Transitioning to Preconception Care

Section 1115 Demonstration Waiver Application

Governor Henry D. McMaster

August 23, 2018

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August 23, 2018

Mr. Tim Hill
Acting Director
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Mr. Hill,

The State of South Carolina submits the attached application to request waivers of certain federal regulations and statutes as necessary to implement the Preconception Care (PCC) program under section 1115 of the Social Security Act. As part of the application, the State engaged in robust public notice and transparency activities, to include five statewide hearings and presentations, notices in South Carolina's newspapers of record, tribal consultation, and the collection of over 550 individual comments.

South Carolina has made great strides in recent years to improve infant and maternal health among Medicaid beneficiaries, as well as realize improvements to preventative care and chronic disease management. To continue this success, we will pursue a comprehensive approach to care that manages a myriad of health services for our beneficiaries, supports clinical practices that integrate care, and promotes providers that seek to improve the collective health and well-being of both parents and children. Further, we intend to improve supports for the diagnosis and treatment of substance use disorders (SUD) in both the full- and limited- benefit Medicaid population as part of our ongoing efforts to improve the health of families and tackle the nation's opioid epidemic head-on.

Thank you for your prompt and thorough consideration of this waiver, which is proposed to commence 90 days after approval for a five-year period. If you have any questions, please contact Joshua Baker, Director, South Carolina Department of Health and Human Services at 803-898-2580 or: Joshua.Baker@scdhhs.gov

Yours very truly,

Henry McMaster

HDM/jb/tw

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Section 1: Introduction

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency responsible for the administration of South Carolina's Medicaid program. SCDHHS provides comprehensive health benefits for over 1 million South Carolinians, as well as a limited family planning benefit for additional 170,000 citizens. Children make up nearly two-thirds of South Carolina's Medicaid population, making SCDHHS the health care payer for nearly three-fifths of all children in the state. Medicaid also funds nearly two-thirds of all births in South Carolina.

Over the past decade, SCDHHS has undertaken several efforts to improve maternal and child health to support positive birth outcomes for mothers and children statewide. These include:

- The South Carolina Birth Outcomes Initiative (BOI) leverages payer policy to reduce pre-term births, support vaginal delivery, encourage breast-feeding and address perinatal behavioral health and substance use disorders.
- SCDHHS employs Healthcare Effectiveness Data and Information Set (HEDIS)-based withhold measures to incentivize Medicaid managed care organizations (MCOs) to focus on prenatal care, neonatal primary care and childhood immunizations.
- In 2016, South Carolina launched a home visitation pay-for-success program in cooperation with Nurse-Family Partnership, Social Finance, Children's Trust Fund of South Carolina and other stakeholders to improve outcomes for high-risk first time mothers and their children.

While these interventions have improved the quality of care provided to Medicaid members, the portfolio of services offered to address prenatal and infant health is incomplete. Efforts to date have focused on the period from conception to early development, and interventions for mothers are focused nearly completely on reproductive health and the brief prenatal period. This narrow approach no longer aligns with clinical evidence or nationally accepted treatment guidelines. A broader approach, one that ensures the delivery of high quality care during the preconception period, is an essential component of ensuring that the mothers, infants and children entrusted to Medicaid's care can achieve their highest level of health and well-being.

To address these concerns, SCDHHS intends to engage in a series of policy initiatives designed to transition from the current state to one that facilitates the adoption of a preconception care (PCC) model. To accomplish this, SCDHHS intends to first modify the limited benefit available to those qualifying for family planning services to align with those services necessary to ensure quality care during the preconception period.

Secondly, SCDHHS seeks to implement a more comprehensive set of provider qualifications to ensure that those providers engaged in the delivery of the PCC model are able to adequately care for the overall health needs of the Medicaid members they serve. These provider qualifications will also ensure that SCDHHS conforms to the requirements set forth in South Carolina Executive Order No. 2017-15 regarding providers who engage in the provision of elective abortions. Finally, to further promote statewide access to reproductive health care, SCDHHS will maintain limited exceptions to supplemental provider qualifications for family planning providers in clinics operated by the state's statutorily designated public health agency, the South Carolina Department of Health and Environmental Control (SCDHEC).

Section 2: Program Description

SCDHHS proposes the use of a Section 1115 Demonstration Waiver to assist in the transition toward a preconception care (PCC) model for the delivery of family planning and related services. Preconception health describes the well-being of women and men during their reproductive years, and the PCC model focuses on improving health, reducing or removing risk factors and identifying disease as early as possible. Improving preconception health is an effective means of improving health outcomes and potentially reducing costs. To provide this care effectively, preconception components must be integrated into primary care and provided in a medical home environment. The delivery of that care outside of the primary care medical home results in fragmented care and threatens the integrity of the delivery model. Identifying and treating chronic disease, such as diabetes and hypertension, are critically important to ensuring high quality preconception care.

Finding the appropriate setting for the preconception care model is a challenge for the Medicaid population. A 2016 survey sponsored by the Kaiser Family Foundation indicated that women with Medicaid were more likely to have discussed reproductive health with a health provider, but were far less likely to have those conversations in a traditional doctor's office or health maintenance organization (HMO) setting, with only 57 percent of Medicaid members discussing reproductive health in this most appropriate setting. Medicaid members are more likely than those with private insurance to access a community health center (13 percent versus 4 percent), family-planning limited service clinic (5 percent versus 2 percent) or "other place" (18 percent versus 8 percent). SCDHHS believes that the ad hoc nature of coordination between reproductive health and primary care services for Medicaid members represents a gap in comprehensive coverage and therefore an opportunity for health and birth outcomes improvement using payer policy and steerage to appropriate settings.

This waiver will operate statewide.

SCDHHS intends to implement the requirements of the waiver on the first day of the quarter following 90 days after CMS approval. SCDHHS proposes a waiver period of five years.

An analysis of the SCDHHS Medicaid State Plan and federal authorities indicates that implementation of the PCC model, as articulated, will require amendments to policy, the Medicaid State Plan, as well as this 1115 waiver. To provide access to the services necessary to meaningfully ensure the delivery of PCC, SCDHHS intends to broaden the scope of family planning related services available to those members eligible only for family planning and related benefits to include additional ambulatory care services and a broader pharmacy benefit that provides for the treatment of select chronic diseases. SCDHHS proposes the implementation of those services through the "family planning-related" allowances of current authorities, and thus does not seek consideration of those policy changes through this waiver.

Hypothesis and Evaluation

SCDHHS hypothesizes that adopting the PCC model and steering utilization of family planning and related services toward providers who routinely and expertly provide the full spectrum of care inherent to that model will improve the health outcomes of the population using family planning and related services. Improvements in outcomes will be assessed using the conditions described above, along with additional aggregate measures of health status.

Although the consequences of poor birth outcomes are far reaching, and SCDHHS expects diversity of health improvements along with improved prenatal health, the analysis presented as part of the Demonstration rational focuses on three common measures of birth outcomes: gestational age at birth, perinatal neonatal intensive care unit (NICU) involvement and prevalence of neonatal abstinence syndrome (NAS). These measures of birth outcomes will serve as the basis for evaluating the success of the Demonstration.

NICU Admission. From 2008-2016, SCDHEC vital statistics data demonstrates that NICU admissions increased 28 percent, while the rate of NICU admissions per 1,000 births increased 41 percent. During this period, NICU admissions for neonates showed no sign of slowing down at the state's eight licensed NICU sites even as total births decreased statewide.

Gestational Age. While the number of births reported to SCDHEC decreased 9.1 percent from 2008-2016, births at a gestational age of less than 32 weeks decreased at a rate of 11.1 percent and those of a gestational age 32-36 weeks decreased at a rate of 14.5 percent. Conversely, the rate of NICU admissions per 1,000 births increased by 13.5 percent and 44.5 percent, respectively. While SCDHHS believes that the accelerated decrease of pre-term birthrates is attributable in part to the efforts of a statewide Birth Outcomes Initiative collaborative, NICU admissions among this population appear persistent. As of 2016, nearly 85 percent of all births with a gestational age of less than 32 weeks involve NICU admissions, as do over one-third of all near-term births. The relatively low rate of NICU admissions for full-term births – 18 of every 1,000 – increased to 33 per 1,000 for 638 more NICU admissions per year than in 2008 for children born from 37 to 41 weeks' gestational age.

Neonatal Abstinence Syndrome (NAS). Across South Carolina's communities, a small but increasing number of infants are the youngest victims of the nation's opioid epidemic. Comprehensive data are sparsely available, but a recent study by the Centers for Disease Control and Prevention (CDC) indicates that South Carolina's incidence of NAS has increased from 1.5 per 1,000 births to 3.9 per 1,000 hospital births from 2008 to 2013. Recent scholarly studies completed and published by the principal investigators of the MAiN program found that 81 percent of all NAS births in South Carolina were paid for by the state's Medicaid program and that the cost of NAS births (total charges) has increased from $39,400 in 2000 to $93,400 in 2012.

Other Indicators of Birth-Related Health Outcomes. The three indicators of birth outcomes initially evaluated for the purposes of South Carolina's Preconception Care Family Planning 1115 Demonstration waiver comprise the highest-cost outcomes associated with poor birth outcomes but are not comprehensive of those proposed for evaluation by the waiver. Others include:

- Birth weight
- Initiation of Neonatal Special Care within 48 hours of birth
- Use of non-mandatory of elective caesarian section as a mode of birth
- Initiation of medically necessary caesarian
- Gestational diabetes
- Gestational hypertension
- Neonatal breast-feeding
- Postpartum depression
- Maternal substance use
- Social supports, including affirmative paternity
- Intent to become pregnant

In conducting the evaluation for this Demonstration, SCDHHS will contract with an independent external evaluator to ensure a critical and thorough assessment of program outcomes that is consistent with accepted research practice. The following table summarizes the hypotheses, evaluation approaches and data sources related to the evaluation of this Demonstration.

Hypothesis	Measures	Data Source	Evaluation Approach
Adopting the Pre-Conception Care Model will **decrease NICU admission rate.**	Rate of NICU Admissions, with NICU defined as nursery level III or IV (revenue codes 0173 and 0174)	South Carolina Medicaid Claims	Comparison of NICU rate trends before and after implementation of the Demonstration. Results will be reported as a rate (for example, NICU admissions per 1,000 birth).
Adopting the Pre-Conception Care Model will **reduce the rate of preterm delivery.**	Rate of delivery with a gestational age less than 37 weeks, using the estimation of gestation as indicated on the birth certificate	South Carolina Medicaid Claims, linked to South Carolina Vital Records (birth certificate) data	Comparison of preterm delivery rate trends before and after implementation of the Demonstration. Results will be reported as a rate (for example, preterm delivers per 1,000 births).
Adopting the Pre-Conception Care Model will decrease the incidence of **Neonatal Abstinence Syndrome (NAS)**	Rate of children born with a diagnosis of NAS, as indicated on the Medicaid claim	South Carolina Medicaid Claims	Comparison and NAS rate trends before and after implementation of the Demonstration. Results will be reported as a rate (for example, NAS diagnoses per 1,000 births).

Section 3: Demonstration Eligibility

SCDHHS does not intend to make any changes to the standards or methodologies used to determine Medicaid eligibility as a result of this waiver; the standards and methodologies currently articulated in the State Plan will continue to govern eligibility determination. This application does not propose an expansion of the Medicaid population or require any modifications to eligibility procedures.

As family planning services are a mandatory benefit for all Medicaid members, the number of individuals potentially impacted by the delivery system changes described in Section 4 of this application would extend to the entire Medicaid population. As of March 31, 2018, current membership includes 1,060,000 full benefit and approximately 170,000 family planning members. Of that population, 95,000 full benefit and 36,000 limited benefit members accessed family planning services during calendar year 2017.

Medicaid members who are currently eligible for family planning benefits will remain the same, and SCDHHS estimates enrollment trends will remain consistent with historical experience. As such, SCDHHS anticipates that the overall population eligible for services for which provider qualifications are addressed in this application will total 1.2 million individuals annually throughout the initial five-year demonstration period. SCDHHS emphasizes that the enrollment estimates represent neither an increase nor decrease in annual enrollment, but are rather a continuation of the current enrollment trends, extrapolated from historical data.

A detailed listing of the eligibility groups that qualify for family planning benefits, and therefore who may be impacted by the additional provider qualifications described in Section 4, is included as Appendix A.

Section 4: Demonstration Benefits and Cost Sharing Requirements

SCDHHS proposes no change to the amount, duration, authorization requirements or cost sharing in benefits available to Medicaid members as a result of this Demonstration application. SCDHHS does propose the addition of provider qualification requirements intended to ensure that family planning service providers are expert, proficient and routinely engaged in the delivery of full preconception care model and are, therefore, able to adequately care for the overall health needs of the Medicaid members they serve.

Benefit	**Description of Amount, Duration and Scope**	**Reference**
Family Planning Services	Additional provider specifications and qualifications	1905(a)(4)(C)
Family Planning Services for Limited Benefit Members	Additional provider specifications and qualifications	1902(a)(10)(G)

In transitioning to a system that encourages the preconception care model, SCDHHS intends to also enhance the services provided through the limited benefit family planning program. SCDHHS anticipates the provision of these enhancements through the authorities currently allowable in the coverage of family planning and family planning related services for this population. SCDHHS will pursue the necessary amendments to the Medicaid State Plan, policy changes and other activities necessary to execute these benefit enhancements. Changes to the covered services provided through the limited benefit family planning program are not, however, part of the application.

Section 5: Delivery System and Payment Rates for Services

Aside from the additional provider qualifications described in Section 4 of this application, the delivery systems used to provide benefits in the context of this Demonstration do not differ from those currently provided through the South Carolina State Plan.

SCDHHS will continue to use the current structure of delivery through fee-for-service and managed care organizations for the provision of preconception care. Guidelines regarding the enrollment in managed care will not deviate from those currently articulated in the State Plan. This current structure provides for the provision of care for most full benefit members through managed care organizations on a statewide basis. Members enrolled in the limited benefit family planning program are excluded from participation in managed care, and these members are managed through the fee-for-service system. Provisions related to access requirements of managed care organizations will not change pursuant to this Demonstration.

No deviation from current provider reimbursement rates or quality-based supplemental payments are anticipated as a result of this Demonstration. While SCDHHS does not anticipate the need to adjust

capitation rates as a result of this Demonstration, as there is no underlying change to the scope, duration or reimbursement rates for available services, the impact of this Demonstration will be considered through the current managed care contracting and rate setting processes.

Section 6: Implementation of Demonstration

The nature of this Demonstration, involving no modification in Medicaid eligibility and limited changes to available benefits, allows for a relatively straightforward implementation. Considering this, SCDHHS intends to implement the provisions of this Demonstration to be effective the beginning of the quarter following 90 days after CMS approval. Implementation will be statewide and will not require a phase-in approach.

Providers who will be subject to the qualification requirements set forth in Section 4 will be notified in advance of the implementation date. SCDHHS will also notify any Medicaid member who has received services from an impacted provider at least 30 days before implementation.

Coordination with managed care organizations throughout the application process will facilitate a seamless transition of the requirements into the managed care delivery system. The necessary contract amendments will be incorporated into the managed care contractual agreement in anticipation of the Demonstration's implementation.

Section 7: Demonstration Financing and Budget Neutrality

As this Demonstration contemplates neither a change in the underlying Medicaid population, nor a change in the breadth of covered services, the cost of delivering care is not anticipated to deviate from historical trends as a result of this Demonstration. As the benefits of the preconception care model are realized through improvements in health outcomes, with resulting moderate and long-term health care savings, SCDHHS anticipates this Demonstration to result in meaningful overall cost savings.

Given no anticipated change expenditure trends resulting from this Demonstration, SCDHHS has modeled the following expenditure estimates based on historical trends. Anticipated expenditures for family planning services are expected to total an average of $35 million annually for the five-year initial duration of the waiver. An accounting of expenditures, by state fiscal year, is included below. SCDHHS emphasizes that these expenditures do not represent an increase or decrease in expenditures, but are rather a continuation of the current family planning expenditure trends, extrapolated from historical data.

	FY 2019	*FY 2020*	*FY 2021*	*FY 2022*	*FY 2023*
Limited Benefit	$6,287,000	$6,104,000	$5,920,000	$5,737,000	$5,554,000
Full Benefit	$26,944,000	$28,178,000	$29,412,000	$30,646,000	$31,880,000
Total Expenditures	$33,231,000	$34,282,000	$35,332,000	$36,383,000	$37,434,000

Section 8: Proposed Waivers and Expenditure Authorities

To effectively ensure that qualified providers participate in the delivery of preconception care, this Demonstration requires waiver of Section 1902(a)(23) of Title XIX of the Act. In adopting the preconception care model, SCDHHS proposes to leverage a focused network of providers for the provision of family planning benefits. Specific requirements for providers who participate in this network will include the ability to treat the entire scope of care, including regularly managing diabetes, hypertension, heart disease and depression. Providers must also either provide direct care for substance use disorder or have established relationships with treatment centers to facilitate referral.

As this application does not seek to expand South Carolina Medicaid's scope of benefits or eligibility population, the authorities for expenditures described in this application exist through 1905(a) of Title XIX of the Act, as approved in South Carolina's current State Plan.

SCDHHS acknowledges the potential need to explore additional waiver and expenditure authorities and is committed to collaborating with CMS to ensure the appropriate authorities exist to ensure the administration of the Demonstration.

Section 9: Public Notice

In advance of the submission of this application, SCDHHS engaged in two separate public comment request periods. The first started May 4, 2018, and ended June 6, 2018. The second comment period started July 23, 2018, and ended Aug. 22, 2018.

SCDHHS used a variety of methods to ensure members of the public and interested stakeholders had ample opportunity to review the application and provide comments in advance of the submission to CMS, in accordance with 42 CFR 431.408. SCDHHS's outreach included written and verbal communications with the Catawba Indian Nation and Indian Health Services, the Medical Care Advisory Committee (MCAC), notices on the SCDHHS website, physically posting public notices and applications in Medicaid eligibility offices across the state, a statewide webinar conducted by SCDHHS staff, three public hearings conducted at various locations across the state, the issuance of two public bulletins, and publishing an abbreviated public notice in the state's two newspapers of largest circulation.

SCDHHS received 519 comments during the first period (May 4-June 6), and 36 during the second period (July 23-Aug. 22). Comments were of consistent themes during both comment periods, with a mix of both support and opposition for the waiver application. Comments are summarized below.

<u>Tribal Consultation</u>

In accordance with 42 CFR 431.408(b), South Carolina consulted with the state's single tribal organization (the Catawba Indian Nation) and sought advice from representatives from Indian Health Services before submission of the application. SCDHHS invited comments and questions through written notification May 3, 2018. There were no questions or comments received from Catawba as a result of the written communication. SCDHHS further conducted a Service Unit Special Call to discuss the waiver application May 9, 2018. During the call, an overview of the application was provided by SCDHHS staff. During the call, a Catawba representative indicated that she thought it was a beneficial policy change because it would catch some of the more serious chronic diseases before child-bearing years. SCDHHS was also asked if there would be any changes in the waiver to the dental program because there is a strong correlation between chronic disease and dental health. There were no further questions or comments during the call. Documentation of tribal communication is at Appendix C.

Medical Care Advisory Committee (MCAC)

On May 15, 2018, the SCDHHS leadership team presented the MCAC with an overview of the PCC waiver application. This presentation included a discussion of the program's objective, anticipated program design and expected program outcomes. The following questions and answers were part of the discussion:

Comment: How will this affect Title X providers who render these services?
Response: SCDHHS will maintain limited exceptions to supplemental provider qualifications for family planning providers in clinics operated by the South Carolina Department of Health and Environmental Control (SCDHEC).

Comment: How will SCDHHS ensure that providers will do the extra care to ensure that beneficiaries get the additional services? Will SCDHHS be working with FQHCs on this?
Response: SCDHHS emphasizes that there is no change to the amount, duration or timeliness requirements pursuant to this waiver application. The application is to waive provider of choice and we acknowledge your concerns. SCDHHS will continue to engage with the MCAC and other stakeholders as additional details related to provider qualifications are formalized.

Comment: There is some concern regarding potential political influences related to the waiver application, and SCDHHS should ensure a thoughtful approach in moving forward.
Response: SCDHHS is pursuing this application in a manner that supports the underlying mission of the Medicaid program by ensuring access to the highest quality care for Medicaid beneficiaries. The underlying model supported in the waiver is evidence-based, and evaluation parameters will ensure the ongoing delivery of high quality care.

Comment: How will SCDHHS solicit public comment?
Response: A well-defined public comment process is a prerequisite for the submission of an 1115 waiver application. SCDHHS will solicit public comments through the release of a public notice, a website specific to this waiver and a series of public comment sessions to be held throughout the state.

Question: Will the public hearings happen before CMS approval?
Answer: Yes.

Statewide Webinar

On May 24, 2018, SCDHHS staff conducted a webinar to provide information about the proposed waiver application. The webinar was open to public.

Public Hearings

In accordance with 42 CFR 431.408(a)(3), South Carolina conducted three public hearings at geographically separate locations around South Carolina. Hearing locations and dates are included below:

Greenville, SC	May 22, 2018
Columbia, SC	June 01, 2018
Charleston, SC	June 04, 2018

Summary of Comments Received

SCDHHS received 555 timely comments pertaining to this waiver application. Comments were submitted by individual Medicaid service providers, provider associations such as the South Carolina Hospital Association and the South Carolina Chapter of the American Congress of Obstetricians and Gynecologists (ACOG)), advocates, Medicaid beneficiaries, community leaders, church organizations and nonprofit organizations. A summary of public comments and SCDHHS's responses are set forth below.

Comments in Support of the PCC Model

Comment: Many commenters expressed support for a more comprehensive approach to the delivery of health care for women who may become pregnant. These commenters expressed support for a shift toward the preconception care model articulated in the waiver application.

Response: SCDHHS appreciates this support and emphasizes that it intends to continue to engage in evaluation of individual access and utilization of relevant health services provided in conjunction with the waiver's care model. The state has also included evaluation parameters that focus on better birth outcomes, birth spacing, and general chronic disease prevention and management among waiver participants.

Comments in Support of Eliminating Funding for Abortion Clinics

Comment: Many commenters expressed support of the ability to exclude abortion providers from the receipt of Medicaid funds for the delivery of family planning services.

Response: While the primary purpose of this application is to improve access to high-quality primary care that includes the coordination of family planning and reproductive health, one result would be the exclusion of providers who focus predominantly on the elective and on-demand termination of pregnancy as defined in Section 44-41-75 of the South Carolina Code of Laws.

Comments Specific to Planned Parenthood

Comment: There were comments that referred directly to Planned Parenthood. Fifty-four of the comments were in support of Planned Parenthood. These comments highlighted the need for the organization to receive continued funding to provide services such as those related to sexually transmitted infections (STIs), contraception and cancer, as well as the role that Planned Parenthood plays in the delivery of care to individuals with low incomes. Comments in opposition to Planned Parenthood centered on a general objection to the organization receiving government funding as well as the need to not fund abortion.

Response: The state's proposed PCC Waiver does not specifically mention any provider, clinic or affiliation by name or brand, but rather focuses on the ability of that provider or clinic to provide high-quality coordinated care and on its licensure as or affiliation with provider organizations with a primary focus on the elective and on-demand termination of pregnancies as defined in Section 44-41-75 of the South Carolina Code of Laws.

Comments in General Opposition to Waiver

Comment: Comments in general opposition to the application included concerns that the PCC Waiver does not take into consideration access to care for vulnerable women. These commenters expressed concerns that the providers restriction described in the applications would result in fewer provider choices for women to receive family planning services, and objection to the removal of providers that perform abortions in South Carolina.

Response: The Medicaid program is one of the largest payers of health and reproductive services for low-income women in South Carolina. The state takes seriously its responsibility to develop and maintain a network of primary care and reproductive health providers directly and through the five Medicaid managed care plans operating in South Carolina.

Comments Regarding the Potential Limits to Provider Access or Provider Capacity
Comment: SCDHHS received comments expressing concerns that limiting of access to certain types of providers or overall provider capacity, as described in the application, could create access challenges. Some commenters objected to the PCC Waiver based on the perception that reproductive specialists, such as obstetricians and gynecologists (OB/GYNs), would be expected to provide care in all areas of health care. One commenter indicated that she did not go to a cardiologist or an endocrinologist for a pap smear and that she did not expect her gynecologist to treat her heart disease or diabetes. Another commenter indicated that South Carolina has a poor record of maternal health care and that access to services is already restricted for many residents. There was reference to the PCC Waiver potentially exacerbating access concerns, especially for economically vulnerable women.

Response: The state observes that both scholarly studies, as well as reviews of Medicaid claims data, indicate that many women engage their OB/GYN as a primary care provider, or access family planning services without additional engagement with a primary care provider. Further, the populations that exhibit this behavior predominantly tend to be younger and of minority groups. The operational objective of the PCC Wavier is to foster comprehensive care coordination among both the OB/GYN and primary care provider communities to ensure that Medicaid beneficiaries receive coordinated primary care and reproductive health services. Further, these comments do not recognize over 275,000 male participants of age in the full- and limited- benefit Medicaid programs that do not access obstetric services at all, but would nonetheless benefit from reproductive health screenings and counseling in a primary care setting.

Comments Concerning Provider Specialty Exclusion
Comment: There were comments from providers who expressed concern that approval of the PCC Waiver would eliminate the ability of family practice and gynecologists to provide family planning services.

Response: SCDHHS intends to promote the coordination of primary care and reproductive health through the operation of this waiver. SCDHHS does not intend to design provider qualifications in a way that would prevent traditional primary care or obstetrical and gynecological practices from providing family planning services.

Comments Regarding Eligibility
Comment: Commenters expressed concern over who would be eligible for services under the waiver. One commenter asked if services under the waiver would be available for the duration of a person's life in the pre-conception period or if the services were limited by time. Another commenter asked about the approval process for eligibility to access services under the waiver.

Response: The state is not proposing any changes to beneficiary eligibility as a component of this demonstration. We thank the commenters for this question and the opportunity to clarify this point.

Comments Concerning Covered Services
Comment: Several commenters asked about services to be covered under the PCC Waiver, including coverage of medications required to manage to manage treat chronic disease such as hypertension, diabetes and thyroid disease; coverage of required laboratory tests; coverage for treatment of hepatitis C; and coverage of vaccinations.

Response: While the state has detailed the services that will be available to participants in the limited-benefit program categorically, it has not yet published a detailed service or code set as part of the application. Such detailed documents will correspond to policy manual and fee schedule changes made pursuant to PCC waiver approval.

Comments Regarding Potential Decreases in Access
Comment: Women and children are losing access to preconception care and family planning services through the PCC model. A few commenters expressed concern that access to preconception care would be eliminated through the PCC Waiver.

Response: SCDHHS is not seeking to eliminate family planning services from the Medicaid benefit. The state is not proposing to eliminate preconception care, but rather enhance preconception care for Medicaid beneficiaries during their reproductive years.

Comments Concerning Political Motive
Comment: SCDHHS received several comments expressing the opinion that the waiver was political in its origin. Comments also included that the waiver would have negative consequences for patients. One commenter referred to the application as a disgraceful, thinly veiled attempt to defund Planned Parenthood.

Response: The state respectfully disagrees with these comments. While the exclusion of abortion clinics from the Medicaid program is one of the results of this demonstration, the ultimate mission of the waiver remains the provision of high-quality coordinated primary care and reproductive health services for Medicaid beneficiaries.

Comments Expressing a Desire for Further Research
Comment: There were comments suggesting that SCDHHS further research the pre-conception care model before pursuing the PCC Waiver, citing reasons such as unknown impact for patients. Some comments questioned the research supporting the application. Most of the comments included language requesting that more time be allowed before the PCC Waiver is pursued.

Response: While the state notes that there is some inherent uncertainty around the implementation of any new program, service or provider criteria, the underlying basis of the application, the transition toward a preconception model of care delivery, is well developed. For example, the Centers for Disease Control and Prevention (CDC) include adoption of preconception care principles as a component of the Maternal, Infant and Child Health objective of Healthy People2020. The proposed demonstration provides safeguards to ensure network adequacy comparable to that in the existing Medicaid fee-for-service and Medicaid managed care programs. Further, the state's demonstration includes ongoing and robust evaluation of outcomes, access and utilization throughout the demonstration period.

Section 10: Demonstration Administration

As director of SCDHHS and state Medicaid director, Joshua D. Baker is the executive sponsor of this waiver application. Bryan Amick, Deputy Director for Health Programs, is charged with the execution of the waiver application and the implementation of the resulting benefit changes. Kevin Bonds, Program Manager, will serve as the contact for questions related to this application. Kevin can be contacted at (803)898-2823 or kevin.bonds@scdhhs.gov.

Appendix A: Eligibility Groups

Mandatory Categorically Needy

Eligibility Group Name	Citations	Waiver Impact
Low Income Families	1931	No eligibility impact
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	No eligibility impact
Extended Medicaid due to Child or Spousal Support Collections	408(a)(11)(B) 42 CFR 435.115 1931(c)(1)	No eligibility impact
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145	No eligibility impact
Qualified Pregnant Women and Children	42 CFR 435.116 - old 1902(a)(10)(A)(i)(III) 1905(n)	No eligibility impact
Mandatory Poverty Level Related Pregnant Women	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	No eligibility impact
Mandatory Poverty Level Related Infants	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	No eligibility impact
Mandatory Poverty Level Related Children Aged 1-5	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	No eligibility impact
Mandatory Poverty Level Related Children Aged 6-18	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	No eligibility impact
Deemed Newborns	1902(e)(4) 42 CFR 435.117	No eligibility impact
Individuals Receiving SSI	1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120	No eligibility impact
Aged, Blind and Disabled Individuals in 209(b) States	1902(f) 42 CFR 435.121	No eligibility impact
Individuals Receiving Mandatory State Supplements	42 CFR 435.130	No eligibility impact
Individuals Who Are Essential Spouses	42 CFR 435.131 1905(a)	No eligibility impact
Institutionalized Individuals Continuously Eligible Since 1973	42 CFR 435.132	No eligibility impact
Blind or Disabled Individuals Eligible in 1973	42 CFR 435.133	No eligibility impact
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	42 CFR 435.134	No eligibility impact

Eligibility Group Name	Citations	Waiver Impact
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	1939(a)(5)(E) 42 CFR 435.135 Section 503 of P.L. 94-566	No eligibility impact
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	1634(b) 42 CFR 435.137	No eligibility impact
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	42 CFR 435.138 1634(d)	No eligibility impact
Working Disabled under 1619(b)	1902(a)(10)(A)(i)(II) 1905(q) 1619(b)	No eligibility impact
Disabled Adult Children	1634(c)	No eligibility impact
Qualified Medicare Members	1902(a)(10)(E)(i) 1905(p)	No eligibility impact
Qualified Disabled and Working Individuals	1902(a)(10)(E)(ii) 1905(s) 1905(p)(3)(A)(i)	No eligibility impact
Specified Low Income Medicare Members	1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii)	No eligibility impact
Qualifying Individuals	1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii)	No eligibility impact
Children with Non-IV-E Adoption Assistance	1902(a)(10)(A)(ii)(VIII) 42 CFR 435.227	No eligibility impact
Independent Foster Care Adolescents	1902(a)(10)(A)(ii)(XVII) 1905(w) 42 CFR 435.226	No eligibility impact
Optional Targeted Low Income Children (M-CHIP)	1902(a)(10)(A)(ii)(XIV) 1905(u)(2)(B) 42 CFR 435.229 and 435.4	No eligibility impact
Children under 21 Not Receiving Cash	1902(a)(10)(A)(ii)(I) – (IV) 1905(a)(i) 42 CFR 435.222	No eligibility impact
Families Who Would Qualify for Cash if Requirements Were More Broad	1902(a)(10)(A)(ii)(III) 42 CFR 435.223 1905(a)	No eligibility impact
Individuals Eligible for Cash except for Child Care Subsidy	1902(a)(10)(A)(ii)(II) 42 CFR 435.220	No eligibility impact
Optional Poverty Level Related Pregnant Women and Infants	1902(a)(10)(A)(ii)(IX) 1902(l)(2)	No eligibility impact
Presumptively Eligible Pregnant Women	1902(a)(47) 1920	No eligibility impact

Eligibility Group Name	Citations	Waiver Impact
Presumptively Eligible Children	1902(a)(47) 1920A 42 CFR 1100-1102	No eligibility impact
Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) 1902(u)(1)	No eligibility impact
Individuals Eligible for but not Receiving Cash	42 CFR 435.210 1902(a)(10)(A)(ii)(I) 1905(a) 1902(v)(1)	No eligibility impact
Individuals Eligible for Cash except for Institutionalization	1902(a)(10)(A)(ii)(IV) 42 CFR 435.211 1905(a)	No eligibility impact
Individuals in HMOs Guaranteed Eligibility	42 CFR 435.212 1902(e)(2)	No eligibility impact
Individuals Receiving Home and Community Based Services under Institutional Rules	42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	No eligibility impact
Individuals Participating in a PACE Program under Institutional Rules	1934	No eligibility impact
Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) 1905(o)	No eligibility impact
Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements	1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	No eligibility impact
Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements	42 CFR 435.234 1902(a)(10)(A)(ii)(XI)	No eligibility impact
Qualified Disabled Children under 19	1902(e)(3)	No eligibility impact
Institutionalized Individuals Eligible under a Special Income Level	42 CFR 435.236 1902(a)(10)(A)(ii)(V) 1905(a)	No eligibility impact
Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) 1902(m)(1)	No eligibility impact
Individuals with Tuberculosis	1902(a)(10)(A)(ii)(XII) 1902(z)	No eligibility impact
Certain Women Needing Treatment for Breast or Cervical Cancer	1902(a)(10)(A)(ii)(XVIII) 1902(aa)	No eligibility impact
Presumptively Eligible Women with Breast or Cervical Cancer	1920B 1902(aa)	No eligibility impact
Work Incentives Eligibility Group	1902(a)(10)(A)(ii)(XIII)	No eligibility impact

Eligibility Group Name	Citations	Waiver Impact
Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV)	No eligibility impact
Ticket to Work Medical Improvements Group	1902(a)(10)(A)(ii)(XVI)	No eligibility impact
Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) 1902(cc)	No eligibility impact
Individuals Eligible for Family Planning Services	1902(a)(10)(A)(ii)(XXI)	No eligibility impact
Individuals Eligible for Home and Community-Based Services	1902(a)(10)(A)(ii)(XXII) 1915(i)	No eligibility impact
Individuals Eligible for Home and Community-Based Services - Special Income Level	1902(a)(10)(A)(ii)(XXII) 1915(i)	No eligibility impact
Individuals at or below 133% FPL Age 19 through 64	1902(a)(10)(A)(i) (VIII) early implementation option	No eligibility impact

Medically Needy

South Carolina Medicaid does not determine eligibility based on medical need.

Appendix B: Demonstration Financing

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable): **Not applicable; the Demonstration proposes the addition of provider qualification requirements but will have no impact on expenditures.**

☐ State General Funds

☐ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Provider taxes. (Provide description the narrative section – Section VI of the application).

☐ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)? **Not applicable**

☐ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ☐ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. **Not applicable**

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. **Not applicable**

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b). **Not applicable**

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount
N/A	**N/A**

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services? **Not applicable**

☐ Yes ☐ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☐ Yes ☐ No ☒ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report? **Not applicable**

☐ Yes ☐ No

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program? ☐ Yes ☐ No Not applicable

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding
N/A	**N/A**	**N/A**

Appendix C: Tribal Notification

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

May 3, 2018

Catawba Indian Nation
Attn: Chief Bill Harris
996 Avenue of the Nations
Rock Hill, SC 29730

Re: Comprehensive Preconception Care Model Waiver

Dear Chief Harris:

The South Carolina Department of Health and Human Services (SCDHHS) desires to consult you regarding a Section 1115 Demonstration Waiver application to adopt a Preconception Care (PCC) Model for family planning for South Carolina Medicaid.

To continue efforts to improve the health and well-being of mothers, infants and children enrolled in the Medicaid program, SCDHHS intends to amend and enhance its family planning benefit to encompass a broader scope of preconceptive care in a manner that aligns with clinical evidence and nationally accepted treatment guidelines. This effort represents a shift from the traditional model of focus on contraception and care during the prenatal period to a model that ensures the delivery of high quality care during the preconceptive period.

The primary focus of this demonstration waiver is to offer more comprehensive coordination of preconceptive care coverage to existing Medicaid beneficiaries, creating a more complete and coordinated healthcare delivery model. The proposed demonstration waiver employs a more robust and focused care model (e.g., the Preconception Care (PCC) Model) to ensure the coordination of family planning and reproductive health care with primary care services and chronic disease management for both full- and limited-benefit Medicaid beneficiaries. To achieve this enhanced level of coordination, SCDHHS intends to implement a series of policies to ensure the delivery of integrated care that addresses overall healthcare needs, focusing on the early identification and treatment of chronic disease.

To adopt a comprehensive Preconception Care Model, SCDHHS proposes the following:

- The enhancement of the benefit available to individuals enrolled in the optional family planning eligibility group to include: (1) additional primary care outpatient services; (2) a limited pharmacy benefit, focused on drugs that treat chronic diseases known to affect reproductive health and birth outcomes; and (3) substance use disorder (SUD) treatment services.

  Note: SCDHHS anticipates the adoption of these enhancements through the family planning-related service option of the state's standard State Plan authority, and does not intend to seek waiver authority for this component.

- Leveraging a focused network of providers for the provision of family planning benefits. Specific requirements for providers who participate in this network will include the ability to treat the entire scope of PCC, including regularly managing diabetes, hypertension, heart disease and depression.

The anticipated benefits of the adoption of the PCC Model are diverse. To evaluate the degree to which this transition in health care delivery models improves outcomes, SCDHHS anticipates the use of the following evaluation parameters:

- NICU admission rates
- Mean gestational age
- Mean birth weight
- Incidence of neonatal abstinence syndrome (NAS)
- Maternal morbidity and mortality
- Initiation of medically necessary caesarian
- Gestational diabetes
- Gestational hypertension
- Depression
- Maternal substance use

Tribal members who currently qualify for the limited-benefit family planning program will be eligible for a broader scope of services, as described above. Tribal members will also be required to seek care from only those providers who are qualified for the provision of the full spectrum of preconception care.

SCDHHS welcomes any comments or questions on this matter. Please direct any comments or questions to Sheila Chavis at chaviss@scdhhs.gov or (803) 898-2707 by June 2, 2018. If desired, SCDHHS will also provide an opportunity for an in-person meeting to foster additional collaboration on this topic. If an in-person meeting is desired, please direct that request to Mrs. Chavis. This matter will also be discussed at the May 15 Medical Care Advisory Committee (MCAC) meeting.

Sincerely,

[redacted]

Joshua D. Baker
Director

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 • Columbia, SC 29202
www.scdhhs.gov

May 3, 2018

Catawba Service Unit
Attn: Ms. Dawn Canty
2893 Sturgis Road
Rock Hill, SC 29730

Re: Comprehensive Preconception Care Model Waiver

Dear Ms. Canty:

The South Carolina Department of Health and Human Services (SCDHHS) desires to consult you regarding a Section 1115 Demonstration Waiver application to adopt a Preconception Care (PCC) Model for family planning for South Carolina Medicaid.

To continue efforts to improve the health and well-being of mothers, infants and children enrolled in the Medicaid program, SCDHHS intends to amend and enhance its family planning benefit to encompass a broader scope of preconceptive care in a manner that aligns with clinical evidence and nationally accepted treatment guidelines. This effort represents a shift from the traditional model of focus on contraception and care during the prenatal period to a model that ensures the delivery of high quality care during the preconceptive period.

The primary focus of this demonstration waiver is to offer more comprehensive coordination of preconceptive care coverage to existing Medicaid beneficiaries, creating a more complete and coordinated healthcare delivery model. The proposed demonstration waiver employs a more robust and focused care model (e.g., the Preconception Care (PCC) Model) to ensure the coordination of family planning and reproductive health care with primary care services and chronic disease management for both full- and limited-benefit Medicaid beneficiaries. To achieve this enhanced level of coordination, SCDHHS intends to implement a series of policies to ensure the delivery of integrated care that addresses overall healthcare needs, focusing on the early identification and treatment of chronic disease.

To adopt a comprehensive Preconception Care Model, SCDHHS proposes the following:

- The enhancement of the benefit available to individuals enrolled in the optional family planning eligibility group to include: (1) additional primary care outpatient services; (2) a limited pharmacy benefit, focused on drugs that treat chronic diseases known to affect reproductive health and birth outcomes; and (3) substance use disorder (SUD) treatment services.

  Note: SCDHHS anticipates the adoption of these enhancements through the family planning-related service option of the state's standard State Plan authority, and does not intend to seek waiver authority for this component.

- Leveraging a focused network of providers for the provision of family planning benefits. Specific requirements for providers who participate in this network will include the ability to treat the entire scope of PCC, including regularly managing diabetes, hypertension, heart disease and depression.

The anticipated benefits of the adoption of the PCC Model are diverse. To evaluate the degree to which this transition in health care delivery models improves outcomes, SCDHHS anticipates the use of the following evaluation parameters:

- NICU admission rates
- Mean gestational age
- Mean birth weight
- Incidence of neonatal abstinence syndrome (NAS)
- Maternal morbidity and mortality
- Initiation of medically necessary caesarian
- Gestational diabetes
- Gestational hypertension
- Depression
- Maternal substance use

Tribal members who currently qualify for the limited-benefit family planning program will be eligible for a broader scope of services, as described above. Tribal members will also be required to seek care from only those providers who are qualified for the provision of the full spectrum of preconception care.

SCDHHS welcomes any comments or questions on this matter. Please direct any comments or questions to Sheila Chavis at chaviss@scdhhs.gov or (803) 898-2707 by June 2, 2018. If desired, SCDHHS will also provide an opportunity for an in-person meeting to foster additional collaboration on this topic. If an in-person meeting is desired, please direct that request to Mrs. Chavis. This matter will also be discussed at the May 15 Medical Care Advisory Committee (MCAC) meeting.

Sincerely,

[redacted]

Joshua D. Baker
Director

SCDHHS-Catawba Service Unit Special Call
May 9, 2018
11:00-12:00

Attendees			
Name	**Present**	**Name**	**Present**
Sheila Chavis- SCDHHS	**Y**	**Dawn Canty- IHS**	**Y**
Kevin Bonds- SCDHHS	**Y**	**Chief Bill Harris- Catawba Indian Nation**	**N**
Dorothy Rodgers- IHS	**Y**	**Betty Driggers –Catawba Indian Nation**	**N**

Item	Topic	Presenter	Time
1	**SPAs/Waivers:** Kevin Bonds presented on the Preconception Care (PCC) Model Waiver. SCDHHS is proposing to submit a waiver to adopt the PCC Delivery model which will add to the Family Planning benefit. The primary focus of this policy shift is to ensure the coordination of family planning and reproductive health care with primary care services and chronic disease management (such as hypertension, Diabetes etc.) for full benefit Medicaid beneficiaries. The goal is to improve the overall health of children born in South Carolina. SCDHHS is currently looking at the types of services and types of providers that will provide these services. Kevin stated there are three meetings that will take place across the state: May 22nd in Greenville, SC; June 1st in Columbia, SC and June 4th in Charleston, SC.	Sheila Chavis	11:00

1 Con't	Dawn stated there is a problem in Rock Hill finding OBGYNs that accept Medicaid especially if they are not excepting new Patients. She thought this was a beneficial policy change because it would catch some of the more serious chronic diseases before child-bearing years. Dawn asked if there would be any changes in this waiver to the dental program because there is a strong correlation between chronic disease and dental health. Kevin stated currently there will be no changes in this waiver that will address the dental program and stated that SCDHHS is aware of the correlation between chronic disease and dental health. Kevin stated the effective date of this waiver is on or after January 1, 2019.		
	No other issues or business No questions or concerns Next call TBD		
	No Follow Up Assignments on this call		