CONCEPT PAPER: STREAMLINING DELIVERY OF HOME AND COMMUNITY-BASED WAIVER SERVICES IN SOUTH CAROLINA



Executive Summary and Policy Direction

South Carolina's Phase II of Streamlining Medicaid Delivery through Managed Care advances the state's multi-year strategy to create a more integrated, coordinated and accountable Medicaid delivery system. During this phase, SCDHHS will transition home and community-based services (HCBS), nursing facility services and hospice services into the managed care service delivery model, while consolidating the Community Choices, HIV/AIDS and Mechanical Ventilator Dependent waivers into a single statewide waiver, Healthy Connections – Long Term Care (HC-LTC). This transition is expected to impact approximately 32,332 Healthy Connections Medicaid members and more than 1,600 providers, reinforcing whole-person care by aligning long-term services and supports with members' medical, behavioral health and pharmacy benefits under a single accountable entity. Preliminary plans identify Summer 2027 as the targeted go-live window, contingent upon CMS approvals, provider contracting, system readiness activities and coordinated outreach to members and providers. Throughout implementation, SCDHHS will maintain key protections: no current waiver participant will lose eligibility solely due to consolidation, all existing services will be preserved within the new waiver structure, and self-directed service options will continue unchanged. Collectively, Phase II is designed to streamline the member and provider experience, strengthen care quality and oversight, improve care coordination and continuity across settings and expand access to additional value-added supports available through the managed care environment.

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South Carolina's Streamlining Medicaid Delivery through Managed Care Initiative

The South Carolina Department of Health and Human Services (SCDHHS) currently provides Medicaid coverage through both a fee-for-service (FFS) and a managed care delivery model. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid member. Under the managed care model, the state pays an actuarily sound capitation rate to a managed care organization (MCO) for each member enrolled in their plan. The MCOs then coordinate care for the Medicaid member and pay providers for the Medicaid services the member may require.

Some Healthy Connections Medicaid members receive services through a home and community-based services (HCBS) waiver program. These programs help people access services normally provided in a nursing home, hospital or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) in their home or in a community-based setting. Accessing these services through an HCBS waiver program allows individuals who are eligible for nursing home care to receive care in their community instead at less than half the cost to the state of delivering care in an institutional setting.

Unlike services covered under the Medicaid state plan, HCBS waiver programs are not entitlement programs. This means that each waiver program is specifically approved by the Centers for Medicare & Medicaid Services (CMS) and funded for a negotiated number of slots. This allows state Medicaid programs, in partnership with CMS, to tailor services to meet the needs of its population and request necessary state matching funding to provide waiver program services to a set population.

In South Carolina, the HCBS population has historically received coverage through FFS Medicaid. Effective, Jan. 1, 2026, the South Carolina Department of Health and Human Services (SCDHHS) added some HCBS waiver members to the managed care delivery model. This concept paper describes how SCDHHS is seeking to streamline access to quality care for Healthy Connections Medicaid members. This includes adding additional services into the managed care delivery model; and consolidating multiple HCBS waivers while maintaining coverage of the services covered by the waiver programs.

SCDHHS is undertaking a multi-year effort to streamline the Healthy Connections Medicaid delivery system and create a more integrated, coordinated and accountable system of care for South Carolinians. Through a phased approach to streamlining Medicaid service delivery, the Department is working to reduce fragmentation across delivery systems, strengthen care coordination and improve the experience of members and providers while maintaining access to high-quality services and critical member protections.

Historically, many Medicaid members with complex health and long-term care needs have received services through multiple delivery systems, with medical, behavioral health and pharmacy benefits administered through managed care while certain long-term services and supports remain in the fee-for-service system. This structure can require members, families and providers to navigate separate processes for care coordination, authorization and service delivery. SCDHHS' initiative is designed to better align these services and establish greater accountability for coordinating care across the full continuum.

The initiative is being implemented in phases to protect continuity of care, allow sufficient time for member and provider engagement and ensure operational readiness. Phase I, implemented Jan. 1, 2026, transitioned additional Medicaid populations to managed care for their medical benefits. Phase II builds on that foundation by integrating HCBS waiver services, nursing facility services and hospice services into managed care for the Phase I population while consolidating three existing HCBS waivers into Healthy Connections – Long Term Care (HC-LTC). Future phases will continue this work toward a more streamlined, coordinated and person-centered Healthy Connections Medicaid delivery system.

Phased Approach

Phase I (Complete) – Overview

Effective Jan. 1, 2026, SCDHHS began the initial phase of its initiative to transition additional Healthy Connections Medicaid members into the managed care service delivery model. This phase applied to approximately 136,000 Medicaid members 18 years of age or older who are:

- Dually enrolled in Medicare and Medicaid
- Enrolled in the HIV/AIDS Waiver
- Enrolled in the Mechanical Ventilator Dependent (Vent) Waiver
- Enrolled in the Community Choices Waiver
- Residing in a nursing facility

During this first phase, MCOs became responsible for all medical services. Waiver services and nursing facility services, however, continued to be authorized and paid for through the FFS delivery system.

MCOs were required to provide a 180-day continuity of care period for newly enrolled members. During this period, MCOs were required to:

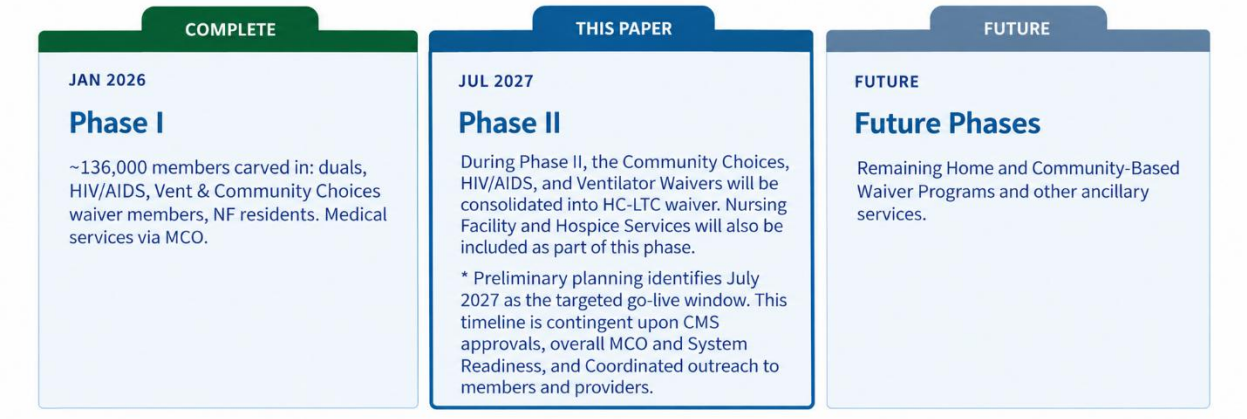
- Honor all existing prior authorizations without requiring new authorization requests
- Reimburse previously authorized services at 100% of the applicable Medicaid FFS rate, unless a contracted rate was already in place, regardless of whether a provider was in-network
- Require providers to complete enrollment with the member's MCO once the continuity-of-care period ended if continuing services

Points of contact and information on prior authorization, provider enrollment, and credentialing for each South Carolina MCO remain available on the SCDHHS website.

Phase II – Overview

During the next phase of this initiative, SCDHHS will transition coverage of HCBS waiver services, nursing facility services, and hospice services into the managed care delivery model for the population included in Phase I. This shift strengthens the integration of long-term services and supports with members' medical, behavioral health, and pharmacy benefits, allowing MCOs to coordinate care more holistically and effectively.

Figure 1: South Carolina's Roadmap



As part of this phase, SCDHHS will also begin implementing the consolidation of the Mechanical Ventilator Dependent, HIV/AIDS, and Community Choices waivers into a single, comprehensive waiver program, Healthy Connections – Long Term Care (HC-LTC). Consolidating these programs will streamline access to HCBS, reduce administrative complexity, and ensure more equitable, consistent services for all members. Integrating this new consolidated waiver into the managed care delivery system will further support coordinated, whole-person care and enhance the ability of MCOs to address members' needs across all care settings.

Under the managed care delivery model, Healthy Connections Medicaid members will gain access to enhanced care coordination and additional value-added services offered by MCOs. Depending on the plan, these additional benefits may include wellness and disease-management programs, expanded home- and community-based supports, caregiver resources, telehealth services, and other offerings designed to address social drivers of health and support community living.

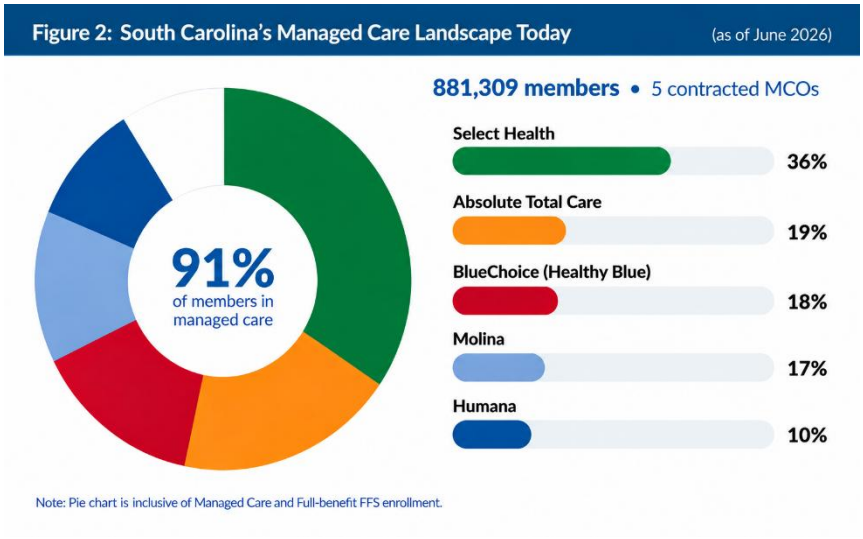
For members who reside in a nursing facility or who receive hospice services, their nursing facility and/or hospice coverage will now also be provided through their MCO. This creates a single point of accountability for the full range of services a member may need, helping support smoother communication, less fragmentation, and more consistent care planning across all settings, including under the new consolidated waiver structure.

Future Phases – Overview

SCDHHS is advancing its long-term strategy to transition the majority of Healthy Connections Medicaid members into a managed care environment, with the goal of creating a more efficient, coordinated, and member-centered system. By shifting additional populations into managed care, the agency aims to streamline administrative processes, reduce fragmentation, and drive improvements in access, outcomes, and overall quality of care. Future phases of this initiative will focus on the intentional, data-driven integration of medically complex children and individuals served through waiver programs operated by the state's Office of Intellectual and Developmental Disabilities (OIDD), along with their associated supports and services. This phased approach allows SCDHHS to build on lessons learned, ensure readiness across partners, and strengthen the foundation for a more integrated system of care.

South Carolina's Current State

South Carolina currently operates a managed care system in which approximately 91%[1] of Healthy Connections Medicaid members receive their medical, behavioral health, and pharmacy benefits through one of the state's contracted MCOs. However, HCBS provided through Medicaid waiver programs remain outside of the managed care delivery system. These services can only be accessed through the specific CMS-approved waivers for which a member qualifies, resulting in separate eligibility processes, assessments, service arrays, and payment structures. As a result, members often navigate two parallel systems—managed care for State Plan benefits and fee-for-service waiver programs for long-term services and supports—which can lead to fragmentation, administrative complexity, and varied experiences across the existing waivers. The proposed consolidation and integration into managed care described in the following sections aim to streamline this structure and create a more coordinated, person-centered system of care.



Managed Care Plans

Currently SCDHHS partners with five managed care organizations to provide state plan services to 881,309[1] individuals. The five managed care plans are:

- Absolute Total Care
- BlueChoice (Healthy Blue)
- Humana Healthy Horizons
- Molina
- Select Health (First Choice)

[1] Enrollment figures are based on SCDHHS' publicly reported end-of-month Medicaid enrollment data. The percent of members enrolled in managed care is calculated using Managed Care enrollment divided by Managed Care plus Fee-for-Service Full Medicaid enrollment (excluding Limited Benefit). Data reflect June 2026 enrollment and were last refreshed on the August 11, 2026 rundate. Public data available at: SCDHHS Medicaid Enrollment Data.

Home and Community-based Service (HCBS) Waivers

South Carolina Healthy Connections Medicaid offers home and community-based waiver programs for eligible Healthy Connections Medicaid members. This helps people access services normally provided in a nursing home, hospital or intermediate care facility to receive this care at home. They can get these HCBS waiver services from providers in the community. Members may also access services through the traditional Medicaid program while on a waiver waiting list. These are called "State Plan" services. Members must meet the service-specific conditions for each service. State Plan services include medical, dental, vision, behavioral health, durable medical equipment, pharmacy and therapy. Examples include in-home children's personal care, children's private duty nursing and incontinence supplies.

SCDHHS Administered and Operated Waivers

SCDHHS' Bureau of Policy administers and operates four HCBS waiver programs. These include Community Choices, HIV/AIDS, Mechanical Ventilator Dependent and Medically Complex Children waivers.

Table 1: SCDHHS Administered and Operated Waivers

Waiver	Description
Community Choices	For Medicaid frail, elderly who are age 65 and older. It is also for Medicaid members ages 18 to 64 with physical disabilities. Eligible persons must meet a nursing facility level of care.
HIV/AIDS	For Medicaid members of all ages with a diagnosis of HIV or AIDS. They must meet an at-risk of hospitalization level of care.
Mechanical Ventilator Dependent	For Medicaid frail, elderly who are age 65 and older. It is also for Medicaid members ages 21 to 64 with physical disabilities. Eligible persons must require mechanical ventilation and meet a nursing facility level of care.
Medically Complex Children	For Medicaid children up to age 21 with chronic physical/health condition(s) expected to last at least one year. They must meet a hospital level of care. They must also rely on hospital, skilled nursing and specialist care, as well as ancillary service and medicine monitoring.

Office of Intellectual and Developmental Disabilities (OIDD) Operated Waivers

The SCDHHS Bureau of Policy also administers three waivers that are operated by another state agency. The South Carolina Department of Behavioral Health and Developmental Disabilities' Office of Intellectual and Developmental Disabilities (OIDD) operates the Head and Spinal Cord Injury waiver, the Intellectual Disability/Related Disabilities waiver and the Community Supports waiver.

Table 2: OIDD Operated Waivers

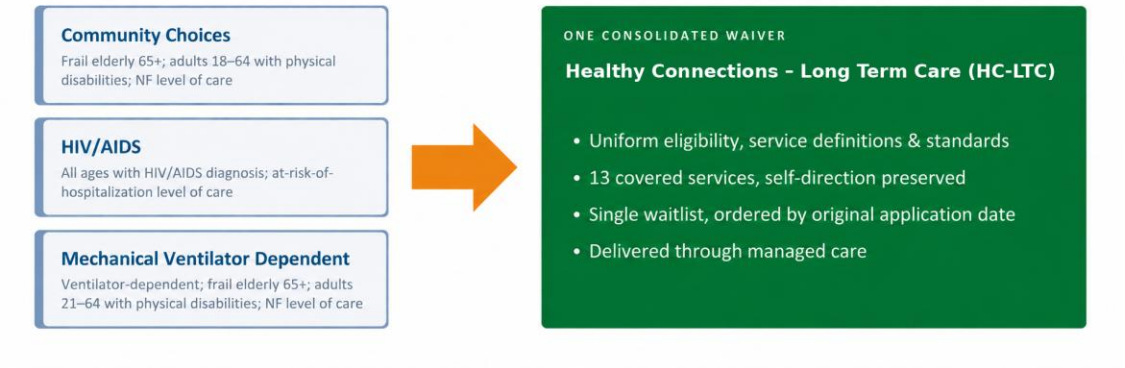
Waiver	Description
Community Supports	For Medicaid members of any age with a diagnosis of intellectual or related disability. They must meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care. Service needs must not go over the set yearly cost limits. This waiver does not include medical services.
Head and Spinal Cord Injury (HASCI)	For Medicaid members of any age with a diagnosis of traumatic brain injury, spinal cord injury or similar disability. They must meet a nursing facility or ICF-IID level of care.
Intellectual Disabilities/Related Disabilities (ID/RD)	For Medicaid members of any age with a diagnosis of intellectual or related disability. They must meet an ICF-IID level of care. Some medical services are offered in this waiver.

Streamlining Access to Waiver Services

Waiver Consolidation

To streamline access to HCBS and create a more consistent, person-centered experience for members, SCDHHS is proposing to consolidate three agency-administered and operated waivers—the Mechanical Ventilator Dependent waiver, the HIV/AIDS waiver, and the Community Choices waiver—into a single, comprehensive waiver program, HC-LTC. This consolidated waiver is being thoughtfully designed using data on current utilization and outcomes, as well as extensive input from providers, members, and community partners. By drawing on the strongest components of each existing waiver, SCDHHS aims to create a more flexible, equitable, and streamlined program that better supports individuals with complex needs across the state.

Figure 3: Consolidating Three Waivers into Healthy Connections - Long Term Care



Building on the successful transition of approximately 136,000 members into the managed care environment, the waiver consolidation represents a natural next step in the agency's broader move toward a more coordinated and integrated system of care. This proposal aligns with SCDHHS' phased strategy to achieve near-universal managed care enrollment for the Healthy Connections Medicaid population. Through consolidation, the agency will be better positioned to advance key strategic priorities, reduce administrative complexity for members and providers, and improve the quality and consistency of services delivered across home- and community-based settings. Ultimately, this effort supports SCDHHS' mission to provide timely, high-quality, whole-person care to Healthy Connections Medicaid members.

Goals of Consolidation

The goals of the waiver consolidation are as follows:

- **Alignment**: Consolidating the waivers establishes uniform eligibility, service definitions, and standards across all populations, reducing fragmentation and enabling consistent statewide oversight.
- **Administrative Efficiency and Sustainability**: Merging the waivers lowers administrative burden, eliminates duplicative processes, and supports efficiency in service delivery through coordinated managed care.
- **Enhanced Quality**: A unified waiver enables consistent quality benchmarks and monitoring, allowing earlier intervention and improved outcomes across all HCBS populations.
- **Streamlined Care Coordination**: Combining waivers and integrating them into managed care creates a single accountable entity that delivers comprehensive, coordinated care across all service types.

- **Social Supports**: Consolidation expands access to non-clinical, community-based supports by enabling MCOs to flexibly invest in services addressing social determinants of health.
- **Whole Person Care**: Integrating these HCBS populations under one waiver and into the managed care delivery system supports coordinated medical, behavioral, functional, and social needs through a single care plan.

Service Alignment

The consolidated HC-LTC will standardize and enhance services as shown in **Table 3** below.

Table 3: HCBS Waiver Services for Healthy Connections – Long Term Care

Vent	HIV/AIDS	CC	Waiver Services	HC-LTC
	✓	✓	*Self-directed Attendant Care Services*	✓
		✓	*Adult Day Health Care*	✓
		✓	*Adult Day Health Care Nursing*	✓
	✓	✓	*Self-directed Companion Care*	✓
	✓	✓	*Companion Care, Agency*	✓
✓	✓	✓	*Home Accessibility Adaptation - Environmental Modifications*	✓
✓	✓	✓	*Home-Delivered Meals*	✓
✓	✓		*Private Duty Nursing*	✓
✓	✓	✓	*Personal Care Services*	✓
✓	✓	✓	*Personal Emergency Response System*	✓

Vent	HIV/AIDS	CC	Waiver Services	HC-LTC
✓	✓	✓	*Pest Control*	✓
✓		✓	*Respite*	✓
✓	✓	✓	*Specialized Medical Equipment, Supplies, and Assistive Technology*	✓
	✓	✓	*Telemonitoring**	
✓	✓	✓	*Waiver Case Management**	

CC = Community Choices | Vent = Mechanical Ventilator

**See the "Transitioning Services" section for more on the future of telemonitoring and case management services.*

Early and Periodic Screening, Diagnostic, and Treatment Services

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid benefit that ensures children and young adults from birth through age 21 receive the preventive care, screenings, and medically necessary services needed to identify and address health issues early. Members ages 18–21 who enroll in the HC-LTC waiver will continue to receive all EPSDT-covered services for which they are eligible.

Eligibility for Consolidated Waiver

The HC-LTC population includes individuals who receive case management along with at least one additional waiver service and who meet the nursing facility level of care. Eligible groups include:

- Elderly individuals (Age 65 & older)
- Physically disabled individuals aged 18-64, including those who are dependent on mechanical ventilation
- Individuals diagnosed with HIV/AIDS

Persons included in the HC-LTC waiver population will be required to enroll in Healthy Connections Medicaid. The state will determine eligibility for the waiver. The role of the MCOs will be to provide assessment information at the time of annual re-evaluation using the state approved assessment tool. MCOs will conduct outreach to members as they do

today to provide reminders and assist with ensuring members respond to requests for information related to annual redeterminations.

Financial Eligibility for Consolidated Waiver

SCDHHS will continue to administer the Medicaid financial eligibility process. Persons who are already financially eligible when HC-LTC starts will not need to go through a different or additional financial eligibility process prior to enrollment in the HC-LTC waiver. New applicants will still need to be determined financially eligible for the program.

To facilitate continuous eligibility of HC-LTC participants, SCDHHS will provide MCOs with eligibility renewal date information so MCOs can assist participants with the regular eligibility renewal process.

Level of Care Process

Persons who are clinically eligible for waiver services when HC-LTC starts will not need to go through a new level of care assessment prior to enrollment in HC-LTC. Persons who are seeking waiver services for the first time will have a level of care assessment as part of the overall eligibility determination process.

SCDHHS will retain final authority for waiver level of care determinations and redeterminations.

Transition Plan for Waiver Participants

In developing its waiver application to consolidate the Community Choices, HIV/AIDS and Mechanical Ventilator Dependent waivers into a single HCBS waiver, SCDHHS has developed a transition plan to ensure the services covered in the HC-LTC waiver match the needs of South Carolina's current and anticipated HCBS population. As part of this transition, SCDHHS affirms that no current participant will lose waiver eligibility solely because of consolidation; all individuals receiving services today will continue to qualify under HC-LTC's intentionally inclusive eligibility criteria.

Transition Goals

Primary goals of the waiver consolidation include:

- Streamlining eligibility, assessments, and service access
- Reducing fragmentation across populations and programs
- Improving quality and accountability through unified standards
- Enhancing member experience and provider navigability
- Strengthening care coordination within the managed care model
- Preparing for future population additions such as medically complex children and OIDD-operated waivers

Eligibility Transition

As part of the transition to the consolidated waiver, SCDHHS will ensure that no current participant will lose waiver eligibility solely because of consolidation, as the new eligibility criteria are intentionally designed to include all populations currently receiving waiver services. This approach protects continuity of care for active participants while aligning eligibility with the waiver's purpose and federal requirements.

Wait List Transition

As part of the transition to the consolidated waiver, SCDHHS will ensure that individuals currently on the waiting lists for the Community Choices, HIV/AIDS, and Mechanical Ventilator Dependent waiver are moved to the waitlist for the HC-LTC waiver. Placement on the waitlist will be determined by the original application date. For individuals with multiple applications, the earliest application date will be used.

SCDHHS will maintain responsibility for waitlist management, including slot releases, approval of reserved capacity status, and ongoing review of the waitlist. As funding is available, the state will release additional waiver slots.

Managed Care Integration

As part of the broader long-term strategy, HCBS under the consolidated waiver will be integrated into the managed care service delivery model. This creates a single accountable entity for coordinating medical, behavioral, and long-term services.

MCO responsibilities will include:

- Comprehensive care coordination
- Person-centered service planning
- Monitoring of service delivery and quality outcomes
- Adherence to statewide HCBS standards
- Ensuring provider network adequacy

Transitioning Services

As illustrated in **Table 3**, the majority of services that are currently offered under the three agency-administered waivers will be available in the new waiver, including multiple services that can be self-directed. Preserving self-directed options is an important part of the new waiver design, as it allows members greater autonomy and flexibility in shaping their own care plans. Self-directed services will continue to be available, ensuring that participants who prefer to manage their supports maintain this level of choice and control.

Some services will look different under the new waiver due to the second part of Phase II, which transitions HCBS services into managed care. Those services include:

- **Telemonitoring services** are being removed because members who currently use this service will continue to receive equivalent support through enhanced case management for chronic disease within the managed care environment, ensuring their needs are fully met without requiring a separate telemonitoring waiver service. Both current and newly enrolled waiver participants that would meet previous service requirements for telemonitoring will have access to chronic disease management programs through their MCO.
- **Nursing Services** (Private Duty Nursing) are currently only available to individuals who participate in the Vent and HIV/AIDS waivers. At consolidation, nursing services will be available to anyone who is assessed and ordered to receive skilled care and meets medical necessity criteria for continuous nursing as defined in the waiver. Updates to the service description as well as monitoring of medical necessity reviews for nursing services will ensure that nursing services are only authorized for waiver participants that meet criteria.
- **Case management** that meets all current waiver case management requirements will be provided by the MCOs for waiver participants. This will include contracting with existing waiver case management providers that are actively serving waiver members for a minimum of one year.

Additional services and benefits that waiver participants will have access to through the managed care environment include:

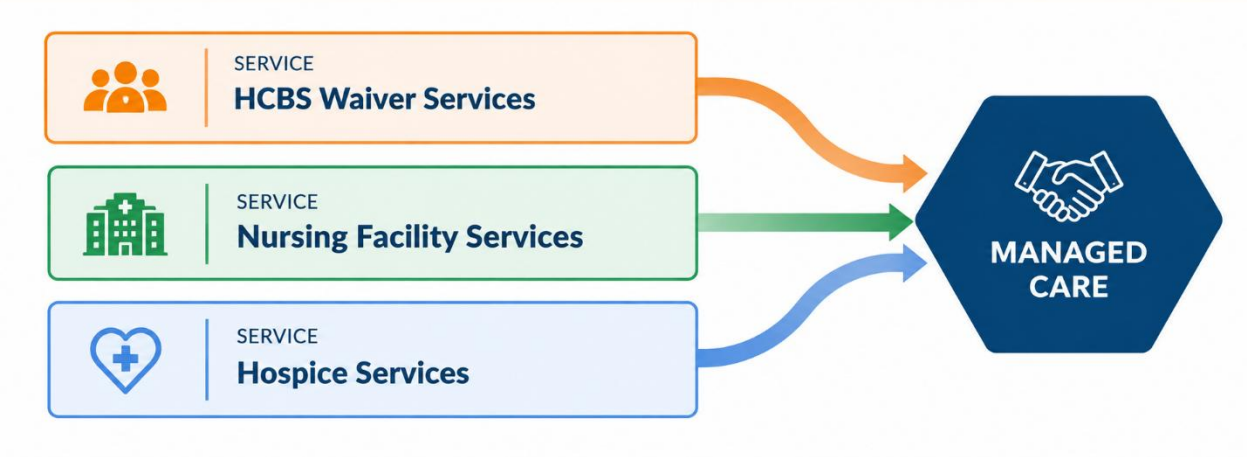
- Streamlined care coordination and social supports
- Integrated, whole person care
- Chronic disease management
- Institutional transition programs, such as programs similar to SCDHHS' current Home Again program

This design ensures all members have access to a robust suite of services while preserving the flexibility needed to support individuals with complex conditions and honoring the importance of self-directed service options.

Accessing HCBS through Managed Care

As part of Phase II of SCDHHS' plans to transition populations and services to the managed care delivery model, SCDHHS is adding HCBS waiver services, nursing facility services and hospice services into managed care. Under this model, MCOs become responsible for authorizing, coordinating, and paying for these services in addition to members' medical and behavioral health benefits. This integration allows for a single point of accountability, reduces fragmentation across care settings, and enables more holistic, person-centered care planning. By aligning long-term services and supports with the broader managed care structure, members benefit from enhanced care coordination, improved access to services, and additional value-added supports offered by health plans.

Figure 4: Service Carve-In



Goals

The goals of adding HCBS, nursing facility and hospice services into managed care are as follows:

- ✓ Create a single accountable entity for coordinating all medical, behavioral health and long-term services to reduce fragmentation across systems
- ✓ Enhance care coordination by aligning HCBS, nursing facility, hospice and State Plan services within one unified delivery model
- ✓ Improve whole-person care, ensuring members receive integrated supports that address clinical, functional and social needs
- ✓ Increase access to services through MCO-provided care coordination, network management and outreach

- ✓ Expand availability of value-added supports, such as telehealth, caregiver resources, chronic disease management and other non-traditional benefits offered by MCOs
- ✓ Streamline administrative processes by eliminating duplicative authorizations, assessments and parallel management systems
- ✓ Strengthen quality oversight with consistent standards, performance measures, and accountability mechanisms across all LTSS and HCBS populations
- ✓ Support long-term sustainability by enabling managed care organizations to use data, care management and coordinated service delivery to help prevent avoidable institutionalization

Services

The following HCBS services and services provided by hospice and nursing facility providers will be covered by the contracted managed care organizations or via subcontracts with existing case management providers in South Carolina.

HCBS Services

- Adult Day Health Care
- Adult Day Health Care Nursing
- Companion Care, Agency
- Home Accessibility Adaptation - Environmental Modifications
- Home-Delivered Meals
- Private Duty Nursing
- Personal Care Services
- Personal Emergency Response System
- Pest Control
- Respite
- Self-directed Attendant Care Services
- Self-directed Companion Care
- Specialized Medical Equipment, Supplies, and Assistive Technology

Hospice Services

In order for a Medicaid beneficiary to be eligible to elect hospice care under Medicaid, the beneficiary must be certified as being terminally ill. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the disease runs its normal course

The services below are covered hospice services:

- Nursing care provided by or under the supervision of a registered nurse.
- Medical social services provided by a social worker who has at least a bachelor's degree and is working under the direction of a physician.

- Physicians' services provided by the hospice medical director or physician member of the interdisciplinary group. Such services must be performed by a Doctor of Medicine or osteopathy.
- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.
- Short-term inpatient care provided in either a participating hospice inpatient unit or a participating hospital or nursing home that additionally meets the special hospice standards regarding staffing and patient areas. GIP care may be required for procedures necessary for 14 pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a nursing home.
- Medical appliances and supplies, including drugs and biologicals. Only drugs used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered DME as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written POC.
- Home health aide services furnished by qualified aides. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse.
- Homemaker services, including assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the POC.
- Physical therapy, occupational therapy and speech-language pathology services provided for purpose of symptom control or to enable the individual to maintain activities of daily living and basic functional skills

Nursing Facility Services

A nursing facility is a health-related facility that fully meets the requirements for state nursing facility licensure and must be surveyed for compliance with the requirements of participation in the Medicaid program by the South Carolina Department of Public Health (DPH) Bureau of Certification and be certified as meeting federal and state requirements of participation for long-term care facilities. All individuals desiring Medicaid payments for nursing facility care must be certified as meeting the level of care criteria for nursing home placement. Covered services include:

- **Resident Care**: The provider accepts responsibility to provide the care needed to any person who is admitted to that facility. The provider further agrees that care shall be provided under the direction of the attending physician in accordance with state licensing regulations and, when appropriate, in accordance with applicable federal and state regulations. Responsibility for care cannot be ended until the attending physician discharges the resident from the facility or needed care is arranged through alternate placement. SCDHHS may assist in arranging alternate placement when requested by the provider.
- **Skilled Nursing Services:** All nursing care facilities must be able to provide skilled nursing services to all residents certified as skilled level of care residents.
- **Intermediate Nursing Services**: All nursing care facilities must be able to provide nursing and personal care services to all residents certified as intermediate level of care residents.
- **Subacute Care**: Subacute care is care provided to the totally ventilator-dependent Medicaid resident in need of less than acute hospital services and who meets level of care criteria for nursing facility services.
- **Complex Care Service:** Complex Care is a program that targets Medicaid-eligible hospital patients who no longer require hospitalization but meet the nursing facility level of care. The program is intended to provide financial incentives to enrolled nursing facilities who admit Medicaid members with complex care needs.

Money Follows the Person – Home Again

The Home Again program is designed to assist eligible individuals who live in a skilled nursing facility or a hospital to move back into their homes and communities. SCDHHS was awarded a Money Follows the Person (MFP) grant from the Centers for Medicare & Medicaid Services in 2013 to develop Home Again program.

To be eligible for the program, an individual must:

- ✓ Currently reside in a skilled nursing facility or hospital
- ✓ Have been in the institution for at least 60 consecutive days
- ✓ Be on Medicaid payment for at least one day before transitioning
- ✓ Meet either Intermediate or Skilled Level of Care
- ✓ The grant targets individuals that are in an institutional setting for short or long-term

Depending on the participant's needs, the services provided by the program may vary. Examples of services include Transition Coordination, which will help participants transition to the community setting, and a Case Manager provider that will assist in requesting and monitoring HCBS waiver services that participants will need to stay safe in the home.

This program has shown great success in South Carolina and as such, SCDHHS will be requiring the managed care organizations to offer additional benefits similar in scope and benefit to the individuals who are currently eligible to participate in the program as part of Phase II.

To view more information on SCDHHS' current program, visit: https://www.scdhhs.gov/resources/programs-and-initiatives/home-again

Transition Plan: Authorization, Payment and Continuity of Care

During Phase II, prior authorization requirements and payment for Medicaid-covered HCBS waiver services, nursing facility services and hospice services will transition from being administered by SCDHHS through the FFS system to being managed and paid directly by the member's Medicaid MCO. This shift establishes the MCO as the central entity responsible for authorizing, coordinating, and reimbursing these services.

MCOs will be required to contract with all active HCBS providers for a minimum of one year. SCDHHS anticipates that all providers will be contracted with the MCOs and service authorizations will be in place on day one of transition. As an added protection, a 90-day continuity of care period for services will begin on July 1, 2027, to ensure a seamless transition for members and providers. MCOs are required to pay claims for authorized services regardless of a provider's network status and must:

- Honor all existing service authorizations without requiring new or additional authorization from providers; and
- Reimburse previously authorized services at 100% of the applicable Medicaid FFS rate unless a contracted rate has already been established.

Coverage of nursing facility and hospice services will also be fully transitioned to managed care, building on the work completed in Phase I when medical services for members residing in nursing facilities were initially added. This approach ensures unified service coordination and reduces fragmentation across care settings. SCDHHS will establish a minimum fee schedule for hospice room and board, hospice services and nursing facility services.

This information will also be published in a Phase II-specific continuity of care MCO policy.

Information Technology (IT) and Project Management Considerations

SCDHHS' Information Technology (IT) changes for Phase II are driven by program level policy decisions and the system updates required to support the Long-Term Care (LTC) services and CLTC waiver program(s). These changes require coordinated efforts across internal SCDHHS systems, external MCO systems, and providers, while remaining aligned with the agency's broader modernization initiatives and their associated dependencies and cutover timelines.

To manage this work, the agency's Project Management Office (PMO) has established a dedicated team to oversee the Phase II initiative using a holistic, enterprise-wide approach. The team will follow a structured Project Management Methodology that incorporates defined System Development Life Cycle (SDLC) checkpoints and approvals.

This methodology aligns internal SDLC processes and external MCO and provider requirements. The initiative will employ standard checkpoints and deliverables within each project phase to validate readiness, manage dependencies, and ensure quality and oversight. Team will also place special emphasis on areas of known risk.

Given the number of critical system and business dependencies, the project will also include explicit implementation-readiness checks covering end-to-end testing, claims and encounters processing, MCO readiness, workforce readiness, and fallback procedures, confirming that the initiative only proceeds when required components are in place. Coordination with MCOs and their downstream vendors will be critical to Phase II. System and operational updates will be required to support additional services, case management activities, new data and reporting requirements, and the establishment or modernization of bi-directional interfaces with SCDHHS necessary for complete integration.

Internal system impacts will involve Phoenix, the Medicaid Management Information System (MMIS), the Encounter Processing System (EPS), and related enrollment and case management processes (see ***Appendix 4*** for current system descriptions). Phoenix will require updates to support revised waiver waitlist, adjustments to the waiver service array,

and new functional logic, while preparing for potential retirement of selected legacy modules. MMIS updates are needed to support the transition of existing waiver populations to the unified waiver and to implement managed care-related updates. These updates will be done in coordination with Maximus, the State's enrollment broker. Reporting updates will be necessary for Management and Administrative Reporting System (MARS) and Transformed Medicaid Statistical Information System (T-MSIS) for CMS. The Data Operations Hub (DOH) will also require updates to ensure accurate capture, transformation, and transmission of new waiver and MMIS data elements. EPS and related data exchanges will need enhancements to support waiver-specific encounter data, timing variations, and updated submission requirements.

In parallel, the State is implementing HHAeXchange as a data broker and state-level aggregator to streamline information exchange between Providers and MCOs. The platform will support provider claims submission, service authorizations, Electronic Visit Verification (EVV), Self-Directed Services financial management (FMS), and LTSS reporting, while providing standardized, bi-directional communication across provider entities and the MCOs. Below is a table outlining current Phoenix/MMIS and future state HHAexchange functionality:

Table 4: System Model Comparison

	Current — Phoenix/MMIS	New — HHAeXchange/MCOs
Provider Claims Submission	✓	✓
Service Authorizations	✓	✓
Provider Documentation/Repository	✓	✓
Electronic Visit Verification	*Closed-system*	*Open Network*
Self-directed Services Supports (FMS)	*Subcontractor*	*Included*
LTSS Reporting	*Limited*	*Comprehensive*
Create Agency-required Encounters	*N/A*	✓

The Phase II implementation will also require updates to communication and public-facing channels, including member and general-public notification systems, MCO websites and MCO marketing materials, State and vendor call center scripts and workflows, the SCDHHS website, and related communication materials, forms and notices. These updates will help ensure clear and consistent information is provided to members, providers, and stakeholders throughout the transition.

Figure 5 presents a high-level preliminary schedule of milestones[2] for Phase II.

Figure 5: Medicaid Managed Care Transition Timeline (2026–2027) (as of Sep 2026)



Preliminary planning project GANTT. This timeline is contingent upon CMS approvals, overall MCO and System Readiness, and coordinated outreach to members and providers.

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[2] Preliminary timeline is contingent upon CMS approvals, overall MCO and System Readiness, and coordinated outreach to members and providers.

Table 5: Preliminary Timeline

Presents the detailed preliminary schedule of milestones for Phase II.

Milestone	Date Complete	Milestone Description
Research & Planning	Spring 2026	Establish goals, project scope, work breakdown structure, and timeline; determine EVV/HHAX role; and begin procurement for OCM support.
Current State Analysis	Spring 2026	Assess current waiver operations, extract data, analyze utilization and provider patterns, and document existing "as-is" processes.
Service Design & Waiver Development	Summer 2026 – Fall 2026	Design future-state processes; conduct gap analysis; define service package for new consolidated waiver, cost estimates, and rate cells.
Readiness Assessments (Agency & MCO)	Fall 2026	Conduct provider/MCO impact reviews, assess obstacles, update policies and contracts, and complete organizational alignment to support the service addition and consolidated waiver.
Communications Development & Rollout	Spring 2026 – Summer 2026	Develop strategy, communication plans, public hearing timeline, and member/provider materials; execute full communication rollout.
CMS Compliance & Submissions	Spring 2026 – Fall 2026	Finalize transition plan, state plan amendment (SPA) needs, and draft waiver application; submit 1915(b) and (c) waivers and complete CMS approval.
MCO Contract Updates	Winter 2026- Summer 2027	Finalize the MCO contract requirements, complete, finalize sub-contractor agreements, submit MCO contracts for review, finalize rates and sign contracts.
Requirements Definition (BRDs)	Summer 2026 – Winter 2026	Conduct requirement sessions and complete business requirements documentation to support system changes.
System Design	Fall 2026 – Winter 2026	Complete system design sessions with MMIS (Clemson), Maximus, and Phoenix. Conduct relevant design discussions with the various MCOs.

Milestone	Date Complete	Milestone Description
System Development	Winter 2026 – Spring 2027	Build required system changes across all platforms and implement parallel development for MCO systems.
System Testing	Winter 2026 – Spring 2027	Define test plans and conduct internal, vendor, and MCO testing, including TMSIS validation.
User Acceptance Testing	Spring 2027	Conduct user acceptance testing which includes Trading Partner Testing.
Training Development	Fall 2026 – Winter 2026	Identify training needs, build training materials, and deliver training for internal and external stakeholders.
Training Delivery	Winter 2026 – Summer 2027	Deliver training to internal and external stakeholders, including Provider contracting and training. Training to include both Business Process and System Training.
Operational Readiness	Winter 2026 – Spring 2027	Develop the deployment plan and validate technical and data readiness. Validates the completion of testing and organizational readiness.
Go-Live Preparation	Spring 2027- Summer 2027	Finalize checklist for go/no-go readiness and end user communications.
Go-Live	Summer 2027	All system and operational changes fully deployed.

Authorities

State Plan

SCDHHS has already amended attachment 3.1-F (managed care) to reflect mandatory enrollment in managed care for the eligibility groups specified in the state plan attachment. Hospice services will need to be added to attachment 3.1-F as approved state plan services to be delivered by the MCO. Nursing facility services for 21 or older are already included in state-plan approved service delivered by the MCO.

1915(c) Authority

The Medicaid HCBS waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

1915(b) Authority

Section 1915(b) of the Social Security Act provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, state wideness, and freedom of choice. Because these program designs restrict enrollees' freedom of choice, Section 1915(b) waivers are often referred to as freedom-of-choice waivers. The application requires states to show that the Section 1915(b) waiver will be cost effective, meaning that its use will not cause expenditures to be higher than they would have been without the waiver.

Tribal Consultation

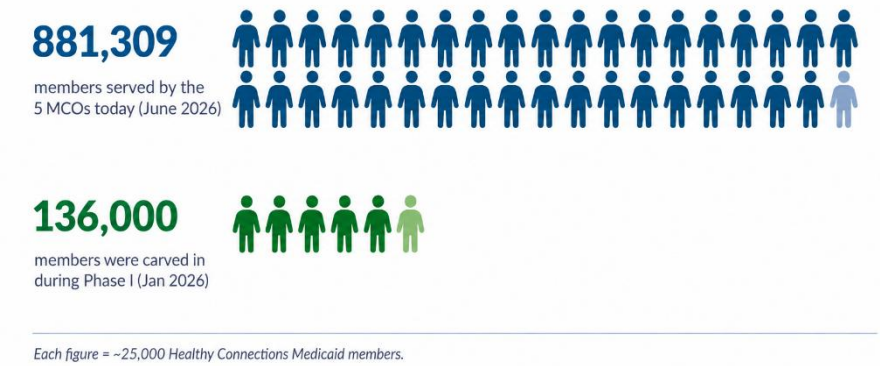
In accordance with state plan and 1915(c) requirements, tribal consultation will be conducted no less than 60 days prior to submission of a waiver application to CMS. Monthly calls occur with the Catawba Indian Nation and Indian Health Services to provide direct tribal consultation. Members of the Catawba Indian Nation also receive information through the state's Medicaid Advisory Council advisements and meetings.

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Population Impact

Effective Jan. 1, 2026, SCDHHS added approximately 136,000 members who are 18 years or older, enrolled in the Community Choices, HIV/AIDS and Mechanical Ventilator Dependent waivers, residing in a nursing facility, or dually enrolled in Medicaid and Medicare into one of the state's managed care plans.

Figure 6: Healthy Connections Members and the Managed Care Transition



Phase II is expected to impact approximately 32,332[3] Healthy Connections Medicaid members. This includes all members who are anticipated to receive waiver services under the new waiver or have a history of receiving nursing facility or hospice services and were still eligible as of June 2026. **Figure 7** shows the distribution of impacted members by managed care organization.

Figure 7: Impacted Members by Managed Care Organization



[3] Estimated member impact is based on distinct counts of Medicaid members as of June 2026, who were eligible and had recently used waiver, nursing facility care, or hospice care services. These counts were calculated using current service authorizations and recent claims data extracted in July 2026.

Eligibility

SCDHHS will ensure that current members maintain their waiver eligibility, as the new eligibility criteria for the HC-LTC waiver are intentionally designed to include all populations currently receiving waiver services.

Outreach

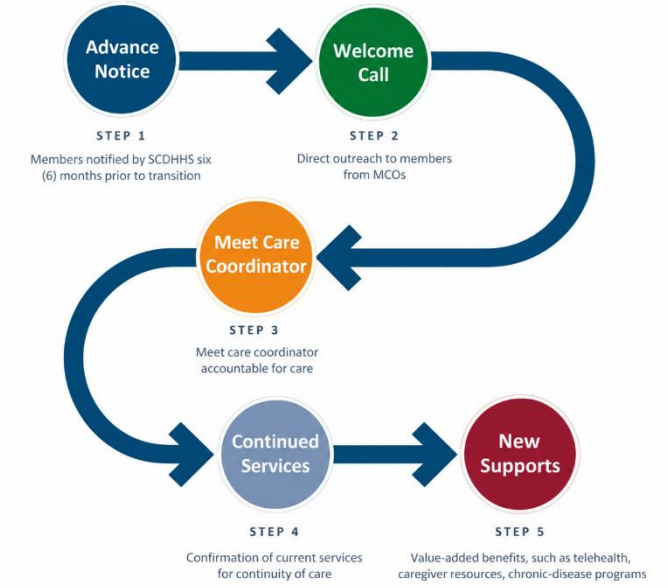
SCDHHS will implement a streamlined outreach effort to help members understand and navigate both the transition of HCBS, nursing facility and hospice services into managed care and the consolidation of three waivers into one statewide HCBS waiver.

Members will receive clear advance notices from SCDHHS at least six (6) months prior to transition and will explain what is changing, what will remain the same, and how their services will continue. MCOs will follow with direct outreach—welcome calls, care coordinator introductions, and confirmation of current services and providers—to ensure continuity of care and address any questions.

Targeted support will be provided to members with complex needs, dually eligible individuals and those who self-direct their services. Outreach materials will highlight continuity protections, new supports available under managed care and how to access help.

Information will be shared through mail, phone, digital messages (where available), and community partners. MCOs will track outreach attempts and report member concerns so SCDHHS can monitor the transition and resolve issues quickly.

Figure 8: What the Transition Looks Like for a Member



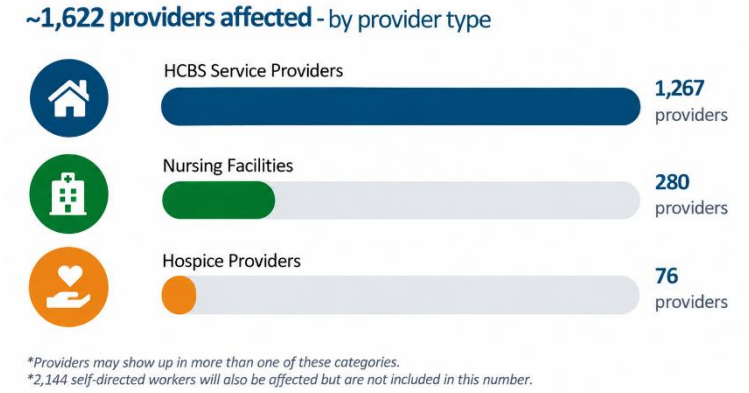
Provider Impact

This phase is expected to affect approximately 1,622[4] providers. This includes approximately:

- 1,267 HCBS service providers;
- 280 nursing facilities; and
- 76 hospice providers

**Providers may show up in more than one of these categories*
**2,144 self-directed workers will also be affected but are not included in this number.*

Figure 9: Provider Affected by Phase II Carve In



Outreach

To support a smooth and coordinated transition of HCBS into the managed care environment, SCDHHS is implementing a proactive and structured provider outreach strategy. This approach ensures that MCOs maintain seamless continuity of care for members, minimize service disruption, and establish early, meaningful engagement with HCBS providers who will serve participants under the new waiver.

SCDHHS will supply each MCO with a comprehensive listing of HCBS providers currently serving their enrolled members. Using this information, MCOs will be required to conduct direct outreach to existing providers to confirm their willingness to continue serving members under managed care, communicate key transition expectations, and identify any provider needs or barriers that may affect service continuity. This outreach step is critical to ensuring that members retain access to their preferred and established providers throughout the transition period.

The MCO must also operate provider services functions at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday). Provider services functions include, but are not limited to, the following:

[4] Provider impact counts reflect distinct providers who delivered waiver, nursing facility, or hospice services to Medicaid members who were eligible as of June 2026. These estimates were developed using current service authorizations and recent claims data extracted in July 2026. Providers may appear in more than one category. Self-directed workers are affected but are not included in these totals.

- Assisting providers with questions concerning the eligibility or enrollment status of HC-LTC participants;
- Assisting providers with the MCO's prior authorization and referral procedures;
- Assisting providers with claims payment procedures and handling provider disputes regarding outstanding claims;
- Facilitating transfer of participant medical records among medical providers, as necessary;
- Coordinating the administration of out-of-network services.

This outreach and support framework ensures that providers are not only informed but equipped to deliver high-quality services under managed care. By establishing early communication channels, offering hands-on operational support, and ensuring providers have reliable access to an MCO point of contact, SCDHHS is committed to minimizing disruptions and preserving the essential provider relationships that form the backbone of HCBS delivery in South Carolina.

Provider Enrollment

All HCBS providers are enrolled as a single provider type, therefore, to facilitate a streamlined enrollment process, MCOs will receive a data file of providers and services authorized for their enrolled members. Due to member movement to the managed care environment in Phase I, credentialing with the MCOs will begin well in advance of the effective go-live date, to ensure that providers have contracts in place, are able to bill for services, and are prepared to continue service delivery through the MCOs on day 1.

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Training

To ensure consistent, high-quality delivery of services within the new waiver and managed care environment, SCDHHS in coordination with HHAeXchange and in partnership with the MCOs will implement a comprehensive provider training program. This training framework is designed to promote compliance with Medicaid policies, strengthen care quality and support a smooth transition for providers delivering HCBS within managed care.

MCOs will be responsible for establishing and maintaining a structured provider training program that ensures all contracted providers, subcontractors, and their staff understand and comply with Medicaid requirements. As outlined in the MCO contract, required elements include:

- Mandatory training for all employees, in-network providers, and subcontractors on Medicaid Managed Care Program policies, procedures, laws, and regulations, including program updates and operational expectations.
- Ongoing provider training, with updates delivered whenever program changes occur, to ensure adherence to the most current Medicaid requirements.
- At least one annual benefit/direct-service provider training session held across four or more regional locations statewide, ensuring geographic accessibility for providers.
- Annual provider training plan, developed and maintained by each MCO, and submitted to SCDHHS for review to ensure alignment with state expectations.

Appendices

Appendix 1: Covered Services Under Consolidated Waiver

- Adult Day Health Care
- Adult Day Health Care, Nursing
- Companion Care, Agency
- Home Accessibility Adaptation - Environmental Modifications
- Home-Delivered Meals
- Private Duty Nursing
- Personal Care Services
- Personal Emergency Response System
- Pest Control
- Respite
- Self-directed Attendant Care Services
- Self-directed Companion Care
- Specialized Medical Equipment, Supplies, and Assistive Technology

Appendix 2: Participant Rights and Protections

Participant Rights and Protections

SCDHHS' contracts with managed care organizations will specify participant rights and responsibilities and will require the managed care organizations to notify participants of their rights and responsibilities in writing.

Grievance and Appeal Processes

All participants will have access to grievance and appeal processes that provide the same protections afforded currently to the population. The member handbook must provide clear information to members regarding the preparation and filing of grievances and appeals.

Protection from Abuse, Neglect and Exploitation

MCOs will be required to adopt policies to protect against and detect abuse, neglect, and exploitation. MCOs will be required to train their network providers in mandatory reporting requirements for any instance of abuse, neglect or exploitation. MCOs will also be required to notify Adult Protective Services of any situations that are reportable to this system under its statutes. MCOs will also be required to comply and ensure that their staff and providers comply with applicable laws, regulations, and policies surrounding abuse and criminal background checks.

MCOs will be required to implement a critical incident reporting and management system for incidents that occur in LTSS delivery settings including nursing facilities and community-based settings. MCOs will be required to track and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues, identify trends and patterns, identify opportunities for improvement, and develop and implement strategies to reduce the occurrence of incidents and improve the quality of services. MCOs will be required to report all critical incidents to SCDHHS. SCDHHS is in the process of procuring a new Health and Welfare Critical Incident Management System.

Appendix 3: Quality Standards

SCDHHS will apply a comprehensive quality management and performance framework to oversee the delivery of home- and community-based services (HCBS) under the consolidated waiver and the managed care delivery system. The quality standards requirements are outlined in the MCO contract. These standards will ensure that services delivered through the new waiver program meet federal and state expectations for safety, effectiveness, access, and member experience.

MCO Quality Framework

The MCO quality framework includes the following core components:

Comprehensive Quality Management and Quality Improvement (QM/QI) Program

MCOs must maintain an ongoing, comprehensive QM/QI program that evaluates and improves the quality of clinical and non-clinical services, identifies gaps in care, and implements interventions to improve outcomes for HCBS populations.

Performance Measurement and Reporting

MCOs are required to collect, analyze, and report performance data using standardized metrics such as HEDIS, CAHPS, 1915c waiver performance measures and other measures specified by SCDHHS. Submissions must support Department-led monitoring of access, quality, and outcomes across HCBS, nursing facility, and hospice services.

Accreditation and Compliance

Contractors must maintain NCQA accreditation (or equivalent) and demonstrate ongoing compliance with federal quality standards, including 42 CFR 438.330 and 438.340. Accreditation status is used by the Department as part of its oversight and performance evaluation.

Quality Assessment and Performance Improvement (QAPI)

MCOs must conduct QAPI activities focused on high-risk, high-volume, and problem-prone areas, including HCBS service delivery, transitions of care, and populations with significant functional or medical needs. Improvement efforts must demonstrate measurable and sustained progress.

Performance Improvement Projects (PIPs)

Contractors must implement PIPs—clinical and non-clinical—designed to produce significant, measurable improvement in HCBS outcomes. Projects must include defined quality measures, system-level interventions, and evaluation processes and must be reported to SCDHHS on a regular schedule.

Member Experience and Satisfaction

Quality standards require evaluation of member experience through tools such as CAHPS and analysis of complaints, grievances, and appeals. Findings must inform targeted improvement strategies, particularly for vulnerable HCBS populations.

Provider Performance and Oversight

MCOs must monitor the performance, credentials, and compliance of HCBS providers, ensuring adherence to service standards, best practices, and contractual requirements. Corrective action plans must be implemented when deficiencies are identified.

Identification of Over- and Under-Utilization

Contractors must maintain systems for detecting patterns of over- or under-utilization of services, particularly in HCBS and long-term services and supports (LTSS), and implement corrective strategies as needed.

External Quality Review (EQR) Participation

MCOs must fully participate in annual External Quality Review activities, provide required data and documentation, and implement corrective actions for identified deficiencies.

Sanctions and Corrective Actions

Failure to meet quality standards may result in corrective action plans, financial penalties, or other sanctions as described in the contract.

Appendix 4: Current Systems Descriptions

The current waiver programs rely on three major systems within the Medicaid Enterprise System (MES): Member Management System (MMS), Phoenix, and Medicaid Management Information System (MMIS). They work together to manage Medicaid eligibility, long-term care and waiver program operations, and claim adjudication. Each system plays a distinct role: MMS determines core eligibility, Phoenix manages waiver-related documentation and casework, and MMIS administers waiver eligibility indicators and processes claims. Across these systems, key programs such as hospice, nursing home, and home and community-based services depend on accurate eligibility, documentation, and claims processing. Together, they form a workflow from eligibility to service management to payment.

Member Management System (MMS) is the system responsible for determining and maintaining Medicaid eligibility. This system processes initial Medicaid application, ongoing eligibility reviews, and eligibility related updates. MMS serves as the authoritative source of Medicaid eligibility before waiver-specific steps occur. MMS sends eligibility status to MMIS.

Phoenix is the Community Long Term Care (CLTC) Case Management and waiver documentation system that maintains waiver eligibility documentation, including required assessments and supporting materials. Phoenix supports case management including service plans, case notes, and member interactions. Initial assessments for waiver services and initial waiver eligibility documentation is stored within Phoenix. This system also manages waitlists for programs with limited capacity. Phoenix receives updates from MMIS.

Medicaid Management Information System (MMIS) is the enterprise system for program administration and claim operations. As it relates to waiver services MMIS, maintains the RSP (Recipient Special Program) indicator which is how eligibility for waiver services is stored within the enterprise. The RSP and other eligibility indicators govern the nursing home, hospice and waiver claim adjudication, ensuring proper processing and payment for these services. MMIS is the system of record for financial, provider, and reporting functions.

Appendix 5: Information Technology Requirements and Overview

In order to achieve Phase II, changes are anticipated in several systems within the MES. To support the addition of these services, systems must be updated to correctly identify when services are included under a Managed Care Organization (MCO), ensure required waiver eligibility information is transmitted to the MCOs, prevent duplicate Fee-For-Service (FFS) payments, and retire some case management functions that will shift from SCDHHS operation to the managed care plans. These combined system updates will ensure seamless enrollment, eligibility, service authorization, and claims and/or encounter processing.

MMS will continue to serve as the foundation for Medicaid eligibility. While no system changes are yet to be identified for MMS, it will ensure Medicaid eligibility feeds correctly to MMIS to support managed care enrollment. There is planned functionality to enhance the member experience to allow plan preference and selection within MMS, but is not solely a part of Phase II work as it will impact the larger population. MMS will be included in end-to-end testing efforts to ensure a seamless transition to Phase II.

Phoenix will continue to support the completion and maintenance of waiver eligibility documentation and assessments required for initial assessment prior to managed care plan enrollment. Critical to the success of the managed care plans care coordination will be receiving pertinent information from the waiver eligibility process. Information will be shared with relevant care coordinators at plans. Some of the main system changes required for Phoenix will be the reduction or partial decommission of case management functions for populations that will now be managed by the MCOs. Phoenix will also need to support these modified business process workflows. Phoenix will continue to support waitlist management and communication to MCOs will be critical in facilitating any services plan conducts prior to waiver enrollment.

MMIS will require the most changes to support Phase II since it is central to program enrollment, eligibility indicators, and claims and/or encounter processing. Phase II requires RSP indicator changes to clearly identify when MCO members are eligible for waiver, hospice, nursing home or other long-term care services will be covered under managed care. RSP changes must drive downstream logic that sends waiver eligibility information to plans, prevent FFS claims payment for services included under the member's managed care benefit, and sending update enrollment segments to the enrollment broker and the plan. Presently, there are no planned changes to encounter processing within MMIS due to planned launch of a new system.

Prior to Phase II, SCDHHS also anticipates the implementation of Encounters Processing System (EPS). This system will need to support encounters from managed care plans who are providing waiver services. This will include quality or adjudication edits that enforce managed care coverage for these services. EPS will also support reporting that will allow SCDHHS to monitor the plans for required quality metrics and waiver service utilization.

End to end testing is essential to ensuring a smooth and stable launch for Phase II. Coordinating testing across all systems – MMS, Phoenix, MMIS, EPS, and vendor platforms – is required to validate that new RSP indicators, managed care enrollment, and other data exchange perform correctly. Thorough end-to-end testing confirms that waiver eligibility data flows properly to MCOs, that FFS payments are prevented when services are included under managed care, and that decommissioned Phoenix case-management functions do not create gaps in the overall workflow.