA)-approved product in the same dose, formulation and/or combination of ingredients.
- ***Effective Jan. 1, 2025, all multi-ingredient compounds exceeding $250 will require prior authorization***. Prescribers should call SCDHHS' pharmacy benefit administrator, Prime Therapeutics', clinical call center at (866) 247-1181 for prior authorization. The call center is open 24 hours per day, seven days per week***. Pharmacy products prescribed for Healthy Connections Medicaid members who are enrolled in the Medically Complex Children (MCC) waiver program are exempt from prior authorization requirements for multi-ingredient compounds.*** Bulk powders used for compounding will also be covered for Medicaid members enrolled in the MCC waiver program.
- ***Hydroxyurea powders will continue to be covered without prior authorization requirements for the treatment of sickle cell disease.***

Injectable GLP1 Obesity Drug Coverage

- Effective November 1st , 2024, SC DHHS instituted coverage of Wegovy(preferred) and Saxenda (non preferred) injectable for members 12 years of age and up who meet certain criteria.
- There are currently only a few states that currently have similar coverage.
- South Carolina will be only the fourteenth state to cover this class for Medicaid.

Injectable GLP1 Obesity Drug Coverage

PEDIATRIC CRITERIA: ALL the below must be met:

1. Age 12 to < 18

2. Attestation of a regimen of increased physical activity unless medically contraindicated by co-morbidity

3. Nutritional Counseling Requirement: Attestation of at least one (1) 30 minute (or two 15-minute encounters) of dietician and/or qualified healthcare provider visits for nutritional counseling over the previous six months

4: Chart notes documenting ONE of the following:

  a. Class 1 Obesity as defined as ALL of the following:

    i. BMI is > 30kg/m2 or the 95th percentile for age and sex

    ii. Body weight is > 60kg

    iii. Two or more clinically significant comorbid conditions, not limited to Type 2 diabetes mellitus (DM), idiopathic intracranial hypertension (IIH), non-alcoholic steatohepatitis (NASH), Blount disease, slipped capital femoral epiphysis (SCFE), gastroesophageal reflux disease (GERD), obstructive sleep apnea (AHI > 5), cardiovascular disease risks (HTN, hyperlipidemia, insulin resistance), depressed health-related quality of life

Injectable GLP1 Obesity Drug Coverage

PEDIATRIC CRITERIA: (CONTINUED)

b. Class 2 Obesity as defined as ALL of the following:

i. BMI is > 35kg/m2 or the 120% of the 95th percentile for age and sex

ii. Body weight is > 60kg

iii. ONE or more clinically significant comorbid conditions, not limited to Type 2 diabetes mellitus (DM), idiopathic intracranial hypertension (IIH), non-alcoholic steatohepatitis (NASH), Blount disease, slipped capital femoral epiphysis (SCFE), gastroesophageal reflux disease (GERD), obstructive sleep apnea (AHI > 5), cardiovascular disease risks (HTN, hyperlipidemia, insulin resistance), depressed health-related quality of life

c. Class 3 Obesity as defined as ALL of the following:

i. BMI is > 40kg/m2 or the 140% of the 95th percentile for age and sex

ii. Body weight is > 60kg

iii. Comorbid conditions are not required but are commonly present

5. No contraindications (disease states or current therapy) should exist unless prescriber documents that benefits outweighs risks

6. Chart notes documenting weight, height, and BMI (within the previous 3 months)

Nutritional Counseling Expansion

- Additions and changes to the nutritional counseling benefit effective 1/1/24 include:
  - Increasing the service limit on medical nutrition therapy to 12 hours per state fiscal year;
  - Covering medical nutrition therapy when used to treat eating disorders;
  - Consolidating covered procedure codes across provider types and age groups (procedure codes previously varied both by rendering provider and the age of the Medicaid member who was receiving services); and
  - Reimbursing for medical nutrition therapy when delivered via telehealth.

Continuous Glucose Monitoring

- Effective July 1, 2024, SCDHHS expanded its existing coverage for CGM to align with the most recent CMS coverage guidelines and American Diabetes Association recommendations as follows:
  - Type 1 diabetes mellitus
  - Gestational diabetes
  - Type 2 diabetes with one of the following:
    - Any type of insulin dependency
    - Non-insulin treated diabetes who have recurrent moderate (Level 2) or at least one severe (Level 3) hypoglycemic event
- Primary care, Ob-Gyn, and endocrinology providers may prescribe CGM
- CGM will be allowed through the durable medical equipment and pharmacy benefit

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Managed Care Organization (MCO) Certification and Plan Limits

MCO Certification and Plan Limits

- SCDHHS does not currently define any limitations on the number of entities it contracts with in its managed care delivery system.
- SCDHHS will be updating the "Selective Contracting under a 1932 State Plan Option" section of Attachment 3.1-F in the South Carolina Title XIX State Plan, pending CMS approval.
- Updates to the State Plan aim to:
  - Enhance the contracting process with MCOs
  - Significantly increase the overall effectiveness of our managed care program
  - Improve member experience
  - Improve operational efficiencies and effectiveness between SCDHHS,MCOs and the provider community
  - The state will intentionally limit the number of contracted MCOs.
  - Limitations on the number of managed care organizations will be defined as a minimum of two and a maximum of four MCOs.
  - Implementation of an enhanced MCO certification process

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EPSDT BENEFIT

EPSDT BENEFIT

The EPSDT benefit is described in Section 1905a of the Social Security Act. The EPSDT Benefit does not just cover pediatric well care.

- E: Early: Assessing and identifying problems early
- P: Periodic: Checking children's health at age-appropriate intervals
- S: Screening: Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
- D: Diagnosis: Performing diagnostic tests to follow up when a health risk is identified
- T: Treatment: Correct, reduce or control health problems found

EPSDT BENEFIT

Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. (Wording from Social Security Act)

- **Other Necessary Health Care Services**
- Additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered by Healthy Connections Medicaid. Medical necessity is determined by Healthy Connections Medicaid on a case-by-case basis (Healthy Connections Medicaid website)

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