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HENRY DARGAN MCMASTER
GOVERNOR

November 4, 2025

Administrator Mehmet Oz, MD, MBA
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Dear Administrator Oz,

I am writing to express my full support for and commitment to South Carolina's proposed Rural Health Transformation Plan, submitted pursuant to Funding Opportunity Number CMS-RHT-26-001, the Rural Health Transformation Program created under the Working Families Tax Cuts Act. Approximately one-in-three South Carolinians live in a rural area. This plan represents a critical step toward strengthening our state's rural health systems, improving health outcomes for citizens, and ensuring the long-term sustainability of care delivery in South Carolina's rural communities.

I am designating the South Carolina Department of Health and Human Services (SCDHHS) as the state agency that will prepare and submit the application on behalf of South Carolina. SCDHHS is the state's Medicaid agency; and its director, Eunice Medina, serves as a member of my cabinet. In close collaboration with my office, SCDHHS has led the development of South Carolina's Rural Health Transformation Program application and will also serve as the lead agency responsible for administering and implementing South Carolina's Rural Health Transformation Plan. SCDHHS will utilize the Agency's proven grant process to ensure funds reach rural communities and advance health for rural South Carolinians.

South Carolina developed its Rural Health Transformation Plan and outcomes-driven initiatives by leveraging longstanding relationships with state agencies, healthcare providers, advocates, community leaders and local and state officials. SCDHHS met with the South Carolina Department of Public Health, the South Carolina Office of Rural Health, the Catawba Nation and other tribal representatives. It also engaged a broad range of other key stakeholders, including hospitals, Federally Qualified Health Centers, emergency medical services providers, behavioral health providers, community organizations, and local government entities. This engagement has included in-person site visits by gubernatorial staff and Director Medina to see the realities

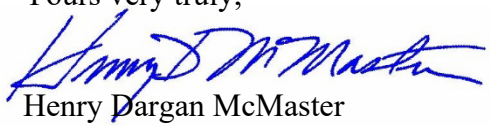
facing rural providers; and virtual interactions to ensure accessibility to stakeholders across the state. This engagement produced more than 350 proposals. Through this collaborative approach, we have developed a plan to improve health outcomes for South Carolinians who live in rural communities that is centered around increasing access to quality healthcare services, particularly those that prevent and manage chronic diseases, in South Carolina's rural communities.

SCDHHS and my office will continue to leverage our relationships and expand this engagement as we implement the South Carolina Rural Health Transformation Plan. South Carolina's ongoing commitment to stakeholder engagement through implementation of the plan will also utilize and expand existing venues, such as: quarterly provider and association meetings; the Medicaid and Beneficiary Advisory Councils; the Master Plan Advisory Committee; and provider collaboratives like the Birth Outcomes Initiative Symposium and Quality Through Innovation in Pediatrics. Using this established infrastructure to continue to gather meaningful input will support ongoing collaboration, cooperation, and coordination with various groups on myriad issues impacting rural health. This approach minimizes administrative burden, supports continued targeted discussions, and prioritizes efficiency.

In addition, I certify that the State of South Carolina will not expend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii) and will adhere to all applicable federal funding requirements and limitations.

I appreciate your consideration of South Carolina's Rural Health Transformation Plan. We look forward to continued collaboration with CMS in advancing this important work.

Yours very truly,



Henry Dargan McMaster

Program Duplication Assessment – South Carolina

SCDHHS affirms that it will ensure award funds are not used to duplicate or supplant current federal, state, or local funding, or be used for the non-federal share of Medicaid payments. Careful consideration has been given to ensure none of the expenses mentioned in either the Project Narrative or Budget Narrative are currently being covered by other means. As described in the Project Narrative, SCDHHS engaged with stakeholders from across the State to collect information on programs serving rural health needs. SCDHHS' Project Narrative was informed by this stakeholder engagement. The following table outlines concurrent funding which will require close collaboration between programs.

Funder	Program	Recipient	Amount	Year	Purpose
HRSA (FORHP)	State Office of Rural Health (SORH)	South Carolina Office of Rural Health (SCORH)	$223,410	FY24	Operations support for the State Office of Rural Health
HRSA (FORHP)	Small Rural Hospital Improvement Program (SHIP)	SCORH – pass-through to eligible rural hospitals	$193,648	FY24	Quality improvement, HCAHPS, value-based purchasing
HRSA (FORHP)	Medicare Rural Hospital Flexibility (Flex)	South Carolina Office of Rural Health (SCORH)	$454,147	FY25	Support Critical Access Hospitals (CAHs), EMS, quality & financial improvement
HRSA (FORHP)	Rural Communities Opioid Response Program – MAT Access	Prisma Health-Upstate	$1,000,000	FY24	Expand access to medications for OUD in rural communities
HRSA (OAT)	Behavioral Health Integration – Evidence-Based Telehealth Network	Medical University of South Carolina (MUSC)	$1,750,000	FY24	Telehealth-enabled collaborative care network for behavioral health in rural SC

Funder	Program	Recipient	Amount	Year	Purpose
	Program (EB-TNP)				
USDA Rural Development	Emergency Rural Health Care Grants (ARPA)	Regional Medical Center of Orangeburg & Calhoun Counties	$1,000,000	2022	Emergency medical equipment and telemedicine to strengthen preparedness
USDA Rural Development	Emergency Rural Health Care Grants (ARPA)	Franklin C. Fetter Family Health Center	$1,000,000	2022	Expand health and nutrition services; testing/vaccination; telehealth & food distribution
USDA Rural Development	Emergency Rural Health Care Grants (ARPA)	Dorchester County (St. George urgent care facility)	$1,000,000	2022	Rehabilitate facility to broaden access to urgent care incl. labs, radiology, telemedicine
USDA Rural Development	Distance Learning & Telemedicine (DLT)	Allendale County Public Schools	$867,790	FY24	Interactive video systems for dual enrollment
CMS → SCDHHS	Transforming Maternal Health (TMaH) Model	SCDHHS (statewide)	$17,000,000	2025–2035	10-year maternal health redesign benefiting rural areas
The Duke Endowment	Rural & statewide health access initiatives	MUSC	$4,690,000	2024	Improve access to care statewide incl. rural initiatives
SCDHHS	Rural & Medically Underserved Area Healthcare Infrastructure Grants	26 projects statewide (incl. Prisma Health)	$48,200,000	2024	Infrastructure for primary, maternal, pediatric, and behavioral health
SCDHHS	Rural Physician & Dentist Program	MUSC/South Carolina Area Health Education	$5,360,962	2025-2028	Provide outreach to rural clinics and help professionals in underserved areas

Funder	Program	Recipient	Amount	Year	Purpose
		Consortium (SCAHEC)			
SCDHHS	USC School of Medicine Rural Outreach Program	USC School of Medicine	$4,167,459	2024-2027	Enhance the quality of healthcare delivered in rural and disadvantaged communities through innovative programs
SCDHHS	The Clemson Rural Health Program	Clemson Rural Health	$2,499,914	2025-2026	Expanding preventive and primary care
SCDHHS	Rural Health Network Revitalization Project	USC School of Medicine	$3,000,000	2022-2026	Support the development and sustainment of a rural health network
SCDHHS	University Specialty Clinics	USC School of Medicine Educational Trust	$7,500,000	2025-2026	Purchase and provision of administrative & medical services
SCDHHS	South Carolina School of Health Academy	University of South Carolina	$3,052,429	2024-2026	Expands training, coaching, and workforce development to strengthen school-based mental health services
SCDHHS	MUSC South Carolina Telehealth Network	Medical University Hospital Authority	$13,500,000	2025-2026	Supports hospitals, regional hubs, and partners to develop and operate a statewide telehealth infrastructure

Additionally, SCDHHS contemplates contract and subrecipient awards with the Cooperative Agreement funding. SCDHHS will require disclosures and attestations from all partnering entities ensuring that federal, state, and local funding is not being used for duplicative programming. SCDHHS has also budgeted for a Data Analyst position who will be responsible for ensuring outcomes data is linked to the appropriate project/initiative. SCDHHS will remain committed to all activities in which it is the lead agency and has planned all staffing and position descriptions to ensure those activities continue under their existing authority. SCDHHS maintains that the best practice for avoiding program duplication is achieved through close communication. As such, SCDHHS will leverage its established stakeholder engagement infrastructure to provide regular updates and gather meaningful feedback on the RHT program.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

COST ALLOCATION PLAN

Updated October 2025

This Cost Allocation Plan (CAP) is the means by which the DHHS identifies and allocates administrative expenditures among the federal grants and contracts administered by DHHS. Expenditures are incurred by this agency for the administration of federally sponsored programs and are eligible charges against federal grants and contracts. Included in this CAP is a substitute methodology of allocating direct salary costs among major programs and among program activities and cost objectives having different federal matching rates.

Table of Contents

CHAPTERS

Chapter 1: Introduction

The last revision of the SC Department of Health and Human Services (DHHS) Cost Allocation Plan (CAP) was effective July 1, 2014. Department of Health and Human Services, Division of Cost Allocation letter dated April 23,2015, approved the last update (Amendment 2015-1).

This CAP is how the DHHS identifies and allocates administrative expenditures among the federal grants and contracts administered by DHHS. Expenditures are incurred by this agency for the administration of federally sponsored programs and are eligible charges against federal grants and contracts. Included in this CAP is a substitute methodology of allocating direct salary costs among major programs and among program activities and cost objectives having different federal matching rates.

DHHS is the single South Carolina state agency administering the federal programs listed at Appendix C. This CAP identifies the administrative costs of each program; the method for allocating the costs of each service to individual user units; and the mathematical allocation of those costs to the user units in the form of a single, formal, comprehensive proposal. It applies to costs incurred on and after July 1, 2025.

Along with direct costs assigned to each appropriate entity, the plan addresses allocated (indirect) costs originating in the DHHS.

Chapter 2: Revised Cost Allocation Plan

To the extent practicable, program costs and administrative costs are recorded as direct costs to the applicable program, federal grant and cost objective within that federal program. Where it is impractical to treat a cost as direct, indirect cost pools are utilized. The basic methodology of identifying direct salary costs and for allocating indirect costs remains essentially the same as previously approved. The method for distributing allocated indirect costs is to identify these costs to cost pools and then to distribute them to programs, in direct proportion to the distribution of direct salary expenditures for FTE and TGE positions.

Direct salary costs are distributed according to the effort devoted to each of the agency's programs. DHHS administers the Medicaid Program. Personnel who provide common administrative support services to all major programs are identified as “indirect” employees. In addition, the Medicaid Program is divided into cost objectives entitled:

Medicaid and Waiver Program Administration (Med Admn)

Skilled Professional Medical Personnel (SPMP)

Family Planning (FP)

Medicaid Management Information System (MMIS)

Pre-Admission Screening Annual Resident Review (PASARR)

Case Management Services (Case Mgmt)

State Children's Insurance Program (SCHIP)

Under South Carolina Enterprise Information Systems (SCEIS) utilizing Systems Applications and Products (SAP), each program activity and cost objective is assigned a Program Cost Account/Functional Area (PCA/FA) to identify the costs. The PCA/FA serves a variety of purposes, including, identification of the appropriate federal grant, grant year, the cost objective within that grant, and the funding split, i.e. federal and state funding percentages. The actual salary costs are entered timely into SCEIS. Indirect costs are initially recorded in SAP based on budget estimates of the expected distribution of indirect costs by grant. This initial distribution of indirect costs is adjusted quarterly to reflect the actual distribution of direct salary costs for the quarter.

Salary Documentation:

All salaries, direct and indirect:

Reference: OMB Circular A-87 Attachment B, Section 8.h. (1) DHHS complies with these provisions as stated: "Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit."

Indirect salaries. OMB Circular A-87 Attachment B, Section 8.h. (2) provides: "No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity." DHHS indirect positions are 100% indirect (no direct%).

Direct salaries. Reference: OMB Circular A-87 Attachment B, Section 8.h. (6) "Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort."

DHHS uses a substitute system for allocating direct salaries to grants. DHHS prepares documentation semi-annually, with certifications from supervisors, as to the program(s) and the percentage of time each employee spends on each of those programs. The Office of Finance and Administration, Controller's Office, prepares the schedules, detailing each position and the program(s) and cost objectives last assigned. The schedules are reviewed by supervisors, corrected as necessary to indicate the current distribution of employee time by program(s) and cost objective(s), and signed by the supervisory official having firsthand knowledge of the work performed by the employee.

Any change noted on the bi-annual certification schedule requires a review of the position description (PD) for each affected position. These PDs are reviewed in correlation to the bi-annual certification and are rewritten as necessary. DHHS uses this process of bi-annual certification and updating position descriptions as the method of continually updating the allocation of direct salaries. Position descriptions for each position are reviewed by the DHHS Controller's Office to assign the appropriate accounting codes to reflect the organizational unit and the funding distribution by grant and by Medicaid activities subject to different rates of FFP.

This substitute system of allocating direct salary costs would be in lieu of the provisions of the OMB Circular A-87, Attachment B, Section 8.h. (3), (4), & (5).

References:

OMB Circular A-87 Attachment B, Section 8.h.

(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semiannually and will be signed by the employee or supervisory official having firsthand knowledge of the work performed by the employee.

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

(a) More than one Federal award,
(b) A Federal award and a non-Federal award,
(c) An indirect cost activity and a direct cost activity,
(d) Two or more indirect activities which are allocated using different allocation bases, or
(e) An unallowable activity and a direct or indirect cost activity.

(5) Personnel activity reports or equivalent documentation must meet the following standards:

(a) They must reflect an after the fact distribution of the actual activity of each employee,
(b) They must account for the total activity for which each employee is compensated,
(c) They must be prepared at least monthly and must coincide with one or more pay periods, and
(d) They must be signed by the employee.
(e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

(i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
(ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly

activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
(iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

Chapter 3: Cost Allocation Methodology

Administrative costs related to grants and contracts are assigned to agency organizational units, by grant funding & match rate, and by type, direct or indirect. Organizational units are identified in SCEIS by "Cost Centers". Grants and matching rates are identified in SCEIS by Program Control Accounts/Functional Areas (PCAs/FAs). Each cost is identified by a combination of these two codes: Cost Center and PCA/FA. A Cost Center may be used with more than one PCA/FA, if more than one federal grant or match rate is applicable to the Cost Center.

Organizationally, the Office of the DHHS Director has reporting to it five (5) Deputy Directors Offices, each identified by a Cost Center. Each of the five Deputy Director Offices has reporting to them, Bureaus or Offices, each of which are assigned Cost Center codes. Some bureaus/offices are further broken down into divisions. Each division has unique Cost Center codes, depending on the size and complexity of the bureau.

Direct costs are assigned to direct PCAs/FAs; indirect costs area assigned to indirect PCAs/FAs. Costs are assigned to direct PCAs/FAs if the costs can be specifically or readily identified with a particular cost objective of a grant or contract.

Indirect costs are incurred for a common or joint purpose benefiting more than one cost objective. Agency wide indirect costs are assigned to specific PCAs/FAs for indirect salaries, indirect fringe costs, indirect non-salary costs and, indirect office lease costs for the DHHS Central Office.

Additionally, there is a PCA/FA used to record the non-salary common operating costs of DHHS organizational units who administer the Medicaid program exclusively and a unique PCA/FA is used to capture non-salary Medicaid common operating costs of the field offices of the Division of Community Long Term Care.

There is no universal rule for classifying certain costs as either direct or indirect under every accounting system. It is essential, therefore, that each cost item be treated consistently either as a direct or indirect cost.

DHHS's cost allocation system uses FTE and TGE direct salary costs, to distribute indirect costs. A key element in this process is identifying each employee's percentage of time spent supporting a program or grant, e.g. Medicaid and each Medicaid Program Category, administration, SPMP, MMIS, etc.

DHHS uses CAP "Bases" as the method for fiscal planning and budgetary purposes. A CAP Base is a methodology by which indirect costs can be distributed to programs using FTE and TGE direct salary costs distributions, adjusted quarterly using actual salaries.

Within DHHS are three indirect cost bases:

BASE ONE - This base is used to allocate agency-wide indirect costs to major programs and Medicaid program categories. Agency-wide indirect costs include all costs for those administrative activities and organizations that provide common services to direct program activities. Base One distribution percentages and match rates reflect the overall direct program salary cost distribution percentages of all direct program employees (FTE & TGE).

BASE TWO - Central Office and Other Space Rent Costs are identified in one cost pool and allocated in accordance with direct program/grant salaries for FTE and TGE positions located at the Columbia central office. The central office lease costs are distributed on a percentage basis to appropriate programs. This allocation uses actual salary distributions of all DHHS direct program staff located at the central office location and excludes staff located in the various area offices (ex: CLTC and Medicaid Eligibility staff).

BASE THREE - This basis is used to allocate common or joint non-salary costs associated with groupings of direct Medicaid program employees. The distribution schedules developed under this base are used to allocate common other operating costs. Common other operating costs are defined as costs that contribute to the support of all employees within the specified group of direct employees. These costs are equitably distributed to Medicaid

program categories through the cost allocation template. These were based upon the FTE salary costs distribution percentages for all employees within a group. There is a PCA/FA that is used to record the non-salary operating costs of DHHS organizational units who administer the Medicaid program exclusively. There is a PCA/FA used to capture non-salary Medicaid operating costs of the field offices of the Division of Community Long Term Care.

In addition to the above cost methodology, the Cost Allocation Plan accounts for expenses incurred in the purchase of service contracts. Service contracts with other governmental and private entities are a direct program charge for the service provided. These charges will be supported by a written agreement that contains a detailed description of the services being purchased, the basis for billing the provider agency, and a requirement that billing will be for actual, allowable direct costs. Other state agencies' indirect costs are charged to contracts with that state agency according to its federally approved indirect cost plan. Furthermore, cost for school-based administrative services will be developed in accordance with the specific contract for School-Based Health Services Medicaid Administrative Claiming approved by CMS.

Home and Community Based Waiver Services and other Waiver Services - Administrative costs of approved waiver services will be identified when appropriate. Regarding Home and Community Based Waiver Services and other waiver services administered by the Division of Community Long Term Care (CLTC), employees in the CLTC field offices will be assigned work as per previous agreement and understanding between CMS and DHHS. That is, regarding the following: Only licensed nurses will perform the Skilled Professional Medical Personnel (SPMP) functions, making medical assessment of clients involved with the various waiver services and Pre-Admission Screening Annual Residential Review (PASARR) functions. These licensed nurse employees' salary costs will be claimed as 95% SPMP and 5% PASARR. Only licensed social workers will be assigned and will perform the case management functions, qualifying for the Federal Medicaid Assistance Participation rate. Their salary costs will be claimed as 100% FMAP. Area administrators and other support staff will be assigned a ratio of their time proportionate to the ratio of licensed social workers (at the FMAP rate) and licensed nurses (at the regular Medicaid Administration rate, 50% FFP). Support staff who work exclusively in support of licensed nurses will earn the SPMP rate and those support staff whom, work exclusively for licensed social workers functions of case management will be claimed at the FMAP rate.

Advanced Planning Documents (APD) - Daily time sheets or updated position descriptions will be required on an "as needed basis" to record staff time spent on APD projects. The directly attributable staff costs will be identified and transferred to the appropriate SCEIS Program Control Account/Functional Area (PCA/FA).

Chapter 4: Conclusion

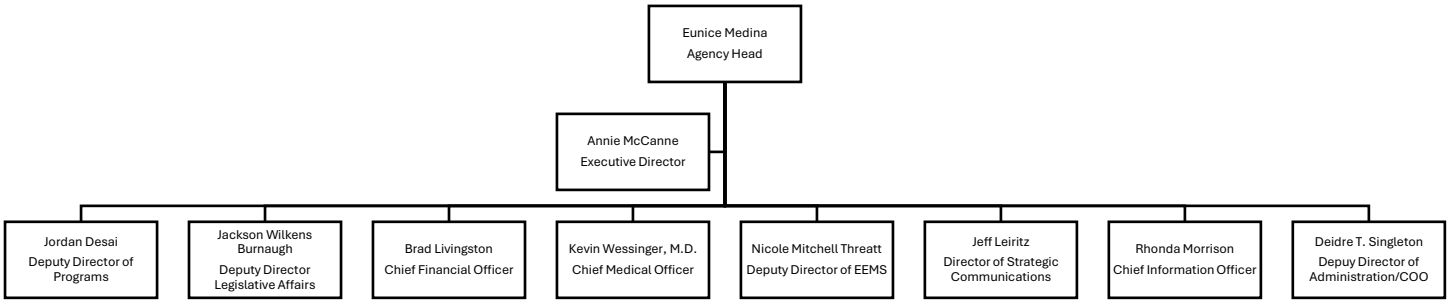
The revised CAP continues to use direct FTE and TGE salaries as the basis for allocating agency indirect costs. Semi-annual certifications of employee time distributions will be prepared and the position description for each employee position will be revised as necessary to reflect the latest time distribution determined by the semi-annual certifications. In accordance with OMB Circular A-87 Attachment B, Section 8.h. (6), approval is hereby requested of the cognizant Federal agency to continue to use this method as a substitute or alternative method for determining and assigning salary costs for DHHS direct FTE and TGE salaries, in lieu of personnel activity reports, time sheets, or statistical samples.

APPENDICES

Appendix A: Organization Charts

South Carolina Department of Health and Human Services

As of October 1, 2025



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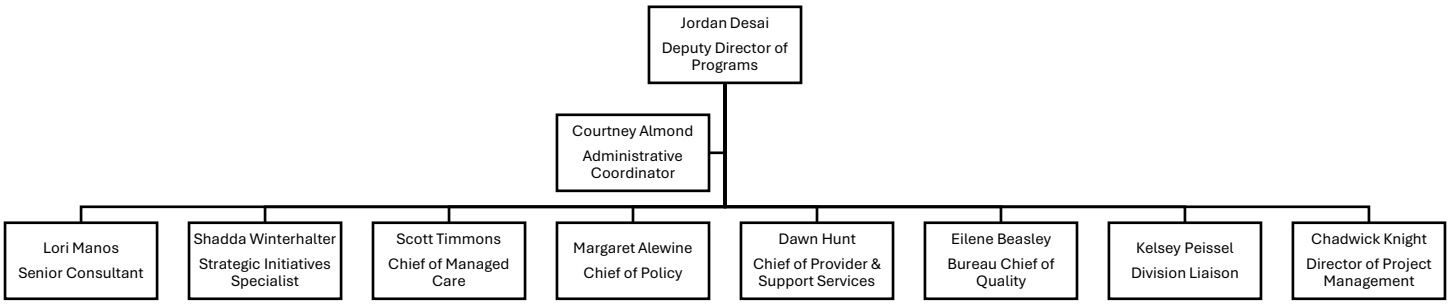
As of October 1, 2025



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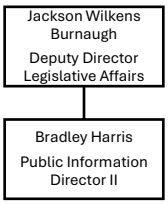
As of October 1, 2025



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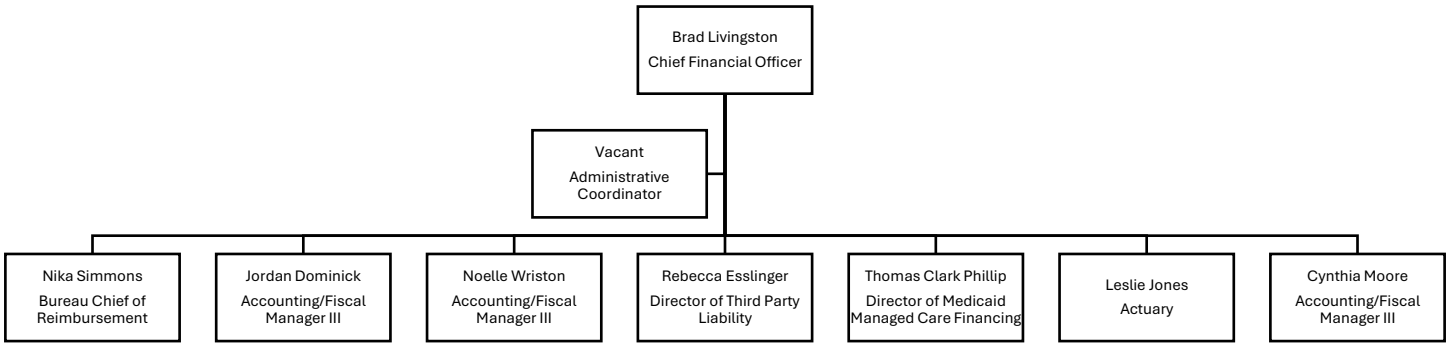
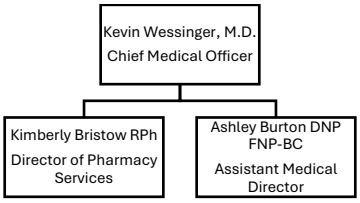


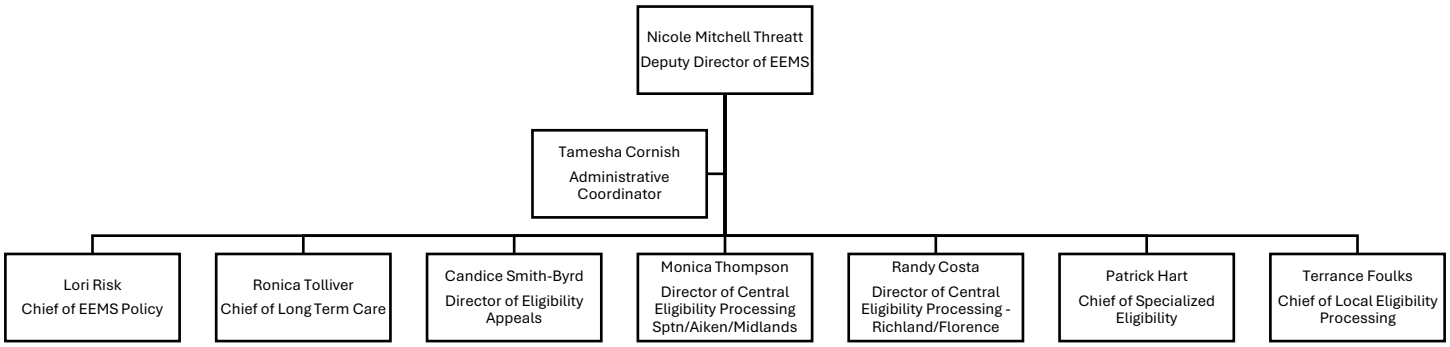
Office of Medical Directors

As of October 1, 2025



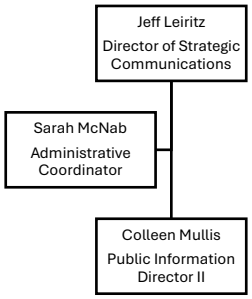
Eligibility, Enrollment, and Member Service

As of October 1, 2025



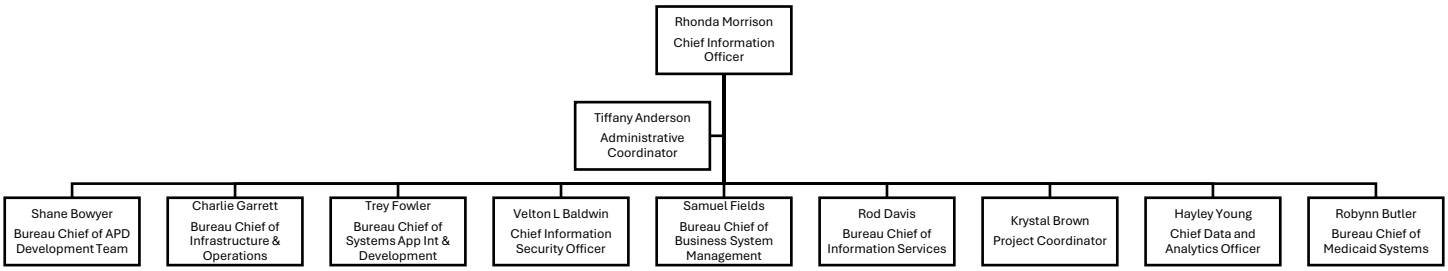
Strategic Communications

As of October 1, 2025



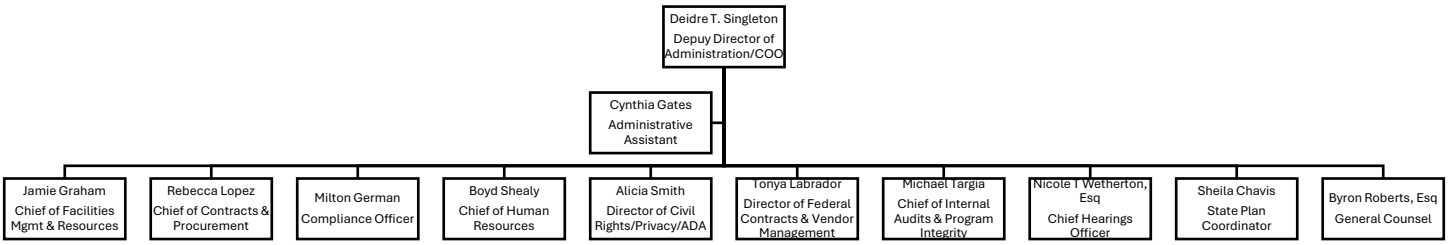
Office of System Technology

As of October 1, 2025



Administration

As of October 1, 2025



Appendix B: Organizational Unit Activities

As of October 1, 2025

Executive Director

The Executive Director (or "Director") of the South Carolina Department of Health and Human Services ('(SCDHHS" or the "Agency") provides executive oversight over all programs and operations of the Agency. The Director serves as a member of the Governor's cabinet. The Agency's Executive Team reports to the Director and includes Deputy Directors and their respective offices.

Legislative Affairs

Legislative Affairs is responsible for providing information to state legislators, monitoring legislation including the State Budget, and managing or supporting legislative-related functions. Legislative Affairs educates and responds to legislative inquiries of all nature, chiefly related to the Agency's budget, and advises Agency staff on matters related to the General Assembly.

Communications

Communications provides prepared and requested information to all stakeholders, both external and internal. Externally, Communications provides information to media, legislators, researchers, provider/advocacy stakeholders, and the general public. Communications also manages strategic internal communications such as regular employee newsletters and announcements of key programmatic or personnel-related issues. Communications advises and supports SCDHHS and its staff on communications-related matters, including how to promote and engage key audiences or partners to ensure the success of Agency initiatives. Communications manages the Agency's brand and identity use.

Office of Medical Directors and Pharmacy Services

The Office of Medical Director and Pharmacy Services is responsible for managing the clinical, operation, appeal and budgetary aspects of the fee-for service pharmacy benefit and the decision making and the application of medical necessity criteria to promote the facilitation and delivery of quality healthcare. The Office of Medical Directors and Pharmacy Services is responsible for ensuring that the Medicaid coverage policy is consistent with evidence-based care. The Office of Medical Directors and Pharmacy Services is also responsible for directing the activities of the Pharmacy Benefit Administrator (PBA) and managing pharmacy policy development through reporting and analysis and State Plan Amendments.

Health Program Operations

Health Program Operations is responsible for day-to-day administration of managed care and fee-for-service programs focused on physical health. Health Program Operations is responsible for the creation, maintenance and administration of many health services contracts including, but not limited to, dental, non-emergency medical transportation, pharmacy (including Welvista). This team also works with other state agencies including the Department of Education (DoE), the Department of Social Services (DSS), the Department of Public Health and and South Carolina's medical school programs such as the Rural Medical School Program. Health Program Operations assists in the development of policy and creates operating procedures to implement policy decisions. The Health Program Operations team includes:

- Account Managers who monitor Managed Care Organizations' (MCOs) compliance with the terms of the Healthy Connections contract and the MCO Policies and Procedures Manual;
- Contract Managers who monitor vendor compliance in Medicaid program areas where the Agency has elected to use contractors beyond the managed care program to provide benefits to Medicaid enrollees;
- Support staff and special projects staff who perform a variety of tasks including the standardization of operational procedures and implementation of new initiatives.

Administration and Chief Compliance Office

Human Resources

Human Resources performs human resource-related tasks for a workforce of over 1,300 employees. This area is responsible for the daily functional duties of workforce management including employee relations, benefits, compensation, hiring/on-boarding, leave, the administration of the Agency's policies and procedures and Equal Opportunity/Affirmative Action (EEO/AA). In addition, Human Resources administers the Agency's Employee Performance Management System (EPMS). Human Resources provides the Agency support in managing the performance of the staff and developing the SCDHHS' culture as a learning organization. Human Resources manages Agency-wide programs to attract and retain staff, train and educate the workforce, and track and analyze employee performance.

Contracts and Procurement

Contracts and Procurement administers the Agency's contracting and procurement activities. Contracts oversight includes the development and management of contracts, grants, and memorandums of agreements. Procurement functions include the acquisition of goods and services, information technology, and consultant services within agency certification limits. Formulation of all contract and procurement policies and procedures are established in accordance with the South Carolina Consolidated Procurement Code and Regulations

Internal Audits and Program Integrity

Internal Audits and Program Integrity oversees the Agency's efforts to manage and review its operations both internally and externally. Internal Audits and Program Integrity carries out five major functions for SCDHHS:

- Performs internal and external audits to help ensure compliance with applicable state and federal rules as well as effective performance of Agency functions;
- Administers the Medicaid program integrity function, which includes developing and managing initiatives for controlling utilization of services;
- Manages automated fraud and abuse detection systems including the Surveillance & Utilization Review system;
- Oversees agency fraud and abuse investigative efforts, which includes coordinating relationships with external regulatory, audit, and law enforcement entities.

General Counsel

The General Counsel represents the Agency in state and federal courts and administrative hearings. The General Counsel also provides legal advice to the Director and Agency staff.

Facilities Management

Facilities Management is an internal service-oriented area and thus provides the support the agency needs to carry out its overall mission. This area manages twenty six (26) facility lease agreements statewide and oversees the Agency's mailroom and postal services. In addition, Facilities Management is responsible for labor requests for repairs and interagency moves. This area handles the management, maintenance and upkeep of the vehicles the Agency leases from State Fleet Management for use by employees.

Appeals and Hearings

Appeals and Hearings presides over appeals from agency determinations brought by applicants, beneficiaries, and providers. An appeal is a request for a fair hearing before a hearing officer. The hearing officer acts as an impartial decision-maker and will determine whether the action proposed or taken by the agency should be reversed or upheld. Petitioners seeking further relief from a hearing officer's decision may make an appeal to the Administrative Law Court of South Carolina.

Civil Rights Division

In accordance with federal regulations, the Civil Rights Division ensures that no individual shall be subject to discrimination in their interactions with the South Carolina Healthy Connections Medicaid program on the grounds of race, color, national origin or disability.

Office of Compliance

The Office of Compliance evaluates program initiatives and ongoing activities to maintain alignment with regulatory requirements in support of Medicaid programs. The Office of Compliance collaborates to respond to compliance challenges and provides guidance to agency staff in the development of corrective actions of deficiencies identified in audit findings.

Office of Federal Contracts and Vendor Management

The Office of Federal Contracts and Vendor Management provides insight and support to agency contract owners and stakeholders. The Office of Federal Contracts and Vendor Management oversees contract compliance and vendor management to ensure contract terms and performance standards are met. The Office of Federal Contracts and Vendor Management ensures adherence to federal and state regulations and agency best practices pertaining to contract management.

Systems and Technology

Systems and Technology is responsible for the claims payment and provider focused operations and information systems to support the Agency's overall operations. OIM is led by the Deputy Director and Chief Information Officer (CIO).

Medicaid Systems

Medicaid Systems is responsible for the daily operations of the Member Management Systems (MMS), the Medicaid Management Information System (MMIS), and Business Information System (BIS). These operations are vital to the agency’s day-to-day business which consist of eligibility determinations, enrollment of providers and members, and claims adjudications.

Information Technology Services (ITS)

Information Technology Services (ITS) provides SCDHHS core technology and associated support needed for operations across the Agency. ITS includes three areas: providing systems and support, help desk and user support, and technical training for the Agency. ITS manages SCDHHS' networking infrastructure, core services including email, collaboration, and information/file sharing and also is responsible for information technology assets statewide.

Systems, Applications, Integration, and Development

Systems, Applications, Integration, and Development is responsible for maintaining the repository for all medical documentation and eligibility for participants, delivering all eligibility work and tasks through in-house designed applications for all eligibility workers, maintaining and authorizing all services and records for waiver participants, providing remote check in and check out capability for providers delivering services for waiver participants.

Office of Cybersecurity

The Office of Cybersecurity is responsible for safeguarding the confidentiality, integrity, and availability of DHHS information and information systems, identity, and data assets. The Office of Cybersecurity provides proactive security expertise, creates and maintains a resilient and secure infrastructure, and fosters a culture of security awareness and compliance throughout the agency.

Medicaid Enterprise System Core

Medicaid Enterprise System Core is responsible for the design, development, maintenance, and operations of the Medicaid systems that are deployed to cloud services such as Amazon Web Services (AWS). Medicaid Enterprise System Core is also responsible for the data integration platform known as the Medicaid Enterprise System (MES) Core that enables the agency to migrate to modular business solutions and the Encounters Processing Solution (EPS) system that targets production implementation and will modernize and expand the agency's ability to validate and report on managed care encounters.

Enterprise Systems

Enterprise Systems is responsible for the strategy and direction of complex change and improvement efforts specializing in the MMIS subsystems and processes.

Advance Planning Documents (APD) Writing Team

The Advance Planning Documents (APD) Writing Team is responsible for writing and coordinating the completion of Advance Planning Documents for submission to the Centers for Medicare and Medicaid Services (CMS) to obtain prior approval to receive and utilize enhance federal funding for data processing system initiatives that support the Medicaid programs. The Advance Planning Documents Writing Team is also responsible for submitting reports regarding projects and on-going operations to CMS regarding enhanced funding projects through CMS's Advanced Planning Document (APD) process.

Office of Delivery of Automated Systems for Healthcare

The Office of Delivery of Automated Systems for Healthcare is responsible for the successful planning and implementation of the various modular Medicaid components that comprise the MMIS. The Office of Delivery of Automated Systems for Healthcare is also responsible for the established project management standards, plans, and controls that are used as a framework for management.

IT Infrastructure and Operations

IT Infrastructure and Operations is responsible for providing agency staff with a secure and reliable data network infrastructure that allows for an efficient and successful work environment to perform daily operational tasks.

Information Assurance

Information Assurance provides security oversight to the Agency's information including both technical and physical security. Information Assurance oversees technical audits of systems and processes and works with internal and external stakeholders to meet security requirements, especially with regard to the SCDHHS; security obligations to Centers for Medicare and Medicaid Services (CMS). Information Assurance is led by the Chief Information Security Officer (CISO).

Data and Analytics Office

The DAO optimizes SCDHHS's use of data and analytics by ensuring a broad understanding of the SCDHHS's Data and Analytics approach and its importance, prioritizing Data and Analytics investments on obtaining the greatest business value and allowing SCDHHS to manage these investments at the enterprise level, enhancing data understanding, clarity, consistency, and quality across the enterprise and increasing data literacy and advanced analytics skills across the enterprise.

Finance and Administration

Finance is responsible for the budgeting, planning, provider reimbursement, CMS financial reporting, and accounts payable and receivables. Finance supports the Director and Executive Team in budgeting and finance management processes and represents SCDHHS in budgeting and financial matters by reporting and responding to the Governor's Office, the General Assembly, other state agencies, and stakeholders. Finance ls led by the Deputy Director and Chief Financial Officer (CFO).

Planning and Budget

Planning and Budget coordinates SCDHHS' annual budget request through the appropriation process, establishes operating budgets, and monitors cost drivers for each service and administrative expense reporting budget to actual variances. This area executes appropriation transfers as it relates to budget. Planning and Budget also oversees planning and estimation models (including eligibility and capitation models) and works closely with the Agency's actuaries for key metric analysis and planning.

Controller

The Controller manages the general accounting functions of the Agency including accounts payable and accounts receivable, payroll, state and federal funds management, account reconciliation, federal budget and expenditure reporting and works closely with CMS, and other federal, state and grant programs. The controller also works closely with other state agencies including the State Treasurer's Office (STO) and the enterprise resource planning (ERP) system, the South Carolina Enterprise Information System (SCEIS), an SAP system. The Controller works with the Agency's reporting team that is focused on operational reports and the data warehouse contract staff.

Third Party Liability

Third Party Liability (TPL) refers to the responsibility of third-party coverage other than Medicaid to pay for medical cost. Section 1902 (a) (25) of the Social Security Act requires that states take all reasonable measures to ascertain the legal liability of third parties to pay for medical services furnished to a Medicaid beneficiary. A third party is defined as an individual, entity, or program that is or may be liable by contract, agreement, or statute, to pay all or

part of the medical cost of injury, disease, or disability of an applicant or beneficiary. TPL operations consist of three departments that ensure Medicaid is the payor of last resort.

- The Health Recovery Department is responsible for identify and/or recovery from third party payers.
- The Casualty Department recovers monies from liable third parties if the Medicaid beneficiary has been involved in an accident or suffered an injury.
- The Estate Recovery Department recoups cost associated with a deceased beneficiary's long term care costs that were covered by Medicaid.

Reimbursements

Reimbursements oversees SCDHHS' rate setting processes and works with internal and external stakeholders regarding rates and rate policies. Reimbursements manages the Agency's cost reporting and Disproportionate Share Hospital (DSH) payments and works closely with providers directly and through their associations.

Managed Care Finance

Managed Care Finance coordinates the development or amendment of MCO capitation rates, rate certifications, and risk adjusted rates in collaboration with actuarial services, and various program areas. Also responsible for the calculation and reporting of preliminary and final Medical Loss Ratios (MLR) of the MCOs for the appropriate rate year.

Pricing

Develops fiscal analysis and research for all Medicaid service lines in collaboration with actuarial services, program areas, Office of Planning & Budget and the Division of Reimbursements. Provides cost studies and analyses to respond to external queries. Develop financial forecasts and projections used in the development of the annual agency budget.

Actuarial Services

Identifies risk, including economic and financial trends as it relates to Medicaid reimbursement. Perform actuarial, economic and demographic studies to estimate reimbursement rates. Design, test and evaluate policies to determine if Medicaid reimbursement procedures are actuarial sound. Oversees the development, submission and implementation of Medicaid reimbursement methodology policy into the South Carolina Medicaid State Plan.

Health Programs

Health Programs administers the Agency's health policies and programs primarily through the oversight of the State Plan, managed care organizations, and the fee-for-service program. Health Programs includes areas that focus on policies and programs related to physicians, hospitals, pharmacy, durable medical equipment, dental, transportation, and medical support services. This area focuses on health outcomes, quality patient care, contract management and the development of innovative initiatives and policies that improve the overall health of our beneficiaries and the citizens of South Carolina.

Policy

The Bureau of Policy develops, maintains, and reviews policy manuals, coverage, and services – state plan services, state contracts/initiatives, waiver & facility services, and behavioral health. Policy also provides guidance and interpretation to internal and external stakeholders, evaluates adequacy of services and ensures access to care for all members, ensures compliance with state and federal authorities and requirements and correctly reflects policy information in the Medicaid Management Information System (MMIS). Policy also Assists in the design and implementation of state mandates and programs.

Quality

The Bureau of Quality is responsible for developing and implementing innovative quality initiatives to promote the health and wellbeing of members. Quality ensures compliance with agency policies by assessing clinical and operational functions based on standardized measures across all programs. They are responsible for the review of the CMS form 416, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Core Set, and waiver performance measures. Quality conducts external quality reviews of managed care plans and monitors health outcomes of Medicaid members and the creation and maintenance of the agency's quality strategy

Provider and Support Services

Provider and Support Services is responsible for ensuring appropriate reference administration files and subfiles are distributed to the managed care plan. Maintains and enhances the MMIS Reviews and adjudicates fee-for-service (FFS), BabyNet, and Waiver claims that require manual review (second pass claims). Ensures access to care through coordination of out-of-state services for Medicaid members. Manages the transportation and prior authorization services for the agency. Reviews and represents the agency in appeals regarding claims and provider enrollment. Maintains and enhances the provider enrollment process for all Medicaid providers per federal and state requirements. Ensures member escalations are researched, tracked, resolved and all inquiries receive communication throughout the process. such as reporting and constituent/provider services Operations and Provider Relations. Operations and Provider Relations manages the operations, policies, process and communications to and from SCDHHS' provider community to ensure providers are executing the Medicaid program correctly and being reimbursed for their services. The Operations team oversees claims payment and resolution and encounter handling. Provider Relations manages the enrollment of new providers into the program and statewide outreach and education of providers regarding current operations and new initiatives.

Managed Care

Managed Care serves as a point of contact for Medicaid and Dual Managed Care Plans, SCAHP, CMS (regulatory) and SCDHHS. The team maintains managed care contracts, Policies and Procedures (P&P) and Report guides and ensures plan compliance with current contract requirements. The Managed Care team assists managed care plans with problem resolution and coordinates efforts with other state agencies such as the Department of Health (DOH), the Department of Education (DOE), and the Department of Social Services (DSS). The Managed Care team also manages the enrollment broker contract which includes coordinating and correcting any membership errors and they manage related administrative tasks which includes participating in the rate setting processes, approving relevant marketing material, grievance and appeal monitoring, assessing managed care networks for adequacy, and requesting appropriate Information Technology (IT) support for required changes

Eligibility, Enrollment and Member Services

Eligibility, Enrollment and Member Services (EEMS) focuses on the enrollment and member management of Healthy Connections Medicaid applicants, members, and former members. EEMS' direction is on creating a consumer-centered environment for our beneficiaries and applicants by streamlining application processes, removing unnecessary barriers and waiting periods for applicants, providing excellent customer service, and increasing access to member services to improve the health of our beneficiaries. This team is also continuing its efforts to develop a community-based work force to ensure the Agency meets its commitment to beneficiaries by providing vital services to those who need them, where they need them - in their homes and communities, where health begins. EEMS maintains at least one office in each of South Carolina's 46 counties. Medicaid applications are taken at the field offices, by mail, online, or over the telephone.

Long-Term Care Eligibility

Long-Term Care Eligibility is responsible for overseeing and supporting the development, management, and administration of long-term care eligibility and enrollment functions. Long-Term Care Eligibility collaborates with interagency partners in the support of long-term care eligibility enrollment functions. Long-Term Eligibility develops and implements strategies, plans, and processes to support long-term care operations. Long-Term Care Eligibility supports and manages long-term care provider relations for eligibility and enrollment.

Eligibility Policy

Eligibility Policy develops and maintains Medicaid eligibility polies and procedures, provides policy and process support to eligibility staff, develops and delivers training for Medicaid eligibility policies, procedures, and systems, and conducts activities related to federal, state and third- party quality reviews and audits

Eligibility Support and Quality

Eligibility Support and Quality is responsible for scanning and indexing documents received through mail, online, and fax into the system of record. Eligibility Support and Quality reviews determinations made by eligibility specialists each month to ensure eligibility decisions are accurate. This includes documenting eligibility and/or procedural errors. Eligibility Support and Quality is also responsible for the eligibility specialist performance and coaching process by tracking the timeliness and accuracy of the eligibility specialists work to ensure the process is implemented consistently and accurately statewide. The Eligibility Support and Quality team also provides onsite support to employees, supervisors, and managers in local eligibility processing (LEP) offices and processing centers.

Eligibility Appeals and Member Relations

Eligibility Appeals and Member Relations represents the agency in eligibility appeal proceedings and provides timely responses to legislative and general inquiries.

Office of Central Eligibility Processing

The Office of Central Eligibility Processing are non-public serving facilities that are responsible for timely and accurate eligibility determinations. Due to Central Eligibility Processing functioning as a non-public serving facility this allows the eligibility specialists to focus more on making eligibility determinations.

Appendix C: List of Federal Grants Administered

List of Federal Grants Administered (by CFDA)

CFDA	Title
84.181	Babynet
93.369	ACL Independent Living State Grants
93.610	Health Care Innovation Challenge
93.767	Children's Health Insurance Program Reauthorization Act
93.767	State Children's Health Insurance Program
93.778	Health Information Technology
93.778	Medical Assistance Program (Medicaid, Title XIX)
93.789	Alternatives to Psychiatric Residential Treatment Program
93.791	Money Follows the Person Demonstration Grant
93.869	Transforming Maternal Health

Appendix D: Cost Impact Analysis

NEW COST ALLOCATION PLAN 2026

Agency Indirect Cost		
MEDICAID	95.97%	$29,943,277.20
CHPADM	3.91%	$1,219,945.96
CHIPRA	0.00%	$0.00
HIT	0.00%	$0.00
CAPRTF	0.00%	$0.00
MFP	0.12%	$37,440.84
Total	**100.00%**	**$31,200,664.00**

PREVIOUS COST ALLOCATION PLAN 2014

Agency Indirect Cost		
MEDICAID	71.34%	$22,258,300.00
CHPADM	27.52%	$8,585,014.00
CHIPRA	0.15%	$46,791.00
HIT	0.62%	$194,048.00
CAPRTF	0.24%	$75,765.00
MFP	0.13%	$40,746.00
	100.00%	**$31,200,664.00**

Cost Impacts (Changes from Previous to New CAP)

MEDICAID	24.63%	$7,684,977.20
CHPADM	-23.61%	($7,365,068.04)
CHIPRA	-0.15%	($46,791.00)
HIT	-0.62%	($194,048.00)
CAPRTF	-0.24%	($75,765.00)
MFP	-0.01%	($3,305.16)
Total	**0.00%**	**($0.00)**

OTHER SUPPORTING DOCUMENTS

Appendix A.....Utilization Levels and Patient Volumes of Existing Rural Health Facilities

Appendix B.....SC Department of Insurance Bulletin 2018-08

Appendix C..... SC Legislative Letter of Support

Appendix D.....SC Stakeholder Letter of Support

Appendix E.....SC RHT Program Summary

Appendix A:

Utilization Levels and Patient Volumes of

Existing Rural Health Facilities

Utilization Levels and Patient Volumes of Existing Rural Health Facilities

Hospital	Discharges	Patient Days	Average Length of Stay	Use Rate per 1,000 Population	Average Daily Census
Abbeville Area Medical Center	327	1513	4.6	116.07	4.1
Allendale County Hospital	130	407	3.1	108.18	1.1
Carolina Pines Regional Medical Center	3,361	11,151	3.3	133.12	30.6
Cherokee Medical Center	1,490	6,221	4.2	118.45	17
Coastal Carolina Hospital	3,319	8,018	2.4	92.68	22
Colleton Medical Center	3,667	17,850	4.9	112.1	48.9
Edgefield County Healthcare	167	2,373	14.2	100.93	6.5
Hampton Regional Medical Center	423	1,992	4.7	154.27	5.5
McLeod Health Cheraw	2,247	9,825	4.4	121.69	26.9
McLeod Health Clarendon	2,368	10,078	4.3	149.91	27.6
McLeod Health Dillon	1,960	7,192	3.7	154.73	19.7
MUSC Health Black River Medical Center	1,312	4,133	3.2	172.28	11.3
MUSC Health Chester Medical Center	903	5,095	5.6	128.74	14
MUSC Health Kershaw Health Medical Center	3,147	14,475	4.6	125.88	39.7
MUSC Health Lancaster Medical Center	5,096	26.261	5.2	68.68	71.9
MUSC Health Marion Medical Center	986	3,576	3.6	197.49	9.8
MUSC Health Orangeburg Medical Center	6,730	35,486	5.3	137.67	97.2

Newberry Health	1,233	4,853	3.9	113.47	13.3
Prisma Health Oconee Memorial Hospital	7,053	28,893	4.1	110.54	79.2
Prisma Health Laurens County Hospital	2,619	11,446	4.4	135.21	31.4
Self-Regional Healthcare	10,097	50,267	5	101.85	137.7
Tidelands Georgetown Memorial Hospital	3,223	16,478	5.1	133	45.1
Tidelands Waccamaw Community Hospital	7,079	28,274	4	139.34	77.5
Union Medical Center	526	1,879	3.6	159.96	5.1

Source: SC Office of Revenue and Fiscal Affairs Inpatient Discharge Summary Statistics

Appendix B:

SC Department of Insurance Bulletin 2018-08

South Carolina Department of Insurance

Capitol Center
1201 Main Street, Suite 1000
Columbia, South Carolina 29201

Mailing Address:
P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6160

HENRY McMASTER
Governor

RAYMOND G. FARMER
Director

BULLETIN NUMBER 2018-08

TO: All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina and all South Carolina Licensed Health Maintenance Organizations (collectively "Health Insurance Issuers")

FROM: Raymond G. Farmer
Director of Insurance

RE: Requirements Applicable to Short-Term, Limited-Duration Insurance (STLDI) Policies Sold in South Carolina

DATE: August 28, 2018

I. BACKGROUND, SCOPE AND PURPOSE

This Bulletin is directed to all Health Insurance Issuers writing short-term, limited-duration insurance policies (STLDI policies) sold in the individual market in South Carolina. It sets forth the Department's requirements for STLDI policies in light of the recently released final rule issued by the federal government.[1] That rule[2], which becomes effective October 2, 2018, permits the sale and renewal of STLDI policies that cover an initial period of less than 12 months, and taking into account any extensions, a maximum duration of no longer than 36 months in total.

Both the new federal rule and the guidelines set forth in this Bulletin apply only to short-term, limited-duration insurance policies sold in the individual market. They do not apply to any other type or category of insurance that is listed separately as excepted benefits in the federal Public Health Service Act (*e.g.*, disability income, hospital indemnity, specified disease insurance, accident insurance, etc.).

[1] The final federal rule was promulgated by the combined efforts of the U.S. Departments of Health and Human Services, Labor and Treasury.

[2] https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/CMS-9924-F-STLDI-Final-Rule.pdf

II. SUMMARY OF FEDERAL REQUIREMENTS FOR STLDI POLICIES SOLD IN THE INDIVIDUAL MARKET

Effective October 2, 2018, the federal government requires that STLDI policies sold in the individual market:

- Must cover a period that is 12 months or less. In other words, the previous federal standard reducing the *maximum* coverage to less than 3 months is no longer in effect.
- May be renewed for a maximum period of 36 months. Insurers must offer a renewal guarantee with the initial policy. For an additional premium, consumers may elect to purchase the renewal guarantee, allowing the consumer to renew the policy for additional terms, up to the maximum term of 36 months, without an increase in premium or additional evidence of insurability.
- Must contain important language to help consumers fully understand the coverage they are purchasing. A notice (one of two versions – depending on the year of issuance) must be displayed prominently in the contract -- and in any application materials provided in connection with enrollment -- using at least 14-point type. This consumer notice differs slightly for polices issued before January 1, 2019 and those issued after that date, as outlined in item III below.

Please Note: South Carolina Notice Requirements differ slightly from the Federal Requirements. Additional South Carolina Requirements are outlined in Sections III, IV and V of this Bulletin.

III. NOTICE TO CONSUMERS

For policies issued in South Carolina with an effective date beginning on or after October 2, 2018, the issuing insurer must include on the first page of the contract and any application materials provided in connection with enrollment one of the notices prescribed below:

A. FOR POLICIES ISSUED IN 2018

Policies having a coverage start date ***before January 1, 2019*** and any application materials provided in connection with enrollment in such coverage must include the notice set forth below, using bold and at least 16 point type:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits

(such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also contain a cap on lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

B. FOR POLICIES ISSUED IN 2019 AND THEREAFTER

Policies having a coverage start date ***on or after January 1, 2019*** and any application materials provided in connection with enrollment in such coverage must include the notice set forth below, using bold and at least 16 point type:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also contain a cap on lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

IV. ADDITIONAL SOUTH CAROLINA STLDI REQUIREMENTS

The Department is requiring the initial term of STLDI policies to be 11 months or less and limiting renewals to a total duration of 33 months or less of coverage. This should assist consumers in differentiating between STLDI health insurance and major medical insurance coverage under the Affordable Care Act, which are required to be 12 months in duration and guaranteed renewable annually.

To further assist consumers, the Department is also recommending that the following attestation clause be placed above the applicant's signature line on the application:

> **I hereby attest that I understand that this coverage is not required to comply with federal requirements for health insurance and does not provide "minimum essential coverage" as defined under the Affordable Care Act.**

V. FILING OF RATES AND FORMS – PRIOR APPROVAL REQUIRED

All forms and rates for STLDI policies should be submitted via SERFF. **Both** forms and rates are subject to prior approval; and consequently, must be filed with and approved by the Department prior to use. All other required documents/forms should also be submitted. These include, but are not limited to, policy forms, riders, rates, certifications, filing fees, etc.

Effective October 2, 2018, previously filed STLDI products must be resubmitted for form and rate review and approval with the appropriate notice displayed prominently in the contract and in any application materials. These products should be submitted as a new product with a new form number and include all required documentation.

VI. QUESTIONS

Questions regarding this Bulletin should be submitted via email to LAHmail@doi.sc.gov and include complete contact information (company name, phone number and email address for follow up.)

Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are Departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

Appendix C:

SC Legislative Letter of Support

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services

Dear Administrator Oz,

As members of the South Carolina General Assembly, we write to express our strong support for the State's proposed Rural Health Transformation Plan and the leadership of the South Carolina Department of Health and Human Services (SCDHHS) in developing and implementing this initiative.

The South Carolina Rural Health Transformation Plan reflects a coordinated effort across state agencies, local health systems and community partners to strengthen rural healthcare infrastructure and expand access to care. We commend the agency and stakeholders for their engagement to shape a plan that will improve health outcomes for rural residents throughout the State.

The General Assembly is committed to working collaboratively with the Governor and SCDHHS to ensure the success of this initiative, including consideration of any State-level actions necessary to support its implementation.

We appreciate the Centers for Medicare & Medicaid Services' partnership in advancing sustainable solutions for rural health, and we urge full consideration and approval of South Carolina's Rural Health Transformation Plan.

Sincerely,

Signed by:
Thomas Alexander
1EF3259FB3174C4...
Thomas Alexander
President of the SC Senate

Signed by:
Brad Hutto
BAA335DAADB54ED...
Brad Hutto
SC Senate Minority Leader

Signed by:
Daniel B. "Danny" Verdin III
7A93010CA2C5472...
Daniel B. "Danny" Verdin III
Chair, SC Senate Medical Affairs Committee

Signed by:
D. Todd Rutherford
EE836C8454B14F8...
J. Todd Rutherford
SC House Minority Leader

Signed by:
David R. Hiott
EE836C8454B14F8...
David R. Hiott
SC House Majority Leader

Signed by:
G. Murrell Smith, Jr.
9BE1A293C3A1484...
G. Murrell Smith, Jr.
Speaker of the SC House of Representatives

Signed by:
Bruce W. Bannister
90CC032672504F9...

Bruce W. Bannister
Chair, SC House Ways and Means Committee

Signed by:
Sylleste H. Davis
EE836C0454B14F0...

Sylleste H. Davis
Chair, SC House Medical, Military, Public and Municipal Affairs Committee

Appendix D:

SC Stakeholder Letter of Support

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services

Dear Administrator Oz,

We represent partner organizations to the State of South Carolina's Rural Health Transformation Program effort. We are pleased to provide this letter of support for the state's plan to utilize the awarded funds to enhance rural health. South Carolina hospitals, healthcare providers, related associations and non-profit groups have witnessed firsthand the critical challenges facing South Carolina's rural communities. These rural communities face significant healthcare access and outcomes challenges that demand immediate attention, including hospital closures in rural counties, provider shortages, geographic barriers to care access and workforce recruitment and retention challenges. If South Carolina is awarded funding, we are committed to collaborating with state leaders to ensure the plan's success.

The Rural Health Transformation Program represents an unprecedented opportunity to address longstanding healthcare inequities in rural America. South Carolina's thoughtful, comprehensive approach demonstrates the state's readiness to leverage this investment effectively to create lasting improvements in rural health access, quality and outcomes.

We urge CMS to approve South Carolina's application and look forward to partnering with the state and federal government to transform rural healthcare delivery in our communities.

Thank you for your consideration.

Sincerely,

DocuSigned by:
Ann Lefebvre
Ann Lefebvre
SC Area Health Education Consortium

Signed by:
Tylee Anderson
Tylee Anderson
Catawba Indian Nation

Signed by:
Brian Clark
Brian Clark
SC Pharmacy Association

DocuSigned by:
Courtnay Thompson
Courtnay Thompson
Select Health

Signed by:
Dietrick Williams
72DE811431464A1...

Dietrick Williams
Humana

DocuSigned by:
Dora Wilson
3CB975AE6A9D4FF...

Dora Wilson
Molina

DocuSigned by:
GRAHAM ADAMS
0E7229B470104D5...

Graham Adams
SC Office of Rural Health

Signed by:
Henry Lewis
2EB2681D1B1A433...

Henry Lewis
SC EMS Association

Signed by:
Dr. James McElligott
03EE0AA6BFC948B...

Dr. James McElligott
SC Telehealth Alliance

Signed by:
Jim Ritchie
CC0074ZD27ED439...

Jim Ritchie
SC Alliance of Health Plans

DocuSigned by:
John Creel
06D3D0C35B154C3...

Dr. John Creel
Edisto Natchez Cuso Tribe

DocuSigned by:
John McClellan
9170E0CED7B1CF...

John McClellan
Absolute Total Care

Signed by:
Kevin Bennett
A9FEB661009D0C4...

Kevin Bennett
SC Center for Rural and Primary Healthcare

DocuSigned by:
Richele Taylor
5E37A2EE57B14BB...

Richele Taylor
SC Medical Association

Signed by:
Scott Graves
2C0073AC91A643F...

Scott Graves
Blue Cross Blue Shield SC

Signed by:
Susan John
75D38AEDC654AB...

Susan John
SC Human Services Providers Association

Thornton Kirby
SC Hospital Association

DocuSigned by:
Timothy K. Vaughn
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Tim Vaughn
Healthy Blue

DocuSigned by:
Vicki Young
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Vicki Young
SC Primary Health Care Association

Appendix E:

SC RHT Program Summary

Project Summary – South Carolina

South Carolina proposes a bold and comprehensive Rural Health Transformation (RHT) plan to address longstanding disparities in health care access, quality, and outcomes across its rural communities. With approximately 1.75 million residents—32.6% of the state's population—living in rural areas, the state faces disproportionate rates of chronic disease, maternal mortality, and limited access to care due to provider shortages; aging infrastructure; and the geographic and logistical challenges inherent to rural communities.

South Carolina's RHT plan is designed to transform the rural health care landscape through five integrated, outcomes-driven initiatives:

Connections to Care – Expands digital infrastructure by implementing electronic health records, remote patient monitoring, telehealth services and a statewide resource database platform to improve care coordination and access.

Leveling Up – Scales successful pilot programs statewide, focusing on chronic disease management, pediatric care quality, and workforce development.

Wellness Within Reach – Deploys mobile health units, crisis response teams, and pop-up clinics to bring care directly to underserved populations.

Shoring Up to Sustainability – Strengthens rural healthcare systems through targeted investments in workforce recruitment and retention, facility upgrades, and provider training.

Tech Catalyst Fund – Supports rural health technology startups and community-based innovations to drive long-term health and economic improvements.

Led by the South Carolina Department of Health and Human Services, South Carolina's plan and its five initiatives, aligns with the RHT's five strategic goals: **Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care, and Tech Innovation**. The program emphasizes one-time, high-impact investments that remove systemic barriers and build long-term capacity, with a focus on improving chronic disease and maternal health outcomes across all rural counties.

To implement this transformative vision, South Carolina is requesting $1 billion in federal funding. This investment will enable the state to modernize rural healthcare infrastructure, expand access to essential services, and build a resilient, sustainable healthcare system that delivers measurable improvements in health outcomes for generations to come.

Business Assessment of Applicant Organization

A. General Information

1. *Provide organization:*
   a. *Legal name*: State of South Carolina
   b. *EIN (include PMS prefix and suffix, if applicable-ex. **1**-12356789-**A1**)*: 576000286
   c. *Organizational Type:* State Government

2. *What percentage of the organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year / organization's total gross revenue in previous fiscal year).* 85%

3. *Does/did the organization receive additional oversight (ex: Correction Action Plan, Responsibility and Qualification (R/Q) findings, reimbursement payments for enforcement actions) from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization)?* Yes

   a. *If yes, please provide the following information: Name of the Federal agency; reason for the additional oversight as explained by the Federal agency.* Centers for Medicare & Medicaid Services (see below).
   b. *If resolved, please indicate how the issue was resolved with the agency.* See Figure 1, below:

Schedule 2

STATE OF SOUTH CAROLINA
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2023

SOUTH CAROLINA DEPARTMENT OF ADMINISTRATION (D50) (CONTINUED)

2023 – 017. Reporting (Continued)

Recommendation: We recommend the Department strengthen procedures to ensure review responsibilities include requiring all State agencies to report expenditures posted to the accounting system as of the tenth day of the month following the period covered by each quarterly report.

Views of Responsible Officials and Corrective Action Plan: Management agrees with the finding. See Corrective Action Plan at page 131.

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (J02)

2023 – 018. Eligibility

Federal Agency: Department of Health and Human Services
Federal Program Title: Medicaid Cluster and Children's Health Insurance Program
Assistance Listing: 93.775, 93.777, 93.778, and 93.767
Federal Grant ID Number: 05-2105-SC-5001, 05-1005-SC-5MAP, and 05-2305-SC-5021
Pass-Through Entity: Not applicable
Award Period: October 1, 2021, through September 30, 2023
Type of Finding: Significant deficiency in internal control over compliance, other matters

Criteria: 2 CFR § 200.303 requires that the non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations and the terms and conditions of the federal award.

42 CFR § 435.916(a)(1) requires the Department renew MAGI-based determinations of eligibility once every twelve months and no more frequently than once every twelve months.

42 CFR § 435.916(b) requires the Department renew non-MAGI-based determinations of eligibility at least once every twelve months..

Condition: The Department's monitoring process and eligibility systems do not ensure recipients' eligibility determinations are renewed annually as required by 42 CFR § 435.916(a)(1) and 42 CFR § 435.916(b).

Cause: The Department did not comply with the annual review requirement due to a backlog in eligibility determination processing.

Effect: Without an annual review, the Department could provide Medicaid and CHIP benefits to ineligible recipients because all recipients are not being recertified as required by 42 CFR § 435.916(a)(1) and 42 CFR § 435.916(b).

Questioned Costs: None

2023 – 018. Eligibility (Continued)

Context: The Department did not complete annual reviews during the Public Health Emergency (PHE) (beginning January 27, 2020) based on guidance from Centers for Medicare & Medicaid Services (CMS).

However, we determined that eight Medicaid and seven CHIP recipients did not have an annual renewal completed during the twelve months prior to the PHE being instituted.

Prior Year Single Audit Report Finding Number: 2022-004

Recommendation: We recommend the Department ensure staffing is adequate to confirm only eligible recipients receive benefits by completing periodic eligibility determination renewals.

Views of Responsible Officials and Corrective Action Plan: Management agrees with the finding. See Corrective Action Plan at page 132.

2023 – 019. Eligibility

Federal Agency: Department of Health and Human Services
Federal Program Title: Children's Health Insurance Program
Assistance Listing: 93.767
Federal Grant ID Number: 05-2305-SC-5021
Pass-Through Entity: Not applicable
Award Period: October 1, 2021, through September 30, 2023
Type of Finding: Significant deficiency in internal control over compliance, other matters

Criteria: 2 CFR § 200.303 requires that the non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations and the terms and conditions of the federal award.

42 CFR § 435.926(b)(1) requires enrolled recipients under age nineteen or under a younger age specified by the Department in its State plan are eligible for CHIP benefits. Section 2.1(d) of the State plan sets the eligibility age for CHIP benefits at under age 19.

Condition: The Department's monitoring process and eligibility systems did not ensure recipients nineteen or older who are deemed ineligible no longer receive CHIP benefits.

Cause: The Department did not complete the close out process to remove the recipients from the list of eligible beneficiaries.

Effect: The Department could be providing CHIP benefits to ineligible recipients.

Questioned Costs: $6,396

Context: The Department provided a closure notice to one recipient detailing that the recipient will no longer be eligible for CHIP benefits. The recipient continued to receive benefits due to the Department not completing the close out process.

Prior Year Single Audit Report Finding Number: Not applicable

2023 – 019. Eligibility (Continued)

Recommendation: We recommend the Department ensure staffing is adequate to ensure that only eligible recipients receive benefits by completion of the eligibility determination close out processes.

Views of Responsible Officials and Corrective Action Plan: Management agrees with the finding. See Corrective Action Plan at page 133.

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2023 – 020. Special Test and Provisions – Medical Loss Ratio

Federal Agency: Department of Health and Human Services
Federal Program Title: Medicaid Cluster and Children's Health Insurance Program
Assistance Listing No.: 93.775, 93.777, 93.778, and 93.767
Federal Grant ID Number: 05-2105-SC-5001, 05-1005-SC-5MAP, and 05-2305-SC-5021
Pass-Through Entity: Not applicable
Award Period: October 1, 2021, through September 30, 2023
Type of Finding: Significant deficiency in internal control over compliance, other matters

Criteria: 2 CFR § 200.303 requires that the non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations and the terms and conditions of the federal award.

42 CFR § 438.8(k)(1) requires the Department, through its contracts, must require each Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) to submit a report to the Department that includes the information required by 42 CFR § 438.8(k)(1)(i) through 42 CFR § 438.8(k)(1)(xiii) each year.

Condition: The Department's review of reporting templates did not ensure the thirteen required elements were included in reports submitted by MCOs.

Cause: The Department stated that it would not be cost effective for the MCOs to include a comparison between audited financial information and other financial information in reports submitted to the Department as required by 42 CFR § 438.8 (k)(1)(xi).

Effect: MCOs could potentially misstate financial information reported to the Department.

Questioned Costs: None

Context: We noted that a comparison of other financial information and audited basic financial statements was not included in all five MCO reports tested.

2023 – 020. Special Test and Provisions – Medical Loss Ratio (Continued)

Prior Year Single Audit Report Finding Number: Not applicable

Recommendation: We recommend the Department strengthen report review procedures to ensure the MCO's provide a comparison between other financial information and audited basic financial statements.

Views of Responsible Officials and Corrective Action Plan: Management agrees with the finding. See Corrective Action Plan at page 133.

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2023 – 021. Special Tests and Provisions – Medicaid Recovery Audit Contractors

Federal Agency: Department of Health and Human Services
Federal Program Title: Medicaid Cluster
Assistance Listings: 93.775, 93.777, and 93.778
Federal Grant ID Number: 05-2105-SC-5001 and 05-1005-SC-5MAP
Pass-Through Entity: Not applicable
Award Period: October 1, 2021, through September 30, 2023
Type of Finding: Significant deficiency in internal control over compliance, other matters

Criteria: 2 CFR § 200.303 requires that the non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations and the terms and conditions of the federal award.

42 CFR § 455.502(c) requires that the Department complies with reporting requirements describing the effectiveness of the Medicaid Recovery Audit Contractor (RAC) programs as specified by Centers for Medicare & Medicaid Services (CMS).

Condition: The Department's review of quarterly CMS-64 reports did not ensure the federal share of overpayments recovered by the Medicaid RAC were included on each report.

Cause: Due to a coding error in the accounting system the Department was not aware of overpayments recovered by the Medicaid RAC that needed to be reported on each CMS-64 report.

Effect: CMS is unable to monitor and evaluate the performance of the State's Medicaid RAC program.

Questioned Costs: None

Context: The Department's RAC program recoveries are not being reported to CMS.

Prior Year Single Audit Report Finding Number: Not applicable

4. *Does the organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?* Yes

5. *Explain your organization's process to ensure annual renewal in System for Award Management including R/Q and Reps and Certs.*
   Approximately 30 days before the current entity registration expires, the agency's AOR will log into Sam.gov via Login.gov to review and update all pertinent information for the agency and submit application for renewal. Once confirmation of renewal is received the AOR will log into Sam.gov to verify that entity registration has updated to the new end date.

6. *Explain your organization's process to comply with (a) 2 CFR 200.113 Mandatory Disclosures and (b) your organization's process to comply with FFATA requirements.* SCDHHS maintains internal procedures to ensure that mandatory disclosures are reported as outlined in 2 CFR 200.113 and requirements under FFATA are met.

7. *Do you have conflict of interest policies?* Yes. *Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds?* No

8. *Does your organization currently, or in the past, had delinquent Federal debt in the last 3 years? If yes, please explain.* No

9. *Have you filed bankruptcy or entered into proceedings for bankruptcy, whether voluntarily or involuntarily?* No

10. *Has the organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?*
Yes -- $5,000,000

11. *Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award.*
    a. *make determinations between subrecipients versus contracts in accordance with 2 CFR 200.331?*
    Determine if vendor will be providing goods or services that are subject to procurement standards and/or sole requirements or if the vendor will be providing program efforts and may be responsible for program decision making.
    b. *notify entities at the time of the award/agreement if they are a subrecipient in compliance with 2 CFR 200.332?*
    Entity will be required to sign a formal agreement that identifies them as a contractor or subrecipient and informs them of their responsibilities as a contractor or subrecipient.
    c. *manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (2 CFR § 200.331 – 200.333)?*
    Create a subrecipient checklist for monitoring activities and schedule regular review meetings and/or visits to discuss project status and to ensure regulation compliance.

B. Accounting System

1. *Does the organization have updated (last two years) written accounting policies and procedures to manage federal awards in accordance with 45 CFR Part 75?* Yes
    a. *If no, please provide a brief explanation of why not.*
    b. *Describe the management of federal funds and how funds are separated (not co-mingling) from other organizational funds.*
    The Finance department creates and sets up codes for each grant received based on award type and purpose.

2. *Briefly describe budgetary controls in effect to preclude incurring obligations in excess of:*
    a. *Total funds available for an award.*
    Upon receipt of grant award approval, the maximum amount of funds to be spent is entered into the state's accounting system (SCEIS South Carolina Enterprise Information System) If the maximum amount is exceeded an error message will be

received when an attempt is made to process an accounting document.

b. *Total funds available for a budget cost category.*
On a monthly basis a fiscal analyst prepares a reconciliation of the grant award amount, and the amount spent per category. If a category has been exceeded, a journal entry is completed to remove the expense from the grant.

3. *Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under Federal awards?* No

4. How does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable for a grant program).
The codes that are created to track grant expenditures are split between federal funds and any nonfederal funds.

5. *Does the organization's accounting system provide identification for award funding by federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? If yes, how does your organization identify awards? If not, please explain why not.*
Codes are created for each grant to track revenue and expenditures. The codes tie to CFDA and grant numbers.

C. Budgetary Controls

1. *What are the organization's controls used to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the federal award?*
The AOR is the only SCDHHS employee authorized to approve any budget changes.

2. *Describe the organization's procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g. Payment Management System) and disbursement for grant activities (See 2 CFR 200.305, "Federal Payment.").*
Each week the Fiscal Analyst prepares a reconciliation for both grant award and expenditures that have occurred. This process determines the amount of funds needed for the week. The amount to be drawn is then entered into the Division of Payment Management's online Payment Management System.

D. Personnel

1. *Does the organization have a current organizational chart or similar document establishing clear lines of responsibility and authority?*
   a. If yes, please provide a copy. Yes (please see appendices).

2. *Does the organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation.* Yes

3. *Does the organization pay compensation to Board Members?* No

4. *Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with federal rules and regulations applicable to grants and cooperative agreements (e.g. 2 CFR 200)?* Yes

5. *Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.*
SCDHHS uses the state's accounting system to process payroll. Each position is assigned codes based on the projects that the incumbent will be assigned to work. The system requires that the percentage of time worked is allocated based on job functions. The percentage of time worked must equal 100 or the system will not allow the entry to be completed.

E. Payroll

1. *In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds and maintain accounting records? Please describe.*
The department's payroll is processed through the state's accounting system SCEIS. The Comptroller General's Office processes and approves payments based on information entered at agency level by Human Resources (salary) and Finance (cost allocation assignment) for each employee. The State Treasurer's Office is responsible for issuing payments to each individual employee.

F. Consultants *(See appendix I in the NOFO for relevant information)*

1. *Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include explanation for each question below):*
   a. *Briefly describe the organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary and reasonable.* Consultant contracts are subject to the SC Procurement pricing tables. When it is determined that a consultant is needed the agency will review the eligible consultant companies
   b. *Briefly describe the organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.*
   SCDHHS only uses consultants that pass the standards and regulations of the SC Procurement code.

G. Property Management

1. *Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 2 CFR 200.313. **Refer to (2 CFR 200) for definitions of property to include personal property, equipment, and supplies.*
Assets are tagged with bar codes and an annual inventory process is completed.

2. *Does the organization have adequate insurance to protect the Federal interest in equipment and real property (see 2 CFR 200.310 "Insurance coverage.")? How does the organization calculate the amount of insurance?* Yes. Agency property is covered under South Carolina's statewide insurance policy. Agency insurance policy ranges from $25,000 up to $2,500,000 for the contents of buildings leased, based on various properties.

H. Property Standards

Describe the organization's property standards in accordance 2 CFR 200.310-327 "Procurement Standards")? If there are no procurement procedures, briefly describe how your organization handles purchasing activities.

a. *Include individuals responsible and their roles.*
Rebecca Lopez, Bureau Chief of Contracts and Procurement

- Responsible for the day to day responsibilities of the Procurement and Contracts Department
- Small Purchases ($0 - $100,000)
- Requests for Quotes (RFQ)
- Requests for Information (RFI)
- Requests for Bid (RFB)
- Fixed Price Bid (FPB)
- Requests for Proposals
- Sole Source Contracts
- Sole Source Contracts

Donna Spigner, Procurement Manager II
- Small Purchases ($0 - $100,000)
- Requests for Quotes (RFQ)
- Requests for Information (RFI)
- Requests for Bid (RFB)
- Fixed Price Bid (FPB)
- Requests for Proposals
- Sole Source Contracts
- Emergency Contracts

Jason Coleman, Procurement Manager II
- Small Purchases ($0 - $100,000)
- Requests for Quotes (RFQ)
- Requests for Information (RFI)
- Requests for Bid (RFB)

Rena Aarons, Procurement Manager 1 (Buyer)
- Issues Purchase Orders

Clarisa Henriquez-Johnson, Procurement Specialist II (Buyer)
- Issues Purchase Orders

Kristen Roche, Procurement Manager I (Buyer)
- Issues Purchase Orders

b. *Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.*
Procurement is governed by the South Carolina Consolidated Procurement Code and Regulations; please refer to links below:
Title 11 – Public Finance, Chapter 35, South Carolina Consolidated Procurement Code:
https://www.scstatehouse.gov/code/t11c035.php
South Carolina Code of State Regulations, Chapter 19, State Budget and Control Borad, Article 4, Office of General Services
https://www.scstatehouse.gov/coderegs/statmast.php

I. Transportation Costs

1. *Describe the organizations written travel policy. Ensure, at minimum, that:*
   a. *Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 2 CFR 200.474, "Travel costs.").*

b. *Receipts for lodging and meals are required when reimbursement is based on actual cost incurred.*

c. *Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates.*
For a., b., and c., upon presentation of a paid receipt, employee will be allowed reimbursement for actual expenses incurred for lodging, not to exceed the GSA rate.
For b. and c., Meal Reimbursement: - The employee will also be reimbursed for the actual expenses incurred for purchasing meals, except that such costs shall not exceed $35.00 per day when traveling within the State of South Carolina; for travel outside of South Carolina, the maximum daily reimbursement for meals shall not exceed $50.00 per day.

d. *Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g. conference hotel).*
A traveler on official business will exercise the same care in incurring expenses and accomplishing an assignment that a prudent person would if traveling on personal business. Excess costs, circuitous routes, delays, or luxury accommodations, unnecessary or unjustified in the performance of an assignment, are not considered acceptable as exercising prudence. Travel by commercial airlines includes the passenger flying in coach or tourist class, except where exigencies require otherwise.

e. *Travel expense reports show purpose and date of trip.* Travel reimbursement form must include dates of travel and purpose of travel, and must be signed by employee and their supervisor.

f. *Travel costs are approved by organizational official(s) and funding agency prior to travel.* Travel request document must be signed by employee and supervisor prior to travel.

J. Internal Controls

1. *Provide a brief description of the applicant's internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see 2 CFR 200.303, "Internal controls.")*
Upon receipt of grant award approval, the maximum amount of funds to be spent is entered into the state's accounting system (SCEIS South Carolina Enterprise Information System) by the Financial Reporting's Senior Accountant. When Accounts Payable or Accounts Receivable attempts to process an accounting document the system automatically checks the available balance and maximum limit, and an error message will be received if the limit has been exceeded. On a monthly basis the Senior Accountant also prepares a reconciliation of the grant award amount, and the amount spent per category. If a category has been exceeded, a journal entry is completed to remove the expense from the grant.

2. *What is your organization's policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?*
N/A; we do not accept cash payments.

3. *Does the organization have internal audit or legal staff?* Yes

4. *If the organization has a petty cash fund, how is it monitored?* N/A; we do not have a petty cash fund.

5. Who in the organization reconciles bank accounts? Fiscal Manager I .

Is this person familiar with the organization's financial activities? Yes

6. *Does your organization authorize this person to sign checks or handle cash?* No
7. *Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?* No

K. Audit

1. *What is your organization's fiscal year?* July-June
2. *Did the organization expend $1,000,000 or more in Federal awards from all sources during its most recent fiscal year?* Yes
3. *Has your organization submitted;*
   a. *an audit report to the **Federal Audit Clearing House (FAC)** in accordance with the Single Audit Act in the last 3 years? (see 2 CFR 200.501, "Audit requirements" and 2 CFR 300.218 "Special Provisions Awards to for-profit organization as recipients.) or (b) an independent, external audit? If no, briefly explain.*
      i. *The date of the most recently submitted audit report.* March 2024
      ii. *The auditor's opinion on the financial statement.* N/A; an opinion was not provided.
      iii. *If applicable, indicate if your organization has findings in the following areas:*
         1) *internal controls* Yes
         2) *questioned or unallowable costs* Yes
         3) *procurement/suspension and debarment* No
         4) *cash management of award funds* No
         5) subrecipient *monitoring.* No
      iv. Include (if applicable): N/A; the findings below were not sited.
         1) A description of each finding classified as Material Weakness.
         2) A description of each finding classified as Significant Deficiency.
4. *Does the organization have corrective actions in the past 2 years for the findings identified above (3(iii))? If yes, describe the status (closed or open) and progress made on those corrective actions.* Yes.
   Internal Control Audit finding -- Open and Partially Resolved.
   Unallowable Costs Audit finding -- Closed and Fully Resolved.
   - Funds were returned to CMS on the QE June 2024 CMS 64 report.