


SOUTH CAROLINA DEPARTMENT OF  
SOCIAL SERVICES FOSTER CARE  
HEALTH PLAN – CARE  
COORDINATION ADDENDUM  
FEBRUARY 2019



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## I. Introduction/Overview

The South Carolina Department of Social Services (DSS) is undertaking a comprehensive reform of its child welfare system with a special focus on the health care needs of children in foster care. In partnership with the South Carolina Department of Health and Human Services (DHHS), Select Health (SHSC) the single managed care organization (MCO) serving children in foster care and other state agencies, and, in consultation with the Foster Care Health Advisory Group<sup>1</sup>, DSS is redesigning the way health, behavioral health and dental services are organized and delivered to children in foster care. We are building on opportunities present in our state Medicaid program so that we bring together in a holistic way the resources, capabilities and talent needed to meet the needs of children in foster care. Our vision is a fundamentally transformed child welfare system that can serve as a model for other child welfare systems around the country.

On August 23, 2018, the Co-Monitors (COM) approved the South Carolina Department of Social Services' Health Plan related to commitments made in the *Michelle H. v. McMaster* Final Settlement Agreement (FSA), pursuant to the condition that an addendum related to care coordination be approved and incorporated into the Health Plan by the Co-Monitors no later than March 1, 2019. As part of the Health Plan, DSS also agreed to undertake a Health Care Pilot that reviewed the health-related experience of a sample of children and youth in care. Based on the Pilot and other activities described below, DSS developed the Health Care Management and Coordination Plan described in this addendum ("Addendum"). See Appendix A for the Health Care Commitments in the Final Settlement Agreement. See Appendix B for Health Care Targets, submitted to the Court on December 21, 2018.

The Health Care Addendum describes the partnership between SCDSS, SCDHHS and Select Health (MCO) to insure that all children in foster care receive required screenings, assessments and follow-up services and supports they need and the integrated health care coordination framework that will be built in order for these things to occur. The health care coordination model envisioned in the Addendum is an integrated framework that includes the roles, activities, staffing and processes of each partner. This integrated framework also includes a description of the different but complementary health-related roles of the DSS case manager, the Select Health care manager and the care coordination roles of DSS, DHHS and Select Health. The health care coordination Addendum includes all of the elements— new health-related staff that DSS will hire and deploy; roles for DSS caseworker staff who maintain specific health-related responsibilities; the data production and sharing commitments from DHHS and the health care management staffing, responsibilities and commitments of Select Health.

## II. Health Care Pilot Case Review and Other Activities

The approved Health Plan included a commitment that DSS, in consultation with the health care consultants, would develop and conduct a Health Care Pilot to better define and design its health care management and coordination system. In addition, the Plan identified a number of other activities that DSS would undertake including data analysis and reporting, outcomes definitions and target setting, and

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<sup>1</sup> The FCHAC is comprised of representatives from the medical and behavioral healthcare fields statewide, including nurses and pediatricians from various clinics, Select Health representatives, Child Advocacy Centers, Department of Mental Health (DMH), private community-based Licensed Independent Professionals (LIPs), Palmetto Association for Children and Families, Therapeutic Foster Care agencies, Group Care and Rehabilitative Behavioral Health Services (RBHS) providers, and Foster Parent support agencies.

continued external stakeholder engagement so that plan implementation could proceed while DSS worked to bring definition to its health care coordination function. The below describes the Pilot and Case Process Review, as well as some of the activities undertaken by DSS since August 2018 related to its health care commitments in the Approved Health Plan.

### **A. The Pilot and Case Process Review**

The Pilot and Case Process Review ran October 2018 through January 2019. The Health Plan Pilot explored the health care experience of 30 children currently placed or replaced in foster care. The sample of children was selected to represent three types of conditions: children who are typically developing with no serious health or behavioral health conditions; children who have a chronic condition that warrants regular follow-up; and, children with complex medical or serious behavioral health care needs, including children with dual diagnoses.

Specifically, the Pilot was used to explore the following areas related to health care coordination:

- Assessing and matching child health, behavioral health needs, and level of care decisions before or at the point of placement
- Assignment of a single DSS case manager (county-based or regional Intensive Foster Care and Clinical Services (IFCCS) case manager), throughout the child's stay in foster care, informed by the child's health or behavioral health needs
- Alignment of DSS casework and Select Health case assignment, tiering and care coordination responsibilities, practice, and protocols
- Automation and simplification of data entry into CAPSS data feeds to reduce the documentation burden on DSS case managers and to leverage data that is available from the Select Health and Medicaid systems of record
- Red flag or high needs rostering of children whose health or behavioral health condition warrants close monitoring (this will include events such as: visits to the emergency room, hospitalization, failure to fill a prescription for a chronic condition, like asthma, failure to fill medication for behavioral health needs leading to ER visits)
- Data-sharing and use including: production of DSS nightly children-in-foster-care roster shared with DHHS notification to Select Health from DHHS' enrollment broker of newly enrolled, re-enrolled, or disenrolled members (an 834 file)<sup>2</sup> production and use of Select Health gap-in-care, care management and other reports derived from administrative data (Medicaid encounter and claims data) and SH electronic record platforms, psychotropic medication data; and, dissemination to DSS field staff for follow-up
- Cadencing and follow-up tracking of gaps in care, high need, immediate need or other special groups of children (including 0-3 year olds, psychotropic medication)
- Supervision and staff training on new health protocols and use of health tools and reports
- Provider education and caregiver engagement by Select Health; and
- Documentation of screenings, assessments and follow-up services and, broadly, evidence of in-network, out-of-network and specialty services provided to the child.

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<sup>2</sup> 2018 MCO Contract, Section 3.4, Member Enrollment Process <https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>

A case review team was established that included three DSS Reviewers, the Director of the DSS Office of Health and Well-Being and the Health Care Consultants. The case review team included foster care program coordinators, supervisors and performance coaches. Each case was reviewed in CAPSS by at least two reviewers using a standard questionnaire developed for this review. A random sample of 30 cases was pulled from Fairfield, Berkley and York Counties and was further stratified using three conditions: children who are typically developing with no serious health or behavioral health conditions; children who have a chronic condition that warrants regular follow-up; and, children with complex medical or serious behavioral health care needs, including children with dual diagnoses. Cases were debriefed in three sessions.

The case review debriefing identified notable strengths and several important challenges. Strengths included findings that all children but two had documented initial health, behavioral health and dental assessments and most had identified providers and a record of follow-up visits captured in the encounter, dictation (where supervision was evident) and linked files sections of CAPSS. Challenges included multiple required forms in CAPSS related to health care that were rarely used and are not useful for DSS case planning or care coordination with Select Health providers, no summary page for case activity related to health care, no evidence of signed consent forms, and no easy way for DSS case managers to obtain health information about children from their health care providers to use in case planning or other decision-making activities. In general, the major finding was that while evidence of screenings, assessments and follow-up services were often present, the case-specific details on basic items like diagnosis, required follow up, treatment modality, links to required medications or presence of required medical supplies or equipment was not.

Although evidence of health services was present in most cases, however, case reviewers often had to go back one year or more in the DSS case managers' dictation notes to confirm health-related detail. DSS case managers routinely use the CAPSS encounter tab, dictation tab and linked-files tab to populate the record for each child. However, there is no easy way to piece together the health information for the children reviewed to obtain a complete health picture, and specifically, to confirm that follow up services were received. To remedy this, DSS will do a comprehensive review of CAPSS-related health requirements with an aim of eliminating redundant forms and creating a health-related summary for each child. In addition, another significant finding of the Health Care Pilot and Case Process Review was that despite the fact that virtually all children whose cases were reviewed received necessary health care and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) well-child visits, there was not a user-friendly and systematic way to enter, measure, and identify or track action items needed for follow up that resulted from those visits.

Halfway through the Pilot, the Select Health Team did a "deep dive" presentation on three cases. These cases were selected because of the complexity of the child's health and behavioral health needs. The goal was to test the hypothesis that the Select Health electronic health record system had detailed information on diagnosis, treatment provided, medication, lab results, utilization of 24-hour nurse line, and the like that could supplement the information sought by DSS case managers and alleviate the burden of case managers chasing down information from family members, foster parents, and providers. The team also confirmed that children flagged with complex conditions such as children with chronic health and mental health conditions, children who are medically fragile, children with complex health/mental health conditions and a developmental disability, etc.) received follow-up services. The richness of data available to Select Health and its network of providers opens new possibilities for electronic data-sharing with DSS in the future.

Select Health information systems called JIVA, Navinet and Treo, capture and generate reports on all patient/case-related information. JIVA is an “end-to-end population health management (PHM) platform” that is restricted to internal personnel use. Navinet and Treo are provider portals accessible to all health and behavioral health providers in the Select Health Network.<sup>3</sup> SHSC’s contracted Providers can use both provider portals to identify and track an individual member’s information and the provider’s performance in quality measures. This information includes, but is not limited to a member’s eligibility status, service utilization details, and specific gap-in-care data. SHSC analyzes all clinical and nonclinical data to evaluate provider performance, the quality of a member’s care, and the need for outreach, training and education. Both portals offer clinically oriented gaps in care reports for providers serving any child in their practice. Both portals are used by SHSC to track provider performance against Healthcare Effectiveness Data and Information Set (HEDIS) targets. HEDIS targets are nationally recognized standards of practice established National Committee for Quality Assurance and required by the federal government and codified in the DHHS contract for all MCOs.

Weekly calls with DSS, Select Health and the Consultants have proven invaluable in strengthening relationships and shared learning. This regular communication will continue to provide a venue for identifying, clarifying and resolving issues.

## **B. DSS Case Management Process Mapping**

During this same time, DSS worked concurrently with the University of South Carolina Center for Child and Family Studies to map the current process that DSS case managers use when a child enters foster care. To help DSS, DHHS, and Select Health to better understand each entity’s processes and to and create a shared understanding of how a child enters, progresses, and exits foster care from a health care perspective, milestones and touch points in their respective case management and care management systems. The mapping sessions revealed three gaps in the current DSS case management process for children in foster care:

- 1) no defined process point for sharing health, behavioral health or dental history or detail prior to placement,
- 2) no process for sharing information between Select Health and DSS while the child is in placement, and
- 3) no transition process for follow up when children exit foster care.

See Appendix C for a map of the current process.

The process mapping exercise offered guidance on when, and how the Select Health, DSS, and DHHS information systems should be bridged and work together to best serve children in foster care. These discoveries informed the health care coordination and care management framework being developed by DSS, DHHS and Select Health and discussed in this Addendum.

On January 10, 2019, the Health Care Consultants facilitated an all-day meeting with DSS, DHHS and Select Health to validate and work through health care management issues. Members of the Co-Monitoring team also attended the planning session. Attendees from Select Health included the Market President, Director of Operations, Medical Director for Behavioral Health, Contract Account Operations Manager, Case Management Care Manager, BH Utilization Management Manager, Utilization Management Manager, Pediatrician Consultant, Market Chief Medical Officer, Integrated Health Care Management Director, Rapid

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<sup>3</sup> Zeomega.com. (2019). POPULATION HEALTH MANAGEMENT SOLUTIONS, JIVA for Managed Medicaid. Retrieved from <http://www.zeomega.com/solutions-2/jiva-population-health-management/medicaid-health-plans/>

Response Director, Behavioral Health Integration Director, Child Welfare Liaison, Provider Network Management Director, and Member Services Manager.

The goal was to frame the components of a new health care management process and that bridges two parallel systems--health care and foster care--and integrates the required activities of DSS, Select Health, and DHHS in providing children in foster care with required screening, assessment and follow-up services. This planning session generated a preliminary design for the new Health Care Management and Coordination Model that is articulated in Section IV of this Addendum.

A large part of the work that is ongoing between Select Health, DHHS, and DSS in developing our integrated care coordination model is developing shared language and definitions. Each system uses its own terminology to describe care coordination, case management, and care management and each have different definitions depending on the entity that is doing the work. In the Addendum, we have adopted the following terms: case management refers to the health-related activities of DSS IFCCS and county caseworkers; health care management refers to activities performed by Select Health care management staff; and care coordination that refers to health, behavioral health and dental health service coordination activities of all partners.

To illustrate the use of the terminology, a pediatrician's office may be coordinating care for a patient when the office makes a referral for community services that will address a social determinant of health. For a managed care organization, care coordination or "care management" may involve several activities aimed at oversight and patient education about a chronic disease such as diabetes or high blood pressure. Care management by an MCO also involves referral for services, assistance in finding providers, and helping members connect to services in their communities. Foster care case managers at DSS have yet another function—helping strengthen a family to address the reasons that their child is in foster care. Their work involves assessing the needs of a family and child, developing a plan with the family to meet those needs, and making referrals to address the needs of the parent and the needs of their child in foster care including health and behavioral health needs.

### **C. Interviews and Research with other States**

DSS expressed interest in learning from the experience of other state child welfare systems that have adopted a single MCO for children in foster care to inform their thinking and approach in developing a new health care management model. At DSS' request, the consultants and DSS staff conducted interviews focused on three states that use a single managed care organization for children in foster care: Washington State, Tennessee, and Texas. The consultants also researched the care coordination model used in New Jersey. The interviews confirmed there are multiple ways to structure how health care management is designed and delivered for children in foster care.

### **D. Foster Care Health Advisory Committee**

The Foster Care Health Advisory Committee (FCHAC) is an existing DSS committee comprised of a broad representation from the medical, behavioral health and dental care fields statewide. Representation from pediatricians who coordinate with the South Carolina Chapter of the American Academy of Pediatrics, nurse practitioners, a dental representative, behavioral health providers, child placing agencies, and representatives from Select Health, DHHS, and DSS. The Committee is charged with helping children in foster care have effective

and coordinated medical and mental health services. The FCHAC has reviewed, discussed, and provided feedback on the Health Plan before it was finalized in August.

Throughout the fall and winter, DSS has continued to convene the FCHAC to discuss the ongoing implementation of the Health Plan, as well as planning related to health care coordination. Specific discussions with the FCHAC focused on the Health Care Pilot and Case Process Review, HEDIS measures specific to children in foster care, outcome measures, draft targets for the lawsuit, child health facts for children in foster care, and timeline and planning to develop preferred provider standards and a care coordination model. Due to the Hearing scheduled for early January, the January FCHAC meeting was cancelled. The Health Care Addendum was discussed at the meeting scheduled for February 20, 2019. Members reviewed, discussed, and provided feedback on the Addendum prior to submission for approval.

#### **E. Data Sharing, Analysis, Reporting and Dissemination to the Field**

Over the last year, DSS has increased its capacity to handle, code and generate reports derived from large Medicaid data sets received from DHHS. DHHS loaned DSS a highly skilled Medicaid data scientist who will continue to support DSS as it builds out its Medicaid data analytics capacity to create the systems, tools and reports that DSS needs and will use in the years ahead. DHHS has committed to provide technical assistance, expert Medicaid coding advice, and data capacity support over the next two years (including through continued loan of data scientist to DSS).

Key to the success of the DSS health care reforms is the capacity to capture, analyze, disseminate and use data. The rationale and intention behind this concept are fully discussed in the approved Health Plan. This capability continues to be critically important in moving the health care work forward.

The DSS' nightly data feed rosters of children in care go to DHHS to certify Medicaid eligibility and then on to Select Health who can then begin providing comprehensive assessments, well-child care, needed follow-up services and care management as needed. Additionally, Select Health has begun to produce gap-in-care reports to track utilization and care gaps, care management rosters and other necessary information for DSS managers and field staff. Currently, SHSC and DSS do not have a formal data-sharing agreement, although the approved Health Plan provides that one will be executed. Ad hoc report requests are submitted by DSS and fulfilled by SHSC under the DHHS 2018 MCO Contract provisions.

DSS completed its data validation and performance management assessment work with Chapin Hall in November 2018. This work is intended to improve the collection of essential data needed to track and report on child welfare system performance and improvement in key areas including a metric that will track progress made on completed health, mental health, and dental assessments. The Chapin Hall assessment report supports the recommendations made in the approved Health Plan to develop, future functionality that would enable feeds from Select Health to go directly into CAPSS to fill in health-related information more easily for casework and administrative use.

#### **F. Cadencing Process and Report**

DSS has been holding Cadencing Meetings weekly since September 17, 2018 as a venue to connect with, share, troubleshoot and follow-up on important case-specific health issues and concerns with its regional and



county field offices. Managed by the Office of Health and Well-Being Clinical Team Lead, these calls have become the route for disseminating, tracking and monitoring initial screenings as outlined in the approved Health Care Plan. These calls have also surfaced new training needs and cases that need escalation.

Five Health Care Liaisons, one for each region who also serve as Performance Coaches, attend weekly cadence calls led by the Lead Clinical Specialist. Each region reports on the actions taken to follow up on children who have been identified as missing an initial medical, initial dental, or initial mental health screening. Follow up actions include requesting documentation that an appointment occurred, scheduling an appointment if needed, or scheduling a staffing. The cadence process for children with psychotropic medication red flags began on February 4, 2019 and runs through a series of separate calls: Regional Clinical Specialists staff children with psychotropic medication red flags with the Lead Clinical Specialist and Child Psychologist weekly on Mondays.

Over time the cadence calls will add new features such as BabyNet referrals (March 4, 2019), and will have corresponding dash boards. This method of communication, monitoring and follow-up with the field has proven effective at reducing the number of children without initial screenings and assessments. Select Health has also expressed an interest in participating in cadence calls to create better efficiencies in health care management services provided by SHSC.

## **G. Health Care Outcomes**

DSS developed a set of health outcomes (targets) submitted to and approved by the Co-Monitors that align with the FSA<sup>4</sup> and approved Health Plan that are consistent with the processes recommended in and developed for the Health Plan Care Management Addendum. See Appendix B for the Health Care Targets.

The last outcome measure required DSS to develop a care coordination model by March 1, 2019, which is the subject of this Health Care Plan Addendum. In consultation with the Health Care Consultants, Co-Monitors, and FCHAC, DSS has drafted three proposed outcome measures consistent with the intent of the FSA and DSS system reform goals. The following are draft proposed outcome measures which will be discussed with Co-Monitors and operationalized in partnership with Select Health, DHHS, and DSS:

- Provide health care orientation packet (member handbook, identification card, provider directory, educational materials, and enrollee rights) and welcome call for 90% of new foster care entrants and their authorized caregivers, including when children experience placement moves.
- Provide transition continuity of primary and/or behavioral health and/or dental health care for 90% of children exiting care, experiencing a placement move or stepping up/down from a residential placement
- Provide assistance to a child's DSS case manager and caregiver with referrals for primary and specialty care and track referral completion and follow-up for 90% of children needing follow-up services identified in a comprehensive assessment, EPSDT visit or case plan

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<sup>4</sup> Excerpt from Co-Monitor Letter to Judge Gergel dated 12-21-2018. "...health care outcome measures related to "initial screening services, periodic screening services, documentation, treatment and other corrective services." (FSA IV.K.5). We have set these measures in accordance with American Academy of Pediatrics and American Academy of Pediatric Dentistry guidelines, after consultation with the parties."

SHSC will assist DHHS and DSS to establish specific operational policies and procedures for monitoring, tracking and reporting of specific outcome measures, such as the proposed outcome measures above. For example, SHSC and SCDSS will prepare technical specifications, instructions and guidance for reports that currently do not exist within the existing MCO Contract. This will include the following:

- How DSS and DHHS will calculate results of the data measured.
- Details about the type of methodologies are used in the evaluations of SHSC's performance (i.e., the evaluations conducted by DSS and DHHS).
- Details about the quantitative values needed to achieve a positive or successful score, and a failure or negative score (i.e., the numerical, percentiles or ratios of the targets/benchmarks for the health outcomes identified within the final Addendum).

### **III. Health Care Coordination in South Carolina – Current State**

Currently, both DSS and Select Health tier their basic case management<sup>5</sup> and care coordination activities and assign children based on a determination about their level of need.

#### **A. DSS**

DSS currently has two types of case managers--county-based case managers and regionally-based IFCCS case managers. DSS does not employ a standardized assessment tool for case management tiering and often, case assignment depends on who is available to manage the case. IFCCS is a remaining vestige of the state's coordinated system of care project that originally required staff to have behavioral health expertise. IFCCS caseloads have a standard of nine children although many children deemed eligible for IFCCS case management are now served by county-based case managers who have a higher caseload standard. The workforce assessment completed in October 2018 recommended that DSS consider eliminating these specialized caseloads and the initial validation assessment completed by the health care consultants in February 2018 included a similar recommendation. Currently, county DSS and IFCCS have the same case responsibilities, including any responsibilities related to the health needs of children in care. Actions to move IFCCS children into generalized caseloads will, however, require that DSS identify and preserve any unique case management and care coordination functions currently performed by IFCCS staff, identify Medicaid or other unique funding for services now provided through IFCCS, and determine whether they can reasonably be transitioned into the generalized foster care workload standard.

Children are referred to IFCCS based on the county case manager and supervisor's assessment of their level of need, but typically do not get transferred from a county case manager to a regional IFCCS case manager until an Interagency System of Care for Emotionally Disturbed Children (ISCEDC) staffing has occurred, typically at least 35 days after a child has entered care. There are expectations that the IFCCS case manager will have

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<sup>5</sup> Throughout this addendum, the terms case management, care management, and care coordination are used. In this context, case management is broader than health care and specifically focuses on activities addressing the safety, permanency, and well-being of children in foster care. Care management focuses on the case-level management of a child's health-related conditions and access to necessary health, behavioral health and dental services. The goal of care management is to improve patient health status. Care coordination refers to the cross-system activities (child welfare case management and health-related care management) and service coordination needed to produce good health, behavioral health, and dental health outcomes for children in foster care.

additional case management responsibilities, including more frequent contacts, case consultation with schools and service coordination activities, though they are flexible by case. Also, IFCCS eligibility is open to interpretation with a potential for creating long waiting lists or over/underserving serving children in care. It appears that county case manager shortages and an underdeveloped placement continuum may have created a work-around centered on IFCCS.

Another complication is the interdependency between IFCCS and foster care children's eligibility for and use of ISCEDC funding, which is in a pooled fund overseen by four state agencies. By Proviso 117.54 enacted by the South Carolina General Assembly in 2018, the Departments of Mental Health, Disabilities and Special Needs and Juvenile Justice each contribute to the fund. The Department of Mental Health contributes \$595,000, the Department of Disabilities and Special Needs contributes \$379,456, and the Department of Juvenile Justice contributes \$225,000, for a total of \$1,199,456. DSS makes up the remaining difference in expenditures for services for these children.

As noted in the Workforce/Caseload Plan, "actions to move IFCCS children into generalized caseloads will, however, require that DSS first identify the specific activities currently performed by these staff that ensure *Medicaid or other unique ISEDEC funding* (italics provided) for services to this population and determine whether they can reasonably be absorbed into the generalized foster care workload standard."

Decisions about dispersing IFCCS caseloads are further complicated by the fact that, currently, IFCCS case managers are paid at a higher salary than staff managing caseloads in general foster care. Resolution of the salary scale for case managers recommended in the Workforce/Caseload Plan will move to bridge these differences. Given the complexities of this change, DSS has proposed to complete the necessary research and determine how best to move forward with its plan for IFCCS and ISCEDC consistent with the timeframes established in its approved Workforce/Caseload and Placement Plans.

As an immediate starting point, it would be useful to align timeframes for IFCCS eligibility with other health, behavioral health and dental assessments happening within the first 30 days of placement in foster care. As envisioned in the "future state" DSS health care coordination model, described below, the goal is to ensure that all children in foster care, regardless of placement type or level of need, have access to services and supports covered through their EPSDT benefits to meet their needs.

Currently, both types of DSS case managers are responsible to ensure that children in foster care have their required health assessments and receive any follow up care. While DSS views birth parents as partners and case managers as ultimately responsible ensuring health care needs of children in foster care, many foster parents actually manage the day-to-day health care of children in their care. DSS policy and practice pertaining to obtaining consent for treatment from parents or other authorized parties will be integrated into the Child Family Team Meetings and other case planning activities.

## **B. Select Health**

SHSC provides care management to all members based on medical necessity and an assortment of other criteria that represents a need. SHSC's care management program is built on industry-accepted models and sound evidence. Under specific provisions in the 2018 MCO Contract, members are risk stratified<sup>6</sup> and provided

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<sup>6</sup> 2018 MCO Contract, Section 5.3. Member Risk Stratification Requirements <https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>

a blend of services based on their individual needs. These services range from overall wellness promotion and illness prevention to special enhanced services based on a member's conditions.

Risk stratification is the act of tiering individuals into groupings of risk based on their clinical and lifestyle characteristics. A risk score may indicate the likelihood of an event, such as a hospital admission within a specific timeframe. A risk stratification framework combines several risk scores to create a broad profile of an individual's complex, ongoing needs. Health care organizations use risk stratification tiers to target interventions and prevent members from developing more serious conditions.<sup>7</sup> Using risk stratification to identify individuals is a way to prevent negative outcomes before they happen. Once a child has a negative outcome, such as a hospital admission, it is too late to prevent that occurrence.

However, SHSC currently uses the same risk stratification formula for all children in Medicaid and does not distinguish between enrollees who are in foster care and those who are not. In other words, Select Health does not currently use a risk stratification methodology specific to children in foster care. The issue of risk stratification and need for a foster care trigger framework emerged in the health care management planning session with DSS, DHHS and Select Health held in January 2019.

Select Health assigns its care coordination staffing based on the severity or complexity of the child's health or behavioral health needs (level of need) and other triggering criteria using a proprietary algorithm.<sup>8</sup> It uses the same formula for all children in Medicaid and has three tiers of care management in its Care Management Program:

- 1) utilization review – an administrative review of service use and authorizations;
- 2) rapid response – a care management function tied to point-of-service (emergency room, hospital admission or hospital discharge); and
- 3) complex care management- a component of an integrated health care management program that offers an intensive<sup>9</sup>care management and care coordination function tied to health and behavioral health needs.

The South Carolina MCO contract<sup>10</sup> held by DHHS, specifies the responsibilities of the Select Health's care management system, staffing and processes. These responsibilities include:

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<sup>7</sup> <https://healthitanalytics.com/features/using-risk-scores-stratification-for-population-health-management>

<sup>8</sup> Specifically, the current Select Health Complex Care Management (CCM) component of the Integrated Health Care Management (IHCM) program at Select Health provides coordination of services for pediatric and adult members with complex medical issues. The CCM program applies a holistic approach to evaluate members' physical and behavioral health needs.

Evidence Used to Develop the Program: The IHCM program was developed with evidence-based guidelines, medical and behavioral healthcare specialty societies. These guidelines form the basis of the program design and content.

Population Health Management Framework: The program is built on a population health management approach that uses key clinical and nonclinical characteristics to segment the population by risk level and to design and implement interventions appropriate for the level of risk.

Person-Centered Care Delivery: The program uses a person-centered approach to assist members with identifying and setting goals; identifying barriers; and developing strategies to achieve their goals. Care management interventions focus on supporting the member in the attainment of their goals.

Care Manager Skills and Training: Care management staff are trained in motivational interviewing techniques, focusing on member perceptions and perspectives using open questions, affirmations, reflections and summaries to help members overcome ambivalence to change. Additionally, care managers have received education on the services offered at Dee Norton Child Advocacy centers and the Continuum of Care. They have received in-house education from Select Health Behavioral Health Directors on rehabilitative behavioral health services and working with children on the autism spectrum. In 2019 all care managers will begin training in Person Centered Thinking and Trauma Informed Care. Annual education also includes review of chronic diseases most commonly managed by our care managers like diabetes, asthma, heart disease, sickle cell disease. Care managers also have access to a Select Health Medical Director for any questions regarding medical management of a member.

<sup>9</sup> Complex care management is the term used in the Addendum to distinguish between intensive case management provided by IFCCS workers and health care management provided by Select Health staff.

- The assessment of a member's physical health, behavioral health and social support service and assistance needs,
- The identification of physical health services, behavioral health services and other social support services and assistance necessary to meet identified needs, and
- The assurance of timely access to and provision, coordination and monitoring of the identified services associated with physical health, behavioral health, and social support service and assistance to help the member maintain or improve his or her health status.

The MCO contract requires Select Health to have a care management and coordination system that: identifies members with complex conditions and refers them for care management services; and determines the need for enhanced services that may be necessary for the member. This is what Select Health refers to as complex care management and coordination, as described in detail below.

The MCO contract details Select Health's scope of work and care management responsibilities. Select Health is required by contract to provide educational information and materials for all enrollees. Under the contract between DHHS and all MCOs in South Carolina, Select Health's care management system must do the following for all of its members:

- Develop programmatic-level policies and procedures for care management and coordination of services.
- Use care management and coordination as a continuous process for:
  - The assessment of a Member's physical health, behavioral health and social support service and assistance needs; and
  - The assurance of timely access to and provision, coordination and monitoring of the identified services associated with physical health, behavioral health, and social support service and assistance to help the member maintain or improve his or her health status.

In addition, Select Health is required to develop a system for complex care management. In particular, Select Health must do the following as a part of its complex care management contract requirements:

- Develop a detailed program description for Complex Care Management (as described above);
- Have policies and procedures for the assessment of characteristics and needs of its Member population (including children/adolescents, individuals with disabilities and individuals with Serious and Persistent Mental Illness (SPMI), and/or Serious Emotional Disorders (SED));
- Have a Care Management System based on sound evidence;
- Have a systematic process for identifying Members with complex conditions and referring them for care management services;
- Determine the need for enhanced services that may be necessary for the member;
- Have a mechanism in place to allow a member direct access to a specialist as appropriate for the member's condition and needs;
- Have automated systems to support the care management staff;
- Have a Care Management System that provides appropriate documentation and follow up; and
- Have a Care Management System with processes for initial assessment and ongoing management of members.

Currently, few children in foster care receive complex care management from Select Health--approximately 75 of the 4,700 children in care. This point in time figure represents approximately 1.5% of the children in foster care.

In the current state, there are neither foster care specific requirements for care management nor are there formalized, joint protocols that connect DSS case managers to Select Health care managers, coordinators or other Select Health care management resources. As outlined above, Select Health employs credentialed, knowledgeable staff and liaisons in its care management functions with all members. However, Select Health presently does not have a dedicated Care Management Unit focused on children in foster care. Similarly, DSS has not provided direction to case managers about how they are supposed to interact with Select Health staff. Recently, however, DSS began informing its case managers about Select Health services and responsibilities at DSS trainings being held related to psychotropic medications, but there is currently no practice or policy guidance available on the role of Select Health in ongoing health care coordination.

At its most basic, neither DSS case managers nor Select Health care managers currently have accurate or timely information on who is assigned to a child's case or what protocols to follow for issues needing attention or escalation. This issue surfaced often during the Pilot and in discussions between DSS and Select Health.

## **IV. New Health Care Coordination Model**

### **A. Defining Health Care Coordination for Foster Children in South Carolina**

While a variety of health care management and coordination models exist (as described in Section II), DSS thinks it is important to first define what it means by health care management and coordination for children in foster care before discussing the model it will develop to deliver it. To this end, building on foster care health care coordination definitions developed in other states, and consistent with federally-approved NCQA practice standards and Fostering Futures, the AAP's guide to best practice, DSS has defined health care coordination for children in foster care as including the following features:

- Ensuring all pre-placement/point-of-placement assessments take into consideration a child's health, behavioral health and dental needs so that immediate health needs are identified, follow-up services are scheduled and placement is matched to a child's needs;
- Ensuring that comprehensive medical and behavioral health exams and dental screenings are conducted within 30 days, except for children who need emergency or forensic exams which will occur sooner, and that immunizations are up to date;
- Participation in-person or remotely in initial and routinely scheduled Child and Family Team Meetings (CFT) when a child's health status and needs, consent is secured (parents and older children) are discussed and where services and placement plans are developed;
- Providing, obtaining and/or reviewing medical records or summary reports, pre-placement/point-of-placement assessments, information from parents, and ensuring the DSS case manager understands the child's health history and needs when service and placement planning occurs;
- Obtaining and/or reviewing medical records periodically, and at critical incident or trigger points for the child, including but not limited to any change in placement, any visit to the emergency room, any

- inpatient admission, hospital discharge or other milestone points;
- Ensuring children receive any/all EPSDT well-child visits, dental visits and necessary follow up care, including access to community-based and trauma-informed services, such as behavioral health services, crisis intervention, home care, dental specialty care and/or long-term services and supports.
  - Monitoring psychotropic medications and treatment;
  - Providing in-person contact, developmental monitoring and follow up for children and youth with certain high-risk profiles;
  - Teaming with child welfare staff, foster parents, families, community providers to support transparent information-sharing, planning and seamless provision of services with sufficient capacity to identify emerging trends related to child health, behavioral health, behavioral health and dental outcomes; and
  - Developing processes and regular touchpoints between the child welfare, health care and Medicaid systems, as needed, to effectively share case and administrative data and monitor performance (using all necessary care to keep personal health, behavioral health and dental information private and shared only within approved guidelines).

## **B. Components of New Model**

The bedrock principle that undergirds the vision for and definition of the new DSS health care and care coordination model is that every South Carolina child in foster care receives the services and health care coordination they need. Children in DSS custody in foster care are among the most vulnerable children in the state, creating a heightened obligation by the state to ensure they receive the health, behavioral health and dental services they need and the necessary case and care management to ensure they get it. Other states have enacted similar foster care health reforms in a managed care context and their experience is instructive. This addendum proposes a health care management and coordination model that is a hybrid of models used in New Jersey, Washington State, Tennessee and Texas among others, taking into consideration local conditions and assets in South Carolina.<sup>11</sup>

The historical tension between central versus regional service delivery and deep versus light touch care manager engagement is a perennial topic in the fields of health and human services network development and organizational design. The difference between the two is a choice to locate staff centrally or in the field and the use of robust administrative data as an important feature in identifying higher needs clients. The pendulum swings back and forth with advances in technology, communication and the evolution of best practice models. There are cost considerations of course, but there is also talent, ease of management and efficiency considerations. The final consideration is the maturity of the system and coordination complexity between multiple entities and systems. All this is to say that there is no one right way to achieve our goal, as evidenced by the experiences of and care management models currently operating in child welfare systems around the country.

DSS seeks to build a state-of-the-art care management and coordination system for children in foster

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<sup>11</sup> Client-engaged care management is now a more prevalent feature of health care systems and health insurance payers (e.g., MCOs). Several major medical centers and teaching hospitals are embedding care coordinators in primary care sites and even dispatching them to community sites and sometimes, though less often, to patient homes. Health care payers (MCOs) have moved from all-telephonic care management models to centralized warm-touch care management units assigned regionally which means that specific members are assigned to a specific base manager or care management team. MCOs are also beginning to move care managers and health care navigators into community settings or provider sites. In South Carolina, Select Health is piloting an on-site care management model in two locations— one at a Department of Mental Health Community Mental Health Center and the other is at the Medical University of South Carolina. These industry shifts and Select Health's experience with its pilot offer a window into the future.



care. To do this, we have borrowed elements from other state child welfare systems, and from the health care industry keeping in mind the framework and standards established for MCOs by the federal government, articulated in the contract between DHHS and Select Health and commitments made in the FSA.

It is important to note that DSS, DHHS and Select Health speak regularly and understand that care coordination for children in foster care going forward will be different from the care coordination offered now, given the trauma history and complex living conditions experienced by children and youth placed in foster care. Indeed, it was in recognition of this fact that South Carolina chose a single MCO, Select Health, for children in foster care and extended to it a higher “per member/per month” rate to serve this population.

DSS, DHHS and Select Health are proposing of a new model that will build on the best features of the Select Health care management infrastructure, develop new functions and adding resources designed to meet the unique needs of children in foster care and better align with DSS’ foster care processes and touchpoints. What this means is the health care management and coordination model proposed by DSS will include the following features:

- a robust and staff-enhanced DSS Office of Child Health and Well-Being,
- combined with the enhanced resources of Select Health, including the establishment of a dedicated Foster Care Unit in Select Health focused exclusively on meeting the needs of children in foster care, and
- dedicated regional lead staff in both DSS and Select Health; and
- local DSS care coordination that is supported by a more robust practice model through the work with Chapin Hall, sufficient staff support, better assessment tools, engagement in child and family team meetings meet children’s service and support needs.<sup>12</sup>

Details of the model are described below.

### **1. A Robust and Enhanced Office of Health and Well-Being within DSS**

The DSS Office of Health and Well-Being is currently responsible for child and adolescent health, child and adolescent clinical and behavioral health through the IFCCS, therapeutic foster care, specialized treatment services, oversight and monitoring of psychotropic medication, clinical consultation, child and adolescent education services and health care management through the cadencing process. The Office is currently staffed with a Director hired in April 2018, one full-time Psychiatrist, one full-time Lead Clinical Specialist, and one full-time Intensive Foster Care and Clinical Services (IFCCS) Manager. Other staff in the Office include five State Office IFCCS contract administrators and four administrative assistants located in the regions, a program coordinator for the medically fragile population, a network systems administrator, a program coordinator for sex trafficking, and an administrative assistant who supports the lead clinical specialist and child psychiatrist.

Going forward, the Health Care Consultants have recommended that the Office of Health and Well-Being build out its care management and care coordination function. This includes rounding out its clinical staffing to include medical expertise and new care management and coordination functions. A team of six registered pediatric nurses will be added and serve under the supervision of the Lead Clinical Specialist and Child Psychiatrist. A team of five Program Coordinators will also be added and serve on this team. This team will

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<sup>12</sup> As used in Tennessee and described in the DSS Placement Plan.



support the clinical consultation, medication management, training, staffing (case planning), care management and similar functions now available for mental health services only. The DSS Health Care Team will be responsible for coordinating with the Select Health Care Management Unit to ensure that every child is linked to the health care management and health, behavioral health and dental services they need and will handle health care management for non-Select Health enrolled children. It is also recommended that the Office of Health and Well-Being add this staff to build out its capacity to train DSS case managers in health and behavioral health issues (service array, accessing care, medication use, etc.), monitor care quality provided by the Select Health network and other out-of-network and specialty care providers, troubleshoot cases referred from the field and handle time-sensitive case escalations.

DSS nurses in the Office of Child Health and Well-Being will serve several key functions, including most importantly, reviewing EPSDT visit summaries to flag any follow up identified by the provider, in Medicaid terms, an “abnormal finding”, and creating action steps and a case worker-completion due date in CAPSS. The nurses will also review Medicaid dental and specialty dental visit data to flag missed visits and any follow up identified by the provider and create action steps including completion due date in CAPSS. In the future, CAPSS will include an automatic health care action item drop down screen, which DSS case managers will complete when follow up is completed. DSS nurses will develop an interim process through cadencing calls to ensure follow up is completed. Medicaid administrative data on EPSDT visits will be used to verify and cross check data collected by nurses’ real time review of EPSDT visits.

The Office will initially add two nursing staff and three program coordinators, currently in the budget being considered by the South Carolina General Assembly. These staff will be assigned regionally to build out capacity to train DSS case managers in health, behavioral health issues and dental issues (service array, accessing care, medication use, specialty care, etc.), monitor care quality provided by the Select Health network and other out-of-network and specialty care providers, troubleshoot cases referred from the field and handle time-sensitive case escalations needing follow-up attention, review EPSDT summaries and dental data and identify children needing follow-up. Funds are expected to be available on July 1, 2019, and the positions will be filled by September 30, 2019. The agency will make a budget request for the remaining ten staff in the fall of 2019, and those staff will be hired by September 30, 2020.

Additionally, the Office will add other care management and care coordination capacity and has requested funding for two positions to manage vendor relations and performance for Select Health including the annual assessment of network adequacy and service capacity review, review of service denials and alignment and other quality improvement and performance monitoring activities outlined in the approved Health Care Plan and required for children in foster care. These staff will also centralize, and handle appeals and denials to maintain necessary services for children where there is a level of care or level of need dispute and reduce the burden on DSS case managers.

Finally, the Office will work with DHHS and Select Health to define and include these new and enhanced responsibilities in an MCO Provider Guide that will become part of DHHS performance expectations for Select and any future MCO that enrolls children in foster care. This document will cover all required elements related to care provision for children in foster care. In the longer term, DSS will enhance its regional clinical capacity and bring Regional Clinical Specialists into a direct line report with a new set of duties as part of the Office of Health and Well-Being Team. In light of improvements called for in the Health Plan Care Management Addendum,

Workforce/Caseload and Placement Plans there are opportunities to restructure these roles and build deeper in-the-field health care capacity.

DSS also anticipates changes to the health care data fields and screens in CAPSS and in reports generated from CAPSS and other data feeds. As noted in Section II, The Health Care Pilot revealed limitations in CAPSS health forms in need of review and improvement. Aligned with data improvements recommended by Chapin Hall, DSS will incorporate health-related enhancements into its planning for CAPSS including developing a plan to review, consolidate and eliminate forms and fields. Because the health care management, coordination and follow-up work of DSS depends on data-sharing between DHHS, Select Health and other partners in care, the production of new tracking and performance reports and health care adaptations needed in CAPSS, DSS will also add three data management, analytic and technologist positions to analyze data and implement CAPSS changes in the department to manage this work (see resources). See Appendix D, DSS Care Coordination Model.

Moving forward, the DSS Health Plan implementation activities already underway and the activities outlined in its new Health Care Management and Coordination Addendum will be sequenced and coordinated with new activities detailed in its Workforce/Caseload and Placement Plans. We expect to include in our Annual Staffing Report, to be submitted to the Co-Monitors, will include data on health care staffing in the Office of Health and Well-Being, at Select Health and DHHS (if needed). This reporting will reflect additional capacity at DSS, focus on full utilization of the resources and commitments of Select Health, monitor needs and gaps and provide an opportunity to course-correct based on experience and the health needs of the children in care. This report will inform an annual assessment by DSS, in consultation with the Co-Monitors, at the end of each implementation year, to determine whether the care coordination model is adequate to meet the healthcare needs of children in DSS custody.

The proposed changes for DSS track favorably against other child welfare systems, notably Washington State, Tennessee and Texas. To illustrate, all three states have a single MCO whose contract is held by the state Medicaid agency. They all have central units internal to foster care that handle care coordination with the MCO and designated care managers in the MCO assigned regionally. The MCO staffing models for care management and coordination in these states are based on regional assignment, some co-location in child welfare field offices, and no direct care management caseloads of children. Internal staff handle appeals and denials and track screening and assessment, missed EPSDT visits, medication and follow up services, among other duties. These units also provide clinical consultation to the field. All three states use the CANS assessment tool, rely on strong data-sharing agreements to generate case, regional, and system-wide data and have a strong governance framework.

Despite significant and notable progress, DSS only recently established its Office of Health and Well-Being in March 2018 and began its direct relationship as co-partner with DHHS in vendor management and as a Super User with Select Health at that same time. DSS and Select Health are now deeply engaged in weekly and as-needed meetings to deepen system understanding and resolve operational solutions to issues that emerge. As well DSS, Select Health and DHHS communicate regularly to streamline business processes and address issues that arise.

All partners – DSS, DHHS and Select Health will be tasked to build out the new features, functions and operations outlined in the Health Plan and Addendum with DSS holding responsibility for insuring that the health, behavioral health and dental health needs of children in foster care are met.. DSS, Select Health and

DHHS will develop a regular meeting schedule (as-needed and weekly now, moving to monthly in 18 months) to implement Health Plan, Addendum and other DSS plan recommendations. As future reforms at DSS occur, this communication, information-sharing and governance framework and the care coordination processes in use may change or be enhanced to ensure that health-related functions and operations are in alignment, and most importantly, to ensure that children in the custody of DSS receive the health care they need.

## **2. Dedicated Select Health Foster Care Unit and New Care Management**

Select Health has extensive health care coordination staff and services in their complex care management, rapid response, utilization management and member services units. However, until now, staffing resources committed exclusively to foster care have been more limited. Under the new care management model, Select Health has committed to expanding its complex care management staff – RNs and navigators called care connectors—dedicated exclusively to children in foster care. For the Select Health Foster Care Unit, Select Health will employ six complex care managers (clinical RNs), eight care connectors (non-clinical), a halftime RN Manager, one RN supervisor, two care manager IIs (LCSW), a halftime medical director, and one quality improvement specialist, for a total of nineteen dedicated staff. See Appendix D, DSS Care Coordination Model.

Select Health will also reorganize its care management staff to align with DSS regions so there is a designated Select Health Care Management Lead known and available for each regional office. Initial regional realignment can begin in June 2019, using existing staff. Select Health also employs Physician Administrators who are available to consult on foster care (in fact, at least two Physicians – primary care and behavioral health - from Select Health join weekly meetings between DSS and Select Health). Select Health also provides tiered provider quality and performance improvement training and assistance to improve care delivery.

With this new staffing model, Select Health will assume primary health care coordination responsibilities at the beginning of every case until a child’s health status is in good standing and stable and will share routinely, information the DSS case manager needs for planning and follow-up. Select Health will continue to review its case and provider-specific data to identify children who need rapid response or complex care management. DSS case managers will check monthly, as they normally do, to ensure safety, permanency and well-being and to monitor completion of required screening, assessment or follow-up appointments. At specific identified instances detailed below where a foster care trigger is identified, Select Health will assign a complex care manager to work with the child, youth, caregiver and DSS case manager until the situation has stabilized.

### **Proposed Risk Stratification Triggers for Select Health Complex Care Management**

#### Process Touchpoints

- Admission to hospital in the last six months
- Emergency room visit in the last six months
- Planned admission or surgery
- Use of three or more medications
- Use of medical equipment (including nebulizer)
- Admission to foster care
- Planned exit from foster care (at child and family team meeting prior to reunification, when goal changes to adoption, when youth ages out of system)
- Any placement instability which could result in a loss of services (geographic change or entry/exit

- from residential treatment)
- Repeat maltreatment in care

#### Functioning

- Eating/Feeding Issues
- Medication Management
- Behavior Issues
- Physical and Sexual Abuse
- Severely Emotionally Disturbed
- Intellectually Disabled
- Medically Complex (medically fragile)
- Gender/Identity

#### Medical and Mental Health Conditions

- Premature and/or low birth weight baby
- Baby born without prenatal care
- Baby born to substance abusing mother
- Asthma
- Mood Disorder (such as depression, bipolar, and others)
- Psychotic Disorders (such as schizophrenia)
- Neurodevelopmental Disorders (such as autism)
- ADHD (not managed well with medication)
- Lead Poisoning
- Sickle Cell anemia
- Pregnancy
- Suicide Risk
- SUD/Addiction

As outlined above, under Select Health's current complex care coordination program that does not include foster care-specific trigger, approximately 1.5% of children in foster care receive complex care coordination at any point in time. Under the proposed risk stratification triggers, Select Health estimates that at a minimum at any given time, 10% of children in foster care will receive complex care coordination. The exact percentage of children in DSS custody requiring complex care coordination is unknown at this time. Using analytic tools Care Analyzer and John Hopkins Adjusted Clinical Groups (ACG)<sup>®</sup> System, Select Health will identify children who are at high risk and use this information and the new child welfare triggers to predict utilization. For additional information on these analytic tools, see Appendix E, Request for Additional Information from Select Health.

The Center for Disease Control and Prevention produces the National Survey of Children with Special Health Care Needs. This survey identifies a broad range of children and youth with chronic health conditions and disabilities.<sup>13</sup> The federal Maternal and Child Health Bureau identifies children with special health care needs as those who have or are at increased risk for a chronic, physical, behavioral, or emotional condition and

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<sup>13</sup> <https://www.cdc.gov/nchs/slais/cshcn.htm>

require health and related services beyond what is required by children generally.<sup>14</sup> The South Carolina rate of children with special health care needs is 16.5%.<sup>15</sup> Based on analysis of existing data Select Health has on children in foster care, Select Health estimates that 8-10% of children enter and exit care coordination in any given month. While not all children with special health care needs will need complex care management all the time, many children will receive complex care management throughout the course of the year when they enter or exit placement, if their placement changes or if their health condition or other trigger warrants it (see Trigger list above). For additional information in estimates of the numbers of children needing complex care coordination and duration of that complex care coordination, see Appendix E, Request for Additional Information from Select Health.

### **3. Strengthened Local Care Coordination Increasing Access to In-Network and Out-of-Network Services (Service Array)**

Federal law requires that DSS ensure the safety, well-being and permanency of children in foster care. Attaining the caseload standard of 1:15 for DSS case managers in South Carolina will make it possible for to improve exponentially the level and quality of care to children in foster care. While DSS case managers are not health care clinicians or health care managers, they do know and are responsible to know the child's service needs and routinely develop service plans for them. Child welfare systems around the country require that DSS case managers collect information, plan and otherwise be familiar with the health, behavioral health and dental health needs of children on their caseload. Without this knowledge, DSS case managers are not in a position to judge child safety, progress to permanency or monitor well-being, which they must do routinely. Given this, every DSS case manager will have some involvement in a child's health status and activities.

From the outset of a case, DSS child protection case managers are expected to collect information on child health and well-being from their initial contact with a family and to include this information in the child's case record. The passage of the Family First Prevention Services Act, as noted in all DSS Michelle H. Implementation Plans, places new requirements on states related to both its prevention efforts and to insuring that children are placed in family-based settings that consider upfront their strengths and needs, including any health and behavioral health needs. While the Health Care Plan and this Addendum are focused on children already in custody, DSS is nonetheless making plans to comply with Family First Prevention Services Act outside of the FSA, including developing ways to learn more about children and families in the pre-placement period, such as when children and families are receiving preventive services, other in-home services, family preservation supervision and during the period when a child protective services investigation is underway.

Additionally, most children coming into foster care in South Carolina are already enrolled in Medicaid and some are already known to Select Health. This provides an opportunity to create processes to collect Medicaid administrative data and Select Health medical record data and use them to create an early picture of the child's health and behavioral health service use, medications among other services that can be shared with DSS case managers. The DHHS plan to establish same-day eligibility and DSS' work to refine its consent policy will make it possible for information to flow timely and back and forth between Select Health and Medicaid to DSS. This information will be useful in child and family team meetings and in the development of service plans and cadence follow up and gaps in care reports.

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<sup>14</sup> <https://nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/population-specific-fact-sheet-child-with-special-health-care-needs/>

<sup>15</sup> <https://mchb.hrsa.gov/cshcn0910/state/pages/sc.html>

DSS is building a foster care system for the future and in recognition of its new practice plan goals for children in care and soon Family First Prevention Services Act implementation, it will begin work to implement pre-placement assessment outside of the FSA. Using the pre-placement period to learn more about the child and family is not intended to require that plans be created for every child coming into care. To the contrary, it is intended to ensure that if placements necessary that child protective services case managers have access to the information, they need upfront to make more educated first placement decisions and that information is available in the warm hand-off between CPS, Placement and county case managers. States working toward this model have reported a higher use of kin placements, more collaboration between CPS and permanency case managers, as well as more family team meetings that include both families and foster caregivers and that build on both the child and family's strengths to identify and deliver needed services in the least restrictive placement environment.

Both the Placement Plan and the Health Plan contemplate that DSS will adopt a more standardized assessment tool, like the CANS (Child and Adolescent Needs and Strengths), to be used to assess children's strength and needs, and to support service planning and placement decisions. Both Plans describe a placement process where assessment, service planning and information sharing occurs in the child and family team meeting at regular intervals during a child's stay in foster care. Both plans also envision a collaborative relationship among birth families, foster families, DSS case managers, Select Health care managers, and providers. Below is a description of the health care management and coordination process in action, from pre-placement to point-of-placement to in-placement assessments until a child achieves permanency.

Throughout this process, DSS, Select Health and DHHS will continue to communicate regularly about case-related issues, with unscheduled calls as needed and in weekly meetings. As both systems gain experience, we expect to hold monthly meetings to review cases, policies, staffing, provider performance, data-sharing, service availability and outcome performance targets.

### **C. Key Process Points**

Although many implementation details remain, the foundation of the health care coordination and care management system as described above is already being built by DSS, Select Health and DHHS. Discussed below are key process points DSS will use to ensure that children in foster care get the health care they need, including (1) next-day enrollment into the Select Health plan; (2) completion of necessary assessments (placement and health), service plan development and follow-up monitoring; and (3) connection to Select Health for care coordination, troubleshooting and appeals.

In addition, responsibilities of the Office of Child Health and Well-Being, Select Health care managers, Foster Parents, DSS Case Managers and Families are outlined in Appendix D, a chart that identifies milestones and touchpoints and illustrates how the care coordination process will work starting from the first day that a child enters care and on an ongoing basis. The roles of families is central to the achievement of a child's safety, permanency and well-being goals and is a key feature of the Child and Family Team Meetings that are included as important touchpoints in Appendix D.

#### **1. Enrollment in the Select Health Plan**

DSS, DHHS and Select Health all agree that children in foster care should be enrolled in the Select Health plan and connected to Select Health care coordination as soon as they enter care. Ideally, as DSS, DHHS and Select Health become more knowledgeable and sophisticated about each other's data systems, process gaps will be identified and resolved quickly. For example, DHHS and Select Health recognized that the daily data file roster of children entering foster care needed to be transmitted more regularly to prevent lags in outreach to new enrollees and access to providers and services and are working to resolve this issue.

Critically important, DHHS issued policy guidance that resolves the 30-day enrollment gap identified in the Health Plan so that children in foster care need not wait until the first day of the month to be enrolled in the Select Health Medicaid plan, which is the typical way enrollment has occurred in South Carolina and other states. DHHS guidance creates the guarantee that children in foster care have active Medicaid coverage from their first day in foster care. This means that Select Health will be able to get involved in the child's care at the very outset of placement.

A related guidance clarifies that children in foster care can receive unlimited EPSDT visits. In addition to opening the door to more than the number of required EPSDT exams, this guidance created the underpinning for the Department's approved outcome targets. This was a very important issue negotiated between DSS, DHHS and Select Health over the past six months. While it is outside the scope of this Addendum, as DSS' reform work continues, sharing any pre-placement assessment findings with Select Health before a child is taken into custody could be leveraged to ensure children in family placements have sufficient services wrapped around them and their kin/foster family from the start of the case.

## **2. Completion of Pre-Placement/Point-of-Placement Assessments to Quickly Identify and Meet Child's Health Needs**

As noted above, DSS believes that all children who enter foster care (approximately 200 children per month) need an early and basic level of care coordination to ensure that any immediate needs are met, comprehensive assessments are completed, and any follow up services are put in place. For planned placements and emergency placements of children known to the system, DSS can make better use of information about a child's health, behavioral health and dental health status collected during the initial stage of a child protective services investigation or from carrying a family preservation case. DSS will assess and redesign its initial assessment process to focus on health, behavioral health, and well-being status. Pre-placement and point of placement assessments also include an initial medical screening performed by a DSS case manager within 48 hours of entering foster care and action taken to identify and address health conditions requiring urgent attention. DSS will work with Select Health to develop a process where either an Office of Child Health and Well-Being nurse or a Select Health nurse case manager will review results of 48-hour screenings to determine if there is a diagnosis or condition that needs immediate attention.

Initial training for case managers on the 48-hour medical screening will be conducted by either nurses, if hired in time, or by contracted medical professionals. Over time, these nurses will continually train DSS case managers on how to properly conduct a medical screening within 48 hours of a child entering foster care. The 48-hour screening guidance and protocol will be developed by a medical professional. This training will include identifying health conditions that require prompt medical attention such as acute illness, chronic diseases requiring therapy (such as asthma, diabetes, or seizure disorders), signs of abuse or neglect, signs of infection or communicable diseases, hygiene or nutritional problems, pregnancy, dental needs, and significant

developmental or mental health disturbances. The purpose of this training is to teach DSS case managers when a child should be taken immediately to an emergency department or within a short period of time to a primary care provider. The training will be provided in all regions and will also be available online so that new DSS case managers do not have to wait to receive the training in person. All caseworkers who are expected to perform initial medical screenings will be trained by August 31, 2019.

Further, over the longer-term, DSS plans to adopt a standardized level of need/level of care assessment tool like CANS to support decision-making and feed into the child and family team meetings, and inform case assignment and care coordination with Select Health care managers.<sup>16</sup> Again, as noted above, while pre-placement activities are not part of this court-ordered Plan, DSS will explore CANS implementation, training and certification processes used in Washington state, Tennessee, and other jurisdictions, and will develop an implementation plan for each region in the state.

### **3. Initial and Ongoing Connection to Select Health Care Coordination**

As discussed above, there will be intersections between the care coordination model proposed and the placement process described in the DSS Placement Implementation Plan. As the Placement Plan and process are finalized, DSS will work to develop protocols that best align with practice expectations for the first 90 days of a child's initial placement or placement move.<sup>17</sup>

## **V. Care Management for Children Not in Select Health Plan**

As of May 31, 2018, there were 65 children in a DHHS Medicaid waiver that would not be eligible for Select Health. In addition, 30 children are ineligible for enrollment in Select Health because of their immigration status. For these 95 children, and an estimated 100 children going forward, the care coordination function described for Select Health will be performed through the DSS Office of Child Health and Well-Being nurse and program coordinator staff.

DSS Office of Child Health and Well-Being nurses and program coordinators will follow these children so that they have assessments completed and any necessary follow up care delivered in a way that mirrors the services available through Select Health. This includes connecting with the DSS case manager to inform foster parents of contact information, participating in initial child and family team meetings, collecting available historical health information, reviewing the child's immunization status, sending the foster parent a welcome package and information on how to submit health care bills for payment, assisting foster parent in scheduling initial well-child visits, and if needed behavioral health assessments, reviewing findings from EPSDT well-child visits, and creating action items as a result of those visits.

DSS Office of Child Health and Well-Being nurses and program coordinators will also have primary responsibility for ensuring that dental visits for children in foster care are scheduled, follow up appointments are tracked as action items, and semi-annual dental visits and specialty dental appointments are scheduled.

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<sup>16</sup> A discussion of the case assignment and tiering process to be used by Select Health can be found in the Health Plan Care Management Addendum.

<sup>17</sup> Note that that this chart was developed in discussion with DSS and is based on the Family Teaming recommendations in the Placement Plan, including specifically the holding of family team meetings on the first and seventh day that a child enters care.



This will ensure that children's dental needs are assessed and met timely and appropriately. DSS nurses will review Medicaid dental claims data for every child to identify which children have had, and which children have missed the required dental screenings, as well as necessary referrals to specialty follow up. The nurses will add dental action items to CAPSS, as needed.

## **XI. Resource Needs**

As noted above, the Office of Health and Well-Being is the center of DSS' health and behavioral health leadership and field support. As a new unit for DSS, it was established with one new FTE for the Director position. The Health Care Pilot, ongoing work with DSS, DHHS, Select Health, other state agencies and the Foster Care Health Advisory Committee coupled with recommendation in the Health Plan Care Management Addendum led the Health Care Consultants to identify the following additional resource needs that, when funded, will enable full implementation of the new care management and coordination plan.

### Program Coordinator II (three positions current budget request, two positions next year's budget request)

5 FTE program coordinators responsible for monitoring and disseminating data to regions and counties on monthly initial screening reports, psychotropic medication reports, and gaps in care reports. They will also track other action items such as vision and hearing screenings. The additional staff will also provide technical assistance, training, and coaching to regions and counties on psychotropic medication issues and gaps in care, and assist with implementation of new policies, procedures and practices. They will also assist nurses with care coordination for children who are ineligible for enrollment in Select Health.

### Clinical Consultation to the Field (two positions current budget request, four positions next year's budget request)

6 FTE medical specialists (Registered Nurses and/or Physician's Assistants) who will bring pediatric medical expertise to the Office. These staff will also support other Health Care Team activities described in the body of the Addendum. These nurses will also provide care coordination for children who are ineligible for enrollment in Select Health. These staff will be assigned regionally and will manage using the same criteria and care management triggers used by Select Health. They will interface with DSS case managers following adapted but similar protocols developed for Select Health.

### Quality and Performance Improvement and Contract and Relationship Management (two positions next year's budget request)

2 FTE administrative managers who will be responsible for monitoring and coordinating quality, performance and deliverables required in the Select Health foster care contract including: the annual network adequacy review, managing the DSS-Select Health relationship, handling and troubleshooting administrative, operational or case-related issues, monitoring consistency in the use of the standardized assessment tool, managing denials and appeals.

### Data Analytics and Reporting (3 positions next year's budget request)

3 FTE data scientist/technologists for the Department's data and technology units to handle health care improvements to CAPSS, daily data feeds to DHHS, manage and configure data shared from DHHS and Select and produce reports and data for managers and the field. This additional analytic capacity will also add bandwidth that can be used to generate the annual Workforce/Caseload and other reports, as well as DSS' role

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as Super User and possibility of future access to SH provider portal. DHHS has provided DSS technical assistance in development of health care data reporting mechanisms through a state Medicaid billing and coding expert. This Medicaid data expert has developed Statistical Analysis System (SAS) computer programs to provide routine health care data reporting. This data expert continues to serve as a technical guide in developing reporting mechanisms outlined in this Addendum and the approved Health Care Plan.

Standardized Assessment Tool Implementation (Current Budget Request)

Training and/or Certification - \$90,000 to certify regional trainers, develop curriculum for DSS Child Welfare Basic Training for all DSS case managers and develop refresher courses. Training course and bundles are available for free or fee-based from various providers.

Select Health Care Management Enhancement

Select Health will enhance its capacity to assign care managers regionally. Select Health will expand its geographic assignment to ensure that each of the five DSS regions has dedicated care manager leads who will also carry cases, ensure that all Select Health care management and coordination resources (UM, rapid response, member services, 24/7 nurse hotline) are available for children in foster care.

Specifically, Select Health will add the following full-time equivalent positions: six complex care managers (clinical registered nurses), eight care connectors (non-clinical care managers), .5 manager (registered nurse), one supervisor (registered nurse), two care manager IIs (licensed clinical social worker), .5 medical director, and one quality improvement specialist, for a total of 19 new positions.

The care management enhancement will be incorporated into the managed care rates through the standard rate setting process and will require actuarial certification and CMS approval. DHHS anticipates financing this work initially with existing resources to expedite ramp up. Ongoing funding for these activities will be through the customary annual budget process along with other costs associated with the managed care program.

Because DHHS provides funding in MCO capitation rates that begin on July 1, 2019, Select Health staffing will begin staffing on that date. Within two months, or August 31, 2019, 20% of staff (one nurse, three care connectors) will be hired. Within four months, or October 31, 2019, 50% of staff (four total nurses, five care connectors, .5 nurse manager total) will be hired. Within six months, or December 31, 2019, 100% of staff (six nurses, eight care connectors, one nurse supervisor, .5 nurse manager, 2 social workers, .5 medical director, 1 quality specialist) for a total of 19 associates by the six-month mark.

## APPENDIX A: Health Care Commitments in the Final Settlement Agreement

### A. Health Care Commitments in the Final Settlement Agreement

In the final Settlement Agreement (FSA) in *Michelle H. v. McMaster* (FSA), DSS committed to develop and implement a Healthcare Improvement Plan (the “Plan”). In addition, DSS agreed that the Plan would include enforceable dates and targets for phased implementation related to initial screening services, periodic screening services, documentation, and health care treatment services for Class Members in the areas of physical health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health. Pursuant to the FSA, the Plan will address:

- (a) Developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due;
- (b) Assessing the accessibility of health care screening and treatment services throughout the state, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and
- (c) Identifying the baselines and interim percentage targets for performance improvement in coordinating screens and treatment services.

**APPENDIX B: Health Care Targets**

**APPENDIX C: Process Map for Health Care for Children Entering and Progressing Through  
Foster Care**

## APPENDIX D: DSS Care Coordination Model—Responsibilities and Staffing

## APPENDIX E: Request for Additional Information from Select Health